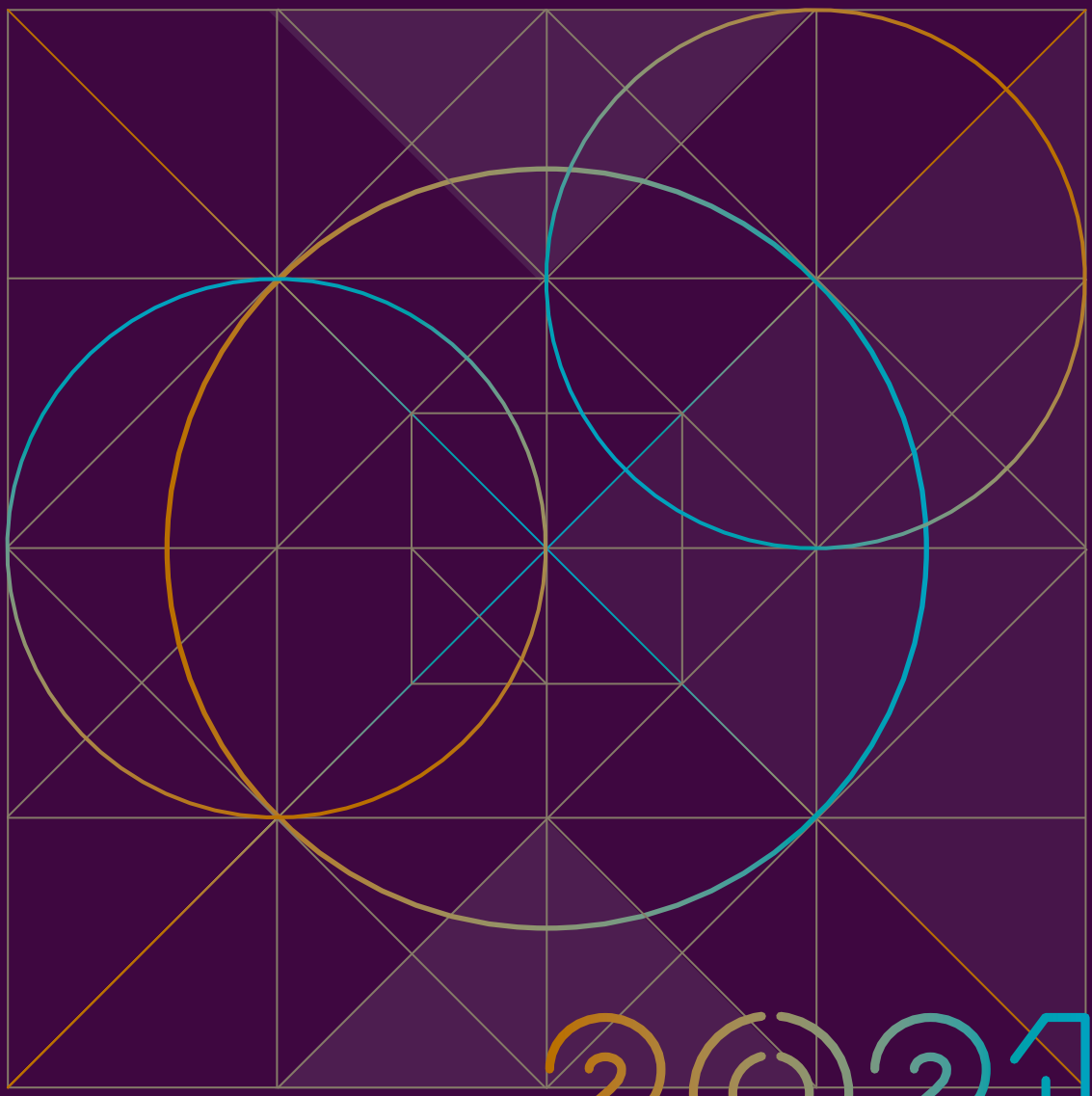
RTE

REGIONAL EUTHANASIA REVIEW COMMITTEES



ANNUAL REPORT 2021

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FOREWORD

In 2021 the Regional Euthanasia Review Committees (RTEs) received 7,666 notifications of euthanasia.[1] In seven cases they found that the physician had not acted in accordance with the due care criteria. The main conclusion is therefore once again that in the Netherlands the procedures relating to euthanasia are carried out with great care.

The vast majority of notifications are categorised as straightforward, which means they do not raise any questions after careful consideration by the committee. As is customary, this annual report describes a number of these straightforward cases. The findings of some of these cases are also regularly published on the website. Most of the RTEs' capacity is devoted to reviewing these notifications, often cases involving elderly people in a very advanced stage of a terminal illness.

The social and political debate about euthanasia continued in 2021. The RTEs do not involve themselves in this debate. They review cases on the basis of, *inter alia*, the Act[2] and the Supreme Court's interpretation of the Act, and account for their work by publishing this annual report and a selection of their findings on the website. Last year, a start was made on implementing plans for publishing all findings with their substantiation. The RTEs realise that this focuses a disproportionate amount of attention on a relatively small number of notifications, i.e. the notifications that raise questions due to their nature or the procedure followed. Although these are exceptional or borderline cases, they provide insight into the issues and dilemmas the RTEs are faced with. The variety of examples provided by the RTEs can make a useful contribution to public debate.

Over the past year, a great deal of attention has been devoted to updating the Euthanasia Code 2018. This process will be completed in the first half of 2022. The Euthanasia Code sets out the general review standards used by the RTEs, which are distilled from the RTEs' findings following review of numerous individual notifications. The Code provides clarity in advance, which is very important for physicians who perform euthanasia. They need to know where they stand. The Code is not the only standard for physicians who perform euthanasia. In 2021 a new version of the KNMG/KNMP Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide was adopted and the KNMG (Royal Dutch Medical Association) published its position paper on end-of-life decisions. This

1 *In this annual report, termination of life on request and assisted suicide are jointly referred to as euthanasia.*
2 *The Act: the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.*

was done in close consultation with the RTEs. For their part, the RTEs will discuss the updated Euthanasia Code with organisations including the KNMG, the Public Prosecution Service, the Health and Youth Care Inspectorate (IGJ) and the Euthanasia Expertise Centre (EE) prior to its adoption.
A situation in which physicians who perform euthanasia become the victims of a dispute between the various authorities concerned with euthanasia must be avoided.

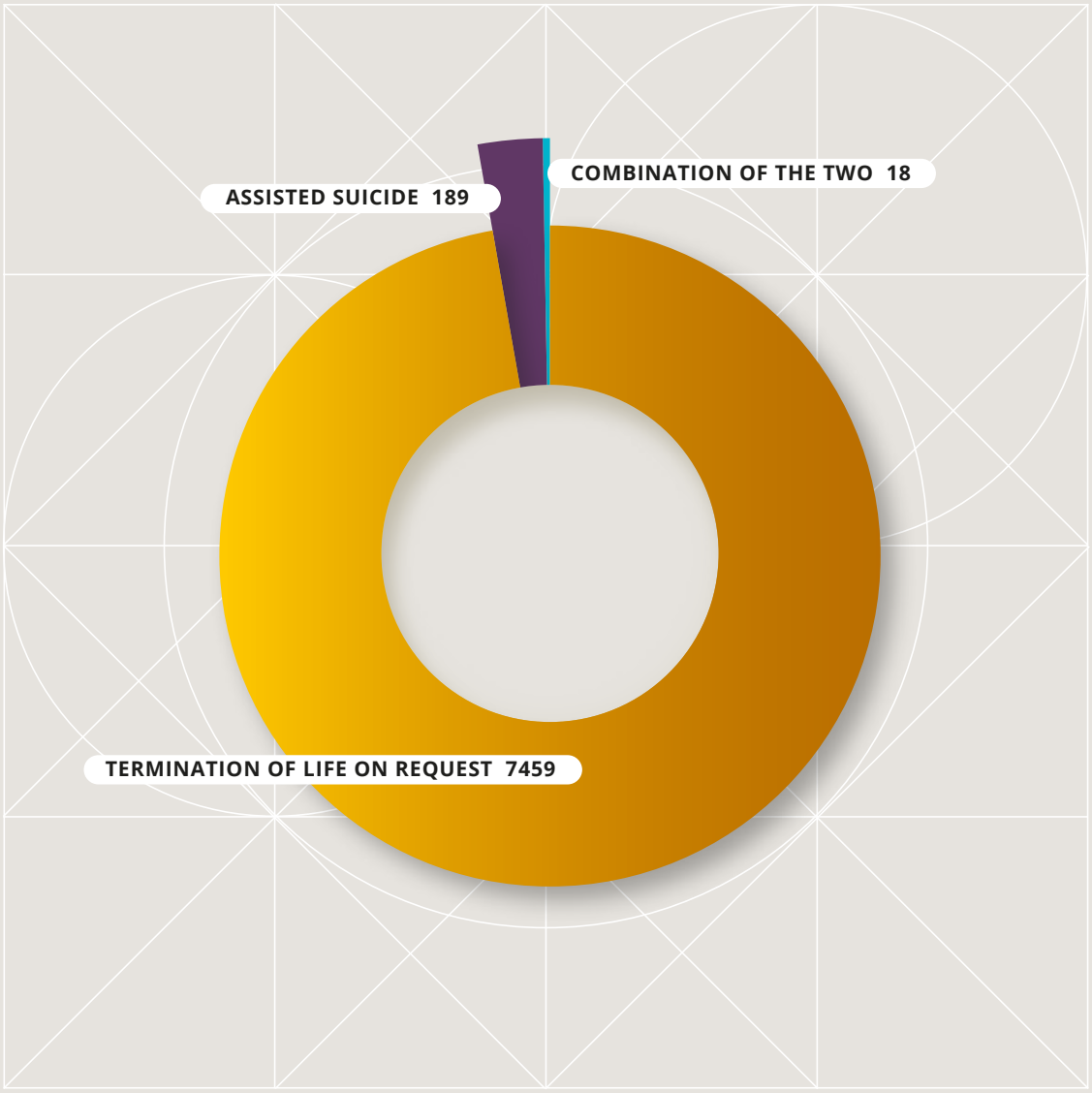
In 2021, the number of notifications of euthanasia (7,666) was 10.5% higher than in the previous year and was also higher as a percentage of the total number of deaths (170,839): 4.5% compared to 4.1% in 2020. Relatively, the increase is even greater, because in practice COVID-19 has not been observed to be independent medical grounds for euthanasia. In a handful of cases a coronavirus infection was mentioned as a secondary cause of suffering alongside to another serious condition. The excess deaths resulting from the pandemic have thus had little to no effect on the number of euthanasia cases. No explanation can be given for the increase in this number in relation to the total number of deaths, as this has not been studied yet. The fourth evaluation of the Act, which will take place in 2022 and early 2023, may shed some light on this.

The pandemic made 2021 a difficult year for the RTEs too. This was compounded by the move of all five review committees to one building in Utrecht, and the subsequent integration of the different parts of the RTE organisation (members, secretariats, process support). Many thanks to all those who went above and beyond to ensure that the day-to-day activities of the committees could continue smoothly and with due care. Thanks also go to the Ministry of Health, Welfare and Sport and the Disciplinary Boards and Review Committees (Secretariats) Unit (ESTT) for their support this year.

This was my first year as coordinating chair of what I have found to be a very solid organisation, one which scrupulously reviews every notification of euthanasia in the Netherlands on the basis of the due care criteria set out in the Act. I have been particularly impressed by the courage of patients and physicians, who together decide on a dignified end to the patient's life to relieve the patient's unbearable suffering without prospect of improvement.

JEROEN RECOURT
Coordinating chair

RATIO BETWEEN TERMINATION OF LIFE ON REQUEST AND ASSISTED SUICIDE



CHAPTER 1
FIGURES AND DEVELOPMENTS IN 2021

1 ANNUAL REPORT

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

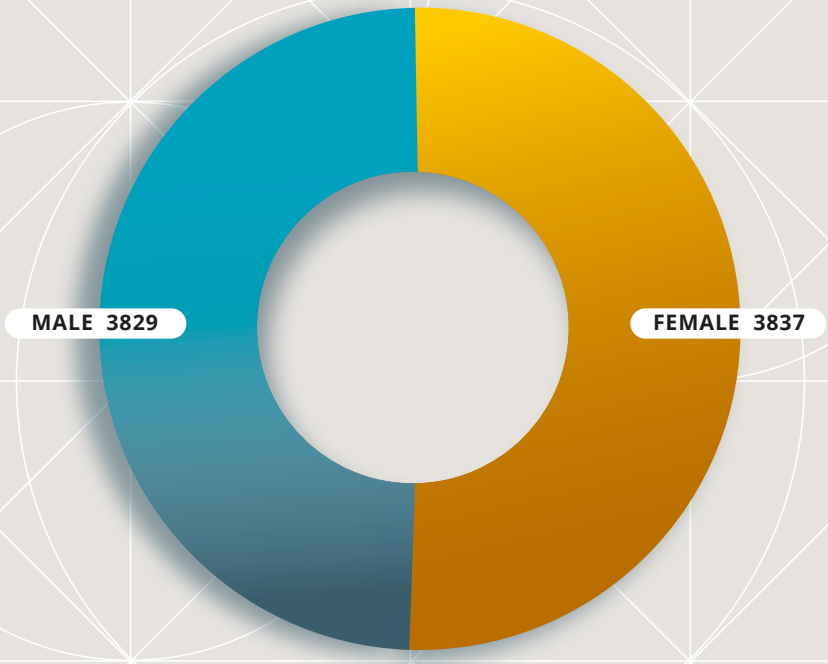
Another aim of the annual report is to give physicians and other interested parties insight into the way in which the committees have reviewed and assessed specific notifications. Chapter 2 therefore gives an extensive account of common and less common review findings.

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

For more information on the outlines of the Act, the committees' procedures, etc., see the revised Euthanasia Code 2018 and the website of the RTEs: https://english.euthanasiecommissie.nl.[3]

3 *The Euthanasia Code 2018 (revised in 2020) is under review at the time of writing. The Euthanasia Code 2022 is expected to be published in the first half of 2022.*

MALE-FEMALE RATIO



2 NOTIFICATIONS

NUMBER OF NOTIFICATIONS

In 2021 the RTEs received 7,666 notifications of euthanasia. This is 4.5% of the total number of people who died in the Netherlands in that year (170,839).[4] The number of notifications increased by 10.5% compared to 2020 (6,938). The number of notifications relative to the total number of deaths increased by 0.4 percentage points compared with 2020.

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

MALE-FEMALE RATIO

The numbers of male and female patients were, as in previous years, almost the same: 3,829 men (49.9%) and 3,837 women (50.1%). However, it is the first time since the RTEs began including the male-female ratio in their annual reports (2016) that the number of women was higher than the number of men.

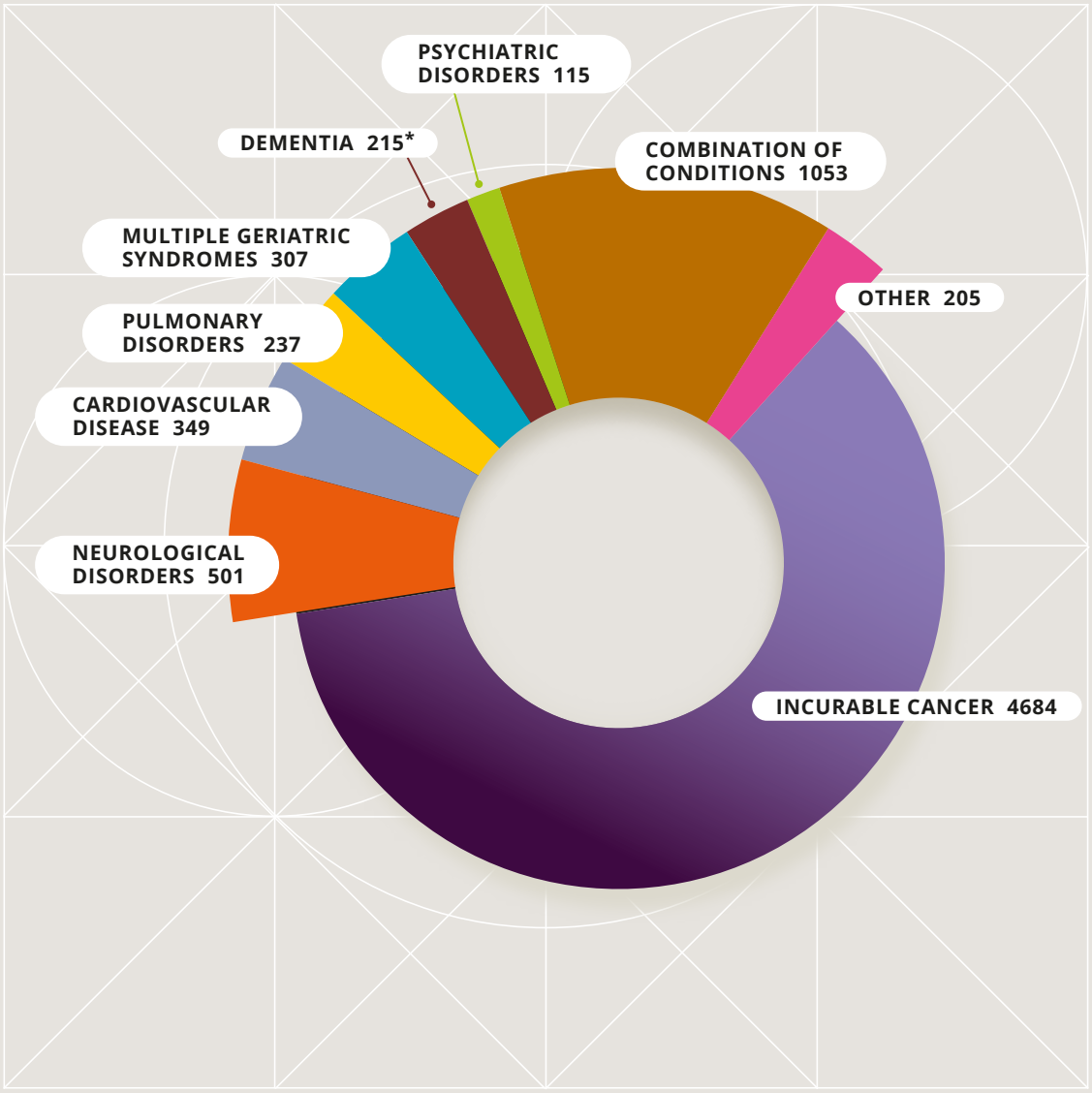
RATIO BETWEEN CASES OF TERMINATION OF LIFE ON REQUEST AND CASES OF ASSISTED SUICIDE

There were 7,459 notifications of termination of life on request (97.3% of the total), 189 notifications of assisted suicide (2.5%) and 18 notifications involving a combination of the two (0.23%). 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.

For points to consider regarding due medical care, see pages 35 ff of the revised Euthanasia Code 2018 (only available in Dutch).

4 *Source: Statistics Netherlands, 4 March 2021.*

CONDITIONS



* *early-stage dementia: 209*
(very) advanced stage of dementia: 6

CONDITIONS

MOST COMMON CONDITIONS

In 2021 89.0% (6,824) of the notifications received by the RTEs involved patients with:

- incurable cancer (4,684; 61.1%)
- neurological disorders such as Parkinson's disease, multiple sclerosis and motor neurone disease (501; 6.5%);
- cardiovascular disease (349; 4.6%);
- pulmonary disorders (237; 3.1%);

or a combination of conditions (1,053; 13.7%).

DEMENTIA

Six notifications in 2021 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 (2021-90) is described in Chapter 2 of this report. All of these notifications have been published on the website of the RTEs.

In 209 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 2021-86, described in Chapter 2, is an example.

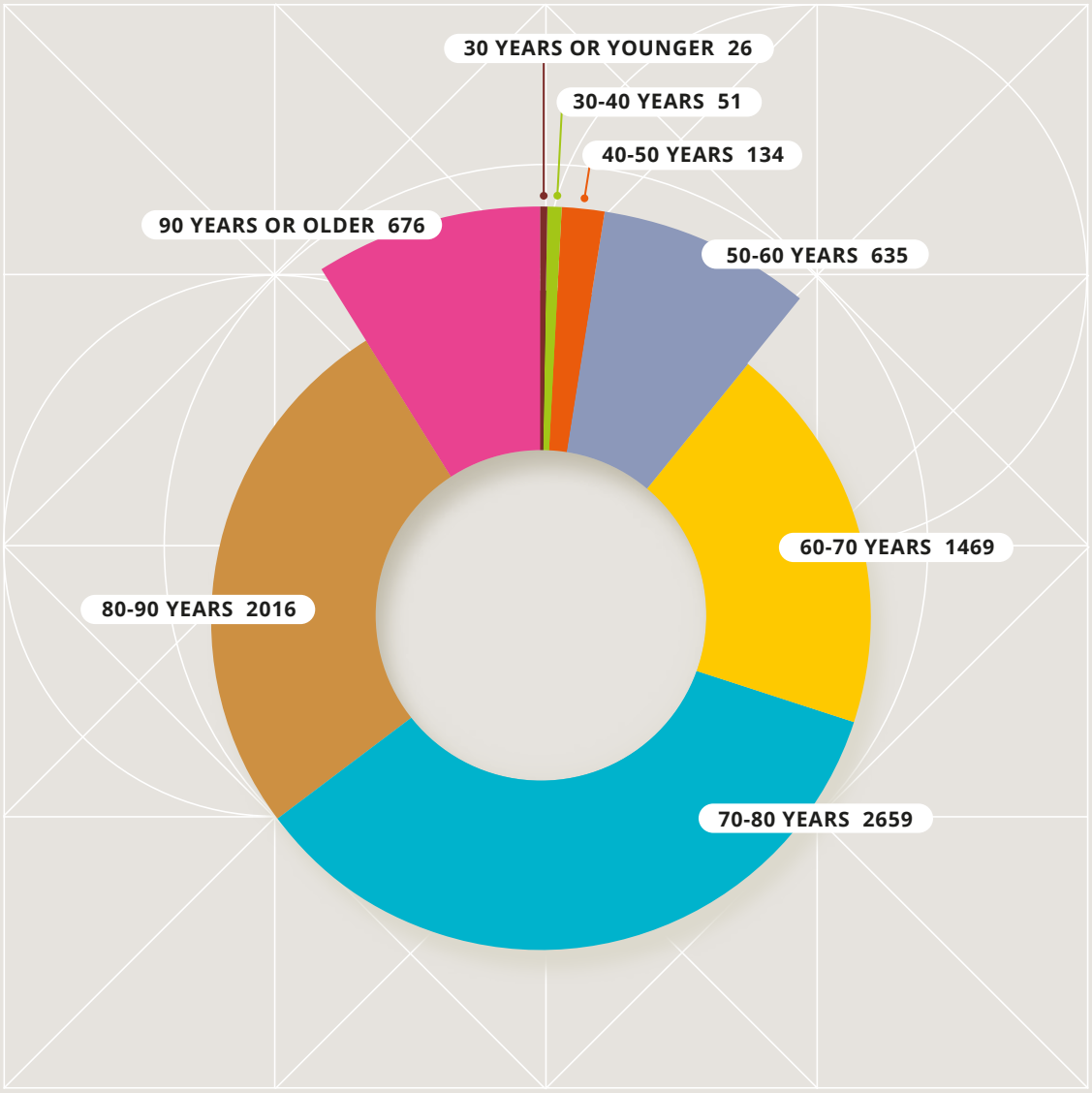
For points to consider regarding patients with dementia, see pages 46 ff of the revised Euthanasia Code 2018 (in Dutch).

PSYCHIATRIC DISORDERS

In 115 notified cases of euthanasia the patient's suffering was caused by one or more psychiatric disorders. In 51 of these cases the notifying physician was a psychiatrist, in 23 cases a general practitioner, in 3 cases an elderly-care specialist and in 38 cases another physician. In 83 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 exer-cise particular caution in cases where the patient's suffering is caused by a psychiatric disorder, as was done in case 2021-148 (described in Chapter 2).

For points to consider regarding patients with a psychiatric disorder, see pages 44 ff of the revised Euthanasia Code 2018 (in Dutch).

AGE


30 YEARS OR YOUNGER 26
30-40 YEARS 51
40-50 YEARS 134
90 YEARS OR OLDER 676
50-60 YEARS 635
60-70 YEARS 1469
80-90 YEARS 2016
70-80 YEARS 2659

MULTIPLE GERIATRIC SYNDROMES

Multiple geriatric syndromes – such as sight impairment, hearing impairment, osteoporosis (and its effects), 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 several 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 2021 the RTEs received 307 notifi-cations of euthanasia that fell into this category. A notification reviewed by the RTEs relating to multiple geriatric syndromes is included in Chapter 2 and has been published on the website (2021-54).

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

OTHER CONDITIONS

Lastly, the RTEs register cases involving conditions that do not fall into any of the above categories, such as chronic pain syndrome or a rare genetic disorder, as 'other conditions'. There were 205 such cases in 2021.

AGE

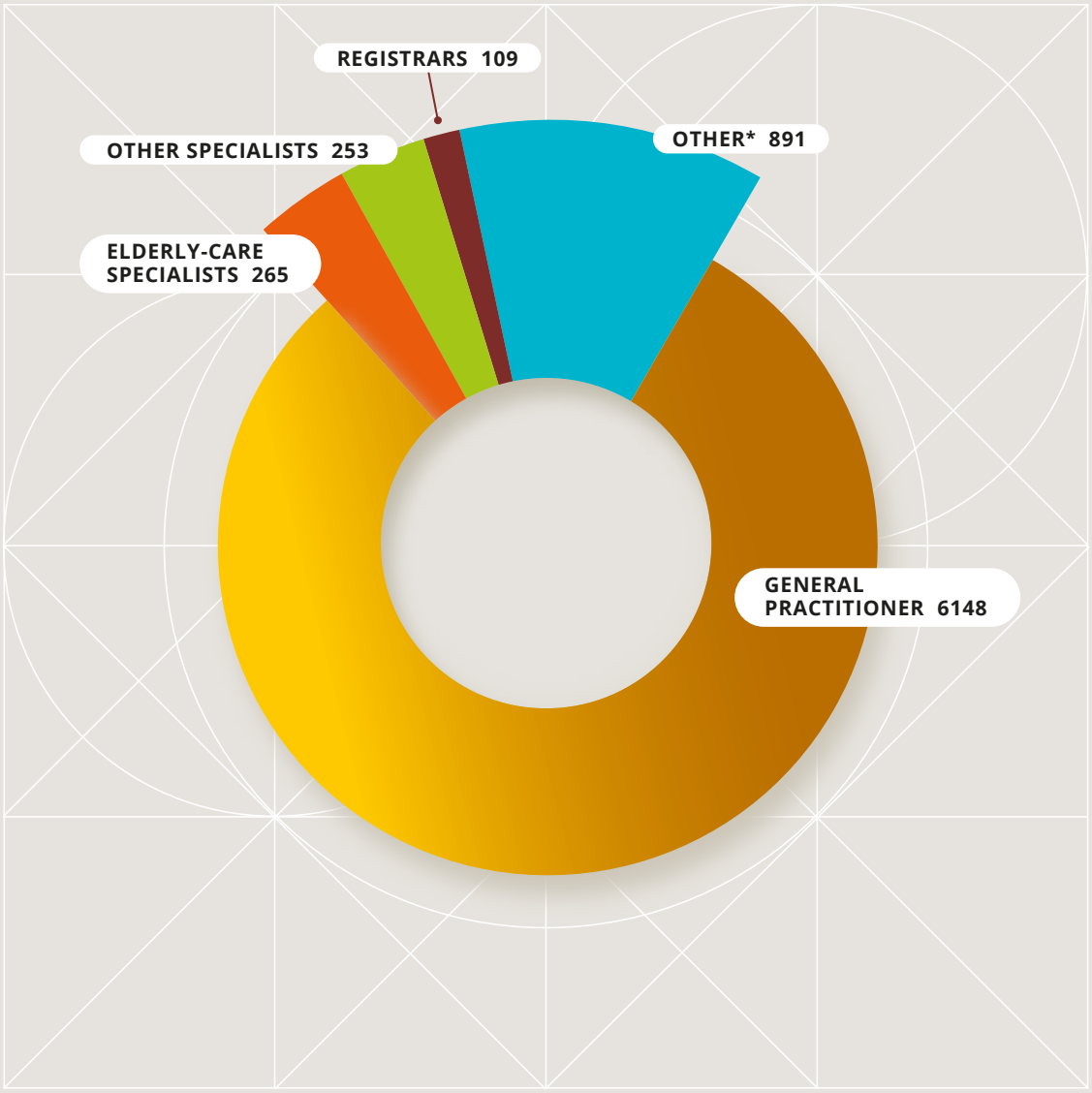
The highest number of notifications of euthanasia involved people in their seventies (2,659 cases, 34.7%), followed by people in their eighties (2,016 cases, 26.3%) and people in their sixties (1,469 cases, 19.2%).

In 2021 the RTEs reviewed one notification of euthanasia involving a minor. This notification has been published on the website (2021-02). In 30 cases the patient was over 100 years of age. The oldest patient was 105.

For points to consider regarding minors, see page 44 of the revised Euthanasia Code 2018 (in Dutch).

There were 77 notifications concerning people aged between 18 and 40. In 34 of these cases, the patient's suffering was caused by cancer and in 31 cases it was caused by a psychiatric disorder. In the category 'dementia', the highest number of notifications involved people in their eighties (89 cases), followed by people in their seventies (88 cases). In the category 'psychiatric disorders', there were 25 notifications involving people in their fifties and 22 involving people in their sixties. In the category 'multiple geriatric syndromes' most of the notifications concerned people aged 90 or older (188 cases).

NOTIFYING PHYSICIANS



** e.g. physicians affiliated with the Euthanasia Expertise Centre*

NOTIFYING PHYSICIANS

The vast majority of cases were notified by a general practitioner (6,148, or 80.2% of the total number). The other notifying physicians were elderly-care specialists (265), other specialists (253) and registrars (109). There was also a group of notifying physicians with other backgrounds (891), most of them affiliated with the EE.

The number of notifications by physicians affiliated with the EE (1,123) increased by more than 200 relative to 2020, when there were 916 notifications by this group. EE physicians are often called upon if the attending physician considers a request for euthanasia to be too complex. Physicians who do not perform euthanasia for reasons of principle or who will only perform euthanasia if the patient has a terminal condition also often refer patients to the EE. In some cases, rather than being referred by an attending physician, the patients themselves contact the EE or ask their families to do so. Many of the notifications involving patients with a psychiatric disorder came from EE physicians: 83 out of 115 notifications (over 72%). Of the 215 notifications of cases in which the patient's suffering was caused by a form of dementia, 99 (46.0%) came from EE physicians. Of the 307 notifications involving patients with multiple geriatric syndromes, 158 (51.4%) came from EE physicians.

LOCATIONS

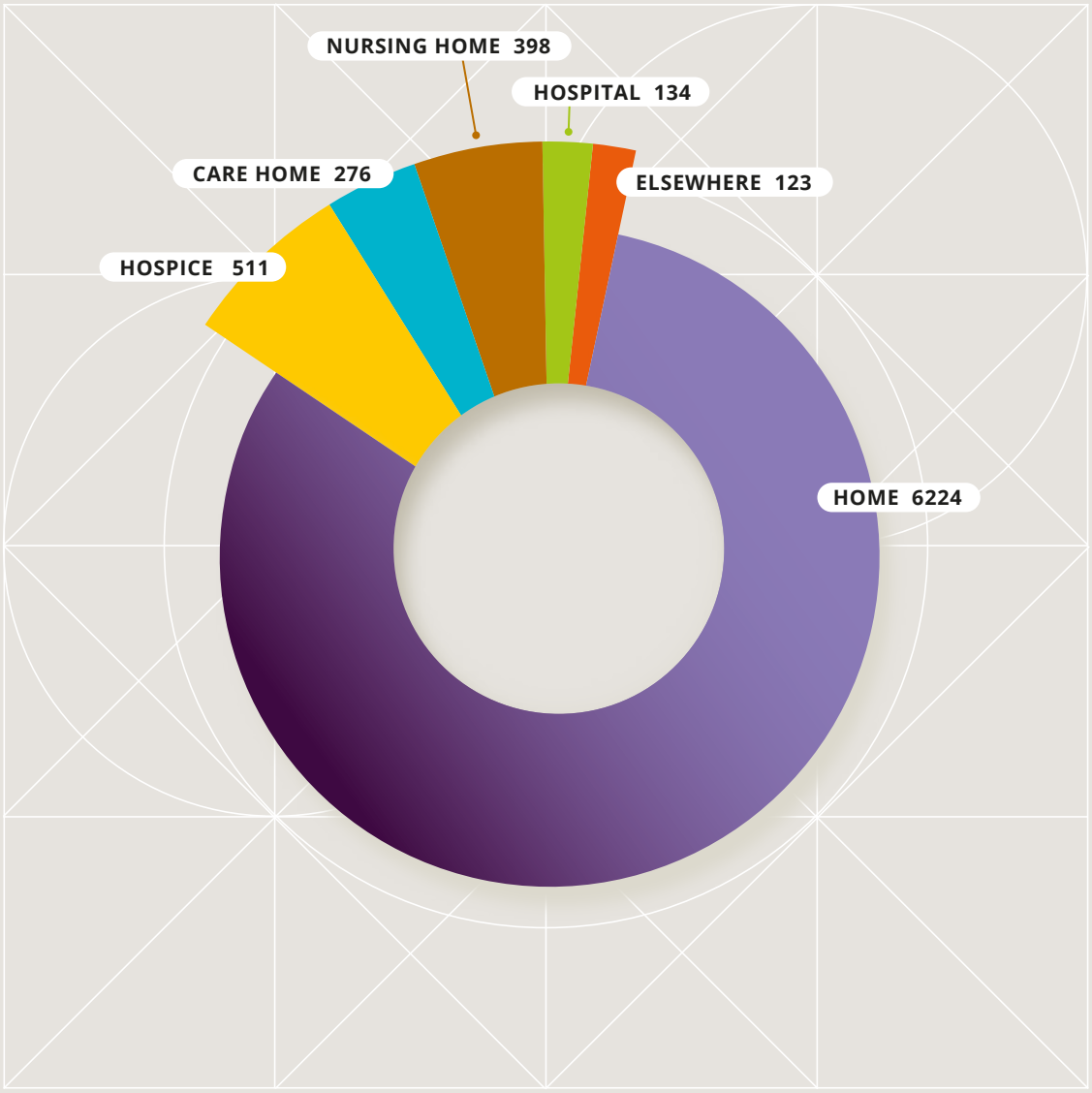
As in previous years, in the vast majority of cases the patient died at home (6,224 cases, 81.2%). Other locations were a nursing home or care home (674 cases, 8.8%), a hospice (511 cases, 6.7%), a hospital (134 cases, 1.7%) or elsewhere, for instance at the home of a family member, in a sheltered accommodation centre or a convalescent home (123 cases, 1.6%).

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.[5] In 2021, the RTEs received five notifications that mentioned specifically that organ and tissue donation had taken place after euthanasia.

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

LOCATIONS


NURSING HOME 398
HOSPITAL 134
CARE HOME 276
ELSEWHERE 123
HOSPICE 511
HOME 6224

COUPLES

In 32 cases, euthanasia was performed simultaneously on both members of a couple (16 couples). Cases 2021-22 and 2021-23 on the website are an example of this. Of course, the due care criteria set out in the Act must be satisfied in each case separately. Each partner must be visited by a different independent physician in order to safeguard the independence of the assessment.[6]

DUE CARE CRITERIA NOT COMPLIED WITH

In seven of the notified cases in 2021, the RTEs found that the physician who performed euthanasia did not comply with all the due care criteria set out in section 2 (1) of the Act. These seven cases are discussed in Chapter 2.

6 *Revised Euthanasia Code 2018, p. 31 (in Dutch).*

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 provisionally 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 cate-gory that is by definition considered non-straightforward. That category includes, for instance, cases in which the patient's suffering is caused by a psychiatric disorder. 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 and discusses it at a meeting. In 2021 it did so in 75 cases (1% 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.

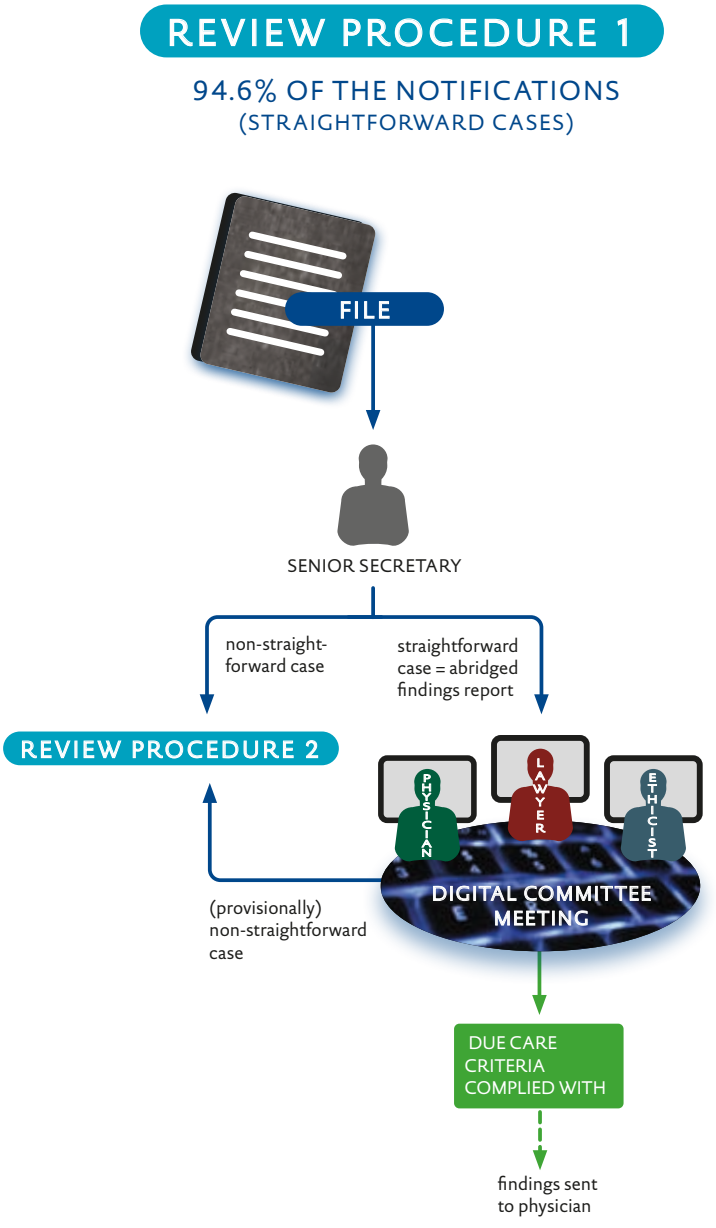
Full findings are issued in non-straightforward cases. In a full report of findings the committee explains which aspect of the notification raised questions. It also explains the considerations that led the committee to its finding: either the physician did or did not comply with the due care criteria. The committee limits its explanation to the aspect of the case that raised questions.

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

Cases 2021-05, 2021-07, 2021-36, 2021-40 and 2021-65 are included in Chapter 2 as examples of straightforward notifications. It should be noted that these are summaries of the cases in question and not of the findings sent to the physician, as in these cases the physician receives abridged findings only. Descriptions of some of the straightforward cases are published (in Dutch) on the website of the RTEs (https://www.euthanasiecommissie.nl).

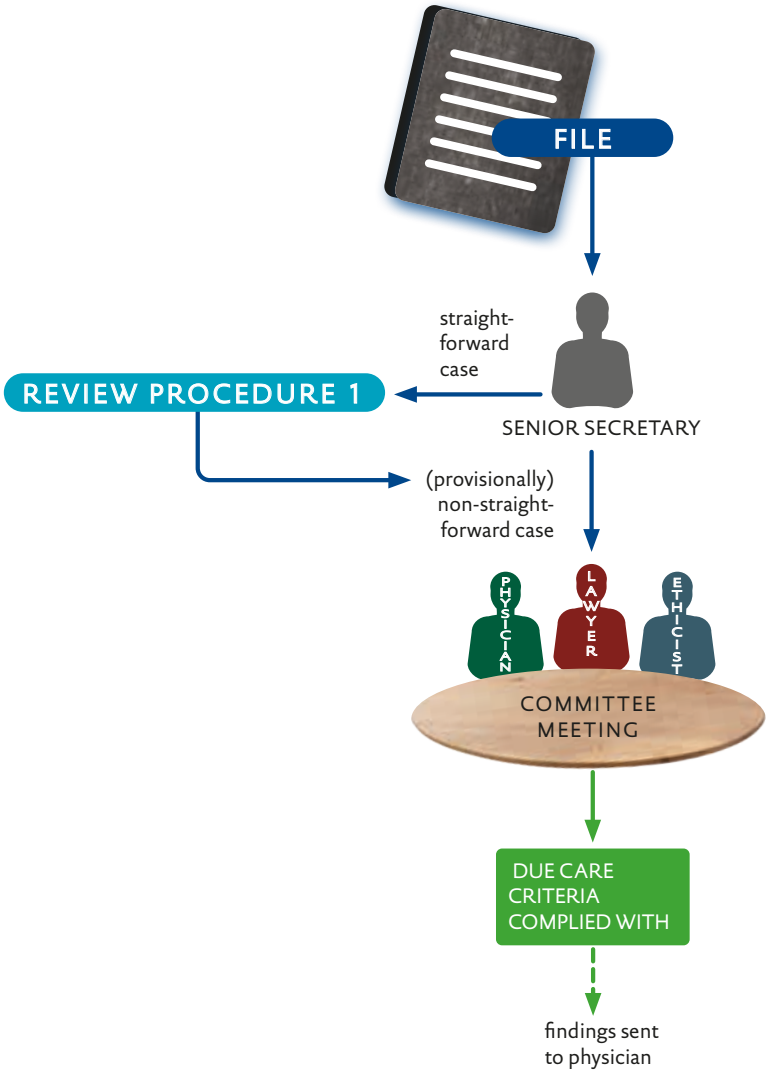
In 2021, 94.6% of the notifications received were categorised as straightforward by the secretaries of the committees.

Of all the notifications received, 5.4% were immediately categorised as non-straightforward because, for example, they involved patients with a psychiatric disorder, there were questions about how euthanasia had been performed, or because the case file submitted by the notifying physician was not detailed enough for the committee to reach a conclusion.



REVIEW PROCEDURE 2

5.4% OF THE NOTIFICATIONS
(NON-STRAIGHTFORWARD CASES)



In 2021 the average time between the notification being received and the findings being sent to the physician was 32 days. This is within the time limit of six weeks laid down in section 9 (1) of the Act, however it is three days longer than in 2020.

WRITTEN AND ORAL QUESTIONS PUT BY THE COMMITTEES

In some cases the reports completed by the physician and the independent physician and the accompanying documents do not provide enough information for the committee to be able to assess the notification. The committee can then decide to ask the physician or the independent physician for further clarification.

In 21 cases, the committee asked the notifying physician after its meeting for a further written explanation. In one case it asked the independent physician for such an explanation. These included the above-mentioned seven cases in which the committee found that the due care criteria had not been complied with.

In 23 cases the committee invited the notifying physician (and in one case the independent physician) to answer the committee's questions in person at the next committee meeting, sometimes after having first put written questions to the physician. 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. Nevertheless, the committees also regularly advised physicians on how they could improve their working methods and their notifications in the future.

COMPLEX NOTIFICATIONS

Some cases are considered to be so complex that all the RTE members and secretaries should be able to have a say in the matter. This leads to intensive 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 all the committee members and secretaries on the RTE intranet site. Notifications of cases in which a physician granted a request for euthanasia by a decisionally incompetent patient on the basis of their advance directive are handled in the same way. The committee reaches a final conclusion after studying the comments from other committee members.

The same is done in other cases where the committee feels it would benefit from an 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. Thirty cases were discussed in this way in 2021. They include the cases in which it was found that the due care criteria had not been complied with.

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. These questions generally concern issues that go beyond the scope of the cases that prompted them. 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. In 2021 the reflection chamber began updating the Euthanasia Code 2018. The updated version is expected to be published in the first half of 2022.

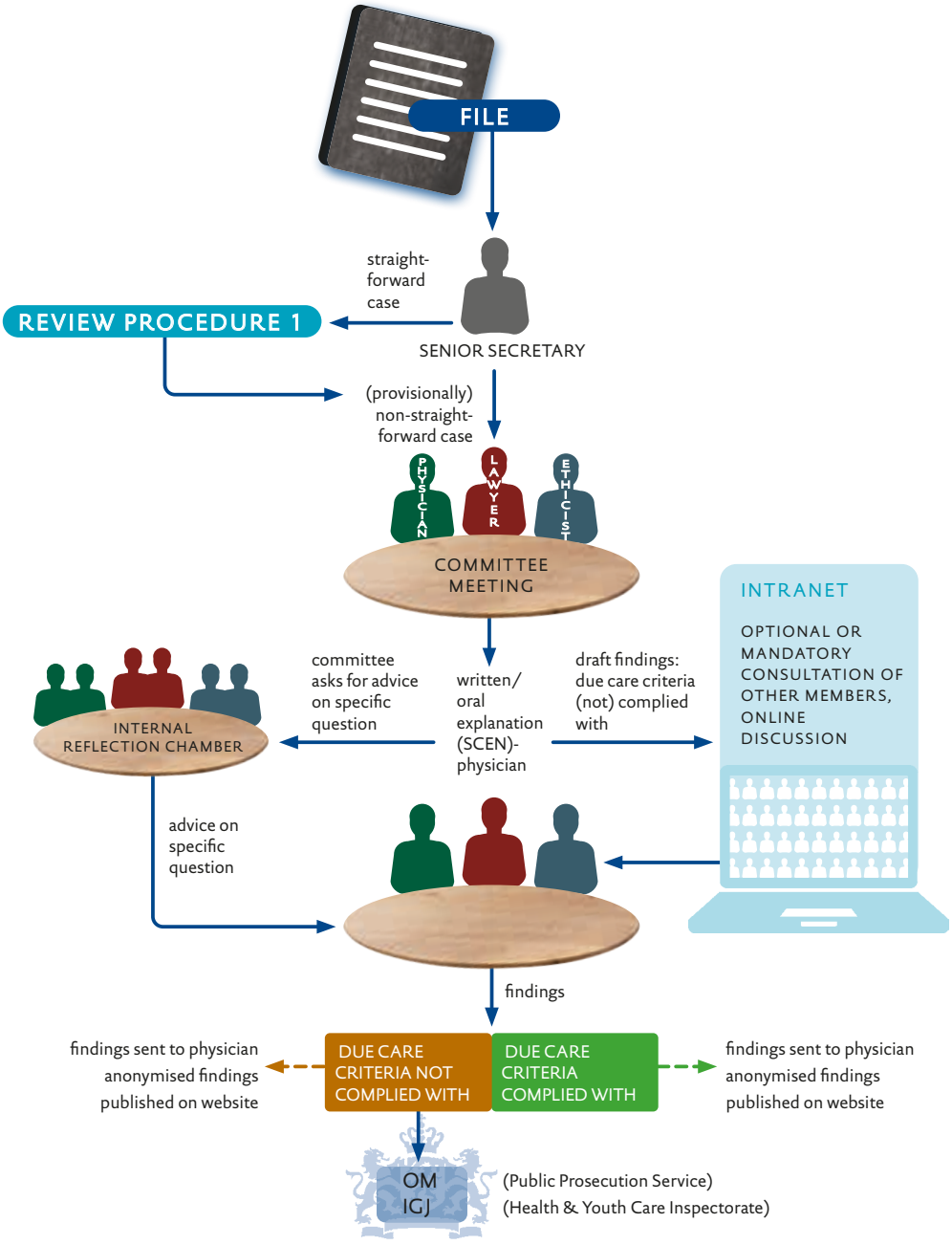
MISCELLANEOUS

The development of a new software system for the RTEs began in 2021. The system is expected to be operational by the summer of 2022.

In 2021 the Minister of Health, Welfare and Sport commissioned a fourth evaluation of the Act, to be started in 2022.

REVIEW PROCEDURE 3

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



ORGANISATION

There is one RTE for 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.

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. In March 2021 the secretariat moved to Utrecht. When the coronavirus restrictions are eased, all committee meetings will also take place in Utrecht. In the past year, some of the meetings were held by video conference.

CHAPTER 2
CASES

1 INTRODUCTION

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

A physician who has performed euthanasia has a statutory duty to report this to the municipal pathologist. The municipal pathologist then sends the notification and the various accompanying documents to the RTE. The main documents in the notification file submitted by physicians are the notifying physician's report, the independent physician's report, excerpts from the patient's medical records such as letters from 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 whether the due care criteria set out in (a) to (d) have been fulfilled;
f. have exercised due medical care and attention in terminating the patient's life or assisting in his suicide.

The RTEs review notifications in the context of the Act, its legislative history, the relevant case law and the revised Euthanasia Code 2018,[7] 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 could reasonably conclude that these three due care criteria had been met. In so doing they also look at the way in which the physician substantiates this conclusion. The independent physician's report often contributes to that substantiation.

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

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

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

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

In subsection 2.3 we describe four cases of euthanasia involving patients who fall into special categories: patients with a psychiatric disorder, patients with multiple geriatric syndromes and patients with dementia. As regards the category of patients with dementia, the first case concerns a patient with dementia who was still decisionally competent regarding her request for euthanasia and the second concerns a patient with dementia who was no longer decisionally competent.

Section 3 describes the seven cases in which the RTE found this year that the due care criteria had *not* been met. Two of the cases concern the requirement to consult an independent physician, two concern due medical care and three concern the particular caution that must be exercised in euthanasia cases involving patients whose suffering is caused by a psychiatric disorder.

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

2 PHYSICIAN ACTED IN ACCORDANCE WITH THE DUE CARE CRITERIA

2.1 FIVE EXAMPLES OF THE MOST COMMON NOTIFICATIONS

As stated in Chapter 1, the vast majority of euthanasia cases involve patients with cancer (61.1%), neurological disorders (6.5%), cardio-vascular disease (4.6%), pulmonary disease (3.1%) or a combination of conditions (13.7%). The following five cases, all straightforward notifi-cations, are examples. 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. In the other cases, the focus is mainly on the suffering of the patients.

KEY POINTS: straightforward notification, independent physician establishes initially that the due care criteria have not yet been fulfilled, number 2021-36 on the website.

The patient, a woman in her seventies, was diagnosed with a brain tumour, which was probably malignant, around two months before her death. Her condition was incurable. She could only be treated palliatively. The sight in her right eye was deteriorating, and she had increasing difficulty in speaking (aphasia) and carrying out complex movements (apraxia). She also suffered from memory problems. The patient could no longer do the things that used to provide her with distraction. She became frustrated by this physical deterioration.

She suffered from her increasing dependence on other people. Her world became smaller and she had fewer and fewer prospects. The patient had a real fear that she would become limited in her day-to-day functioning. 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 longer any acceptable ways to alleviate the patient's suffering.

The patient had discussed euthanasia with the physician before. Four days before her death, she asked the physician to actually perform euthanasia. The physician concluded that, despite her communication and memory problems, the patient was able to clearly substantiate her request. The physician and the specialist had informed the patient about her situation and her prospects. The physician concluded that the request was voluntary and well considered.

The physician consulted an independent SCEN physician. The independent physician visited the patient for the first time five weeks before her death. He came to the conclusion that the due care criteria had not yet been fulfilled, because at that point the patient was not yet suffering unbearably. However, this would possibly be the case in the near future. After speaking to the physician on the phone, the independent physician visited the patient again, three days before her death. The independent physician then established that the patient was now suffering unbearably. He considered the patient to be still decisionally competent regarding her request for euthanasia. The independent physician was satisfied that the due care criteria had been complied with.

The physician performed the euthanasia using the method, substances and dosage recommended in the KNMG/KNMP's 'Guidelines for the Practice of Euthanasia and Physician-assisted Suicide' of August 2012.

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

NEUROLOGICAL DISORDER

KEY POINTS: straightforward notification, motor neurone disease, speaking via a speech-generating device, number 2021-65 on the website.

The patient, a woman in her seventies, was diagnosed with amyotrophic lateral sclerosis (ALS), also known as motor neurone disease (MND), nine months before her death. Motor neurone disease is a disease of the nervous system which causes muscles to gradually waste away. The condition is incurable.

Communicating with other people had always been very important to the patient. However, her speech eventually became unintelligible. She could use a communication app to 'talk' to people, but to her it felt like a summary of sentences and words instead of an actual conversation. She was very frustrated by this. In addition, the patient had difficulty swallowing, and as a result often had problems with excess saliva. She was therefore hardly able to eat, whereas she had always very much enjoyed her food. The patient often choked, and this was unpleasant and frightening.

The patient was suffering from her physical deterioration, the loss of autonomy, the lack of prospect of improvement in her situation and the real fear of suffocating. She also feared further deterioration. 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 longer any acceptable ways to alleviate the patient's suffering.

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

PULMONARY DISEASE

KEY POINTS: straightforward notification, rapid deterioration due to pulmonary fibrosis, number 2021-05 on the website.

The patient, a man in his eighties, was diagnosed with pulmonary fibrosis (a serious lung disease) two years before his death. Six months before his death, the disease had reached an advanced stage. Around a month and a half before the patient's death, it was established that he could no longer be treated. His situation deteriorated rapidly.

Even though he was continuously receiving extra oxygen, he was severely short of breath after the slightest exertion. Even sitting upright had become too much for him. In a short space of time, the patient became bedridden and therefore dependent on others. There was very little he was capable of doing, whereas he had always been very active and enterprising. As a result he was suffering all the more from the rapid loss of his independence and the knowledge that his situation was only going to get worse. He had a real fear of suffocating and he did not want to experience that.

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

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

CARDIOVASCULAR DISEASE

KEY POINTS: straightforward notification, lack of prospect of improvement, number 2021-40 on the website.

Two months before she died, the patient, a woman in her eighties, suffered a cerebrovascular accident (CVA), a stroke. She was left with muscle weakness on the left side of her body, dysarthria (a speech disorder) and pain. After she was discharged from hospital, she was admitted to a nursing home three weeks before her death. In consultation with her attending physicians, it was decided not to start rehabilitation, partly on account of her age.

The patient's suffering consisted of the sudden loss of her independence and her complete dependence on care. There was very little she was capable of doing. Even picking up a glass or turning over in bed was too much for her. She had difficulty speaking, pain in her entire left side, and was severely fatigued She wanted assisted suicide, because she found her situation terrible.

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 her 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, combination of different conditions, number 2021-07 on the website.

The patient, a man in his eighties, had been suffering from several conditions for a long time before his death. He suffered from chronic obstructive pulmonary disease (COPD) – a serious, debilitating lung disease – serious kidney problems, bowel cancer, rectal cancer and lung cancer. Eight years before his death he had also been diagnosed with heart failure. Around four months before his death, his heart failure became much worse. His condition was incurable.

The patient's suffering consisted of his loss of strength. The slightest exertion was making him increasingly short of breath. The patient became more and more fatigued, swallowing became more difficult and he lost his sense of smell and taste. He became bedridden, and a few weeks before his death he developed painful pressure sores on his coccyx. He was completely exhausted and did not want to experience any further suffering.

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

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

2.2 FIVE CASES ILLUSTRATING THE DUE CARE CRITERIA IN THE ACT

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

VOLUNTARY AND WELL-CONSIDERED REQUEST

The Act states that the physician must be satisfied that the patient's request is voluntary and well considered. 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: non-straightforward notification, patient experienced delirium two days before her death, oral explanation from physician, number 2021-146 on the website.

The patient, a woman in her eighties, was diagnosed with bowel cancer five months before her death. Her condition was incurable. From a few weeks before her death, she regularly experienced bleeding and her situation deteriorated rapidly. The patient suffered from the fact that she was completely bedridden and, as a result, dependent on others. She had abdominal pain which could not be treated effectively with medication because this made her delirious. In addition, she knew that she would not get better.

It was unclear to the committee whether the physician had discussed euthanasia sufficiently with the patient. Two days before her death, the patient had delirium, which meant that she had been in a confused state shortly before euthanasia was performed. The committee therefore questioned whether the due care criterion of a voluntary and well-considered request had been fulfilled.

The physician explained that five months before the patient's death he had had a good conversation about euthanasia with her. During that conversation she had said that she wanted euthanasia if her suffering became unbearable. In the subsequent period the physician and the patient had been in regular contact. At that time her suffering had not yet been unbearable. Shortly before her death, the patient was admitted to hospital. She was confused at the time. When she came home she could no longer get out of bed by herself. The patient was completely dependent on others and experienced her suffering as unbearable. This was the turning point for the physician too, because he knew that independence was very important to the patient. The day before euthanasia was performed, the physician spoke with the patient for 20 minutes. At that time she was neither confused nor drowsy and she stated her wishes clearly. On the day when euthanasia was performed, the patient knew why the physician had come and she confirmed her wish for euthanasia. The physician had no doubts whatsoever about the patient's decisional competence and in his opinion her request was voluntary and well considered. The independent physician, who visitedthe patient the day after she was discharged from hospital, also concluded that she was not confused. He considered her to be decisionally competent regarding her request for euthanasia.

In the committee's view, the accounts of the conversations between the physician and the patient were too brief. The physician realised that he should have given better account of the details of the conversations. On the basis of the physician's oral explanation, the committee found that he 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

A patient is regarded as suffering with no prospect of improvement if the disease or disorder causing the suffering is incurable and there are no means of alleviating the symptoms so that the suffering is no longer unbearable. There is no prospect of improvement if there are no realistic curative or palliative treatment options that may – from the patient's point of view – be considered reasonable. It is thus clear that the assessment of the prospect of improvement is closely linked to determining whether there is a reasonable alternative that would alleviate or end the suffering. [...] It is sometimes hard to establish whether suffering is unbearable, for this is a subjective notion. What is bearable for one patient may be unbearable for another. This depends on the individual patient's perception of his situation, his life history and medical history, personality, values and physical and mental stamina. It must be palpable to the physician, also in light of what has happened so far, that this particular patient's suffering is unbearable (revised Euthanasia Code 2018, pp. 24 and 25 (in Dutch)).

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

UNBEARABLE SUFFERING WITHOUT PROSPECT OF IMPROVEMENT

KEY POINTS: non-straightforward notification, stroke, short period of time between stroke and performance of euthanasia, oral explanation from physician, number 2021-147 on the website.

The patient, a man in his eighties, suffered a stroke just over two weeks before his death. As a result the left side of his body was paralysed. He began with a rehabilitation programme but soon thereafter requested euthanasia. The option of waiting was discussed with him, as it was possible he might feel differently about it after a while. The patient said that would not happen. Due to his disabilities he could no long perform his daily activities without help, and he remained consistent in his wish for euthanasia.

It was clear to the committee from the documents and the correspondence with the physician that the patient was unable to move around or take care of himself. The patient had been living alone for 30 years and had always been fully independent. He had always been a fighter: he had seized every opportunity for treatment for his health problems. As a result of the paralysis he was confined to a wheelchair and lost full control of his life. Although some rehabilitation was still possible, he knew he would never be able to return to his independent life. From that moment on, he no longer had the strength to undergo any more treatment. He had no quality of life and experienced his suffering as unbearable and without prospect of improvement. The physician knew the patient well and considered the unbearable nature of the suffering without prospect of improvement to be palpable.

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

NO REASONABLE ALTERNATIVE

KEY POINTS: non-straightforward notification, Euthanasia Expertise Centre, geriatric syndrome with alopecia, independent expert's advice not followed, number 2021-28 on the website.

The patient, a woman in her nineties, experienced deteriorating health due to several geriatric syndromes. They consisted of wear and tear of her joints and bones, shortness of breath, weight loss, sight impairment and cognitive deterioration. The patient also suffered from alopecia universalis (a complete absence of any body hair).

All her life the alopecia had caused her psychological suffering, in part because people had bullied her for it. She had always put a lot of effort into hiding her baldness. Her increasing joint problems would make her dependent on others for her personal care. The fact that she would then no longer be able to keep her baldness a secret was unbearable to her.

The physician decided to consult a psychogeriatric physician to see if there were any treatment options. The psychogeriatric physician believed there was a reasonable alternative: waiting for a period of time and having talks aimed at acceptance of her baldness.

The physician took this assessment into account in making his decision, but did not consider it to be a reasonable alternative. The independent physician came to the same conclusion after speaking with the patient. In view of her age and how long she had had to cope with her baldness, he believed that waiting and talking were no longer reasonable alternatives.

In the committee's view the physician must put himself in the patient's situation in order to be able to draw conclusions. The physician had done so, in the committee's view. The committee therefore found that the physician had carefully explored whether there were any further treat-ment options. This was not the case. 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 independence of the independent physician in relation to the patient implies among other things that there is no family relationship or friendship between the independent physician and the patient, and that the independent physician is not currently treating the patient, and has not done so in the recent past. Contact on a single occasion in the capacity of locum need not present any problem, although this will depend on the nature of the contact and when it occurred (revised Euthanasia Code 2018 p. 31 (in Dutch)).

CONSULTATION

KEY POINTS: non-straightforward notification, cancer, independent physician recognised patient from a previous examination, number 2021-42.

The patient, a man in his eighties, was diagnosed with incurable cancer three months before his death. He requested euthanasia. The physician contacted an on-duty SCEN physician as the independent physician. The SCEN physician visited the patient four days before euthanasia was performed. However, the SCEN physician had met the patient once before, three months before the latter's death, when he had examined the patient. The committee considered to what extent the SCEN physician knew the patient, as there cannot be a treatment relationship between the independent physician and the patient.

When the SCEN physician had examined the patient three months earlier, the patient had been in a state of reduced consciousness, so there had been no close personal contact. In addition, there was no connection between the results of that examination and the patient's condition. The SCEN physician also said that the patient had not recognised him. He believed he was able to form an independent opinion regarding the due care criteria.

The committee found that, because he had examined the patient previously, the SCEN physician could be considered to be an attending physician. However, the committee could go along with the views of the physician and the independent physician. The contact had not been such that the SCEN physician could no longer form an independent opinion. Nevertheless, in the committee's view, the physician should always consult an independent physician with regard to whom there can be no suggestion whatsoever that they are not independent. It is therefore better to consult a SCEN physician who has no connection with the patient.

The committee found that in this case the physician was able to assume that he had consulted an independent physician. The other due care criteria were also fulfilled, in the committee's view.

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, until September 2021 the committees referred to the KNMG/KNMP 'Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide' of 2012 (referred to below as the Guidelines). [...] According to the Guidelines, the physician must have an emergency set of substances available in case something goes wrong with the first set (revised Euthanasia Code 2018 p. 35 (in Dutch)).

In addition it is important that the physician performs every step of the procedure himself. This also means that the physician must remain present until death occurs and the consultation with the pathologist has ended (revised Euthanasia Code 2018, p. 36 (in Dutch)).

DUE MEDICAL CARE

KEY POINTS: non-straightforward notification, combination of conditions, physician left patient during euthanasia procedure, but registrar stayed with patient, number 2021-30 on website.

In the case of this patient, a man in his eighties, there were difficulties with the euthanasia procedure. The physician gave the following clarification.

Ten minutes after she had administered the coma-inducing substance (2000mg of thiopental) to the patient, he was not yet in a sufficiently deep coma. She therefore had to use the emergency set. Around half an hour after the first dose, the physician administered a second full dose of the coma-inducing substance. Again, this did not lead to a sufficiently deep coma. Although the physician did not see any signs that the cannula was not placed in the vein, she suspected that this was the case. After contacting the pharmacy, the physician went there to collect a third set of euthanatics. The registrar, who had accompanied the physician to provide assistance, stayed with the patient until the physician returned. When she returned, the physician inserted a new cannula in the patient's other arm. Two and a half hours after administering the second dose, the physician administered a third dose of the coma-inducing substance, through the new cannula. The patient subsequently fell into sufficiently deep coma and the muscle relaxant (150mg of rocuronium) could be administered. A few minutes later the physician established that the patient had died.

The committee noted that the euthanasia procedure carries risks that may require immediate action by a physician. That is why the Guidelines and the Euthanasia Code do not permit the physician to leave the patient during the euthanasia procedure. In the committee's view the physician was permitted to deviate from that rule in this situation, because there was a physician with the patient the whole time. The registrar would have been able to respond to any complications.

It follows that in the committee's view the physician had exercised due medical care in these specific circumstances. In the committee's view, the other due care criteria had also been 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 patients with a psychiatric disorder, 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 or an independent physician who is also a 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, pp. 44-45 (in Dutch)).

KEY POINTS: non-straightforward notification, depression and PTSD, general practitioner performs euthanasia, number 2021-148 on the website.

The patient, a woman in her seventies, had suffered from severe, recurring depression for 25 years. She also suffered from post-traumatic stress disorder (PTSD) and had liver problems. The patient had attempted suicide several times. She was mentally and physically exhausted due to her depression, and incapable of doing anything anymore. There were no periods of improvement. About one month before her death, the patient asked her general practitioner (GP) for euthanasia. Before her death, the patient was visited by an independent psychiatrist and an independent physician.

VOLUNTARY AND WELL-CONSIDERED REQUEST

During her conversations with the physician, the patient had always been lucid and clear. She was able to assess her situation well. In the independent psychiatrist's view, during the conversations the patient had a good sense of time, place and person. She was able to reflect clearly on her wish to end her life. The independent physician also said the patient was lucid, clear and considered during their conversation. The physician, the independent psychiatrist and the independent physician all found that the patient was decisionally competent regarding her request for euthanasia.

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

It was apparent from the physician's report that the patient had cooperated with all therapies and tried every form of treatment. However, due to her liver problems she could not tolerate medication well. The patient underwent eye movement desensitisation and reprocessing (EMDR) therapy and electroconvulsive therapy (ECT), but neither had a sufficient or lasting effect. The patient continued to relive her traumas and again became depressed. She was completely exhausted, both mentally and physically; there was little she was capable of doing and she no longer experienced any periods of improvement. As a result, all the physicians who were involved in her case were of the opinion that she was suffering unbearably without prospect of improvement and that there was no reasonable alternative for her.

The committee found, in view of the above, that the physician could be satisfied that the patient's request was voluntary and well considered and that she 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 had also been 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 (in Dutch)).

MULTIPLE GERIATIC SYNDROMES

KEY POINTS: straightforward notification, activities of daily living limited, number 2021-54 on the website.

The patient, a woman in her eighties, had been suffering from several geriatric syndromes for a long time before her death. She had an eye disease, balance problems and difficulty in swallowing. In addition she suffered from uterine prolapse, problems urinating and regular vaginal infections. The patient had frequent falls due to her poor balance, often with serious consequences, such as broken bones, open wounds and wound infections. As a result she had to have several skin grafts. She also had torn tendons and joint disorders in many different joints. Eating became increasingly difficult, and she could only eat pureed food. The patient was suffering as a result of these physical conditions. In addition, she no longer had complete control over her body as a result of the medication.

She also suffered from her increasing loss of independence. Over the years she had come up with various adjustments in order to remain self-reliant, but she was no longer able to carry out her hobbies and could not even read or watch television anymore. The patient had lost the things that were meaningful to her. She suffered from the futility of her situation and dreaded further deterioration.

The patient had discussed euthanasia with the physician on more than one occasion. One month before her death, the patient asked the physician to actually perform the procedure to terminate her life. 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. 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 particular caution when considering whether the statutory due care criteria have been met. This is especially true of the criteria relating to the voluntary and well-considered nature of the request, and unbearable suffering. In the early stages of dementia, the normal consultation procedure is generally sufficient. If there are any doubts as to the patient's decisional competence, it is wise for the physician to seek the advice of another physician with relevant expertise (revised Euthanasia Code 2018, pp. 46 and 47 (in Dutch)).

In nearly all the cases notified to the committees, the patient still has sufficient understanding of his disease and is decisionally competent in relation to his 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. (revised Euthanasia Code 2018, p. 46 (in Dutch)).

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* (revised Euthanasia Code 2018, p. 38 (in Dutch)).

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

DECISIONALLY COMPETENT PATIENT WITH DEMENTIA

KEY POINTS: straightforward notification, Alzheimer's disease, decisionally competent, number 2021-86 on the website.

The patient, a woman in her seventies, was diagnosed with Alzheimer's disease by a neurologist around five years before her death. The disease appeared to be progressing slowly, but in the final months before the patient's death, her aphasia (a speech and language disorder) became more severe.

The patient could no longer communicate very well, because it was increasingly difficult for her to form words and sentences. It cost her a great deal of energy to make herself understood. This situation left the patient completely exhausted. Communication had been very important for her, both in her work and in her private life. The fact that she could no longer communicate very well took a great emotional toll on her. She also knew that the future held further deterioration and she wanted to preempt that. The patient experienced her suffering as unbearable.

She had discussed euthanasia with the physician before. Five 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. She established that, despite the aphasia, the patient was able to communicate her request well in clear terms and using facial expressions. The physician had no doubts about the patient's decisional competence with regard to her request.

The physician was satisfied that this suffering was unbearable to her and that there was no prospect of improvement. There were no alternative ways to alleviate her suffering that were acceptable to her. The physician gave the patient sufficient information about her situation and prognosis.

The physician consulted an independent physician who was also a 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. Despite her limited ability to communicate, the patient could make it clear to him that she had a realistic perception and understanding of her illness and was aware of the implications of her request.

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

ADVANCED DEMENTIA

On the basis of the Supreme Court judgment of 2020 (ECLI:NL:HR2020: 712) a number of changes were made to the way notifications are reviewed that involve an advance directive containing a request for euthanasia. These changes are set out in the amended Euthanasia Code 2018. As regards the following notification of euthanasia, which involved a patient with advanced dementia, the following sections are of particular importance.

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'. (revised Euthanasia Code 2018, pp. 38-39 (in Dutch)).

This means that 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. The physician must also establish that the patient's current situation corresponds to the situation described by the patient in his advance directive. (revised Euthanasia Code 2018, p. 39 (in Dutch)).

The physician must also be alert to contraindications that are inconsistent with the request for euthanasia, as apparent from verbal utterances and actions on the part of the patient. The physician will have to assess whether any such contraindications preclude the performance of euthanasia (revised Euthanasia Code 2018, p. 40 (in Dutch)).

When euthanasia is performed, the physician must be satisfied that the patient is experiencing unbearable suffering. 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. [...] When establishing whether there is current unbearable suffering, 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 (revised Euthanasia Code 2018, p. 40 (in Dutch)).

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 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. [...] The fact that the patient can no longer express their wishes will generally prompt the physician to consult a second independent physician with specific expertise. That expert must give an opinion on the patient's decisional competence, whether the patient is suffering unbearably with no prospect of improvement, and possible reasonable alternatives (revised Euthanasia Code 2018, p. 41-42 (in Dutch)).

The euthanasia procedure should be as comfortable as possible for the patient. With patients who are no longer decisionally competent with regard to their request for euthanasia, there may be signs that they could become upset, agitated or aggressive during the euthanasia procedure. In such cases 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. (revised Euthanasia Code 2018, p. 42 (in Dutch)).

PATIENT WHO IS NO LONGER DECISIONALLY COMPETENT WITH REGARD TO THEIR REQUEST FOR EUTHANASIA

KEY POINTS: non-straightforward notification, Alzheimer's disease, advance directive, Euthanasia Expertise Centre, number 2021-90 on the website.

The patient, a woman in her sixties, was diagnosed around four years before her death with Alzheimer's disease on the basis of symptoms from which she had been suffering for some time. The patient had for many years been a member of NVVE (a Dutch organisation that provides information and advice about euthanasia and assisted suicide). Four and a half years before her death, she had signed an advance directive. She had subsequently reaffirmed the advance directive several times with her signature. The last time was two years before her death. During that time she had also added a personal dementia clause to the advance directive.

The patient contacted the Euthanasia Expertise Centre (EE) because for reasons of principle the attending elderly-care specialist did not perform euthanasia. During the second consultation with the EE physician, two years and ten months before the patient's death, the patient confirmed the circumstances in which her request would become an actual request to perform euthanasia, which it was not at that time. At that point there was no doubt about the patient's decisional competence with regard to her request for euthanasia.

Around two and a half years before her death, the patient agreed to be admitted to a psychogeriatric ward of a nursing home. There, her condition continued to deteriorate. In the end she no longer knew who she was or where she was, and did not recognise her children. The patient could no longer communicate with those around her and became with-drawn. She was upset and very sad, but she could no longer express what was making her sad.

Nine months before the patient's death, her children asked the physician to carry out the advance directive. During this third conversation with the patient it was clear to the physician that the patient did not recog-nise him. She was withdrawn and could no longer communicate about her request. The physician visited the patient another three times, in the presence of her children.

VOLUNTARY AND WELL-CONSIDERED REQUEST

The committee noted that the patient had drawn up a clear advance directive in which she specified what she meant by suffering from

dementia. She mentioned, among other things, no longer knowing who she was and where she was, and not recognising her loved ones. She had also discussed this with the physician. She had previously said similar things to her GP and her attending neurologist; she did not want to lose control and she did not want to become a 'vegetable'. In addition, the patient had discussed her request with her children. In the physician's view, the patient had been able to express her request clearly during all of these conversations.

It was also clear from the documents that after she was admitted to the nursing home, the patient had become agitated and irritable. More than a year before her death this had led to aggression and the patient had injured another resident. Medication made her less agitated, but caused excessive salivation and drowsiness. Since the medication was stopped, around five months before her death, the patient had constantly been sad. She was always crying and whimpering. The physician's subsequent visits to the patient confirmed to him that the patient was now in the situation that she had described in her advance directive. The patient's children and the other physicians involved in her case shared this view. On the basis of this information, the committee concluded that the patient was in the situation which, when she drew up her advance directive, constituted unbearable suffering to her.

The committee also concluded that the patient's advance directive ful-filled the two essential elements identified by the Supreme Court. It followed from the advance directive that the patient wanted euthanasia if she became decisionally incompetent, and the suffering resulting from the dementia was the basis of her request.

The committee noted that the physician had made several attempts to communicate with the patient. He had tried to ascertain whether the patient could indicate verbally or non-verbally that she no longer wanted euthanasia. It was clear from the file that there were no such indications. She had, however, made utterances that could point to her still wanting euthanasia. She had made remarks such as 'I don't want this' and 'I want to go'. Although it was not possible to attach a specific meaning to those remarks, in the committee's view the physician could conclude 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 AN ALTERNATIVE

Unbearable suffering

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. He visited her six times and consulted with all the various people involved in her situation. The physician took note of the findings of the independent expert and the independent physician. He also discussed the patient's situation in the EE's multidisciplinary consultation.

On the basis of the conversations with the patient and her children and other reports, the physician established that the patient was suffering unbearably. The physician had come to know her as an independent, cheerful and well-groomed woman, who attached great importance to autonomy. She had a clear idea of the point at which she would experience her suffering from dementia as unbearable, and she had therefore set this out specifically in writing.

The patient's cognitive condition continued to deteriorate. In the end she could no longer make contact or make clear what she wanted. Physically, she was not well either. She had difficulty walking and therefore was at great risk of falling. In the end she could no longer get out of bed by herself and was fully incontinent.

The physician concluded that the patient was no longer happy and was suffering from her dementia. He was satisfied that the future suffering described in the patient's advance directive had now become current, unbearable suffering.

The physician consulted an independent elderly-care specialist, who confirmed the physician's assessment. The patient had completely lost her grip on her surroundings. The elderly-care specialist concluded that the patient's dementia was at an advanced stage and that this was causing unbearable suffering. She was suffering from her sorrow and any attempts at comforting her did not reach her. All the elements of unbearable suffering that the patient had listed in her advance directive had become reality.

The physician also consulted an independent physician, who was also of the opinion that the patient was suffering unbearably from the consequences of her dementia. The patient's physical condition had deteriorated. The independent physician, too, saw signs of current suffering, such as sadness, crying and utterances such as 'I don't want this anymore'.

Suffering without prospect of improvement and absence of a reasonable alternative

The physician was satisfied that there was no reasonable alternative that would alleviate the patient's unbearable suffering. In his view this was clear from the fact that the patient's mood could no longer be influenced. In addition, resuming treatment with medication and behavioural interventions had not had the desired effect. The elderly-care specialist shared this view. The patient would only become even more withdrawn as her dementia progressed. Her ability to communicate would decline even more and this could lead to further behavioural disorders. In his view there were no conceivable palliative options either. The patient's suffering would increase and there was nothing that could alleviate it. The independent physician consulted by the physician also concluded that there was no reasonable alternative.

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 that would alleviate her suffering.

Informed about the situation and prognosis

It was clear from the documents that the patient had been fully informed by her neurologist, her GP and the physician about her condition, its likely progress and the prognosis. The patient had drawn up and signed her advance directive on the basis of this information. During the first two conversations with the physician, the patient had explained in what circumstances she wanted euthanasia. In the committee's view this showed that the patient was aware of the disease from which she was suffering and its progression.

Consultation

The committee noted that the physician consulted an independent physician. The independent physician had seen the patient and tried to speak with her. She concluded that the patient was decisionally incompetent with regard to her request for euthanasia. The independent physician also studied the patient's case file, read her advance directive and spoke with all other persons involved. She concluded that the due care criteria she had to assess had been fulfilled.

The committee noted that the physician had consulted an expert who was an independent elderly-care specialist. The elderly-care specialist read the case file and spoke with the various persons involved. He visited the patient and tried to have a conversation with her. The independent expert concluded that the patient was decisionally incompetent during his visit. He shared the physician's view that the patient was suffering

unbearably without prospect of improvement, that her suffering was current and that there was no reasonable alternative that would alleviate her unbearable suffering.

Due medical care

The committee noted that, in preparation for the euthanasia procedure, the physician had consulted with the attending elderly-care specialist and the nurse. The reason for this was the fact that the patient had previously responded strongly to painful stimuli and it was not possible to discuss the insertion of the cannula with her. After this consultation the physician decided to give the patient premedication in her coffee and to apply a lidocaine medicated plaster to numb the spot on her arm where the cannula would be inserted. He also had an injection at the ready in the event that this did not work.

In the end, the premedication did not have to be given, as the patient was already drowsy before the procedure started. The cannula was inserted without any problems. 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. In summary, the committee found 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 seven cases that the physician had not acted in accordance with the due care criteria in performing euthanasia. Two cases concerned the requirement to consult an independent physician, two cases concerned the requirement to exercise due medical care and three concerned the particular caution that must be exercised with regard to patients suffering from a psychiatric disorder.

CONSULTING AN INDEPENDENT PHYSICIAN

The Act states that physicians must consult at least one other, independent physician, who must see the patient and give a written opinion on whether due care criteria (a) to (d) have been fulfilled. The Euthanasia Code 2018 says the following with regard to that physician's independence.

The Act requires consultation with at least one other, independent physician. 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 requesting his opinion (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. 29 (in Dutch)).

In the following two cases, the committee concluded that there was a suggestion of non-independence, because the independent physician was registered as a patient in the physician's GP practice.

CASE 2021-71

The physician was assigned an independent physician for consultation via the usual system. In his report, the physician gave the following response to the question of how the physician and the independent physician were independent of one another: *'We do not work in the same practice or locum group. We know each other superficially because we work in the same city.'*

As regards his independence in relation to the physician, the independent physician wrote the following: *'You are my GP and we know each other from previous SCEN consultations (...) You have no objection to my doing this SCEN consultation and I feel free and independent in relation to this consultation.'*

From the oral explanation given to the committee it became clear that, immediately after receiving the request for consultation, the independent physician phoned the physician. They discussed the fact that the independent physician was registered as a patient in the physician's GP practice. They both thought that this did not affect the independent physician's independence. It also became clear during that conversation that the independent physician had been registered as a patient for around 20 years and in that period had visited the surgery as a patient four or five times.

In his oral explanation the physician said he was aware of the fact that the independence between physician and independent physician must be guaranteed. But he did not know that the RTEs consider a doctor-patient relationship between the physician and the independent physician to constitute a suggestion of non-independence. The physician was not familiar with the Euthanasia Code 2018. The independent physician was familiar with the Code, but not with that requirement. After having been invited to provide an oral explanation, he discovered that the section of the Euthanasia Code 2018 that deals with this issue has been tightened up in the revised version.

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

The committee finds it regrettable that the physician was unaware of this standard. In the committee's view, a physician who performs euthanasia can be expected to ensure he is familiar with the RTEs' current review standards. The same applies to the independent physi-cian. The committee could therefore only conclude that no independent physician had been consulted.

The physician had fulfilled the other due care criteria.

CASE 2021-142

In this case, the physician wrote the following about the independent physician in his report: 'We know each other as fellow doctors; Mr [...] is a patient in my practice. We have a purely professional relationship.' The SCEN physician wrote: '[...] I know the physician requesting consultation as my GP. Nevertheless I feel I am independent in relation to providing the SCEN consultation for this patient.'

The physician and the independent physician were invited by the committee to give an oral explanation regarding the relationship between them. At that meeting it became clear that the physician was not aware of what the Euthanasia Code 2018 says about the relationship between the physician and the independent physician. Neither was the independent physician aware of this. He had never come across this kind of situation, nor had it been discussed at any peer supervision meetings. Neither of them had stopped to think there could be a conflict of interest. The physician stressed that the suggestion of non-independence had not hampered a critical assessment. The independent physician also said that if he had had a different opinion from that of the physician regarding the due care criteria, he would have said so.

The committee noted that the Euthanasia Code 2018 is clear on this matter: an independent physician who is a patient of the physician performing euthanasia cannot act as the independent physician. As there was such a relationship in this case, the committee found that the physician had not fulfilled the due care criterion requiring him to consult at least one independent physician. In the committee's view, the physician did not adduce any circumstances that would justify deviating from the Euthanasia Code 2018. It therefore found that this due care criterion had not been fulfilled.

The physician had fulfilled the other due care criteria.

DUE MEDICAL CARE

In assessing whether the physician has exercised due medical care, the RTEs refer to the KNMG/KNMP 'Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide'. Page 13 of the Guidelines states: 'During the euthanasia or assisted-suicide procedure, the physician must be and remain present.' The Guidelines also prescribe that the physician must bring an extra set of intravenous euthanatics and the means to prepare and administer them. Lastly, the Guidelines emphasise that the physician may not leave the patient alone with the euthanatics (these three standards are also set out in the Euthanasia Code 2018). These requirements were not fulfilled in the following case.

CASE 2021-81

In this case the euthanasia procedure was complicated by the fact that the patient did not fall into a coma until a second dose of the coma-inducing substance had been injected. Once the patient was in a coma, the physician administered the muscle relaxant. Unfortunately, the patient did not die within the time prescribed by the Guidelines. It occurred to the physician that the cannula had probably not been inserted correctly. He decided to reinsert it, and therefore needed a new needle. As he did not have a needle with him, he had to go to another room in the building.

At the meeting with the committee, the physician explained that he had had the ambulance service insert the cannula. He had received the euthanatics from the pharmacist, but the pharmacist had not supplied any needles. It had not occurred to him at that point to go to the room where the needles were stored, partly because he assumed that the ambulance service had inserted the cannula correctly. When the physician came to the conclusion that he needed a new needle, he considered asking a nurse or a nursing assistant to bring one, but he thought it would take too long for them to get there. Moreover, he would have had to explain which kind of needle he needed and where to find it. He did not have a phone with him and there was no landline in the room where the euthanasia procedure was being carried out. He also did not know the number. The physician had not asked anyone else to assist him during the procedure, in order to maintain a sense of privacy, for the family's sake too.

The needles were in a room one floor down. The physician had gone there quickly and was back within 10 minutes. When he left the room it did not occur to him to take the remaining dose of muscle relaxant with him. This was because he was focused on returning as quickly as possible. When the physician returned, the patient was still in a deep coma. He had not suffered any discomfort and the family had remained calm.

In hindsight, the physician realised that there had been a lack of due care in the procedure, but, in the given circumstances, he tried to do the right thing and act in the patient's interests. Afterwards he discussed what had happened with the patient's family and with colleagues. He intends to review the internal protocol and contact the pharmacist.

In the committee's view the aforementioned standards must be upheld, and they must be interpreted strictly. This is because termination of life on request involves risks that may require immediate intervention. These

risks mean that the physician must stay with the patient until death occurs.

The committee, which did not doubt the physician's good intentions, noted that the physician had placed himself in a fairly vulnerable position by not having a phone with him, not asking anyone to assist him and not organising any other form of backup. As a result he was unable to easily request assistance when a complication arose during the procedure. The committee could not ignore the fact that the physician did not act in accordance with the three aforementioned standards: he did not have an extra needle with him, he left the patient, and he left the muscle relaxant with the patient and the patient's family. The committee found that the physician had not fulfilled the criterion of due medical care.

The physician did fulfil the other due care criteria.

The parliamentary documents concerning the Act, the Euthanasia Code 2018, the KNMG/KNMP 'Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide' and the KNMG's position paper on euthanasia all state that it is the physician who must perform euthanasia and that the physician may not allow anyone else to do it.

CASE 2021-92

In this case, a specialised ambulance team inserted a cannula at the physician's request on the day euthanasia was to be performed. When the physician arrived, she saw that it had been inserted in the patient's ankle, and in her view it looked fine. She first administered a saline solution and a painkiller. That went well. But when she proceeded to administer the coma-inducing substance, she felt such a strong resistance that she was unable to administer the substance. As turning the cannula stopcock had no effect, the physician phoned the ambulance team as she thought the cannula had perhaps not been inserted correctly after all.

The paramedic checked the cannula. He believed it was placed correctly and said something along the lines of 'Give it to me, I'll do it'. The physi-cian then gave him the syringes with the coma-inducing substance, and the paramedic injected them without any problem. After the physician had established the patient's coma was sufficiently deep, the paramedic rinsed the cannula with a saline solution. The physician then gave the paramedic the syringe with the muscle relaxant and he administered it to the patient.

Looking back on her actions, the physician suspected it was the relatively high viscosity of the coma-inducing substance that had caused the resistance she felt. She had never used this substance before. It had been given to her by the pharmacy and there was no alternative. Although she had prepared herself mentally for the fact that she would have to push hard, the physician was afraid that if she pushed harder the substance would end up under the patient's skin instead of in her vein. The difficulty she was having had also made her doubt whether the cannula was placed correctly.

The paramedic in question was described by the physician as 'resolute' and 'practical'. The process whereby she handed the paramedic the syringes with the coma-inducing substance and he injected them occurred very naturally. The paramedic was not in charge, and neither did he act on his own. The physician did not feel taken by surprise or pushed aside. Both the physician and the paramedic knew what had to be done.

The physician did not give clear instructions, but by handing the substances to the paramedic she did determine which substance was administered at what time. She also established the depth of the coma. As the paramedic was administering the injections, it did not occur to her to administer the muscle relaxant herself. According to the physician there was no reason to postpone the euthanasia procedure once it was clear that the cannula was inserted correctly. That would not have been desirable, given that the patient and her family had prepared themselves mentally for the euthanasia procedure.

Following the physician's oral explanation, the committee established that – contrary to what was written in the physician's report – the euthanatics had not been administered by the physician. In that regard, the committee considered *ex proprio motu* whether it was competent to review this notification and came to the conclusion that it was indeed competent to do so.

The committee noted first of all that, apart from the fact that the physician did not administer the euthanatics herself but handed them to the paramedic, the euthanasia procedure was carried out according to the method described in the Guidelines. The committee also noted that the patient did not suffer any discomfort. Furthermore, it was the physician who decided what was to be done at each moment. In that sense the physician controlled the euthanasia procedure. In that regard the euthanasia procedure was carried out correctly from a medical point of view. Nevertheless, the committee could not ignore the fact that the physician did not administer the euthanatics herself, as laid down in the Act and specifically described in the Euthanasia Code 2018. The physician let another person do it.

The committee understood from the physician's explanation how the situation arose. However, given the facts of the matter the committee had no other option but to find that the physician did not act in accordance with the requirement to exercise due medical care.

The physician had fulfilled the other due care criteria.

EXERCISING PARTICULAR CAUTION

If a request for euthanasia is based (mainly) on suffering caused by a psychiatric disorder, physicians are expected to exercise particular caution. Such caution must be exercised especially when assessing the voluntary and well-considered nature of the request, the absence of any prospect of improvement, and the lack of a reasonable alternative. In such cases, the physician must also consult an independent psychiatrist or an independent physician who is also a psychiatrist, in addition to the regular independent physician. That person must consider all three aspects (revised Euthanasia Code 2018, pp. 44-45 (in Dutch)). In the following three cases, the committees established that the physicians were unable to sufficiently substantiate their reasons for performing euthanasia.

CASE 2021-76

This case concerned euthanasia for a patient who was suffering from borderline personality disorder (a disorder that causes severe shifts in mood, thoughts and behaviour) with antisocial characteristics (not taking other people's feelings and wishes into consideration). Psychotic episodes (loss of grip on reality) occurred regularly. Over a period of many years, the patient had undergone various psychiatric treatments for this disorder, including admission to a psychiatric institution on several occasions. None of the treatments had had a lasting positive effect. Due to the adverse consequences of suicide attempts and to diabetes, the patient was in poor physical condition too. Three years before her death it became increasingly clear to her that her suffering would not improve, and from then on she regularly talked to the physician about her wish to die.

The physician was willing to look into the request for euthanasia and studied the patient's history of psychiatric treatments. Two weeks before the patient's death, in consultation with the independent physician and at the request of the physician, an independent psychiatrist assessed the patient's decisional competence.

In her oral explanation to the committee, the physician said that she was not very familiar with what the Euthanasia Code 2018 says about consulting an independent psychiatrist in the event of a request for euthanasia by this type of patient. She had asked the independent physician what to focus on. The independent physician had pointed out that it was necessary to assess the patient's decisional competence regarding a request for euthanasia, but not that the unbearable nature of the patient's suffering, and the absence of reasonable alternatives also needed to be assessed by an independent psychiatrist. The physician told the committee that she had relied on the independent physician's advice and expertise throughout the euthanasia process. She had assumed that the independent physician would be familiar with the applicable legislation. She therefore took the independent physician's word for it that only an assessment of the patient's decisional competence by an independent psychiatrist was necessary.

The committee observed that the physician herself was responsible for the euthanasia process and that she should have familiarised herself with the relevant legislation. In her oral explanation to the committee, the physician stated that she was now well aware of this and that she would certainly do so in the event of any future euthanasia cases.

The committee realised that the physician had been faced with a complex question from a complex patient. The committee also realised that the physician had been willing to look into the request for euthanasia precisely because she felt so involved with her patients and did not want to let them down. The physician wanted to exercise great care and particular caution. This was clear, for instance, from the fact that she asked the independent physician beforehand what to focus on.

Nevertheless, the committee found that the physician had not exercised the required caution, as she consulted the independent psychiatrist only about the patient's decisional competence regarding a request for euthanasia. The physician was satisfied that the patient was suffering unbearably and that there was no reasonable alternative. She explained her arguments at length to the committee. However, by not consulting an independent expert regarding these aspects, the physician was unable to reflect critically on her own convictions. This was all the more problematic because the physician did not have sufficient expertise regarding the patient's psychiatric condition, nor did the independent physician consulted by the physician. The physician was therefore unable to substantiate sufficiently how she had reached the conclusion that the patient was suffering unbearably and that there was no reasonable alternative.

The physician had fulfilled the other due care criteria.

In the second case, too, an expert was consulted, but this time the expert in question did not assess whether the patient was decisionally competent regarding a request for euthanasia.

CASE 2021-97

This case concerned a patient with post-traumatic stress disorder (PTSD). Her mental suffering also manifested physically in muscle spasm episodes which occurred increasingly often and became increasingly severe. Despite the fact that the patient took part in various psycho-therapy treatments, and was motivated to do so, her situation did not improve. The medication that she was given had only a temporary effect. Physiotherapy and counselling had been unsuccessful too. In the end, the only option that remained was to inject diazepam (a relaxant) to reduce the symptoms. The patient was dependent on others for the injections.

In addition to a regular independent physician, the physician consulted a clinical psychologist. The physician, who as a GP specialised in mental healthcare had extensive knowledge in this area, was referred to this psychologist by the Centre for Consultation and Expertise. The physician chose the centre because it has a large group of experts with knowledge of dealing with complex situations. According to the physician, the patient's case was discussed by a multidisciplinary group within the CCE, including at least one psychiatrist. In that meeting it was decided that the independent psychologist was the best person to examine the patient, on account of her expertise in the area of psychopathology (the study of psychological disorders and their treatment).

In her oral explanation to the committee, the physician stressed that she regretted that she had overlooked the fact that the Euthanasia Code stipulates that an independent psychiatrist must be consulted. She thought that by consulting an independent physician and the clinical psychologist she had fulfilled the statutory due care criteria. Her assumption was confirmed by the independent physician, who had stated in her report that she, too, was of the opinion that the statutory due care criteria had been fulfilled.

First of all the committee held that, since no independent psychiatrist was consulted, the physician had overlooked the requirement laid down in the Euthanasia Code. On the other hand, it was clear from the physician's explanation that she had made a conscious and well-considered decision to approach the CCE on account of their specific expertise. In addition, the CCE was convinced that, from a professional point of view, the clinical psychologist was the best person to assess

whether the patient's suffering was without prospect of improvement and whether or not there was any reasonable alternative.

In the committee's view, the physician's course of action is understandable. In reaching that conclusion, the committee took account of the fact that, according to the National Psychiatry Association (see page 27 of its guidelines on 'Dealing with requests for assisted suicide from patients with a psychiatric disorder'), in exceptional cases a second opinion can be given by a professional who is not a psychiatrist. For instance in situations where that other professional has very specific expertise relating to the patient's condition. With due regard for the above considerations, the committee was of the opinion that the clinical psychologist who was consulted in this case could be considered an expert on the subject matter, whose opinion would be taken into account in the committee's deliberations.

As regards the three due care criteria that must be assessed by the independent expert, the committee established that the clinical psychologist was not asked to assess the patient's decisional competence, nor did she report on it. The physician explained that she was not familiar with this instruction. The physician also argued that there was no reason whatsoever to doubt the patient's decisional competence, nor did her disorder give cause to do so. In this context the physician referred to the abovementioned guidelines, which state that a patient is deemed decisionally competent until proven otherwise. In this case that was the physician's guiding principle. After assessment against the four customary questions regarding decisional competence, according to the physician there was nothing that pointed to circumstances that had affected the patient's ability to make well-considered choices.

The independent physician also considered the patient to be decisionally competent regarding her request for euthanasia. And no circumstances were mentioned in the clinical psychologist's report that gave reason to doubt the patient's decisional competence.

The committee noted that the physician had demonstrated a strong commitment to the patient by dealing with the request for euthanasia herself. She studied the patient's situation carefully and reflected on it at length. The committee also considered it plausible that the patient was indeed decisionally competent with regard to her request for euthanasia; there were no circumstances in her medical history that contraindicated this and, besides the physician, the independent physician was also of the opinion that the patient was decisionally competent with regard to her request for euthanasia.

Nevertheless, the committee found that the physician had not exercised the required particular caution. After all, the requirement is that a psychiatrist or another expert on the subject must (also) assess this aspect of the due care criteria, so that the physician performing eutha-nasia can reflect on their own considerations in this respect. Consulting an independent expert was all the more important in this case as neither the physician nor the independent physician was a psychiatrist.

During the meeting with the physician the fact was discussed that the physician alone is responsible for the euthanasia process and that the physician must ascertain that the relevant legislation and guidelines have been complied with. The independent physician's opinion or advice does not change this. The physician endorsed this, as she had done before in her response to written questions from the committee, and reiterated that she regretted the fact that she had been unaware of what the Euthanasia Code prescribed in this regard.

Given this state of affairs, the committee had no alternative but to find that the physician had failed to sufficiently demonstrate that she could be satisfied that the patient was decisionally competent with regard to her request for euthanasia and that her request was voluntary and well considered.

The physician had fulfilled the other due care criteria.

In the third case, no independent expert was consulted.

CASE 2021-143

This notification concerned a patient who had suffered from abdominal complaints for 25 years. Despite considerable efforts, no physical cause was found for his symptoms. About seven years before his death, the patient's abdominal complaints were deemed to be medically unexplained physical symptoms (MUPS) Four years before his death, the patient suffered from bladder cancer, for which he received treatment. According to the attending oncologist, the treatment was successful, but the patient was convinced that the cancer had widely metastasised. He had pain everywhere and became increasingly tired. As a result he could no longer undertake any activities. He sat or lay on the couch all day long. He no longer experienced any quality of life. He found it difficult to accept that no explanation had been found for his physical symptoms. In the final months before his death, the patient was completely inactive and exhibited severe self-neglect. He could no longer stand.

Between the time of the bladder cancer diagnosis and his death, the patient attempted suicide several times, for which he was admitted to an intensive care unit and then to a secure ward in a psychiatric institution. After he was discharged from the psychiatric institution he received counselling at home for depression. He was advised to get treatment for MUPS, but did not follow that advice.

It was clear from the file submitted by the physician, who was the patient's GP, that she did not consult an independent psychiatrist. However, 14 days before the patient's death, she did speak with the patient's attending psychiatrist by phone. When the physician contacted him, the attending psychiatrist said that the patient was not suffering from major depressive disorder, which would have rendered him decisionally incompetent. The psychiatrist offered to visit the patient if the independent physician asked him to.

The physician was invited to a meeting with the committee. At the physician's request, the independent physician she had consulted attended the meeting too.

The committee noted that the independent physician consulted by the physician concluded that the patient's request for euthanasia was voluntary and had been made repeatedly. He did not observe any pressure from other people. He established that the attending psychia-trist and the patient's mental health nurse both considered the

patient to be decisionally competent and that he was not suffering from real depression.

When asked about it, the physician said that the attending psychiatrist had not pointed out to her that it was necessary to consult an independent psychiatrist as part of the euthanasia process. The independent physician had not pointed this out either. During the physician's oral explanation, the independent physician stated that it had been 'too late for an independent psychiatric assessment'. In her oral explanation the physician said that she was not familiar with the RTEs' Euthanasia Code. She did not know that she should have consulted an independent psychiatrist.

In the committee's view the physician demonstrated a strong commitment to the patient by dealing with his request for euthanasia. She studied the patient's situation carefully. Nevertheless the committee found that the physician did not exercise the required particular caution. As the patient was suffering from MUPS, an independent psychiatric assessment was necessary to establish whether he was decisionally competent. Although the independent physician did not advise the physician accurately, it is the physician who remains responsible for the euthanasia process. The committee therefore found that the physician should have familiarised herself with the relevant legislation and guidelines.

As regards the requirements that the physician be satisfied that the patient is suffering without prospect of improvement and that there is no reasonable alternative, the committee came to the same conclusion, for the same reason.

In view of the above, the committee found that the physician could not be satisfied that the patient's request was voluntary and well considered, that he was suffering without prospect of improvement and that there was no reasonable alternative in his situation.

The physician had fulfilled the other due care criteria.

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