



**Regional
euthanasia
review committees**

Annual report 2011

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Foreword

This is the 2011 annual report of the five regional euthanasia review committees. In our annual reports we account for the way in which we review cases on the basis of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act. The report provides details of the number of notifications received, which again increased sharply, the nature of the cases, the committees' findings and the considerations on which these were based.

This year again, the committees in several cases seriously exceeded the statutory deadline for issuing their findings to the physicians concerned. This situation is both undesirable and unlawful. The committees greatly regret this state of affairs, which they also made known to the notifying physicians.

Chapter I (Developments in 2011) describes the problems that the committees faced, and still face, and the steps taken to resolve them and reduce the backlog in cases.

Naturally we are grateful to the Ministry of Health, Welfare and Sport for increasing the staffing of the secretariats, and for the decision to appoint 15 extra alternate committee members.

One matter of continuing concern to the committees is that their reviews of notifications should be unequivocal. While taking account of the principle that every notification should be reviewed according to the specific circumstances of the case, the committees are always at pains to harmonise their findings. This has become even more important with the substantial increase in the number of committee members. It is crucial that the committees describe their findings – including the considerations on which they are based and the relevant legal history and case law – as clearly as possible. A clear understanding of the scope of the Act benefits both physicians and patients.

The way the regional committees apply the Act is communicated to the notifying physician in the committee's findings on the notification and to third parties through publication of the findings on the website and in the annual report.

The publication of case 10 in the 2010 annual report led to a discussion with the Royal Dutch Medical Association (KNMG) concerning the advance directive as referred to in section 2, subsection 2, of the Act, in particular the significance of such a directive in the case of a reversible coma, to which the KNMG's 'Guidelines on euthanasia for patients in a state of reduced consciousness' do not apply. This discussion led to a clarification of the text of this report (see Chapter II, section 'Coma and reduced consciousness (non-comatose)').

There was considerable public debate in 2011 following media coverage of the termination of the life of a patient with advanced dementia (case 7 – not discussed in this abridged version). After consulting members of the other committees, the regional committee reviewing the case found that the physician concerned had acted in accordance with the due care criteria. The case, and the media coverage of it, prompted the KNMG to amend its guidelines for SCEN physicians at the beginning of this year, in close consultation with the regional euthanasia review committees and acknowledging each party's own role and responsibility in this area.

Naturally, the broad debate in medical circles as well as in civil society on the voluntary termination of life also led to a joint discussion of the matter by the committees. These discussions were considered invaluable for the (internal) review process.

Besides reviewing notified cases and publishing their findings, the regional euthanasia review committees provide extensive information on the euthanasia procedure with a view to contributing to the transparent and manageable development of euthanasia practices and to public debate. However, the committees are bound to a statutory duty of confidentiality and will not give a response on individual cases. This is why they did not respond publicly during the media coverage of the above-mentioned dementia case.

The committees are currently thinking of ways to make their assessment of past cases more widely known, in addition to being published on the website, in annual reports and communicated to notifying physicians.

The committees are always pleased to receive feedback.

W.J.C. Swildens-Rozendaal

Coordinating chair of the regional euthanasia review committees

The Hague, august 2012

Chapter I **Developments in 2011**

The following developments took place in 2011.

Notifications

In 2011, the regional euthanasia review committees ('the committees') received 3,695 notifications of termination of life on request (often referred to as 'euthanasia') or assisted suicide¹. In each case the committees examined whether the physician who had performed the procedure had acted in accordance with the due care criteria set out in section 2 (1) of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act ('the Act').

In 4 cases the committees found that the physician had not acted in accordance with the Act. The most relevant elements of these cases – as well as a number of cases in which the committees found that the physician had acted in accordance with the due care criteria – are described in Chapter II (Due care criteria: specific) under the criterion concerned.²

Increase in number of notifications continues

The number of notifications received by the committees in 2011 showed an increase of 18% compared to 2010 (3,136). The number of notifications actually reviewed has not kept pace and has been a matter of great concern to the committees for some time. The period within which notifications are dealt with has become unacceptably long. The committees consider this a highly regrettable situation; dealing with notifications in good time and complying with the law is essential if they are to enjoy continuing confidence. The committees and the secretariats worked hard on a structural, future-proof solution to the problems, with a number of important steps taken in 2011.

New working procedures

First, the committees decided to adopt a new procedure, within the framework of the Act, for processing notifications. In the new procedure, an incoming notification is recorded and examined by an experienced member of the secretariat ('secretary') who estimates the likelihood that the review committee will have further questions regarding the notification ('straightforward' or not).

Notifications are considered straightforward if an experienced secretary, on receiving the papers (i.e. at the start of the review procedure), can establish with a high degree of certainty that the due care criteria have been complied with and that the information provided is so comprehensive that it raises no questions. The secretary's assessment is based on the committees' long experience in reviewing notifications of euthanasia. In fact, this experience predates the Act as, when the Act came into force in 2002, the committees had already been reviewing the practice of euthanasia for four years. The committees estimate that some 80% of all notifications will be processed in this way once the new procedure is fully implemented.

The committees have decided that documentation concerning straightforward notifications will be sent electronically to three committee members (a lawyer, a physician and an ethicist) for assessment. If all three members confirm that the notification is a straightforward case, which means they have no further questions and the due care criteria have been complied with, the findings on the notification can be finalised. However, even if just one committee member has questions with regard to the notification, the file will be sent to all committee members for plenary discussion at a monthly meeting.

In 2011, ICT experts worked together with the committees to develop a new registration and assessment system to support the new electronic procedure described above. The system was tested in pilot projects and will be rolled out nationally in April 2012.

¹ More information about these notifications and a breakdown by region can be found in annexe I.

² The passages included here as cases mainly concern the due care criterion that is being discussed at that point.

Regional euthanasia review committees expanded

Secondly, in 2011 the committees held intensive discussions with the Ministry about reducing the backlog of work, which resulted in the decision to increase the membership of each of the committees by half. Currently, each regional committee comprises three members and three alternate members. In 2012, an extra three alternate members will be appointed to each regional committee, bringing the total membership to nine (three in each area of expertise). It was also decided to increase the staffing of the secretariats as of 2012.

The committees are confident the new working procedure and the expanded committees and secretariats will enable them to tackle future challenges successfully. The effects of the changes will probably start to become apparent in the second half of 2012.

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

At the request of the Ministry of Health, Welfare and Sport, a third evaluation of the Evaluation of Termination of Life on Request and Assisted Suicide (Review Procedures) Act covering the years 2007 to 2011 was scheduled for 2011 and 2012. The evaluation will include a critical examination and analysis of the committees' findings and interviews with committee members and secretariat staff. The committees and secretariats will naturally cooperate fully with the evaluation and give the investigators every possible assistance. The sharp increase in the number of notifications will also be examined. The evaluation results will probably be published in the autumn of 2012.

Website

In consultation with the Ministry of Health, Welfare and Sport, the committees have decided that in the future the website www.euthanasiecommissie.nl will focus on presenting the committees' integral assessments of non-straightforward notifications of euthanasia with a view to promoting the development of general norms on euthanasia and the knowledge and expertise of physicians and other parties concerned. Cases where the committees found that the physician concerned did not satisfy all the due care criteria will always be published on the website, as well as

cases where the due care criteria were satisfied but which initially raised questions, for instance cases involving conditions that are less prevalent in connection with euthanasia (dementia, psychiatric disorders and multiple geriatric syndromes). In other words, the type of notifications that the committees have always discussed extensively in their annual reports.

In exceptional cases a finding may not be published, for instance when publication would compromise the patient's anonymity.

The website's search function has been improved with a view to providing optimum accessibility and further improvements are in progress.

Due medical care

In assessing compliance with the due medical care criterion, the committees carefully consider the current standard in medical and pharmaceutical research and practice, normally taking as their guide the method, substances and dosage recommended by the Pharmacy Research Institute (WINAP) of the Royal Dutch Association for the Advancement of Pharmacy (KNMP). The Institute's *Standaard Euthanatica, toepassing en bereiding 2007* ('*Standaard Euthanatica 2007*') also states which substances – and dosages – the KNMP does or does not recommend for use in cases of termination of life on request or assisted suicide. In 2008, the committees drew attention to *Standaard Euthanatica 2007* and announced that they would continue to take it as their guide in the journal *Medisch Contact*.³

The committees note that, while the vast majority of attending physicians followed *Standard Euthanatica 2007* in 2011, they were also confronted with poor availability of thiopental, the recommended first-choice coma-inducing substance. In December 2010, the KNMP and the KNMG therefore published a supplement to *Standaard Euthanatica 2007*, listing alternatives for thiopental, additional to the second-choice substances on page 26 of *Standaard Euthanatica 2007*.

Nevertheless the committees in 2011 again came across the use of substances not recommended in *Standaard Euthanatica 2007* (or its supplement), and notifications in which the dosage was not specified or was not in accordance with the recommendations in *Standaard Euthanatica 2007* or its supplement. In these cases the committees asked the physician to explain why *Standaard Euthanatica 2007* or its supplement was not followed. Unfortunately, they note that not all the physicians were able to give adequate reasons. In

three cases this year, the committee found that the attending physician had not complied with the due medical care criterion. In two cases (cases 18 and 19) the dosage of coma-inducing drug administered to the patient was only half that recommended in *Standaard Euthanatica* 2007. In all three cases, the attending physicians subsequently failed to check whether the patient was in a sufficiently deep coma before administering the muscle relaxant. The physicians concerned thus took the risk that their patients would experience a feeling of asphyxiation shortly before death, a possibility that must be avoided at all times.

New guidelines

In 2010, a joint KNMP/WINAP and Royal Dutch Medical Association (KNMG) working group began drawing up new guidelines. On request, the committees provided the working group with information on their experiences in assessing how the euthanasia procedure was performed (of course, always in general terms, and hence anonymously). The new KNMP/KNMG guidelines are due to be published in the autumn of 2012. Until such time the committees will take the 2007 version of *Standaard Euthanatica* as their guide, and physicians who do not follow its recommendations must give adequate reasons for doing so.

New KNMG position paper

In June 2011 the KNMG published its new position paper on the role of physicians in termination of life at the patient's request (for more details, see the KNMG's website). The KNMG considers this paper a response to the public debate that arose in 2011 on whether people who are 'finished with life' should be enabled to die with dignity. The initiative group *Uit Vrije Wil* ('Of one's own free will') presented a proposal for legislation that would enable people aged 70 years and older who consider their life 'finished' and who wish to die with dignity to request assistance in terminating their life. Providing this type of assistance when there is no unbearable suffering without prospect of improvement falls outside the scope of current Dutch legislation on euthanasia and is always a criminal offence. The initiative group holds the position that it should not be an offence when the individual making the request is elderly.

The regional euthanasia review committees assess whether the actions of notifying physicians were in accordance with the Act. In all the notifications reviewed by the committees, the patient's unbearable suffering with no prospect of improvement was chiefly due to a recognised disease or disorder, including disorders associated with old age.

Chapter II Due care criteria

Due care criteria: general

The committees assess whether the attending physician has acted in accordance with all the statutory due care criteria.

These criteria, as laid down in section 2 of the Act, are as follows. Physicians must:

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

Procedures for termination of life on request and assisted suicide are almost always carried out by the attending physician; in practice, this is often the patient's general practitioner. In some cases the procedures are performed by a locum because the patient's situation rapidly deteriorates or because the attending physician is absent or does not wish to carry out the procedure himself, for instance because of his religious or ethical views. In such situations it is important that the physician who carries out the procedure, and hence submits the notification, should obtain sound information in advance about the patient's situation and be personally satisfied that the due care criteria have been complied with.

The information provided by attending physicians is of crucial importance to the committees' reviews. If the physician gives an account of the entire decision-making process in his notification, he may not be required to answer further questions at a later stage. The physician is expected to use the model notification form established in 2009. The questions in it provide attending physicians with a guide as

to how to make it clear to the committee that they have complied with the due care criteria.

The committees sometimes require further information, which can often be provided by telephone or in writing. In some situations, however, the committees prefer to interview the physician in person in order to obtain a clearer picture of the decision-making process at the end of the patient's life or what happened when the procedure was performed.

The committees are aware that such an interview, besides taking up the physician's time, may be distressing to him. They wish to emphasise that the purpose of the interview is to give the physician an opportunity to provide further details regarding a notification which the committee still has its doubts about even after the physician has provided further information by telephone or in writing. In the absence of such details, the committee would be unable to find that the physician acted in accordance with the statutory due care criteria. The interview also gives the physician an opportunity to answer questions about his actions (which can of course be expected of him).

In 2011, the great majority of notifications gave no grounds for further discussion or questions when they came before the committees. In those cases the committees could swiftly conclude that the physician had acted in accordance with the due care criteria. Case 1 is included as an example of such a notification.

Case 1

The due care criteria were fulfilled.

Finding: criteria complied with

In mid-2010, the patient, a woman in her sixties, was diagnosed with colon cancer that had metastasised to the peritoneum and liver. Her condition was incurable. She was given palliative chemotherapy which had to be stopped after a few months because of toxicity. The attending specialist indicated that no more treatment was possible for her.

Towards the end of the year, she developed ileus, which caused her to vomit frequently and made it impossible for her to eat. She lost more than ten kilograms in weight and became debilitated.

She was given fentanyl patches for the pain and temazepam to reduce her anxiety.

The unbearable nature of her suffering was due to severe pain, frequent vomiting and general debilitation. In addition, she developed decubitus ulcers. She also found the absence of any prospect for improvement in her situation unbearable.

The physician was convinced that this suffering was unbearable to her and that there was no prospect of improvement. Apart from the palliative measures that had already been taken, there were no other means to alleviate her suffering.

The documents make clear that the physician and the specialists gave her sufficient information about her situation and prognosis.

The patient first broached the subject of euthanasia with her physician in the autumn of 2010.

After that, they spoke about euthanasia several times. The patient first asked her physician to terminate her life more than a fortnight before her death, a request she later repeated several times, also in the presence of her husband.

There was a recent advance directive.

According to the physician there was no pressure on the patient from those around her, and she was aware of the implications of her request and of her physical situation.

The independent physician consulted was a retired general practitioner who was also a SCEN physician. He saw the patient just over two weeks before the termination of life was performed, after he had been told about her situation by the attending physician and had examined her medical records.

It stated that the independent physician gave a summary of the patient's medical history.

According to his report, the patient was sitting on the sofa in the living room, dressed, when he saw her. She gave a clear, coherent account of her medical history. She said medication made the pain bearable, but it was all but impossible to control the vomiting. She was no longer able to eat. The patient considered her situation – the severe pain and frequent treatment-resistant vomiting – unbearable. She indicated that, with a view to an upcoming visit by family, she wanted to try to hold out for a little longer, but she was afraid that the intestinal obstruction could lead to an acute situation.

The unbearable nature of the patient's suffering was clearly palpable to the independent physician. He considered that the patient's request was voluntary and that her suffering was unbearable and without prospect of improvement. He was satisfied that the due care criteria had been complied with.

The attending physician performed euthanasia in January 2011 by administering 2000 mg of thiopental and 20 mg of pancuronium intravenously.

The committee examines retrospectively whether the attending physician acted in accordance with the statutory due care criteria laid down in section 2 of the Act. The committee then decides whether, in the light of prevailing medical opinion and standards of medical ethics, the due care criteria were complied with.

In view of the above facts and circumstances, the committee found that the attending physician could be satisfied that the patient's request was voluntary and well-considered, and that her suffering was unbearable with no prospect of improvement. The physician gave the

patient sufficient information about her situation and prognosis. Together, the physician and the patient could be satisfied that there was no reasonable alternative in the patient's situation. The physician consulted at least one other independent physician, who saw the patient and gave a written opinion on whether the due care criteria had been complied with. The physician performed the euthanasia with due care.

The committee found that the physician had acted in accordance with the statutory due care criteria laid down in section 2 (1) of the Act.

In a number of other cases, a notification gave rise to in-depth, lengthy discussions within the committee. The remaining cases included in this chapter are examples of cases that gave rise to such discussion and, usually, further questions. Contrary to the description of case 1 in which the committee's findings on all the due care criteria were presented, discussion of the other cases, below, will focus on those elements that pertain to a specific due care criterion..

Due care criteria: specific

a. Voluntary, well-considered request

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

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

Four elements are crucial here:

1. The request for termination of life or assisted suicide must have been made by the patient himself.
2. The patient must be decisionally competent, that is he must have a clear understanding of relevant information about his situation and prognosis, be able to consider any possible alternatives and understand the consequences of his decision.
3. The request must be voluntary. There are two aspects to this. The request must be internally voluntary, i.e. the patient must have the mental capacity to determine his own wishes freely, and externally voluntary, i.e. he must not have made his request under pressure or unacceptable influence from those around him.
4. The request must be well-considered. In order to make a well-considered request, the patient must be fully informed and have a clear understanding of his disease.

Examples of situations where the committees would examine these points more closely are cases 2 (patient with intellectual disabilities) and 3 (patient with aphasia) but these are not discussed here.

Mental illness or disorder

In general, requests for termination of life or assisted suicide because of unbearable suffering arising from a mental illness or disorder, with no prospect of improvement, should be treated with great caution. If such a request is made by a psychiatric patient, even greater consideration must be given to the question of whether the request is voluntary and well-considered. A mental illness or disorder may make it impossible for the patient to determine his own wishes freely. The attending physician must then ascertain whether the patient appears capable of grasping relevant information, understanding his condition and advancing consistent arguments. In such cases it is important to consult not only an independent physician but also one or more experts, including a psychiatrist. It is important that their findings are also made known to the committee.

In 2011 the committees received 13 notifications of euthanasia or assisted suicide involving patients with psychiatric problems. All 13 notifications were found to have been handled with due care. Two (cases 12 and 13) are discussed in the full report.

Depression

In the year under review, there were again notifications in which the patient was suffering from depression in addition to one or more somatic conditions. Depression often adds to the patient's suffering. The possibility that it will also adversely affect his decisional competence cannot be ruled out. If there is any doubt about whether the patient is depressed, a psychiatrist will in practice often be consulted in addition to the independent physician. If other medical practitioners have been consulted, it is important to make this known to the committee. It should also be noted that it is normal for patients to be in low spirits in the circumstances in which they make a request for euthanasia, and that this is not in itself a sign of depression.

Advance directive

The Act requires the physician to be satisfied that the patient has made a voluntary and well-considered request. The request is almost always made during a conversation between the physician and the patient, and hence is made orally. The Act makes specific provision for a written directive. Provided it was drawn up when the patient was still decisionally competent, an advance directive replaces an oral request in cases where the patient is no longer capable of expressing his wishes when the time comes to consider ending his life. The due care criteria likewise apply here.

It is advisable to draw up the directive in good time and update it at regular intervals. It should describe as specifically as possible the circumstances in which the patient would wish his life to be terminated. The clearer and more specific the directive is, the firmer the basis it provides for the physician's decision. The latter, as well as the independent physician, will have to decide in the light of both the described and the current situation – and having regard to the entire process that the physician has gone through with the patient – whether the patient has made a voluntary and well-considered request, whether he is suffering unbearably with no prospect of improvement and whether he has no reasonable alternative.

The advance directive played an important role in cases 4 and 7 (not discussed here).

If, on the other hand, the patient is capable of expressing his wishes and can request that his life be terminated, a written directive can help eliminate any uncertainty and confirm the oral request. A handwritten directive drawn up by the patient in which he describes the circumstances in his own words often provides additional personal confirmation, and is therefore more significant than a standard form, particularly one that is conditionally worded.

Contrary to popular belief, the Act does not require an advance directive to be drawn up. Although in practice, the existence of such a directive makes it easier to subsequently assess the case, the committees wish to emphasise that it is not the intention that people be put under unnecessary pressure to draw up such a directive in difficult circumstances, in some cases only shortly before they die. The physician can help eliminate any uncertainty by recording details of a patient's wish for euthanasia and the physician's and patient's decision-making process concerning the end of his life in the patient's records. This may, for example, be of help to locums and others involved in reaching a decision.

Dementia

All 49 notifications dealt with in 2011 concerning termination of life on request or assisted suicide involving

patients with demential syndrome were found by the committees to have been handled with due care. In the majority of cases, the patients were in the early stages of dementia and still had insight into the condition and its symptoms (loss of bearings and personality changes). They were deemed decisionally competent because they could fully grasp the implications of their request. Cases 5 (not discussed here) and 6 serve as illustrations.

The committees adhere to the principle that physicians should normally treat requests for termination of life from patients suffering from dementia with additional caution. They must take the entire course of the disease and the other specific circumstances of the case into account when reaching a decision.

Patients at a more advanced stage of the disorder are less likely to be decisionally competent. In these cases, it is essential that there is a record of the patient expressing the wish for euthanasia in the past, namely a clear advance directive written by the patient when still decisionally competent, which incontrovertibly applies to the situation at hand. A patient at a more advanced stage of dementia will still engage in certain behaviours (unlike a patient in coma but comparable to a patient with aphasia). Interpreting this behaviour and the various ways in which the patient expresses his wishes will be a difficult task for the attending physician (and the independent physician), but is nevertheless crucial as the physician must be satisfied that the patient still wishes euthanasia to be performed. The independent physician will not be able to converse with the patient, as he normally would, and will have to determine whether the request is voluntary and well-considered based on information provided by the attending physician, an advance directive, the patient's behaviour and expressions of his wishes since the directive was written, and statements by others, such as the patient's family. Although it is difficult to make any general statements as to the circumstances under which euthanasia may be performed in such situations, the possibility may not be excluded, bearing in mind the tenor of the Act. Case 7 (not discussed here) illustrates this exceptional situation.

If a patient is suffering from dementia, it is advisable to consult one or more experts, preferably including a geriatrician or a psychiatrist, in addition to the independent physician. Apart from whether or not the request is voluntary and well-considered, the question of whether there is no prospect of improvement in the patient's suffering, and above all whether his suffering is unbearable, should be key elements in the physician's decision. He should also make it clear to the committee that he made his decision with the utmost care.

Case 2 (not included here)

Case 3 (not included here)

Case 4 (not included here)

Dementia

Cases 6, 7 and 8 are examples of a notification concerning a patient suffering from dementia. In cases such as this physicians must pay special attention to the question of whether the request is voluntary and well-considered and whether the patient's suffering is unbearable with no prospect of improvement.

Case 5 (not included here)

Case 6

Voluntary and well-considered request from a patient with Lewy body dementia

Finding: criteria complied with

In the years before his death, a man in his fifties developed progressive memory problems. Two years before his death, he was diagnosed with Lewy body dementia, a condition for which there is no cure. Six months after this diagnosis, it was confirmed by a second opinion requested by the attending physician. Despite attempts to slow down the disease, the patient's cognitive functions deteriorated progressively. He began to develop choreic movements and experience hallucinations, which made him sleep poorly. The patient's suffering was caused by consciously experiencing his own decline, the progressive deterioration of his cognitive functions, very realistic visual hallucinations and continual, severe, choreic movements. He also suffered from the knowledge that his situation would only worsen and that he might have to be admitted to a nursing home in the future. It was palpable to the attending physician that the patient's suffering was unbearable to him. His suffering was clearly without prospect of improvement.

The documents make it clear that the attending physician and specialists gave the patient sufficient information about his situation and prognosis.

Two months before his death the patient discussed the circumstances in which he would want euthanasia with his attending physician. They spoke about euthanasia again a number of times after that occasion. A few days before he died, the patient specifically requested euthanasia and repeated this request several times. There were several advance directives. An independent physician (a specialist who was also a SCEN physician) saw the patient two weeks before his death. According to her report, the patient gave an impression of old age, responded slowly, spoke haltingly and initially made only brief eye contact. He was visibly restless and tense. At his wife's suggestion, he sat down on the sofa. During their conversation, the patient clearly described the uncertainty and sadness that developing this condition at his age had caused him. He knew the dementia now largely determined his life. He knew that there was no treatment that would allow him to live a little longer with at least some dignity. He wanted to stay in charge of his situation and had dictated his wishes to his wife, who had written them down for him. He was aware of his changing cognitive capacity and of the other limitations that, among other things, prevented him from working, driving and riding a motorcycle. These cognitive and physical limitations would only worsen. He absolutely did not want to be admitted to a nursing home or any other institution and he knew the time was coming that this would become unavoidable. He did not want to become incapable of recognising his wife and children. He was exhibiting increasing impulsivity as a result of his demential syndrome, requiring him to be restrained by his wife. He knew that these behaviours would only get worse, and experienced this as degrading.

According to the independent physician, the patient had a clear opinion about when he would want euthanasia to be performed and he had discussed this at length with his

physician and close family. The patient was decisionally competent during this conversation. His request was voluntary and well-considered. The independent physician believed that the patient's condition was untreatable and he was already at a stage that it was almost impossible for him to live with dignity. The patient's suffering was palpably unbearable. It was caused not only by his physical decline, fears and hallucinations but also by the knowledge that further deterioration, physically, cognitively and behaviourally, was inevitable.

The independent physician was convinced that the due care criteria would be fulfilled at the point where the patient actually requested the euthanasia procedure to be performed, provided this took place within six weeks. But if euthanasia were not performed within six weeks, the attending physician would have to consult an independent physician again. In reviewing this notification, the committee considered that a request for termination of life from a patient suffering from progressive dementia must be responded to with even greater care than usual. There may be doubts about whether the patient is decisionally competent, and whether the request is voluntary and well-considered. It is also necessary to ascertain whether the patient's suffering is in fact unbearable. In the committee's opinion, the attending physician acted with due care in this case.

A detailed advance directive, dictated by the patient and describing his suffering and his wishes, was included in the records. The patient's records show that the patient's wish for euthanasia in the event of unbearable suffering had existed for some time, and that he had arrived at a point where he wanted his wish to be carried out because his suffering had become unbearable to him. The records also revealed that the patient remained oriented to time, place and self. The independent physician, after discussing the patient with the attending physician, examining relevant documents and extensively interviewing the patient, concluded that she had no doubts about the unbearableness of the patient's suffering and his decisional competence. The independent physician was a geriatrician which the committee considered made her opinion sufficiently authoritative.

In view of the above facts and circumstances, the committee found that the due care criteria had been complied with.

Case 7 (not included here)

b. Unbearable suffering without prospect of improvement

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

There is no prospect of improvement if the disease or condition that is causing the patient's suffering is incurable and alleviation of the symptoms to such an extent that the suffering is no longer unbearable is also impossible. It is up to the physician to decide whether this is the case, in the light of the diagnosis and the prognosis. In answering the question of whether there is any realistic prospect of alleviating the symptoms, account must be taken both of the improvement that can be achieved by palliative care or other treatment and of the burden such care or treatment places on the patient. In this sense, 'no prospect of improvement' refers to the disease or condition and its symptoms, for which there are no realistic curative or

palliative treatment options that may – from the patient's point of view – be considered reasonable.

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

Case 8 (not included here)

It is harder to decide whether suffering is unbearable, for this is essentially an individual notion. What is still bearable to one patient may be unbearable to another. Whether suffering is unbearable is determined not only by the patient's current situation, but also by his perception of the future, his physical and mental stamina, and his personality.

Notifications often describe unbearable suffering in terms of physical symptoms such as pain, nausea and shortness of

breath and feelings of exhaustion, increasing humiliation and dependence, and loss of dignity. In practice, a combination of aspects of suffering almost always determines whether it is unbearable. The degree of suffering cannot be determined merely by looking at the symptoms themselves; it is ultimately a matter of what they mean to the patient, in the context of his life history and values.

The physician must find the patient's suffering to be palpably unbearable. The question here is not whether people in general or the physician himself would find

suffering such as the patient's unbearable, but whether it is unbearable to this specific patient. The physician must therefore be able to empathise not only with the patient's situation, but also with the patient's point of view. A crucial factor when the committees make their assessments is whether the physician is able to make it clear that he found the patient's suffering to be palpably unbearable.

Case 9 (not included here)

Case 10

Unbearable suffering with no prospect of improvement in a patient suffering from multiple geriatric syndromes and loss of dignity

Finding: criteria complied with

The patient, a man in his eighties, had increasing physical disabilities due to deteriorating visual, auditive and motor functioning. Shortly before his death he contracted a urinary tract infection and pneumonia, for which he did not want to be treated. He was in pain.

Due to his physical debilitation he was increasingly dependent on others, needing assistance to get out of bed, wash and dress, and go to the toilet. He had been fitted with a urinary catheter. He needed a stairlift to get to the living room. He could walk a few steps with a rollator. It was becoming increasingly difficult for him to read large-print books and his ability to concentrate was declining. He slept badly because he could not find a position in which he was free of pain. In recent months he had had more falls because of balance disorders. The patient's suffering was caused by his deteriorating condition, as a result of which he could no longer walk, read or listen to music, and by the knowledge that his condition would only decline further and he would lose his dignity. For a man who had always been very independent and who loved reading and listening to music, this suffering was unbearable, which the attending physician found palpable. His suffering was clearly without prospect of improvement.

The independent physician consulted reported that she met with a cachectic man, seated on a sofa. He stood up with difficulty, using a rollator, in order to greet her. During their conversation he told her about his life. He considered himself an artist, but in recent years he had been increasingly unsuccessful in executing the ideas he had in his mind. Recently, he had become completely unable to do so. He felt his situation could get no worse. In addition, he needed help with everything and had become completely dependent on others, a situation he could not tolerate. He wanted to die with dignity. According to the independent physician, the patient's suffering was unbearable and without prospect of improvement due to a progressive motor and sensory decline.

In reviewing this notification, the committee felt that the attending physician had not given sufficient information about the patient's personality and the interaction between patient and doctor that led the physician to conclude that the patient's suffering was unbearable. It therefore invited him for a personal interview to provide more information.

In the interview, the physician explained that the patient had been registered with his practice for over 35 years. During most of that time, he saw the patient infrequently. The patient was very self-aware. He had always made clear choices in life. He had discussed euthanasia with his attending physician at an early stage. Quality of life was very important

to him, but in more recent years it had been deteriorating increasingly. The patient slept badly, became short of breath just moving about the house, and could hardly enjoy listening to audio books anymore due to increasing deafness. He had already had to give up reading due to loss of visual acuity.

The patient wanted to die with dignity. On being invited to give further details, the physician said the patient had told him that he no longer had any quality of life and wanted the doctor to help him. The physician had informed him about various aids such as a mobility scooter and low vision aids, but the patient had rejected these as they would not solve the main problem: the fact that he was suffering from a declining quality of life. He was deteriorating physically, becoming increasingly dependent, he could no longer read and had trouble concentrating when he had visitors. He perceived this situation as humiliating.

The physician explained that when patients ask him about his position on euthanasia, he always tells them it is not something they are entitled to have, but he is willing to discuss such a request. He said that he could only agree to the patient's request once the unbearableness of the patient's suffering had become palpable to him. If he had had any doubts about whether the patient's suffering was palpable, he would have asked the SCEN physician to pay close attention to this point.

In view of the above facts and circumstances, the committee found that the patient's suffering was unbearable and without prospect of improvement and that the remaining due care criteria had also been complied with.

Case 11 (not included here)

Dementia

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

Another key issue is whether dementia patients can be said to be suffering unbearably. What makes their suffering unbearable is often their perception of the deterioration that is already taking place in their personality, functions and skills, coupled with the realisation that this will only worsen and eventually lead to utter dependence and total loss of self. Being aware of their disease and its consequences may cause patients great and immediate suffering. In that sense, 'fear of future suffering' is a realistic assessment of the prospect of further deterioration. Here, too, the specific circumstances of the case will determine whether the doctor is satisfied that the patient's suffering is unbearable. Cases 5 and 7 (not discussed here) illustrate this point.

Mental illness or disorder

It has already been emphasised elsewhere in this report that a wish for euthanasia or assisted suicide expressed by a patient suffering from a mental illness or disorder requires the attending physician to exercise particular caution. Apart from the question of decisional competence and whether the patient can be deemed capable of making a voluntary,

well-considered request, a key question is whether his suffering is unbearable, and if so, whether this unbearable suffering is without prospect of improvement.

Case 12 (not included here)

Case 13 (not included here)

Coma and reduced consciousness (non-comatose)

Suffering assumes a conscious state. Since a patient in a coma is in a state of complete unconsciousness, he cannot be said to be suffering. In this situation, there can be no euthanasia.

One exception can be made to this principle: unlike in cases where coma has occurred spontaneously as the result of illness or complications associated with illness, euthanasia may be justified in the case of medically induced coma, resulting from the administration of medication to alleviate pain and symptoms and therefore in principle reversible. In this case, it is considered inhuman to wake the patient simply so that he can confirm that he is again, or still, suffering unbearably.

If a patient is in a state of reduced consciousness (but not in a coma) – either spontaneously or as a result of medication to reduce pain or symptoms – the physician may, in the light of the patient's responses, reach the conclusion that the patient is indeed suffering unbearably. To assist physicians in assessing level of consciousness, the Glasgow

Coma Scale is included in the KNMG Guidelines entitled 'Euthanasia for patients in a state of reduced consciousness', published in mid-June 2010. These guidelines deal specifically with the situation where, after the attending physician has consulted an independent physician and is ready to carry out euthanasia, the patient – spontaneously or otherwise – falls into a state of reduced consciousness (in which suffering cannot be ruled out) or is put into reversible coma. In these circumstances the physician may proceed with the euthanasia without again consulting an independent physician. Although the patient is no longer able to express his wishes immediately prior to euthanasia, an advance directive is not required. Case 14 (not discussed here) concerns such a situation.

In exceptional cases, a physician may – on the basis of section 2, subsection 2 of the Act – want to carry out a patient's request for euthanasia, which the patient can no longer express because he is in a state of reduced consciousness or reversible coma, but which is stated in an advance directive, without first having consulted an independent physician. The guidelines do not apply to this type of situation, although the Glasgow Coma Scale remains a valuable tool to assess the level of consciousness or depth of coma (and therefore the possibility of suffering). In this situation, too, it is considered inhuman to wake the patient so that he can confirm that his suffering is unbearable. Case 4 (not discussed here) serves as an example.

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

Case 14 (not included here)

Palliative sedation

Palliative sedation means deliberate reduction of the patient's consciousness in order to eliminate untreatable suffering in the final stage of his life. Palliative sedation can only be considered if the patient is expected to die within two weeks.⁴ The possibility of palliative sedation does not always rule out euthanasia.

There are patients who expressly refuse palliative sedation and indicate that they wish to remain conscious to the very end. In such situations, the physician and patient may conclude that palliative sedation is not a reasonable alternative.

c. Informing the patient

Physicians must inform the patient about his situation and prognosis.

In assessing compliance with this criterion, the committees determine whether, and how, the physician, or other attending physicians, have informed the patient about his disease and prognosis. In order to make a well-considered request, the patient must have a full understanding of his disease, the diagnosis, the prognosis and the possible forms of treatment.

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

d. No reasonable alternative

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

It must be clear that there is no realistic alternative way of alleviating the patient's suffering, and that termination of life on request or assisted suicide is the only way left to end that suffering. The focus is on treating and caring for the patient and on limiting and where possible eliminating the suffering, even if curative therapy is no longer possible or the patient no longer wants it.

The emphasis in medical decisions at the end of life must be on providing satisfactory palliative care. However, this does not mean that the patient has to undergo every possible form of palliative care or other treatment. Even a patient who is suffering unbearably with no prospect of improvement can refuse palliative care or other treatment. One factor that can lead a patient to refuse palliative or other treatment is, for example, that it may have side effects which he finds hard to tolerate and/or unacceptable. In that case, he does not consider that the effect of the treatment outweighs its disadvantages. There are also patients who refuse an increased dose of morphine because of a fear of becoming drowsy or losing consciousness. The physician must then ensure that the patient is properly informed and discuss with him whether this fear is justified.

⁴ KNMG guidelines on palliative sedation, revised in 2009

Refusal of palliative treatment or other care is an important subject for discussion between physicians and patients. If the physician and the patient then reach a joint decision,

the physician will be expected to indicate in his report to the committee why the patient did not consider other alternatives reasonable or acceptable.

Case 15

Possibility of reasonable alternatives; the importance of the independent physician's opinion

Finding: failure to comply with the criteria

The patient, a woman in her seventies, had suffered severe back pain for many years. She could not remember a time when she had not had back pain. Four years before her death, her general practitioner had concluded on the basis of x-rays that she had lumbar compression fractures at several levels due to osteoporosis. The only available treatment was to attempt to reduce her pain to a bearable level through medication. Her condition was expected to worsen in the future. Three years after the x-rays were taken, the patient started using fentanyl patches in increasing dosages. Even the maximum dosage had no effect on the pain.

The patient also started taking the antidepressant amitriptyline, but it had no effect except that she became increasingly drowsy and more likely to fall. On her doctor's advice, she was temporarily admitted to a nursing home, so someone could keep an eye on her and her medication could be finetuned. This created a more restful situation, but her pain did not diminish. The pain caused her unbearable suffering. After her temporary stay, the patient returned home. She consulted a manual therapist independently of her GP, but he was unable to treat her.

The patient longed to leave this life behind her and enter a new life. Every activity of daily living caused her pain. The unbearable nature of her suffering was also due to the absence of any prospect for improvement in her situation. Based on consultations with pain specialists about similar cases, the attending physician was convinced that a nerve block, even with an epidural catheter, would have no effect on referred pain. The physician was satisfied that this suffering was unbearable for the patient. According to the physician, there was no other way to relieve the suffering apart from the palliative measures already taken.

According to the independent physician's report, the patient was bedridden most of the time. She only got out of bed to go to the toilet. She could give a clear account of her medical history. She told the independent physician that she had suffered back pain ever since she was thirteen years old. Until five years ago, the cause of this pain had never been investigated. An x-ray taken four years ago showed that she had scoliosis with osteoporotic and collapsed vertebrae. Her doctor had concluded that this had to be the cause of her severe back pain. Based on this diagnosis, the physician was of the opinion that there was no curative or palliative treatment for her condition and that her complaints would only worsen. The patient's life was dominated by pain and she was becoming increasingly immobile. As a result of the overwhelming pain, her life had no meaning for her anymore.

According to the independent physician, the request for euthanasia was voluntary and well-considered. Her suffering was both mentally and physically unbearable. The patient's suffering was palpable to the independent physician in part due to her dependence on others. However, the independent physician also believed the attending physician had not done enough to alleviate her pain. She had only been given fentanyl patches with a maximum dosage of 50 micrograms, supplemented with oxycodone and, for a limited time, amitriptyline.

When the notification was first reviewed in the regional committee meeting, it became apparent that the notifying physician and the independent physician held fundamentally

different opinions on whether there was scope for palliative treatment to reduce the patient's unbearable back pain. The committee wondered if the attending physician had consulted a back specialist, a palliative care team or a pain management team. The committee also wanted to examine the written conclusions of the back clinic in The Hague that the patient had visited with her son a year before her death, apparently at her own initiative. Finally, the committee wanted to interview both the attending physician and the independent physician regarding their respective roles in the euthanasia procedure. During the interview, the independent physician told the committee that he could not understand how a patient who had suffered back pain since she was 13 years old could now, after sixty years, suddenly experience this pain as unbearable. This was one of the reasons why he had phoned the attending physician after seeing the patient. He believed he did not have enough information about the patient's medical condition to give his opinion. The patient had had back pain since she was thirteen, but her complaints increased after childbirth. The independent physician had been unable to ascertain precisely when her complaints had worsened. The patient clearly explained that her back pain dominated in her life. Whenever she got up out of bed and went downstairs, she would soon want to lie down again. The patient showed the independent physician the medication that she had been prescribed. He believed she was not being given enough. As a general practitioner, he had several female patients with similar back conditions who responded well to pain medication. In his opinion, the attending physician had done little in terms of pain management in this case.

The patient also told him that she had seen a doctor at a back clinic, but she could not remember the name of the doctor or the clinic. The independent physician believed the doctor was an orthopaedic surgeon, but was not certain of this. In his conversation with the patient, it became clear to the independent physician that euthanasia would not be necessary if her pain were treated effectively, as her suffering would no longer be unbearable. The patient had explicitly said that if she was no longer in pain, she would not want euthanasia. During his interview with the committee, the attending physician stated that he had extensive experience with pain management teams and in his opinion, referring a patient to a pain management team was only effective in the case of radiculitis. Pain in bones, tendons and ligaments could be treated by a general practitioner as they regularly deal with these complaints; referral to a pain management team would offer no benefits.

The attending physician also told the committee that he saw no indications of other pathology, e.g. ovary-related disorders or bone metastases. The patient's pain was aggravated by movement and in his opinion there could be no other cause than vertebral collapse. The pain she suffered in the last year of her life was the same pain she had had four years earlier (when the x-rays were taken), but she had struggled on because she thought the doctor would not want to carry out euthanasia.

The attending physician made it clear that he did not take seriously the patient's visit to the manual therapist, which she had done on her initiative. The manual therapist had telephoned him to say that he could not help the patient because of spinal malformations at several levels. He, too, had said there would be no point in referring her to an orthopaedic surgeon or a pain management consultant, an opinion that the physician shared.

The attending physician considered giving the patient morphine but this was a risk as she lived alone. He also explained that he considered the possibility the patient might have psychological symptoms, but he did not believe any significant psychological problems were present.

He told the committee he had the patient admitted to a nursing home to create a restful situation. At home, the patient had fallen as a result of taking morphine. However, she did not retract her wish for euthanasia. The physician indicated that he did not feel obliged to automatically comply with a request for euthanasia. He would only respond to such a request if it was both palpable to him and genuine. He said that his experience of the past twenty years had taught him that patients whose wish for euthanasia was not genuine would change

their minds and not go through with it in the end. He explained that when, as a doctor, you respond to a request for euthanasia, it soon becomes clear whether or not the patient's wish is genuine. Considering the pain this patient suffered, her wish was palpable to the doctor. Physicians at a pain management clinic could do nothing to ease her unbearable suffering. The committee noted that suffering is without prospect of improvement if there is no realistic possibility of treatment. The disease or condition that is causing the suffering is incurable and there is no realistic prospect of alleviating the symptoms. 'Realistic prospect' means that the improvement that can be achieved by palliative care or other treatment must be in reasonable proportion to the burden such treatment places on the patient.

In this case, the committee was not convinced that the patient's suffering was without prospect of improvement. The reasons for its findings are as follows. When the patient first registered with the practice more than 12 years ago, she was already suffering back pain, but no diagnosis was made. She had had back pain since she was 13 years old, but the cause of this pain was not known to the physician. The physician acknowledged that he did not have a diagnosis made previously to the patient registering with his practice nor any other medical information on her chronic back pain. The patient did not visit the surgery often. The physician ordered x-rays of her lumbar vertebrae twice – six and four years ago. The most recent x-rays revealed progressive compression of the third and fourth lumbar vertebrae as well as discopathy and spondylosis at all levels, but the doctor could not confirm that the pain the patient suffered in recent years was the same pain that she had always had.

In view of these findings, the physician believed there was no point in referring the patient to a pain management clinic as that would only help in the case of radiculitis, which she did not have. Nor did the physician refer her to an orthopaedic surgeon.

It was not clear to the committee (and could not have been clear to the attending physician) whether the patient's back pain was explained sufficiently by the diagnosis made four years ago based on x-rays, particularly as she had had this pain since her youth. Without further diagnosis, it was impossible to establish whether or not treatment options existed. The committee was therefore unable to conclude that the patient's unbearable situation was untreatable. To reduce the pain, the patient had only been given fentanyl patches with a maximum dosage of 50 micrograms, supplemented with oxycodone and Lyrica. She had also taken amitriptyline for a period.

Furthermore, the independent physician too did not believe that all possible pain management options had been exhausted. He considered, based in part on his own experience with this type of patient, that the attending physician had not prescribed enough analgesics. He also considered it important that the patient had told him that she would not want euthanasia if her pain could be treated.

This leads to the conclusion that the physician could not have been satisfied that no other realistic option was available in this patient's situation.

As it was impossible to establish incontrovertibly that the patient's back pain was due to osteoporotic deterioration, especially as the complaints had existed for more than 60 years, the committee found that the attending physician should at least have referred the patient to a specialist or a multidisciplinary team for further diagnostics and/or treatment. Even if osteoporosis had been the only cause of the pain, the attending physician had not exhausted all palliative treatment options. On consulting a pain management team at a university hospital, the committee learned that the type of pain suffered by this patient often responds well to treatment, even when it is not radiculitis.

Without a clear diagnosis and considering that palliative treatment might yet have been possible, the committee concluded that the patient's suffering at the time of euthanasia was unbearable to her, but not (yet) without prospect of improvement.

In summary, the committee finds that the physician did not act in accordance with the statutory due care criteria described above.

e. Independent assessment

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

The physician is legally required to consult a second, independent physician who will give an independent expert opinion on whether the due care criteria set out under (a) to (d) have been fulfilled before the termination of life on request or the assisted suicide takes place, and draw up a written report. The purpose of this is to ensure that the physician's decision is reached as carefully as possible. The independent assessment helps the physician confirm that he has complied with the due care criteria, and reflect on matters before granting the request.

The independent physician sees the patient to determine whether the physician who intends to perform the procedure has not overlooked anything regarding the due care criteria under (a) to (d); the same applies to any other independent physicians who are consulted. If an independent physician who has been consulted earlier is consulted again, this consultation may, depending on the circumstances described below, take place by telephone. The consultation must be formal, and specific questions must be answered. The committee interprets the term 'consult' to mean considering the independent physician's findings and taking account of them when deciding whether to grant the patient's request for termination of life.

Independent physician

The independent physician must be independent of the attending physician and the patient. The KNMG's 2003 Position Paper on Euthanasia also explicitly stated (p. 15) that the physician's independence must be guaranteed. According to the KNMG, this implied that a member of the same group practice, a registrar, a relative or a physician who was otherwise in a position of dependence in relation to the physician who called him in could not normally be deemed independent. The need to avoid anything that might suggest the physician was not independent was once again emphasised. What this means, in sum, is that there must not be any family or working relationship between the two physicians, or in principle any other form of partnership.

The physician's independence may also appear open to question if the same two medical practitioners very often act as independent physicians on each other's behalf, thus effectively acting in tandem. This may create an undesirable

situation, for their independence may then – rightly – be called into question. The committees feel that, if a physician always consults the same independent physician, the latter's independence can easily be jeopardised. As stated above, it is vital to avoid anything that may suggest the physician is not independent.

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

In the interests of an independent assessment, attending physicians are advised to – and usually do – consult a SCEN physician as independent physician, via the Euthanasia in the Netherlands Support and Assessment Programme (SCEN) (see below).

In the case of the patient there must, among other things, be no family relationship or friendship between them, the physician must not be helping to treat him (and must not have done so in the past) and he must not have come into contact with him in the capacity of locum.

Independent physician's report

The independent physician's written report is of great importance when assessing notifications.⁵ A report describing the patient's situation when seen by the physician and the way in which the patient talks about his situation and his wishes will give the committee a clearer picture.

The independent physician must give his opinion on whether the due care criteria set out in (a) to (d) have been fulfilled. He should also specifically mention his relationship to the attending physician and the patient. The independent physician is responsible for his own report. However, the attending physician bears final responsibility for performing the life-terminating procedure and for complying with all the due care criteria. He must therefore determine whether the independent physician's report is of sufficient quality and whether the independent physician has given his opinion as to whether the due care criteria set out in (a) to (d) have been fulfilled. If necessary, he must ask the independent physician further questions.

⁵ The checklist for reporting by independent physicians on euthanasia and assisted suicide can be used as a guide (see www.euthanasiacommissie.nl)

Situation after consulting independent physician

Sometimes an independent physician concludes on seeing the patient that one or more of the due care criteria have not yet been fulfilled. In such cases, it is not always clear to the committees what exactly happened subsequently, so that further questions have to be put to the notifying physician. This might, for example, occur in the following situations.

- If the independent physician is called in at an early stage and finds that the patient is not yet suffering unbearably or that a specific request for euthanasia has not yet been made, he will usually have to see the patient a second time.
- If he has indicated that the patient's suffering will very soon become unbearable and has specified what he believes that suffering will entail, a second visit or a second consultation by telephone or in any other manner will not normally be necessary if the patient's suffering does indeed become unbearable very soon. However, it may still be advisable for the two physicians to consult by telephone or in some other manner.
- If the unbearable nature of the patient's suffering is already palpable to the independent physician, but the patient has not yet made a specific request for euthanasia to be performed – in order to say goodbye to relatives, for example – a second visit or a second consultation by telephone or in any other manner will not normally be necessary.

If a longer period of time is involved or if the prognosis is less predictable, the independent physician will normally have to see the patient a second time (see case 16).

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

The committees also receive notifications in which the independent physician was consulted, saw the patient and made his report very shortly before the patient died, or even on the day of death. In such cases it may be advisable for the attending physician to make clear when and how he received the independent physician's report.

The physician should take the independent physician's opinion very seriously, but if there is a difference of opinion between the two, the attending physician must ultimately reach his own decision, for it is his own actions that the committees will be assessing.

SCEN

The Euthanasia in the Netherlands Support and Assessment Programme (SCEN) trains physicians to make independent assessments in such cases. In most cases it is 'SCEN physicians' who are called in as independent physicians. The committees are pleased to note that specialists these days almost always call in a SCEN physician when euthanasia is performed in a hospital. Increasingly, they are themselves trained SCEN physicians. SCEN physicians also have a part to play in providing support, for example by giving advice. The committees note that by no means all physicians consult the SCEN physician about how the euthanasia or assisted suicide procedure is performed. Although section 2, subsection 1 (e) of the Act only requires the independent physician to give an opinion on compliance with criteria (a) to (d), there is no reason why the attending physician should not discuss with the independent physician (who is usually a SCEN physician) how he intends to perform the procedure.

The committees also note that some SCEN physicians offer to advise the attending physician on the performance of the procedure – an excellent example of the support component of the SCEN programme.

Case 16

Independent assessment four months before death

Finding: failure to comply with the criteria

Five years ago, the patient, a woman in her sixties, was diagnosed with adenocarcinoma in the first half of her colon. After surgery she was given chemotherapy. Three years later she was admitted to hospital with probable ileus, but a colonoscopy revealed no abnormalities. After six months, abnormalities were found and the patient underwent a laparotomy, which revealed incurable recurrent and metastasised colon carcinoma. Palliative surgery was performed.

The patient's suffering consisted mainly of vomiting, nausea and abdominal pain. In the period before her death, her bouts of abdominal pain became more frequent and she had increasing difficulty tolerating the food supplied by nasogastric intubation. Her symptoms were also becoming more severe. Her physician found her suffering palpably unbearable. Eight months before her death, the patient had discussed termination of life in a general

sense with the attending physician. She had also discussed the subject before that time with her former general practitioner. Three days before she died, she specifically requested that euthanasia be carried out. She repeated her request several times. There was an advance directive.

According to the physician there was no pressure on the patient from those around her and she was aware of the implications of her request and of her physical situation.

An independent general practitioner, who was also a SCEN physician, was consulted as an independent physician. The independent physician saw the patient four months before her death (after discussing the patient with the attending physician and examining her medical records) and confirmed the patient's case history. He confirmed that the patient was suffering unbearably without prospect of improvement. There were no alternative ways to reduce her suffering. The patient's request was voluntary and well-considered. The independent physician was satisfied that the due care criteria had been complied with. The physician performed euthanasia by administering 2000 mg of thiopental and 20 mg of pancuronium.

In its acknowledgement of receipt of the notification, the committee asked the notifying physician for further details about the method of administration of the euthanatics. By letter, the physician explained that, contrary to what he had indicated in his report, ninety minutes after intravenously administering 2000 mg thiopental and 20 mg pancuronium, he had administered an additional 20 mg of pancuronium (five ampoules). The patient died 20 minutes later.

The physician's letter did not give the committee a clear picture of what had happened when the procedure was performed. The committee also noted that it was not clear how the patient's situation had developed since the independent physician's visit four months before the termination of life was performed.

The committee therefore invited the physician for an interview to provide further information on the procedure leading up to the patient's death. The physician explained to the committee that, before the independent physician saw her, the patient was in pain due to ileus. From experience he knew that it is impossible to predict how such situations will develop, so he decided to ask for an independent assessment without delay. After the independent physician saw the patient, her condition improved and she retracted her request for termination of life.

After this episode, she initially showed great perseverance, in part due to her children's difficulty accepting the notion of termination of life, but as time went on it became harder and harder for her to deal with the symptoms she was experiencing. Shortly before her death, the patient's pain had steadily worsened and she became unable to keep down any food. The patient said that her suffering was unbearable to her and wanted euthanasia to be performed.

The physician assessed the patient's condition as fundamentally unchanged since the independent physician's visit and did not think that a second visit was necessary or would provide new insight.

As regards the procedure to terminate life, the physician said he had not expected that the patient would not die after administering the usual course of euthanatics. This led to a stressful situation, while he could not let his anxiety show in any way. He contacted the pharmacist who advised him to administer another 20 mg dose of pancuronium. He trusted the pharmacist's advice as he assumed the latter would know more about drugs than he did. Before he administered the additional dose of pancuronium, he had observed that the patient was in a state of deep unconsciousness. She did not respond to stimuli. He had checked whether she was in a deep coma by looking at the patient, talking to her and touching her arm. Considering that the physician administered the extra dose of pancuronium ninety minutes after injecting thiopental and the first dose of pancuronium, the committee was of the opinion that he should have established the depth of the coma correctly, such as by testing the corneal reflex. The physician explained that he was in such a

stressful situation that he did not question whether the patient was in a sufficiently deep coma.

After his interview with the committee the physician provided further details in writing a number of times, prompted in part by the interview report. However, the new information was inconsistent and contradicted information that he had previously supplied to the committee both orally and in writing. The physician explained that this was due to the stress he experienced during the interview, so that he had been unable to clearly recollect the events.

With regard to the independent assessment, the committee made the following observation. The Act requires physicians to consult at least one other independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in section 2, subsection 1 (a) to (d) have been fulfilled. The independent physician must make an independent expert assessment and put his opinion in writing. The purpose of this is to ensure that the physician's decision is reached as carefully as possible. The independent assessment helps the physician confirm that he has complied with the due care criteria, and reflect on matters before granting the request. In this case, the documentation supplied with the notification did not give the committee a clear picture of how the patient's situation changed after the independent physician had seen her. The physician provided more information about this during his interview with the committee. The physician had assessed the patient's condition as fundamentally unchanged since the independent physician's visit and had therefore not considered a second visit necessary or useful.

In the committee's opinion, however, the improvement in the patient's condition after the independent physician saw her – to the extent that she decided not to go through with the termination of life – constituted a new situation. In that light, the physician should have consulted the independent physician again (if necessary by telephone) when the patient again requested termination of life.

In the committee's opinion, by not seeking a second independent opinion, the physician failed to comply with the due criterion under section 2, subsection 1 (e) of the Act.

With regard to the procedure for terminating life, the committee noted that the physician is responsible for performing the euthanasia with due care, even if he has obtained his information from an expert, in this case a pharmacist.

The committee observed that, considering the length of time between administering thiopental and the additional dose of pancuronium, the physician should first have established the depth of coma before administering the latter. Neither the information provided in writing nor the interview with the physician made it clear to the committee whether or not a coma check had taken place and, if so, whether it could be considered adequate in the circumstances. The information supplied by the physician after the interview with the committee contradicted his statements during the interview.

The committee acknowledged that terminating life is not part of normal medical practice and that it can be an extremely stressful experience for physicians. The committee could well imagine that a termination of life that had not proceeded as expected would be a stressful experience that would be burned into the physician's memory.

If, on the other hand, the physician had forgotten the details of what actually happened during the procedure, the committee could also conceive that – on being asked to provide further details or attend an interview with the committee on the termination of life – he would make every effort to refresh his memory.

Considering the above, especially the fact that supplementary written information was not supplied until after the interview, which moreover contradicted earlier statements made orally and in writing, the committee finds that the physician did not perform the euthanasia procedure in accordance with good medical practice and hence did not act in accordance with the statutory due care criterion described under section 2, subsection 1 (f) of the Act.

Case 17 (not included here)

f. Due medical care

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

In the case of euthanasia, i.e. termination of life on request, the physician actively terminates the patient's life by administering the euthanatics to the patient intravenously. In the case of assisted suicide, the physician gives the euthanatic to the patient, who ingests it himself.

The physician must remain with the patient or in his immediate vicinity until the patient is dead. This is because there may be complications; for example, the patient may vomit the potion back up or death may not ensue as quickly as expected. In that case the physician may perform euthanasia. The physician must discuss these possible events with the patient and his family beforehand. The physician may not leave the patient alone with the euthanatics. This may be hazardous, to other people as well as to the patient.

Termination of life on request or assisted suicide is normally carried out using the method, substances and dosage recommended in *Standaard Euthanatica 2007*, the guidelines drawn up by the KNMP.⁶ In cases of termination of life on request, *Standaard Euthanatica 2007* recommends intravenous administration of a coma-inducing substance, followed by intravenous administration of a muscle relaxant. In the guidelines, the KNMP indicates which substances should be used to terminate life on request. It makes a distinction here between 'first-choice' substances⁷ and 'second-choice' substances.⁸ Physicians have less experience with the latter category of substances. *Standaard Euthanatica 2007* also lists substances that are not alternatives to first-choice substances, and substances that should not be used at all.

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

The use of non-recommended substances may have negative consequences for the patient. This can be avoided by using the appropriate substances. There must be a guarantee that a patient is in a deep coma when the muscle relaxant is administered.

The committees have no objection to the use of a substance such as midazolam as pre-medication before a recommended coma-inducing substance is administered. Before performing euthanasia, physicians are advised to discuss with the patient and his relatives what effect the substances will have. Subject to the constraints imposed by the KNMP's recommendations in *Standaard Euthanatica 2007*, it is important to fulfil patients' personal wishes as far as possible.

Standaard Euthanatica 2007 also states which dosages the KNMP recommends for termination of life on request and assisted suicide. The committees will ask the physician further questions if the dosage is not mentioned or if it differs from the dosage indicated in *Standaard Euthanatica 2007*. As already indicated, there must be a guarantee that a patient is in a deep coma when the muscle relaxant is administered. The use of a coma-inducing substance recommended in *Standaard Euthanatica 2007*, as well as the correct dosage, is crucial in order to ensure that the patient cannot perceive the effects of the muscle relaxant. In case 18 and case 19 (not discussed here), the physician used a lower dosage than recommended in *Standaard Euthanatica 2007*.

In case 16 the physician had taken advice from a pharmacist. The committee notes that it is the physician, not the pharmacist, who bears responsibility for performing the life-terminating procedure with due care, and hence for the choice and dosage of the substances used. In this case, and in cases 18 and 19, the committees found that the physician concerned had not complied with the criterion concerning due medical care as he was unable to guarantee that the patient was in a deep coma when the muscle relaxant was administered.

The physician must check the depth of the coma in an appropriate manner before administering the muscle relaxant. The joint KNMP/WINAP and KNMG working group (referred to in Chapter 1) will draw up guidelines on the subject.

⁶ *Standaard Euthanatica 2007: toepassing en bereiding*

⁷ Listed in the table on page 22 of *Standaard Euthanatica: toepassing en bereiding, 2007*

⁸ Listed in the table on page 26 of *Standaard Euthanatica: toepassing en bereiding, 2007*

Case 18

Procedure performed using too low a dose of the coma-inducing substance; failure to establish depth of coma

Finding: failure to comply with the criteria

The patient, a man of 80 years, was diagnosed with bronchus carcinoma a month before his death. Metastasised tumours were found throughout the body. The cancer was incurable. The disease progressed rapidly in the weeks before death.

The patient's suffering consisted of nausea with vomiting, which was difficult to treat, and being bedridden and in pain. The patient found this suffering unbearable, which was palpable to the attending physician. The patient had requested the physician to perform termination of life. The independent physician consulted by the attending physician was a geriatrician and SCEN physician. The independent physician was of the opinion that the due care criteria had been complied with and reported his findings to the attending physician the same day. The physician performed euthanasia by administering 1000 mg of thiopental followed by 20 mg of pancuronium. He explained that he had determined the dose of thiopental based on 20 mg thiopental per kg body weight.

In response to the physician's notification, the committee asked him to provide further information regarding the euthanasia procedure.

The day after the SCEN physician saw the patient, the duty physician phoned the attending physician to report that the patient's condition was very poor. The duty physician asked whether he could sedate the patient. The attending physician decided to see the patient himself and he performed euthanasia the same day.

The physician explained that when the patient's condition deteriorated, he had not consulted the most recent guidelines on euthanasia, but he had seen a previous version and looked into it on the internet. The most recent guidelines had to be ordered by post, which he had done. He received this document a few days after performing the termination of life. He performed the euthanasia in the same way as he had done on previous occasions, namely by administering 1000 mg of thiopental and 20 mg of pancuronium. On being invited to give further details, he said that the patient's respiratory rate became severely depressed within one minute. Two or three minutes later he administered pancuronium and the patient died. The physician referred the committee to articles that he had found on the internet which provided established that a thiopental dose of 20 mg/kg can be considered good medical practice.

The physician said he was in no doubt that the patient had felt nothing when the muscle relaxant was administered. The patient was seriously cachectic, weighed some 50 kg, and rapidly went into respiratory depression. The physician also said he did not think it was appropriate to check the depth of coma immediately after administering the thiopental by such means as corneal or eyelash reflex, or pain stimuli. He had relied on clinical observation. The physician stated that he had positive feelings about this case of euthanasia. He did affirm that he would administer 2000 mg of thiopental in similar cases in the future.

The committee noted the following in connection with the performance of the procedure. When determining whether euthanasia was performed in accordance with prevailing medical opinion, the committee normally takes *Standaard Euthanatica 2007* as its guide. This recommends using a 2000 mg dose of thiopental to induce a coma; the reason for this is that the 1500 mg dosage recommended in the previous (1998) version of *Standaard Euthanatica* had in some cases proved too low.

The committee adhered to the principle that there must be a guarantee that the patient cannot come round from the coma and perceive the effects of the subsequently administered muscle relaxant. This is why it considered the dosage of the coma-inducing substance so important. The committee noted that the physician followed an outdated guideline in which the dose of euthanatics is based on the patient's body weight. In view of

the fact that the physician administered 1000 mg of thiopental instead of 2000 mg, the committee considered it imperative to establish whether the patient had been in a sufficiently deep coma before being injected with the muscle relaxant.

The patient in this case was a seriously cachectic man who weighed about 50 kg. According to the physician's observation, his respiratory rate became depressed shortly after thiopental had been administered. The physician had established the depth of coma by clinical observation. He had not tested for corneal or eyelash reflex or pain response.

Respiratory depression alone is not a sufficient indication of a deep coma. By not testing the depth of coma, the physician took the risk that the patient may have felt the muscle relaxant take effect but have been physically unable to make this clear. The committee could only conclude that the physician had not performed the euthanasia procedure in accordance with due medical care.

Case 19 (not included here)

Case 20 (not included here)

Chapter III Committee activities

Statutory framework

Termination of life on request and assisted suicide are criminal offences in the Netherlands (under Articles 293 and 294 of the Criminal Code). The only exception is when the procedure is performed by a physician who has fulfilled the statutory due care criteria and has notified the municipal pathologist. If the physician satisfies both conditions, the procedure he has performed is not treated as a criminal offence. The aforementioned articles of the Criminal Code (Articles 293 (2) and 294 (2)) identify compliance with these conditions as specific grounds for exemption from criminal liability.

The due care criteria are set out in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, and the physician's duty to notify the municipal pathologist is dealt with in the Burial and Cremation Act. The Termination of Life on Request and Assisted Suicide (Review Procedures) Act also states that it is the task of the regional euthanasia review committees to determine, in the light of the physician's report and other documents accompanying the notification, whether a physician who has terminated a patient's life on request or assisted in his suicide has fulfilled the due care criteria referred to in section 2 of the Act.

Role of the committees

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

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

The committees decide whether, in the light of prevailing medical opinion and the standards of medical ethics, the physician has acted in accordance with the statutory due care criteria. If a committee has any questions following a notification, the physician will be informed. Physicians are sometimes asked to respond in writing to additional questions.¹⁰ The committees sometimes contact physicians by telephone if they need extra information. If the information thus provided by the physician is insufficient, he may then be invited to provide further information in person.

A physician will usually be invited to an interview if the committee reviewing his case is inclined to find that he did not act in accordance with the due care criteria. This gives him an opportunity to explain in more detail what took place in this particular case.

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

For a number of years capacity at the committee secretariats had not kept pace with the increase in the number of notifications. In 2011 the committees took on more staff. However, owing to the backlog, the need to train the new staff and the fact that some secretariat staff were on extended sick leave, it was unfortunately still not possible to meet the six-week deadline in a large number of cases. The committees have now changed their working procedures and have improved efficiency. In mid-2011, the committees launched a pilot project on a new working procedure in two regions, in which straightforward notifications are processed digitally. The new procedure complies with statutory provisions and does not affect the quality of the committee's findings. It will be rolled out in all the regions from the beginning of 2012. The committees issue findings on the notifications they assess. In almost every case they conclude that the physician has acted in

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

¹⁰ According to the evaluation of the Act, this happened in some 6% of the cases reported in 2005.

accordance with the statutory due care criteria. In such cases, only the attending physician is informed.

If the committee is of the opinion that the physician has not acted in accordance with the due care criteria, it will send its proposed findings to all the members and alternate members of its own and other committees for their advice and comments. This helps ensure harmonisation and consistency of assessment. The ultimate decision is reached by the competent committee.

In 2011 4 physicians were found not to have acted in accordance with the criteria. In such cases, the findings are not only sent to the attending physician but are also, in accordance with the Act, referred to the Board of Procurators General and the Healthcare Inspectorate. The Board decides whether or not the physician in question should be prosecuted.¹¹ The Inspectorate decides in the light of its own tasks and responsibilities whether any further action should be taken. This may range from interviewing the physician to disciplinary action. The coordinating chair and the alternate coordinating chair of the committees hold consultations with the Board and the Inspectorate every year. There are five regional euthanasia review committees. The place of death determines which committee is competent to review the case in question. Each committee comprises three members: a lawyer, who is also the chair, a physician and an ethicist. They each have an alternate. Each committee also has a secretary, who is also a lawyer, with an advisory vote at committee meetings. The committees act as committees of experts; it should be noted here that, in cases where physicians are found to have acted with due care, their findings are final. The secretariats are responsible for assisting the committees in their work.

For organisational purposes the secretariats form part of the Central Information Unit on Healthcare Professions (CIBG) in The Hague, which is an implementing organisation of the Ministry of Health, Welfare and Sport. The secretariats have offices in Groningen, Arnhem and The Hague, and the committees meet there every month.

The committees help the KNMG's Euthanasia in the Netherlands Support and Assessment Programme (SCEN) to train physicians to perform independent assessments. The committees see all the reports by the independent physicians consulted by the attending physicians, and thus have an overall picture of the quality of these reports. The quality of reporting needs to be constantly monitored, but the committees are very pleased to have noted a definite

improvement in this regard. The committees' general findings are forwarded to SCEN each year.

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

¹¹ Instructions on prosecution decisions in the matter of termination of life on request and assisted suicide, Government Gazette, 6 March 2007, no. 46, p. 14.

Annexe I

Overview of notifications

Overview of notifications, total

1 January 2011 to 31 December 2011

Notifications

The committees received 3,695 notifications in the year under review.

Euthanasia and assisted suicide

There were 3,446 cases of euthanasia (i.e. active termination of life at the patient's request), 196 cases of assisted suicide and 53 cases involving a combination of the two.

Physicians

In 3,329 cases the attending physician was a general practitioner, in 212 cases a specialist working in a hospital, in 139 cases a geriatrician and in 15 cases a registrar.

Conditions involved

The conditions involved were as follows:

Cancer	2,797
Cardiovascular disease	114
Neurological disorders	205
Other conditions	394
Combination of conditions	185

Location

In 2,975 cases patients died at home, in 189 cases in hospital, in 111 cases in a nursing home, in 172 cases in a care home, and in 248 cases elsewhere (e.g. in a hospice or at the home of a relative).

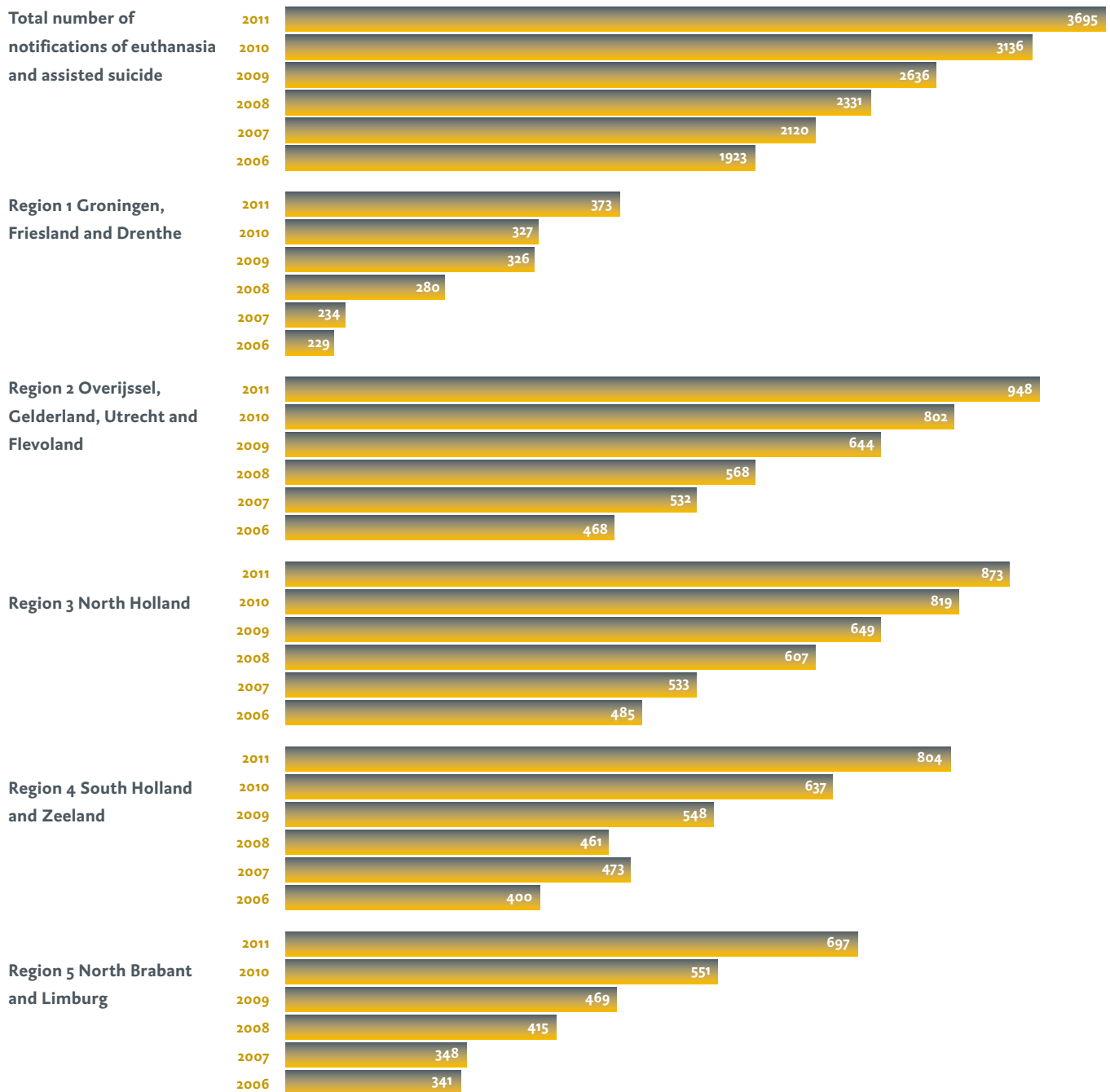
Competence and findings

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

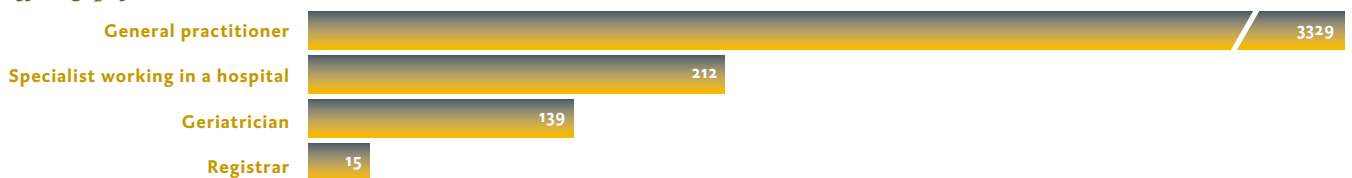
Length of assessment period

The average time that elapsed between the notification being received and the committee's findings being sent to the physician was 111 days.

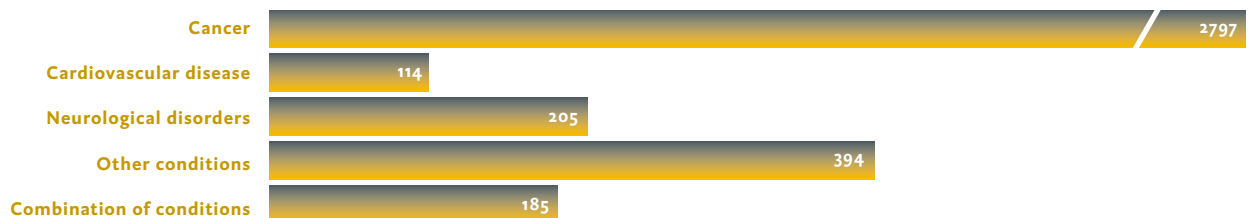
Number of notifications of euthanasia and assisted suicide 2011, 2010, 2009, 2008, 2007 and 2006



Notifying physicians 2011



Conditions involved 2011



Overview of notifications, by region

I

Groningen, Friesland and Drenthe

1 January 2011 to 31 December 2011

Notifications

The regional committee received 373 notifications in the year under review.

Euthanasia and assisted suicide

There were 328 cases of euthanasia, 43 cases of assisted suicide and 2 cases involving a combination of the two.

Physicians

In 350 cases the attending physician was a general practitioner, in 14 cases a specialist working in a hospital, in 8 cases a geriatrician and in 1 case a registrar.

Conditions involved

The conditions involved were as follows:

Cancer	284
Cardiovascular disease	23
Neurological disorders	20
Other conditions	25
Combination of conditions	21

Location

In 314 cases patients died at home, in 14 cases in hospital, in 9 cases in a nursing home, in 23 cases in a care home, and in 13 cases elsewhere (e.g. in a hospice or at the home of a relative).

Competence and findings

In all cases the committee deemed itself competent to deal with the notification. The committee convened 11 times. In one case in the year under review the committee found that the physician had not acted in accordance with the due care criteria.

Length of assessment period

The average period between receipt of the notification and the forwarding of the committee's findings was 50 days.

2

Overijssel, Gelderland, Utrecht and Flevoland

1 January 2011 to 31 December 2011

Notifications

The regional committee received 948 notifications in the year under review.

Euthanasia and assisted suicide

There were 897 cases of euthanasia, 34 cases of assisted suicide and 17 cases involving a combination of the two.

Physicians

In 866 cases the attending physician was a general practitioner, in 43 cases a specialist working in a hospital, in 37 cases a geriatrician and in 2 cases a registrar.

Conditions involved

The conditions involved were as follows:

Cancer	744
Cardiovascular disease	19
Neurological disorders	51
Other conditions	103
Combination of conditions	31

Location

In 801 cases patients died at home, in 40 cases in hospital, in 23 cases in a nursing home, in 37 cases in a care home, and in 47 cases elsewhere (e.g. in a hospice or at the home of a relative).

Competence and findings

In all cases the committee deemed itself competent to deal with the notification. The committee convened 12 times. In one case in the year under review the committee found that the physician had not acted in accordance with the due care criteria.

Length of assessment period

The average period between receipt of the notification and the forwarding of the committee's findings was 145 days.

3

North Holland

1 January 2011 to 31 December 2011

Notifications

The regional committee received 873 notifications in the year under review.

Euthanasia and assisted suicide

There were 795 cases of euthanasia, 60 cases of assisted suicide and 18 cases involving a combination of the two.

Physicians

In 741 cases the attending physician was a general practitioner, in 78 cases a specialist working in a hospital, in 44 cases a geriatrician and in 10 cases a registrar.

Conditions involved

The conditions involved were as follows:

Cancer	608
Cardiovascular disease	43
Neurological disorders	42
Other conditions	117
Combination of conditions	63

Location

In 629 cases patients died at home, in 73 cases in hospital, in 34 cases in a nursing home, in 66 cases in a care home, and in 71 cases elsewhere (e.g. in a hospice or at the home of a relative).

Competence and findings

In all cases the committee deemed itself competent to deal with the notification. The committee convened 12 times. In one case in the year under review the committee found that the physician had not acted in accordance with the due care criteria.

Length of assessment period

The average period between receipt of the notification and the forwarding of the committee's findings was 175 days.

4

South Holland and Zeeland

1 January 2011 to 31 December 2011

Notifications

The regional committee received 804 notifications in the year under review.

Euthanasia and assisted suicide

There were 759 cases of euthanasia, 36 cases of assisted suicide and 9 cases involving a combination of the two.

Physicians

In 734 cases the attending physician was a general practitioner, in 42 cases a specialist working in a hospital, in 27 cases a geriatrician and in 1 case a registrar.

Conditions involved

The conditions involved were as follows:

Cancer	630
Cardiovascular disease	16
Neurological disorders	52
Other conditions	65
Combination of conditions	41

Location

In 632 cases patients died at home, in 39 cases in hospital, in 27 cases in a nursing home, in 29 cases in a care home, and in 77 cases elsewhere (e.g. in a hospice or at the home of a relative).

Competence and findings

In all cases the committee deemed itself competent to deal with the notification. The committee convened 12 times. In one case in the year under review the committee found that the physician had not acted in accordance with the due care criteria.

Length of assessment period

The average period between receipt of the notification and the forwarding of the committee's findings was 91 days.

5

North Brabant and Limburg

1 January 2011 to 31 December 2011

Notifications

The regional committee received 697 notifications in the year under review.

Euthanasia and assisted suicide

There were 667 cases of euthanasia, 23 cases of assisted suicide and 7 cases involving a combination of the two.

Physicians

In 638 cases the attending physician was a general practitioner, in 35 cases a specialist working in a hospital, in 23 cases a geriatrician and in 1 case a registrar.

Conditions involved

The conditions involved were as follows:

Cancer	531
Cardiovascular disease	13
Neurological disorders	40
Other conditions	84
Combination of conditions	29

Location

In 599 cases patients died at home, in 23 cases in hospital, in 18 cases in a nursing home, in 17 cases in a care home, and in 40 cases elsewhere (e.g. in a hospice or at the home of a relative).

Competence and findings

In all cases the committee deemed itself competent to deal with the notification. The committee convened 12 times. In all cases in the year under review the committee found that the physician had acted in accordance with the due care criteria.

Length of assessment period

The average time that elapsed between the notification being received and the committee's findings being sent to the physician was 96 days.