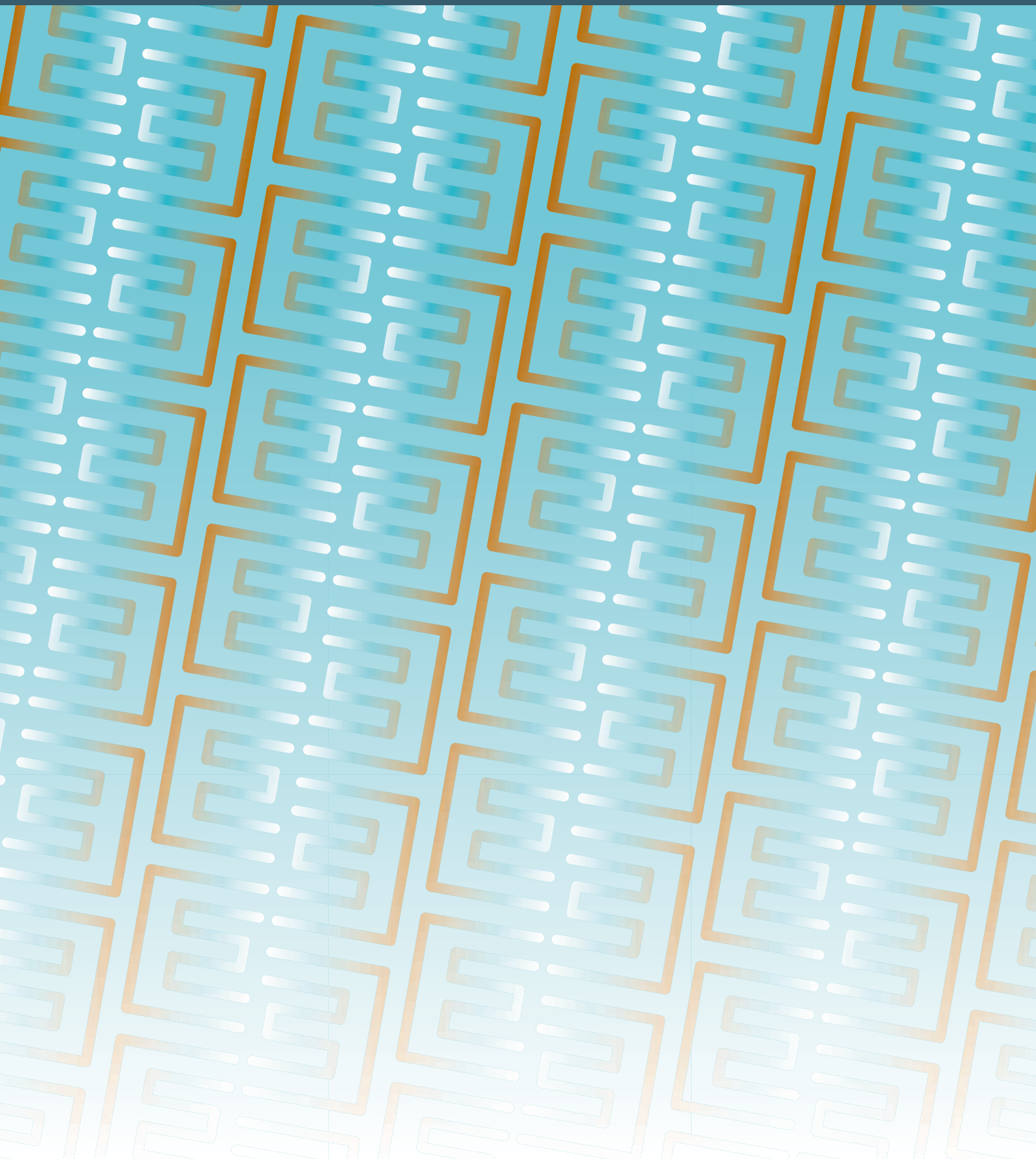
REGIONAL
EUTHANASIA
REVIEW COMMITTEES

RTE

ANNUAL REPORT 2015



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CHAPTER IV THE REGIONAL EUTHANASIA REVIEW COMMITTEES

ANNEXE I

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ANNEXE II

Relevant statutory provisions

FOREWORD

This is the 2015 annual report of the five regional euthanasia review committees (RTEs). In their annual reports the committees account for the way in which they fulfil their statutory task of reviewing cases on the basis of the due care criteria laid down in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

The committees examine the actions of the notifying physician in the context of the Act, its legislative history and the relevant case law. They also take their own previous findings into account, as well as the decisions of the Public Prosecution Service and the Health Care Inspectorate listed in Annexe I to the annual reports.

Chapter I describes relevant developments, followed by an overview in Chapter II of the number of notifications received in 2015 (5,516; a 4% increase compared with 2014) and their nature. Chapter III focuses on cases and findings. It lists 19 cases that illustrate the type of issues the committees deal with. All findings that have been described in the form of cases can be found in full on the website. Chapter IV provides further information on the statutory framework and the role and procedures of the committees.

In early 2016, a completely revamped website (www.euthanasiecommissie.nl) was launched, including an improved, more accessible search function. The website contains around 80 findings from 2015, selected by the Publication Committee and published in full since they are deemed important for the development of standards. They include all cases in which the committees found that the physician had not complied with one or more of the due care criteria. There were four such cases in 2015, all of which have been included in the annual report, as is customary.

Notifications of more complex cases, for example patients who have a psychiatric disorder or who are in an advanced stage of dementia, are nearly always first put to the members of all the committees before the competent committee makes a final decision. The often lively internal discussions are aimed at harmonising the findings of the various committees, while taking account of the principle that every notification should be reviewed according to the specific circumstances of the case.

With the Code of Practice, presented in 2015, the annual reports, and the relevant selections of findings published on the website, the committees aim to give the greatest possible insight into the subjects and factors they consider relevant to their statutory task. They also want to provide clarity concerning the options the law provides to physicians, independent physicians, patients and other interested parties.

A third review of the Act began in 2015. One of the focal points is the functioning of the RTEs. The results are expected in 2017.

On 2015 the average amount of time taken to deal with a notification was 39 days (in 2014 it was 47 days); this is within the statutory time limit, which can be extended once by six weeks.

I would like to touch on a number of topics that sparked widespread debate in early 2016. In early February, the committee advising on the subject of assistance to people who regard

their life as completed presented its report. The committees took careful note of the report. The Minister of Health, Welfare and Sport and the Minister of Security and Justice have announced that the government will issue a policy response before the summer.

The publication of the report has by no means stilled public debate on the issue of euthanasia. That much was clear, not only from the many, diverse responses to the report, but also from the responses to a documentary about the End-of-Life Clinic, aired on television shortly after the report's publication. The documentary, which highlighted three complex cases dealt with by physicians of the End-of-Life Clinic, sparked considerable controversy. It should be noted that the RTEs had full access to the files of the notifying physicians, the SCEN physicians consulted and other specialists, which could not be made clear in the context of a short documentary. On the basis of that information they found these three cases to have been handled with due care. The anonymised findings concerning these three notifications have been published in full on the website.

I would like to thank the committee members, the general secretary, the secretaries and the staff of the secretariats for their great efforts and commitment. A special word of thanks goes to Ms W.J.C. Swildens-Rozendaal, who ended her work for the committees as of 31 December 2015, having completed the maximum term of office. She chaired the North Holland committee for 12 years and also served as the national coordinating chair of the committees for the past five years. Throughout the years she brought great expertise to the committees and served the organisation with heart and soul, for which we owe her a debt of gratitude.

Following a carefully considered, public application procedure, the Minister of Health, Welfare and Sport and the Minister of Security and Justice appointed Mr J. Kohnstamm as the new national coordinating chair and chair of the North Holland committee. We are pleased with this appointment and look forward with confidence to the committees' future under his chairmanship.

The committees would be pleased to receive feedback via their general secretary (email: n.visee@toetscie.nl).

P.J.M. van Wersch
Deputy coordinating chair of the regional euthanasia review committees

The Hague, April 2016

Ch.1

DEVELOPMENTS IN 2015

NOTIFICATIONS

Number of notifications

In 2015, the regional euthanasia review committees (RTEs) received 5,516 notifications of euthanasia, i.e. termination of life on request or assisted suicide. The number of notifications received in 2015 again showed an increase (4%) compared to 2014 (5,306). Chapter II gives a detailed overview of these notifications, both for the Netherlands as a whole and per region. Figures on euthanasia in relation to the total number of deaths in the Netherlands (on average 140,000 per year) can be found on the website of the Royal Dutch Medical Association (KNMG).[1]

In each case the committees examined whether the physician who had performed euthanasia had acted in accordance with the due care criteria set out in section 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act (the Act). In four cases, less than 0.1% of the total, they found that the physician had not acted in accordance with the due care criteria (in three cases it concerned the procedure for terminating the patient's life and in one case it concerned several due care criteria). These cases are described in Chapter III. In all other cases the committees found that the physicians had acted in accordance with the due care criteria. Several of these findings, which concerned the more complex cases, are described in Chapter III. Chapter IV, which is about the RTEs, describes the statutory framework and the committees' activities in greater detail.

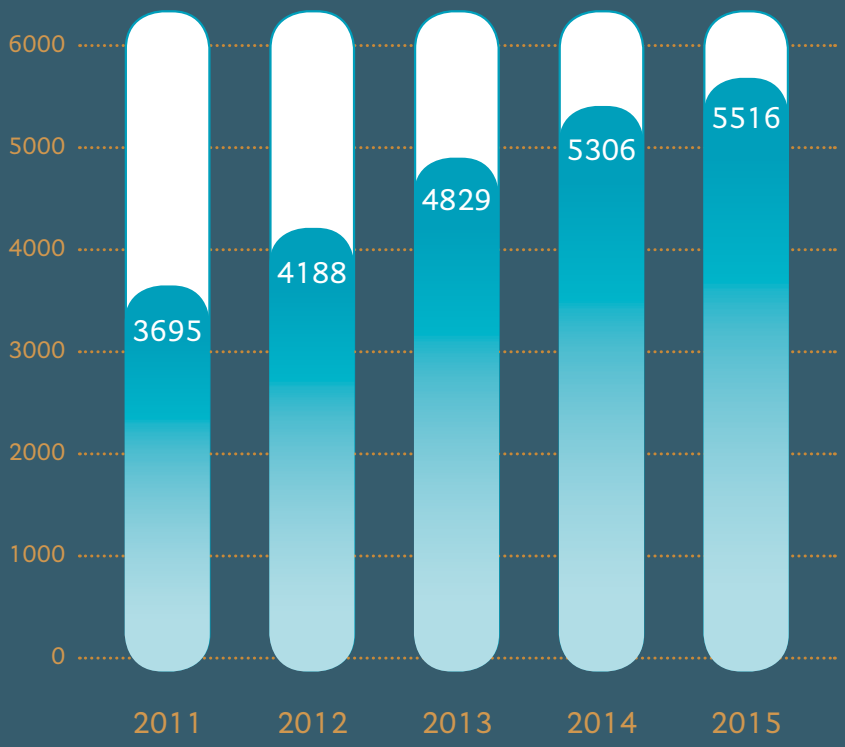
Psychiatric disorders

Patients' suffering was caused by a psychiatric disorder in 56 notifications of euthanasia. In 2013 and 2014 the figures were 42 and 41, respectively. In 25 of these 56 cases the notifying physician was a psychiatrist, in 16 cases a general practitioner, in 2 cases a specialist, in 4 cases an elderly-care specialist and in 9 cases another physician. In 33 cases, euthanasia was performed by a physician affiliated with the End-of-Life Clinic (SLK).

In view of the continuing public interest in the subject, a relatively large number of these cases (15) were anonymised and published on the committees' website, along with summaries.[2]

In an increasing number of cases that involved a psychiatric disorder, there were also somatic disorders which in part caused the patient's suffering. As the unbearable suffering was mainly caused by the psychiatric disorder(s) in these cases, they too were registered as psychiatric cases (see, for instance, *case 2015-46*, described in Chapter III).

1 KNMG infographic on euthanasia can be found on www.knmg.nl.
2 www.euthanasiecommissie.nl.



TOTAL NO. OF NOTIFICATIONS
EUTHANASIA AND ASSISTED SUICIDE

At a meeting with the permanent parliamentary committee in November 2014, the Minister of Health, Welfare and Sport indicated a desire to have psychiatric expertise embedded in the RTEs. In the spring of 2015, the committees appointed a psychiatrist to fill a vacancy for a physician-member of the RTEs.

Pages 26 and 27 of the Code of Practice published by the RTEs in April 2015 refer to the necessity of seeking advice from an independent psychiatrist to assess the patient's decisional competence, the absence of any prospect of improvement and the lack of a reasonable alternative if euthanasia is requested by a patient suffering from a psychiatric disorder.

In 2015 a working group of the Dutch psychiatry association *(Nederlandse Vereniging voor Psychiatrie)* began revising the guidelines on 'Dealing with requests for assisted suicide from patients with a psychiatric disorder'.

Chapter III describes *case 2015-21*, in which the patient's suffering was caused by psychiatric problems.

Dementia

Patients' suffering was caused by dementia in 109 cases notified to the committees in 2015. In 2013 and 2014 the figures were 97 and 81, respectively. In the vast majority of these cases, the patients were in the initial stages of the disorder and still had insight into their condition and its symptoms (loss of bearings and personality changes). They were deemed decisionally competent with regard to their request because they could still grasp its implications. In a few cases the patients were in an advanced stage of dementia. *Case 2015-107*, described in Chapter III, is an example. In 28 of these 109 dementia cases, the physician who performed euthanasia was affiliated with the End-of-Life Clinic. All 109 dementia cases were found by the committees to have been handled with due care.

In addition to these 109 cases, there were eight cases in which dementia played a part in addition to another disorder, such as cancer or Parkinson's disease. In these cases, too, the committees found that the physicians had acted in accordance with the due care criteria. The findings in 10 cases in which the patient's suffering was caused by dementia have been published on the website. Chapter III discusses cases *2015-66* and *2015-107*, in which the patient's suffering was caused by dementia.

Decisional competence of patients with psychiatric disorders and dementia

When assessing a request for euthanasia made by a patient whose suffering is caused by a psychiatric disorder, physicians must exercise particular caution. It must be ruled out that the patient's psychiatric disorder has impaired his ability to form judgments. If that were the case the patient's request would no longer be voluntary and well-considered. Assessing decisional competence requires particular expertise. The physician must consult an independent psychiatrist to obtain that expertise.

If a euthanasia request is made by a patient with dementia, assessing his decisional competence also requires special attention. If the request is made by a patient in an advanced stage of dementia, the physician must consult a physician with the required expertise. At the stage where dementia has progressed to such an extent that the patient is no longer decisionally competent and is no longer able to communicate (or is able to communicate only by simple utterances or gestures), it is only possible to grant a request for euthanasia if the patient drew up an advance directive when he was still decisionally competent.

The advance directive must pertain to the situation that has arisen (for a detailed description of euthanasia for patients with a psychiatric disorder, see the Code of Practice, sections 4.3 and 4.4, pp. 26-28.)

The significance of the advance directive

Following the public debate on the significance and value of the advance directive with regard to euthanasia, in mid-2013 the Minister of Health, Welfare and Sport established the 'Advance directive and euthanasia' working group, consisting of staff members from the Ministry of Health, Welfare and Sport, the Ministry of Justice and the Royal Dutch Medical Association (KNMG).[3]

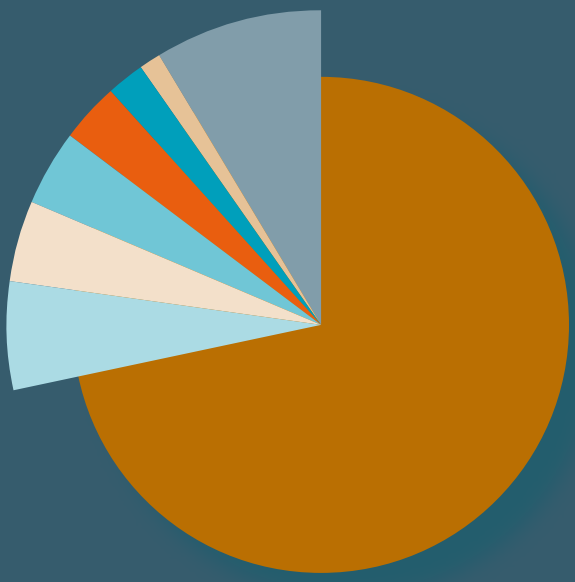
The working group was tasked with providing legal and practical clarity concerning the significance of the advance directive in the context of decisionally incompetent patients, as laid down in section 2 (2) of the Act.[4] At the working group's request, members of the RTEs contributed to its analyses and research. The working group's ultimate aim was to draw up two guidelines, one for physicians and other care professionals and one for the public. The guidelines were published in December 2015.

3 Parliamentary Papers, House of Representatives, 2012/2013, 32 647, no. 16.

4 Section 2 (2) of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act reads as follows: 'If a patient aged sixteen or over who is no longer capable of expressing his will, but before reaching this state was deemed capable of making a reasonable appraisal of his own interests, has made a written declaration requesting that his life be terminated, the physician may comply with this request. The due care criteria referred to in subsection 1 apply *mutatis mutandis*'.

NOTIFYING PHYSICIANS IN 2015

General practitioner	4,730
Specialist working in a hospital	180
Elderly-care specialist	216
Registrar	45
Other physician (e.g. a junior doctor or a non-practising physician).	345
of these, physicians affiliated with the End-of-Life Clinic	*366*



NATURE OF CONDITIONS IN 2015

Cancer	4,000
Neurological disorders	311
Cardiovascular disease	233
Pulmonary disorders	207
Multiple geriatric syndromes	183
Dementia	109
Psychiatric disorders	56
Other conditions	417

COMMITTEE PROCEDURES – DEVELOPMENTS

Code of Practice

In Chapter I of their 2014 annual report, the RTEs discussed at length the Code of Practice, the first copy of which was presented by the coordinating chair, W.J.C. Swildens-Rozendaal, to the president of the Royal Dutch Medical Association, Professor R.J. van der Gaag, on 23 April 2015 at the KNMG's symposium on 'The SCEN physician's puzzle' at Domus Medica in Utrecht. As indicated in the 2014 annual report, the Code of Practice outlines the issues and considerations that the committees regard as relevant in connection with the statutory due care criteria for euthanasia. The aim of the text is not to describe every conceivable situation. Rather, the Code is intended as a summary of the considerations that the committees have published in their annual reports and findings over the past few years. The Code focuses on these considerations; it does not examine specific cases.

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

The Code of Practice can be found on the committees' website.[5]

In February 2016, an anonymous mini-survey was conducted (with support from the KNMG) among notifying physicians and SCEN physicians into their experiences with the Code of Practice. The Code will be updated at some point in the future.

Harmonisation

In 2015, too, the committees devoted a great deal of time and attention to harmonising their findings. While taking account of the principle that every notification should be always reviewed according to the specific circumstances of the individual case, the committees as always strove for consistency with regard to their findings.

For instance, if the committees intended to find that a physician had *not* acted in accordance with one or more due care criteria, they always submitted the provisional findings and the accompanying file – digitally – to all members and alternate members of the committees for their advice and comments. Similarly, the draft findings on a number of notifications concerning complicated cases, stating that the physician *had* acted in accordance with the due care criteria, were submitted to all members and alternate members of the committees as well. In all these cases, the committee which initiated the discussion wanted to hear the views of the other committee members regarding its draft findings and the considerations on which the findings were based.

This internal exchange of views and considerations has proven to be a valuable tool for the harmonisation of findings. It helps ensure consistency in the committees' consideration of more complicated cases. After the discussion has been closed, it is up to the competent committee of three members (physician, ethicist and lawyer) to take all factors into consideration and reach a final decision. In very exceptional cases, after all the arguments submitted have been considered, draft findings are submitted to the national consultative

5 www.euthanasiecommissie.nl

council for an authoritative opinion. Even then, the final decision falls to the competent committee.

The notifications from the Health Care Inspectorate and the Public Prosecution Service and the considerations therein (see Annexe 1) also contribute to the harmonisation of findings.

In addition to the aforementioned internal discussions on individual cases, the committees also regularly hold meetings on current topics to discuss developments in the field more generally.

For instance, in 2015 they held an 'away day' on further professionalisation and sharing and improving knowledge, where they spoke with external experts about reviewing more complex cases. The desirability of establishing a 'reflection chamber' – in addition to the internal discussions – to further increase harmonisation was also discussed and is now being looked into.

Although the national consultative council is tasked with harmonising the findings – as well as with the general functioning of the committees (section 13 of the Act) – working together and receiving input from *all* members (chairs/lawyers, physicians and ethicists) is essential, in terms of both substance and procedure. To this end, a closer look will be taken at how the involvement and responsibility of physicians and ethicists can be better embedded in the committees' organisational structure.

Straightforward and non-straightforward cases

In 2015, 79% of the notifications received concerned straightforward cases. These notifications were submitted digitally to the members of the committee for review.

Notifications were considered straightforward if the committee secretary/lawyer could establish that the information provided was comprehensive and that it was highly likely that the committee would conclude that the due care criteria had been complied with. In almost all cases, the notifications that were considered straightforward could be reviewed digitally and thus handled without further delay (see, for instance *cases 2015-15* and *2015-22*).

A small number of notifications that were initially considered straightforward were later deemed to be non-straightforward, and as a result were discussed in a committee meeting. The other 21% of the notifications received did raise questions that required discussion in person and were reviewed at the monthly committee meetings.

Thanks to the working method introduced in 2012 and the increase in the number of committee members and secretariat staff, the backlog of the previous years was cleared in 2013 and 2014. The average time that elapses between the notification being received and the committee's findings being sent to the physician is now 39 days (in 2014 the average time was 47 days).[6]

6 Section 9 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act states that the committees must notify the physician within six weeks of receiving the report of their findings, giving reasons. This period may be extended once by six weeks.

Complaints procedure

In 2015 the committees received no complaints from notifying physicians or independent physicians concerning the way notifications were dealt with. As announced in previous annual reports, the committees have decided to establish an independent complaints committee to deal with any complaints they receive. Complaints regulations have now been drawn up, setting out in greater detail the complaints committee's procedures, as well as its powers and composition. The complaints regulations are published on the committees' website.[7]

The complaints procedure is intended for dealing with complaints from physicians, particularly notifying physicians and independent physicians. Complaints may only relate to the way the physician has been treated. Physicians cannot lodge complaints about the substance of and grounds for a committee's findings.

Every year the committees receive several requests from members of the public who would like to see a particular file or a committee's findings on a case. Pursuant to section 14 of the Act, the committees are obliged to maintain confidentiality with regard to all the information that comes to their attention in the course of their duties. Only in special cases (prescribed by law) can exceptions can be made. All these requests must therefore be denied.

End-of-Life Clinic (SLK)

In 2012 the committees received the first notifications of euthanasia performed by a physician affiliated with the End-of-Life Clinic (SLK). This was a new phenomenon. The committees decided to review the first 10 of such notifications – which are reviewed in the same way as any other notification – together. After this it was agreed that notifications from SLK physicians would be deemed to be non-straightforward and discussed at the committee meetings.

In late 2015 the committees decided that, having gained substantial experience with reviewing notifications from physicians affiliated with the SLK, these notifications could in future also be treated as straightforward notifications if, in the opinion of the experienced secretary/lawyer who categorises the notifications, the selection criteria have been met. The committee can always later decide to discuss a notification at the committee meeting as a non-straightforward notification.

In fact, notifications from SLK physicians are often reviewed by the committees together because the SLK physicians are often called upon in complex cases. This is apparent from, for instance, the relatively large numbers of notifications of euthanasia relating to psychiatric disorders and dementia (see earlier in the chapter for the figures relating to psychiatric disorders and dementia). In some urgent cases, the physician may also refer the patient to the SLK. See for instance *case 2015-35* in Chapter III.

7 www.euthanasiecommissie.nl

OTHER DEVELOPMENTS

Recruitment of new coordinating chair

As the maximum term of office of the incumbent coordinating chair, Ms W.J.C. Swildens-Rozendaal, would end on 1 January 2016, the committees drew up a job profile in mid-2015 for a new coordinating chair, as well as an extensive recruitment and appointment procedure, which they published on their website.[8] The procedure included the establishment of a selection committee and an advisory committee. Each category of RTE member was represented in both committees.

After a scrupulous recruitment and appointment procedure, the Minister of Health, Welfare and Sport and the Minister of Security and Justice, on the joint recommendation of the chairs of the regional euthanasia review committees, appointed Mr J. Kohnstamm as coordinating chair of the RTEs and (deputy) chair of the North Holland committee as of 1 April 2016.

Mr Kohnstamm is an experienced chairperson and administrator. During the procedure he proved to have a sharp eye for the unbiased position and role of the RTEs and the coordinating chair in performing their statutory tasks within the given parameters. He also enjoys broad support among the committee members. The members are therefore confident that Mr Kohnstamm will do an excellent job as coordinating chair.

Minors

The Act applies to euthanasia for persons aged 12 and over. It does not apply to younger children. For minors to whom the Act does apply, it sets additional requirements:

- if the patient is a minor between the ages of 12 and 16, termination of life at the patient's request may only be carried out with the consent of the parent(s) or guardian (section 2 (4) of the Act);
- if the patient is a minor aged 16 or 17, the parent(s) or guardian must be consulted in the decision-making process, but their consent is not required (section 2 (3) of the Act).

Notifications concerning minors are rare. In the period 2002-2015, the committees received seven such notifications, two of which occurred in 2015. Five cases concerned 17-year-olds and one case (in 2005) concerned a 12-year-old (see 2005 RTE annual report pp.17-19 [Noot vertaler: dit zijn de paginanummers in het Word-document van de Engelse vertaling - graag controleren in de opgemaakte versie]) One of the notifications received in 2015 concerned a 16-year-old (see *case 2015-59*). In all cases, the patient's family was involved, and understood and respected the patient's request for euthanasia.

For a request for euthanasia to be voluntary, as required by law, the patient must be decisionally competent in the matter. Decisional competence means that the patient is able to understand relevant information about his situation and prognosis, consider any alternatives and assess the implications of his decision. If there are any doubts as to the patient's decisional competence, it is wise for the physician to seek the advice of someone with relevant expertise. This request for advice may be included in the specific questions put to the independent physician, but the patient's decisional competence can also be determined by a specialised physician prior to consultation with the independent physician.

Euthanasia involving minors also attracted political attention in 2015. The RTEs were represented at a round table meeting held by the House of Representatives in January 2016.

8 www.euthanasiecommissie.nl

Organ and tissue donation after euthanasia

Physicians regularly encounter patients wanting to donate organs and/or tissue after euthanasia. Most patients who die as a result of euthanasia cannot donate organs due to their condition (often a malignancy). However in some situations it is possible, particularly for patients with degenerative disorders such as motor neurone disease or MS.

There is no formal registration of organ donation after euthanasia. As far as is known, since 2012 there have been 15 cases of this combination of procedures, nine of which occurred in 2015.

The Act does not prescribe what can be done with the body after euthanasia, so it does not preclude organ donation after euthanasia. To prevent the request for euthanasia from being influenced by the possibility of organ donation, a request for organ donation cannot be assessed until it is clear that the due care criteria for euthanasia have been complied with.

Organ donation after euthanasia is a complex combination of procedures, as it requires, among other things, that the euthanasia procedure be performed in hospital. This generally means the patient has to be taken to hospital for the euthanasia procedure. The two procedures must also be strictly separated, but at the same time closely coordinated in view of the speed required. This requires close cooperation and coordination.

To achieve that coordination and to ensure the procedure is carried out with due care, a working group initiated by various universities drew up a guideline that can help physicians in their decision-making process. At the working group's request, the RTEs contributed to the guideline. It describes how physicians can respond to a patient's request that his organs be donated after euthanasia. Physicians who receive such a request can ask the transplant coordinator of the university hospital in their region for a copy of the guideline.[9]

9 For more information (in Dutch): http://www.transplantatiestichting.nl/donor-worden/wie-kan-donor-worden/orgaan-en-weefseldonatie-na-euthanasie.

ch.2

NATIONAL OVERVIEW OF NOTIFICATIONS – 2015

1 January 2015 to 31 December 2015

NOTIFICATIONS The committees received 5,516 notifications in the year under review.

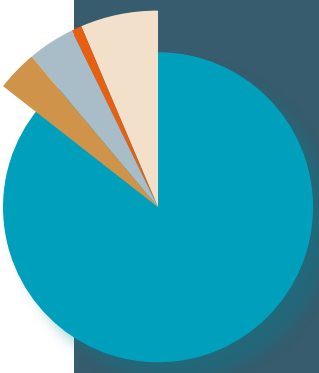
EUTHANASIA AND ASSISTED SUICIDE There were 5,277 cases of euthanasia (i.e. active termination of life by a physician at the patient's request), 208 cases of assisted suicide and 31 cases involving a combination of the two.

LOCATIONS In 4,409 cases patients died at home, in 191 cases in hospital, in 224 cases in a nursing home, in 239 cases in a care home, in 354 cases in a hospice and in 99 cases elsewhere (e.g. at a family member's home).

CARIBBEAN NETHERLANDS In the course of the reporting year, the committees received 1 notification from the Caribbean Netherlands.

COMPETENCE AND FINAL DECISION In all cases the committee deemed itself competent to deal with the notification. In the year under review there were 4 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 39 days.



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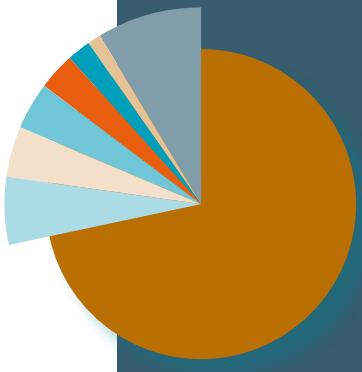

NATURE OF CONDITIONS

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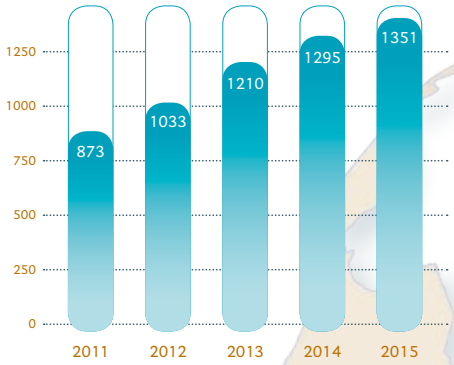
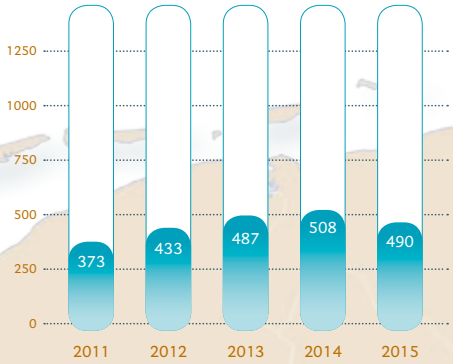
Neurological disorders	311
Cardiovascular disease	233
Pulmonary disorders	207
Multiple geriatric syndromes	183
Dementia	109
Psychiatric disorders	56
Other conditions	417

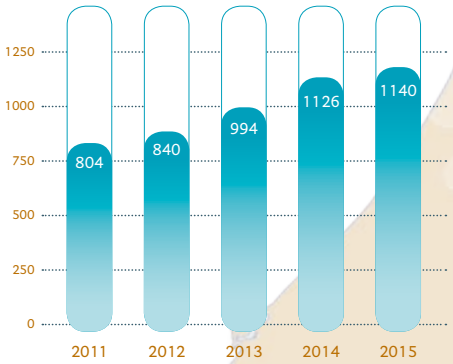
TOTAL NUMBER OF NOTIFICATIONS EUTHANASIA AND ASSISTED SUICIDE BY REGION



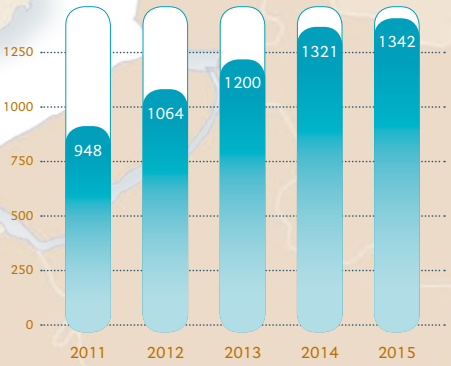
REGION 3
NORTH HOLLAND



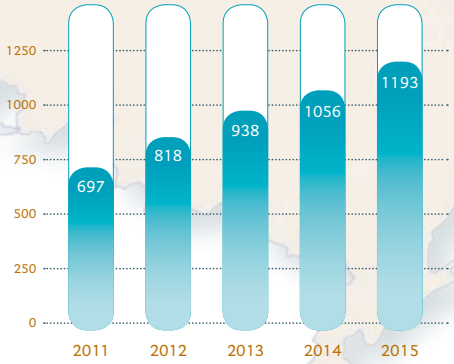
REGION 1
GRONINGEN, FRIESLAND, DRENTHE AND BONAIRE, ST EUSTATIUS AND SABA



REGION 4
SOUTH HOLLAND AND ZEELAND



REGION 2
OVERIJSSEL, GELDERLAND, UTRECHT AND FLEVOLAND



REGION 5
NORTH BRABANT AND LIMBURG

Total number of notifications in 2015 by region (not included here)

Ch.3

CASES

DUE CARE CRITERIA

Up to 2013, Chapter II of the annual report provided an overview of how the committees apply and interpret the statutory due care criteria for euthanasia as set out in the Act and the most important developments, illustrated by cases. The Code of Practice published in 2015 is now the committees' policy guideline. Besides descriptions of cases, this chapter now only gives references to the Code of Practice.[10]

The committees assess whether the notifying physician has acted in accordance with all the statutory due care criteria laid down in section 2 of the Act. These criteria determine that 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 prognosis;

d. have come to the conclusion, together with the patient, that there is no reasonable alternative in the patient's situation;

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

f. have exercised due medical care and attention in terminating the patient's life or assisting in his suicide.

The committees examine whether the notifying physician has acted with due care in the context of the Act, the legislative history and relevant case law. They also take previous committee findings into account, and previous decisions of the Public Prosecution Service and the Health Care Inspectorate in cases where a committee found that the physician had not acted in accordance with the due care criteria. This means that it must be *clear* that the physician complied with due care criteria c. (informing the patient), e. (consulting an independent physician) and f. (due medical care) above, and that he can plausibly argue that, given the circumstances of the case, he was *reasonably able to conclude* that due care criteria a. (voluntary and well-considered request), b. (unbearable suffering with no prospect of improvement) and d. (no reasonable alternative) had been met. To this end, the physician must include with his notification to the pathologist a detailed report (section 7 (2) of the Burial and Cremation Act).

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SELECTED CASES

The first case is an example of a straightforward case. The 'due medical care' section includes another example of a straightforward case. The other cases are non-straightforward. The first case is a general case that involved a rapid procedure. It is followed by cases dealing with the various due care criteria set out in the Act. Lastly, several euthanasia cases are discussed separately that involved psychiatric disorders and dementia. This is done in view of the great interest in such cases among the public.

The cases are described in the form of summarised findings and focus on key aspects of the findings and the committee's deliberation. For each case it is specified which of the due care criteria it illustrates, what points the committee in question had to consider and, of course, what the committee's findings were. The full text of the findings on these cases can be found – under the same numbers – on the committees' website, under year of publication 2015.[11]

STRAIGHTFORWARD NOTIFICATIONS

Nearly all the straightforward notifications in 2015 could be discussed and reviewed digitally by the committees. As mentioned in Chapter I, 79% of all notifications fell in this category. To provide insight into these notifications, the findings are given in full for one of the straightforward cases. Another straightforward notification, *case 2015-22*, has been included under the 'due medical care' heading. More straightforward cases can be found on the committees' website (in Dutch), under the heading 'Uitspraken & Uitleg, Niet vragen oproepende meldingen'.

CASE 2015-15

See also case 2015-15 on the website.

FINDING: DUE CARE CRITERIA COMPLIED WITH

KEY POINTS: straightforward case, locum

SUMMARY: As her general practitioner was temporarily absent, a patient whose suffering was severe asked a locum to perform euthanasia. The locum started the euthanasia process and contacted the SCEN physician. When the general practitioner returned, the patient made the euthanasia request to him, after which the general practitioner performed euthanasia.

Around six months before her death, the patient, a woman in her sixties, was diagnosed with pancreatic carcinoma that had metastasised to the lungs. Her condition was incurable. She could only be treated palliatively.

The patient's suffering consisted of rapidly progressive, severe shortness of breath, despite the use of oxygen. The patient could only speak with difficulty and coughed frequently. She was exhausted. She also suffered from a fear of further deterioration and humiliation.

The patient experienced her suffering as unbearable. The physician was satisfied that this suffering was unbearable to her and with no prospect of improvement according to prevailing medical opinion. There were no alternative ways to alleviate her suffering that were acceptable to her. The documents make it clear that the physician and the specialists

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gave her sufficient information about her situation and prognosis. The patient had discussed euthanasia with the physician before.

Eight days before her death, the patient asked a physician from the same practice, who was acting as her physician's locum, to actually perform the procedure to terminate her life. When her physician returned, a day before her death, the patient repeated her request to him. The next day she again repeated her request to her physician. The physician concluded that the request was voluntary and well-considered.

The locum consulted an independent SCEN physician on the physician's behalf. The independent physician visited the patient four days before the termination of life was performed, after she had been told about the patient's situation by the locum and had examined the relevant medical records. In her report the independent physician gave a summary of the patient's medical history and the nature of her suffering. The independent physician concluded, partly on the basis of her interview with the patient, that the due care criteria had been met.

The physician performed the termination of life on request using the method, substances and dosage recommended in the KNMG/KNMP's Guideline 'Performing euthanasia and assisted suicide procedures' of August 2012.

The committee examined retrospectively whether the physician had acted in accordance with the statutory due care criteria laid down in section 2 of the Act. The committee then decided whether the due care criteria had been complied with in the light of prevailing medical opinion and standards of medical ethics.

In view of the above facts and circumstances, the committee found that the 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 medical 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.

CASE 2015-35 (NOT INCLUDED HERE)

VOLUNTARY, WELL-CONSIDERED REQUEST

CASE 2015-01 NOT INCLUDED HERE

CASE 2015-59

For more information on minors, see page 25 of the Code of Practice. See case 2015-59 on the website for the full text.

FINDING: DUE CARE CRITERIA COMPLIED WITH

DUE CARE CRITERION: voluntary and well-considered request

KEY POINT: decisional competence in relation to the euthanasia request, which was made by a minor in the 16-18 age group (section 2 (3) of the Act).

SUMMARY: The patient was diagnosed for a second time with acute myeloid leukaemia. Following the first diagnosis, she had received a stem cell transplant. She did not want to undergo this treatment again. The patient was suffering unbearably from pain, fatigue, nausea and the loss of control over her life. She requested euthanasia. The committee found that it was clear that the patient was decisionally competent in relation to her euthanasia request. Her parents had been involved in the decision. This was in accordance with section 2 (3) of the Act, concerning minors between 16 and 18 years of age.

In spring 2015, the patient, a woman aged between 16 and 18, was diagnosed for the second time with acute myeloid leukaemia. In 2013, the patient had also had acute myeloid leukaemia and had received a stem cell transplant. In view of the very small chance of success and the severe impact of this treatment, the patient declined the opportunity to undergo another stem cell transplant. The patient's suffering consisted of pain, fatigue and nausea. Above all, however, she was suffering from the loss of control over her life. Now that it was clear that she only had weeks to live, she wanted to determine how that period would be concluded.

Two days before her death, the patient asked the physician to actually perform the procedure to terminate her life.

The committee noted the following with regard to the patient's request. Section 2 (3) of the Act states that if the patient is a minor aged between 16 and 18 and is deemed to be capable of making a reasonable appraisal of his own interests, the physician may comply with a request made by the patient to terminate his life or provide assistance with suicide, after the parent or parents who have responsibility for him, or else his guardian, has or have been consulted. The committee found that in the case under review the physician could comply with the request. It was clear from the information provided by the physician that the patient was decisionally competent in relation to her euthanasia request. Her parents had been involved in the decision concerning her request.

CASE 2015-26 (NOT INCLUDED HERE)

CASE 2015-40 NOT INCLUDED HERE

CASE 2015-52

For points to consider regarding the advance directive, see pages 23 ff. of the Code of Practice. See case 2015-52 on the website for the full text.

FINDING: DUE CARE CRITERIA COMPLIED WITH

DUE CARE CRITERION: Voluntary and well-considered request

KEY POINTS: importance of the advance directive, no prospect of improvement, unbearable suffering, informing the patient, no reasonable alternative, independent physician's judgment.

SUMMARY: After suffering a massive CVA, the patient was no longer able to communicate. The patient had discussed euthanasia with her physician before and drawn up an advance directive. On the basis of the advance directive, patient records, the information given by the physician and conversations with the patient's family, the independent physician concluded that the patient's euthanasia request was voluntary and well-considered. The independent physician found her suffering visibly and palpably unbearable. There was no prospect of improvement. It was clear to the independent physician from the information given by the physician that the latter had discussed the situation extensively with the patient. They had together reached the conclusion that there were no reasonable alternatives available.

Two weeks before the procedure to terminate her life was performed, the patient, a woman in her eighties, suffered a very extensive cerebral infarction. As a result she became hemiplegic, completely aphasic and suffered from severe cognitive impairment.

In the previous year the patient had gradually deteriorated; she was suffering from early-stage vascular dementia as a result of multiple CVAs and TIAs. There were no rehabilitation options available, as the relevant area of the brain had been affected too severely. Her condition was incurable.

The patient's suffering consisted of being unable to do anything and being fully dependent on other people. She was slumped in her wheelchair due to poor trunk balance. She was hardly able to understand anything said to her and hardly able to communicate. The burden of her suffering was apparent from her demeanour. This was confirmed by the attending geriatrician. She would have to be admitted to a nursing home where she would be like a vegetable.

The patient had discussed euthanasia with the physician before. In the final months before the procedure to terminate her life was performed she had on several occasions said emphatically to the physician (her general practitioner), her geriatrician, and her family that she did not want to experience late-stage dementia, as her mother had done. She stated specifically that she wanted euthanasia as soon as she became dependent and would have to be admitted into a nursing home.

Several days before her death, in a moment of lucidity, the patient was able to make clear to her daughter in the presence of others that she indeed wanted euthanasia.

The advance directive, which stated clearly in what situation the patient would request euthanasia, had been updated several months before the procedure to terminate her life was performed.

The independent SCEN physician who was consulted by the physician visited the patient two days before the procedure to terminate her life was performed, after she had been told

about the patient's situation by the physician and had examined her medical records. During the independent physician's visit the patient was somnolent. The independent physician spoke with the patient's family members, who confirmed and gave further details on her request as described in her advance directive. The independent physician could deduce from the patient's demeanour that she was in the situation that she had stated in writing she never wanted to experience. There was no reasonable prospect of a return to a situation with sufficient dignity for the patient.

The independent physician concluded, in part on the basis of her interviews with the family and the medical staff treating the patient, and the medical record, including the advance directive, that the due care criteria had been complied with.

The committee noted the following as regards *the request being voluntary and well-considered*.

The physician was satisfied that the patient was now in the situation she had stated she did not want to experience. He wanted to keep his promise to the patient and end her suffering. On the basis of the advance directive, the conversations that the physician had previously had with the patient and the patient's specific request, expressed a few days before the procedure to terminate her life was performed, the physician was convinced the patient had made a voluntary and well-considered request.

The committee found that it had been established satisfactorily on the basis of the above information that the physician could be satisfied that the request was voluntary and well-considered.

The report showed that the extent of the cerebral infarction meant that rehabilitation was no longer a possibility. In objective medical terms the patient's suffering was without prospect of improvement. The physician, the independent physician and the attending geriatrician were satisfied that the patient was suffering unbearably. It was apparent from her demeanour and her facial expressions. It was also clear that all sense of purpose had gone from the patient's life. The patient's suffering matched what she had previously described orally and in writing as unbearable to her. The committee found that it had been established satisfactorily on the basis of the above information that the physician could be satisfied that the patient's suffering was unbearable and without prospect of improvement.

The committee was satisfied that the physician could conclude that the requirement of informing the patient had been complied with, on the basis of the previous conversations he had had with her, her advance directive, her medical situation and the consultation with her children, and that there was no reasonable alternative for the patient's situation.

The independent physician could not communicate with the patient. On the basis of the advance directive, patient records, the information given by the physicians and conversations with the patient's family, the independent physician concluded that the patient's euthanasia request was voluntary and well-considered. The independent physician found her suffering visibly and palpably unbearable and without prospect of improvement. It was clear from the information given by the physician that he had discussed the current situation extensively with the patient beforehand. They had together reached the conclusion that there were no reasonable alternatives available for such a situation. The independent physician was satisfied that the due care criteria had been complied with.

UNBEARABLE SUFFERING WITHOUT PROSPECT OF IMPROVEMENT

CASE 2015-82

In this case, the patient's state of reduced consciousness was medically induced and therefore, in principle, reversible. For a number of general factors concerning unbearable suffering, see page 13 of the Code of Practice. For information on reduced consciousness see pages 29 ff. of the Code of Practice. See case 2015-82 on the website for the full text.

FINDING: DUE CARE CRITERIA COMPLIED WITH

DUE CARE CRITERION: unbearable suffering with no prospect of improvement

KEY POINTS: reduced consciousness, no perceptible signs of suffering

SUMMARY: The euthanasia process was started for a patient with severe lung disease. However, one day before her death, her condition deteriorated so badly that she was sedated. Despite her state of reduced consciousness, the physician proceeded with euthanasia. The committee found that performing euthanasia was justified.

Twenty years before her death, the patient, a woman in her sixties, was diagnosed with pulmonary fibrosis. In the period between the diagnosis and her death, the patient had suffered several respiratory infections. At first the patient's condition deteriorated slowly, but each respiratory infection was followed by an accelerated decline. The patient's suffering was unbearable. Her condition was incurable. She could only be treated palliatively.

The patient had discussed euthanasia with the physician previously, and approximately one month before her death she asked her general practitioner to actually perform the procedure to terminate her life. The independent physician consulted was satisfied that the due care criteria had been complied with.

One day before the euthanasia was due to be performed, the patient's condition deteriorated rapidly and her shortness of breath worsened. After consultation she was given morphine to help her sleep. A few hours later she developed Cheyne-Stokes respiration and became somnolent, but she did respond to stimuli and at times she was agitated. After consultation with her family it was decided to proceed with the euthanasia as planned, because the physician and the family were satisfied that the patient did not want to be in this situation.

The committee made the following observations. The patient had previously made a specific request for euthanasia, and two days before the procedure to terminate her life was performed the patient had been seen by an independent physician. The physician's report made it clear that, when euthanasia was performed, the patient was somnolent as a result of having been given morphine. She was in a state of reduced consciousness, an unintended side effect of medication administered to reduce symptoms as part of palliative care. It is possible that the state of reduced consciousness would have been reversible if the medication had been ceased. The patient would then have been returned to a situation of unbearable suffering. Under these conditions, the possible reversible nature of the state of reduced consciousness is therefore no reason to bring the patient back to a conscious state, and to do so is considered undesirable. In these circumstances, the committee finds performing euthanasia to be justified, even if there are no perceptible signs of suffering (see also KNMG Guideline 'Euthanasia for patients in a state of reduced consciousness', section 3.3, p. 31).

CASE 2015-84 (NOT INCLUDED HERE)

INFORMING THE PATIENT

No cases concerning this due care criterion have been included here. See, for instance, cases *2015-01* and *2015-52*.

NO REASONABLE ALTERNATIVE

The absence of a reasonable alternative, a due care criterion which must be seen in relation to suffering with no prospect of improvement, is discussed on pages 13-15 of the Code of Practice. No cases concerning this due care criterion have been included here. See. for instance. cases *2015-26*, *2015-52* and *2015-01*.

CONSULTING AN INDEPENDENT PHYSICIAN

CASE 2015-56

As in previous years, this year the committees received several notifications of cases in which euthanasia had been performed simultaneously on a couple. In all these cases, the committee found that the due care criteria had been complied with. See case 2015-56 on the website for the full text.

FINDING: DUE CARE CRITERIA COMPLIED WITH

DUE CARE CRITERION: consultation

KEY POINTS: simultaneous performance of euthanasia on a couple, independent physician's opinion.

SUMMARY: The patient was suffering from metastasised pulmonary carcinoma. He asked his physician to perform euthanasia, a few days after his wife had asked her physician for euthanasia. Both physicians consulted the same independent physician, who spoke with both patients together. The physicians and the independent physician stated that they had discussed this extensively beforehand. The committee found that if, after consideration, it has been decided to consult one independent physician for both partners, the independent physician must in principle speak with each partner separately. In this case, however, the committee had no doubts about the independent judgment of the independent physician.

More than a year before his death, the patient, a man in his seventies, was diagnosed with metastasised pulmonary carcinoma. His condition was incurable. Nine days before his death, the patient asked the physician to actually perform the procedure to terminate his life. A few days earlier, the patient's wife had asked her physician to actually perform the procedure to terminate her life.

The physician consulted an independent physician who was also a SCEN physician. The independent physician saw the patient and his wife five days before the termination of life was performed, after he had been told about the patient's situation by the physician and had examined his medical records. He did not speak with the patient in private. The independent physician concluded, partly on the basis of his interview with the patient, that the due care criteria had been complied with.

The physicians who performed euthanasia and the independent physician stated in a written explanation that they discussed this special situation extensively prior to the procedure. Both patients were terminally ill and their life expectancy was a few weeks at most. Both the physicians who performed euthanasia, who had each gone through the process with their own patient, were satisfied that the patients had decided independently from each

other to request euthanasia. There were no doubts whatsoever that their suffering was unbearable and that their requests were voluntary and well-considered. During his visit, the independent physician had always faced the person who was speaking and felt that he had had two conversations. The independent physician was satisfied that his judgment was independent.

In the event of simultaneous euthanasia requests by a couple, the committee deems it important for the physician(s) to consider carefully whether it is preferable to consult one independent physician for both partners or a separate independent physician for each. If, after deliberation, the conclusion is that one independent physician will be asked to assess both requests, that physician will have to be extra alert to the question of whether he is able to form an independent judgment in both cases.

The committee finds that in such cases the independent physician should in principle speak to each partner separately, to assess whether the request was made under any pressure. There can be cases, however, in which speaking to the partners separately is not necessarily essential.

On the basis of the reports of the physician and the independent physician, and the rest of the file, the committee had no doubts (in both cases) about the independent judgment of the independent physician concerning the due care criteria.

CASE 2015-23 (NOT INCLUDED HERE)

DUE MEDICAL CARE

CASE 2015-28 (NOT INCLUDED HERE)

CASE 2015-29

See case 2015-29 on the website for the full text.

FINDING: DUE CARE CRITERIA NOT COMPLIED WITH

DUE CARE CRITERION: due medical care

KEY POINTS: KNMG/KNMP Guideline 'Performing euthanasia and assisted suicide procedures', adequate assessment of depth of coma

SUMMARY: When performing euthanasia, the physician deviated from the KNMG/KNMP Guideline 'Performing euthanasia and assisted suicide procedures' of August 2012. Instead of administering 1000mg of propofol to induce a coma, he stopped after having administered 200mg because he thought the patient was in a coma. As the physician had not checked the depth of the coma adequately, it could not be ruled out that the patient was in an insufficiently deep coma and that she might have perceived the effects of the muscle relaxant. In view of the above, the physician did not perform euthanasia with due medical care.

The physician performed the termination of life on request on a patient who had been diagnosed with acute myeloid leukaemia by intravenously administering 200mg of propofol and 100mg of rocuronium, after which the patient died.

The physician stated in a written explanation that he did not perform any tests to check the depth of the coma. He thought that it would have been indelicate and ethically improper to carry out such tests in the presence of the patient's husband and four children. He thought it was unnecessary and ethically improper to administer more than 200mg of propofol to a patient who was clearly in a deep coma. He also did not want to further affect the fragile intravenous access site by administering yet more of an irritant fluid.

The committee invited the physician to provide further information in person. The committee asked him why, when performing euthanasia, he deviated from the KNMG/KNMP Guideline 'Performing euthanasia and assisted suicide procedures' of August 2012 and administered 200mg of propofol instead of the prescribed 1000mg. The physician answered that he was satisfied that the patient was already in a deep coma after he had administered 200mg of propofol and that it was unnecessary to administer any more. The physician said it was his practice to continue administering propofol for as long as he thought it necessary. He said that while performing the procedure he would assess from step to step whether it was necessary to administer more, and when he thought the purpose had been achieved, he would stop administering the propofol. When questioned on the matter, the physician said that he thought it was unethical to inject too large a dosage. Another factor in this particular case, the physician said, was that the access site to the vein was very fragile, which in his opinion meant that injecting more propofol might make it difficult to administer the rocuronium. According to the physician the patient was in a deep coma because she was in a deep sleep, her respiration was slow and her pulse was weak. Verbal communication with the patient was impossible. When questioned on the matter, the physician said that he had not checked the patient's protective reflexes, such as the eyelash reflex and/or the corneal reflex, or her response to strong pain stimuli such as pressure on the nail bed or pinching the trapezius muscle, but instead applied a light pain

stimulus to the patient's hand, to which she did not respond. The physician stated that he had not noted this in his response to earlier written questions from the committee, but that he had indeed applied the pain stimulus to the hand. He conducted no further tests. The reason he gave was that he would have to stand up and walk round the bed, which he felt would be distressing for the family.

The committee noted the following in connection with the performance of the procedure to terminate the patient's life. On the basis of the medical records and the interview with the physician, it became clear to the committee that the physician administered 200mg of propofol instead of the 1000mg recommended in the KNMG/KNMP's Guideline 'Performing euthanasia and assisted suicide procedures' of August 2012. This means that the dosage of the coma-inducing substance used was too low. The committee would point out that the use of a coma-inducing substance recommended in the Guideline in the correct dosage is crucial in order to ensure that the patient cannot perceive the effects of the muscle relaxant (death by asphyxiation). The Guideline therefore prescribes that before the muscle relaxant is administered, it must be established that the patient is in a medically induced coma.

It is apparent from the written response to earlier questions from the committee that, after administering the 200mg of propofol, the physician established that the patient was in a deep coma; her respiration was infrequent and rattled a little. The physician had conducted no further tests to check the depth of the coma. As the physician stated in his oral account that he applied a light pain stimulus to the hand, but omitted that information in the written response to earlier questions from the committee, the two statements do not correspond. In the committee's opinion, even if the physician did apply a light pain stimulus to the patient's hand, that did not mean he adequately assessed the depth of the coma, as it has been established that he did not check for the presence of protective reflexes, such as the eyelash reflex, or for a response to a pain stimulus, such as pinching of the nail bed or the trapezius muscle. The committee therefore concluded that the physician did not adequately assess the depth of the coma.

Checking the depth of the coma properly was particularly important in this case, because the physician administered less than the recommended dosage of propofol. According to the committee, it could not be ruled out that the patient was inan insufficiently deep coma and that she might have perceived the effects of the muscle relaxant, i.e. death by asphyxiation. On the basis of the above facts, considered as a whole, the committee found that the physician did not exercise due medical care in terminating the patient's life. The physician's explanation that he did not administer the full dosage of propofol due to the state of the venous access site does not detract from that. The fact that the physician administered too little rocuronium played no role in this finding.

CASE 2015-81 (NOT INCLUDED HERE)

CASE 2015-22

See case 2015-22 on the website for the full text.

FINDING: DUE CARE CRITERIA COMPLIED WITH

DUE CARE CRITERION: due medical care

KEY POINTS: emergency set of substances, straightforward notification

SUMMARY: When performing euthanasia, the physician administered 2000mg of thiopental intravenously, followed by 150mg of rocuronium. Because the patient did not die, after approximately 20 minutes the physician administered the contents of the emergency set, after which the patient died. The physician performed the euthanasia with due medical care.

The patient, a woman over the age of 95, had suffered for years from angina pectoris, osteoporosis and compressed vertebrae. Her symptoms were progressive. She also suffered from progressive asthma and recurrent pneumonia. The patient's condition deteriorated in the months preceding her death. Her condition was incurable. She could only be treated palliatively. The patient experienced her suffering as unbearable.

The patient had discussed euthanasia with the physician before. Six days before her death, the patient asked the physician to actually perform the procedure to terminate her life.

The physician performed the termination of life on request by intravenous administration of 2000mg of thiopental and 150mg of rocuronium. When the patient had not died after approximately 20 minutes, probably because the cannula had been inserted subcutaneously instead of intravenously, the physician administered the emergency set, consisting of 2000mg of thiopental followed by 150mg of rocuronium, via a different intravenous access site, after which the patient died.

The physician performed the euthanasia with due medical care.

PSYCHIATRIC DISORDERS

CASE 2015-21

For points to consider regarding patients with a psychiatric disorder, see pages 26 ff. of the Code of Practice. See case 2015-21 on the website for the full text.

FINDING: DUE CARE CRITERIA COMPLIED WITH

DUE CARE CRITERIA: voluntary and well-considered request, no prospect of improvement, unbearable suffering, no reasonable alternative.

KEY POINT: psychiatric disorder

SUMMARY: A woman with severe psychiatric problems, for whom no treatment had had a satisfactory effect, requested euthanasia. As her attending psychiatrist could not comply with her euthanasia request, she contacted the End-of-Life Clinic (SLK). After consulting with the patient's attending psychiatrists [Noot vertaler: in de vorige zin staat psychiater (enkelvoud), klopt dit?] and two independent psychiatrists, the SLK physician concluded that the due care criteria had been complied with.

The patient, a woman in her forties, had for years suffered from a suspected personality disorder with avoidant and borderline characteristics, which led to chronic depression and post-traumatic stress disorder (PTSD) with dissociation and severe self-harming. She had been severely traumatised in her youth.

The patient underwent a wide range of treatments, including medication, outpatient psychotherapy, cognitive behavioural therapy, group therapy and trauma therapy. The patient tried all the treatments proposed to her. None of them, however, had a lasting positive effect on her problems. Her condition was incurable. She could only be treated palliatively.

The patient's suffering consisted of reliving events and dissociation, resulting in severe self-harm. The patient was preoccupied all day long and could not stop the stream of thoughts running through her head. She was tired and lonely, could not see a single ray of hope and could not bear the thought that she would be depressed for the rest of her life, with dissociation leading to severe self-harm. She suffered from the absence of any prospect of improvement in her situation. The patient experienced her suffering as unbearable.

Four months before her death, the patient and the physician affiliated with the SLK discussed euthanasia for the first time. On that occasion, the patient immediately asked the physician to actually perform the procedure to terminate her life. After that, the physician and the patient talked about euthanasia on five other occasions. The physician also spoke to her attending specialists.

At the physician's request, two independent psychiatrists gave a second opinion following the patient's request for euthanasia. Both concluded that the patient was decisionally competent and her request was voluntary and had been made repeatedly. They were convinced the patient was suffering unbearably and concluded that in the current state of medical knowledge there was no realistic prospect of improvement in the quality of her life. The independent physician was satisfied that the due care criteria had been complied with.

The committee notes that if a patient is suffering from a psychiatric disorder, physicians must exercise particular caution when dealing with a euthanasia request. The committee found that in the case under review the physician did so. In consultation with the patient's attending psychiatrists, the physician went through a process lasting approximately four

months in which he spoke with the patient on six occasions and in which great care was taken in assessing whether there were any treatment options still available to the patient.

The physician asked two independent psychiatrists for a second opinion and consulted an independent physician. Partly on the basis of their findings, the physician was satisfied that the due care criteria had been complied with, in particular that the patient was decisionally competent, that she was suffering with no prospect of improvement and that there were no realistic treatment options available.

CASE 2015-46 (NOT INCLUDED HERE)

DEMENTIA

CASE 2015-66 (NOT INCLUDED HERE)

CASE 2015-107

For information on voluntary and well-considered requests, see page 11 of the Code of Practice, on patients with dementia, see page 27 and on the advance directive see page 23. For information on the recently published Guideline on written euthanasia requests, see Chapter I, under 'Other developments'. See case 2015-107 on the website for the full text.

FINDING: DUE CARE CRITERIA COMPLIED WITH

DUE CARE CRITERIA: voluntary and well-considered request, no prospect of improvement, unbearable suffering, no reasonable alternative

KEY POINTS: advanced dementia, role of the advance directive

SUMMARY: A woman with Alzheimer's disease was suffering unbearably from cognitive deterioration, impaired practical, executive and phatic functioning, and growing dependence. When admission to a nursing home seemed inevitable, she wanted euthanasia. There was an updated advance directive. The physician affiliated with the End-of-Life Clinic (SLK) followed the patient for a long period and consulted a geriatrician and two independent physicians. It was clear to the second independent physician, who was an elderly-care specialist, that the patient's wish for euthanasia was current. The physician could be satisfied that the patient's request was voluntary and well-considered, that her suffering was unbearable, and that there was no reasonable alternative.

Around three years before her death, the patient, a woman in her seventies, was diagnosed with dementia (Alzheimer's disease). The patient refused day care, a case manager and check-ups by the geriatrician.

The patient's suffering consisted of cognitive deterioration, impaired phatic, practical and executive functioning, loss of control over her thoughts and actions, and growing dependence on her husband's care. One of her parents had had dementia and had gone into a nursing home, where they had mostly sat crying. The patient had always said that she thought this was degrading and humiliating, that she would never want to be in that situation of dependence and sadness herself, and that she never wanted to go into a nursing home. Because her husband could no longer care for her properly, she had been assessed as requiring nursing home care and admission was imminent. She was suffering unbearably from the absence of any prospect of improvement in her situation, from fear and uncertainty, and aversion to experiencing a process of deterioration like her parent's and to being taken into a nursing home.

The patient had discussed euthanasia with her general practitioner before. As her general practitioner could not comply with her euthanasia request, she contacted the End-of-Life Clinic (SLK). The physician affiliated with the SLK was in contact with the patient regarding her wish for euthanasia for more than two and a half years. She visited the patient several times and maintained email contact with the patient's husband.

The physician consulted a geriatrician, who examined the patient more than a month before her death to assess her decisional competence in relation to her wish for euthanasia. The geriatrician established that the patient was in an advanced stage of dementia and that there were no signs of an underlying mood disorder. However, she was unable to form a judgment on the patient's decisional competence in relation to her wish for euthanasia, because at no point did the patient spontaneously express a desire to die.

Three and a half weeks before her death, the patient asked the physician to perform the procedure to terminate her life soon. Her husband could no longer care for her properly and as a result the patient would have to go into a nursing home. She indicated that she did not want this; in such circumstances she wanted to die. The physician found that the patient was decisionally competent and the request was voluntary and well-considered.

The physician consulted two independent physicians who were also SCEN physicians. The first visited the patient three weeks before the termination of life was performed.

According to the first independent physician, the patient showed symptoms of an advanced stage of dementia. Her request for euthanasia in the event that she would have to go into a nursing home proved consistent and she was able to substantiate it. The patient was equally consistent in her opinion that she did not want to request euthanasia at that point in time. The independent physician concluded, partly on the basis of his interview with the patient, that the due care criteria had not been met because she did not have a current wish for euthanasia. He advised the physician to consult a SCEN physician with more specific expertise and contacted a colleague in his peer supervision group, an elderly-care specialist, who was willing to assess the patient soon after. The physician followed his advice.

The second independent physician, an elderly-care specialist, visited the patient 11 days before the procedure to terminate her life was performed, after she had been told about the patient's situation by the physician and had examined her medical records. According to this independent physician, the patient indicated that she kept losing things and that she needed more and more help; this caused her great distress. When the independent physician and the patient subsequently talked about the future, the independent physician said that with dementia – the patient was familiar with the word – the expectation was that it would only get worse: it was a brain disease with no prospect of improvement. At that moment, the patient spontaneously said 'But I've had enough' and 'I don't want to go on'. When asked by the independent physician what she'd had enough of, she said 'Everything, all the things I can't do anymore, more and more things'. When asked what she meant when she said she did not want to go on, she said 'I want to die'. When the independent physician repeated the question, asking if she wanted to die *now*, she replied 'Yes, I want to die'. She said these things forcefully, with conviction and spontaneously, without any contribution from her husband. It was clear that her suffering was severe and that 'wanting to die' was now a current reality for her.

The independent physician was satisfied that the request came from the patient herself, also in view of the fact that she expressed her desire to die with conviction and on her own initiative during the interview. The independent physician found the request to be well-considered, in view of the previously documented interviews and the long-term guidance she had sought and received from the physician.

The second independent physician concluded, partly on the basis of her interview with the patient, that the due care criteria had been met.

The physician performed the procedure for assisted suicide. The patient took the beaker with the barbiturate potion from the physician and drank it, even though it could be seen that she did not like the taste.

The committee noted the following in connection with the *request being voluntary and well-considered*. The file contained the patient's advance directive, with a special clause on 'dementia', which had been signed in August 2009 and reaffirmed several times since then.

In January 2013, eight months before she was diagnosed with Alzheimer's disease, the patient drew up an advance directive, in which she stated that the process of dementia in one of her parents had particularly affected her, was never out of her mind and was of great influence on her opinions on growing old and being old. From that time onwards, she had made it clear, orally and in writing, that she did not want to end her life that way. For her, losing her dignity, losing contact with her loved ones, being dependent and being put away would be to suffer unbearably. She wanted to stay in her home as long as possible, where her husband would be her carer. If that were no longer possible, due to deteriorating mental and/or physical circumstances, then for her it would be time for a voluntary, self-determined and dignified end to her life.

The patient contacted the SLK in January 2013, after which the physician visited her for the first time. The physician agreed with the patient that her husband would keep an eye on when the moment for euthanasia was approaching and that the physician would maintain email contact with him. Over the course of two and a half years, the physician visited the patient on several occasions and maintained contact with her and her husband via email. Just over seven weeks before her death, the patient's husband indicated that, given her deteriorating condition, caring for her was becoming too difficult for him.

At that time, the physician began assessing the euthanasia request and the patient's current decisional competence in relation to her request. She consulted a geriatrician. The geriatrician could not form a judgment on the patient's decisional competence in relation to her wish for euthanasia, because at that moment the patient did not express a wish for euthanasia.

Three and a half weeks before her death, the patient asked the physician to perform the procedure to terminate her life soon. Her husband could no longer care for her properly and as a result the patient would have to go into a nursing home. She indicated that she did not want this; in such circumstances she wanted to die. The physician found that the patient was decisionally competent and the request was voluntary and well-considered. The physician recorded this conversation on her iPad and made a transcript.

The physician then consulted an independent SCEN physician, who found that the patient's request for euthanasia in the event that she would have to go into a nursing home was consistent and she was able to substantiate it. However, the patient was equally consistent in her opinion that she did not want to request euthanasia at that point in time.

He advised the physician to consult a physician with more specific expertise. The physician who was subsequently consulted, an elderly-care specialist and SCEN physician, visited the patient 11 days before her death. The patient indicated spontaneously and clearly to the SCEN physician that it had been enough and she wanted to die. The independent physician was satisfied that the request came from the patient herself, also in view of the fact that she

expressed her desire to die with conviction and on her own initiative during the interview. The independent physician found the request to be well-considered, given the previously documented interviews and the long-term guidance she had sought and received from the physician.

On the basis of the above, the committee found that the physician could reasonably conclude that the patient's request was voluntary and well-considered. Although over the course of time there had been moments when the patient did not express a clear desire to die, it emerged that she clearly expressed that desire in the interviews with the physician and the second independent physician – an elderly-care specialist. To them, she indicated unambiguously that she wanted to die now that her husband could not care for her properly anymore and she could no longer live in her own home, in view of her complete dependence on care.

The committee notes the following as regards the patient's suffering being unbearable.

In her advance directive, the patient indicated clearly under what circumstances she would experience her suffering as unbearable and would want her life to be terminated. In the many interviews she and her husband had with the physician about her wish for euthanasia, the patient also indicated in detail what unbearable suffering meant for her.

When the patient asked for euthanasia to be performed, her suffering was real and current i.e. she was suffering from the loss of control over her thoughts and actions, from fears and uncertainty and complete dependence. At that time the patient was in the situation that she had previously described in her advance directive and in the many interviews with the physician as being one of unbearable suffering.

The committee therefore found that the physician could reasonably conclude that at the time when the euthanasia was performed the patient was suffering unbearably.

The committee also considered whether there were any reasonable alternatives. After all, home care would have relieved her husband of some of the burden, thus postponing the need for her to go into a nursing home.

However, in her advance directive, the patient indicated expressly that her husband would be her carer and that if that were no longer possible, the time would have come for a voluntary and self-determined end to her life. Help from other people was not a reasonable alternative, either for the patient or for her husband. They had always refused any help or care that was offered.

Performing euthanasia when her husband could no longer care for her properly was therefore in line with her advance directive. Together, the physician and the patient could be satisfied that there was no reasonable alternative in the patient's situation.

Ch.4

THE REGIONAL EUTHANASIA REVIEW COMMITTEES (RTES)

STATUTORY FRAMEWORK

Termination of life on request and assisted suicide are criminal offences in the Netherlands and the islands of Bonaire, Saba and St Eustatius (articles 293 and 294 of the Criminal Code).

The only exception is when the procedure has been performed by a *physician* who has fulfilled the statutory *due care criteria* and has *notified* the municipal pathologist. 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 section 2 (1) of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, while the physician's duty to notify the municipal pathologist is dealt with in section 7 (2) of the Burial and Cremation Act.

The physician's notification to the pathologist must include a *substantiated report* in which he explains why he believes he has complied with the due care criteria. A model report is available on the website of the RTEs[12] for the physician to fill in, preferably digitally.

The pathologist performs an external examination of the body 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 pathologist notifies one of the regional euthanasia review committees of the euthanasia, i.e. the termination of life on request or the assisted suicide, and includes with that notification the physician's report, the findings of the independent physician concerning the due care criteria and – if there is one – the deceased person's advance directive. He also submits any other relevant documents provided by the physician, for instance the physician's notes and letters from specialists.

ROLE OF THE COMMITTEES

Statutory tasks, powers and methods

The Act states that the committees must review whether the physician has acted in accordance with the due care criteria set out in section 2 of the Act.

The physician must make it clear to the committee that he has complied with due care criteria c. (informing the patient), e. (consulting an independent physician) and f. (due medical care) set out in section 2 (1) of the Act, and that he can plausibly argue that, given the circumstances

12 www.euthanasiecommissie.nl

of the case, he was *reasonably* able to conclude that due care criteria a. (voluntary and well-considered request), b. (unbearable suffering with no prospect of improvement) and d. (no reasonable alternative) had been met. (The way in which compliance with the last three due care criteria is assessed would be described by Dutch lawyers as 'limited review' or a test of reasonableness.)

The review of the physician's actions takes place using the physician's report and all other documents submitted with the notification. Immediately after receiving the notification and a first reading of the documents submitted with the notification, the experienced secretary/lawyer of the committee in question makes an assessment of whether the notification is straightforward or not. A notification is considered straightforward if the assessment is that the statutory due care criteria have been complied with and the information submitted is sufficiently complete.

The straightforward notifications are sent digitally to the committee members (lawyer, physician and ethicist) and, in principle, reviewed digitally by them. These notifications are thus dealt with as quickly as possible. If any of the committee members thinks that the notification does raise questions, it is referred to the monthly committee meeting for discussion with the other non-straightforward notifications.

Euthanasia notifications that, during the first selection or the further review process, raise questions regarding one or more due care criteria are deemed to be non-straightforward. Non-straightforward notifications may also concern types of cases that the committees have decided always need further discussion, such as euthanasia notifications concerning patients whose suffering resulted from dementia, psychiatric disorders or multiple geriatric syndromes.

If the committee has any questions about a notification or requires more information or further explanation, it will contact the physician and/or the independent physician, either by telephone or in writing. If the information acquired in this way is insufficient to conduct a proper review of the physician's actions, the physician and/or the independent physician can be invited to explain their actions in person and answer questions from the committee (section 8 of the Act in conjunction with article 5 (2) (c) of the Decree of 6 March 2002 (Bulletin of Acts and Decrees 2002, no. 141) and the Guidelines on regional euthanasia review committee procedures of 21 November 2006).

A report is made of this interview. Before the report is adopted, a draft is sent to the physician and he is asked whether the report correctly reflects the explanation he gave. The committee then reaches its final conclusion.

In all cases in which the committee intends, on the basis of the documents submitted, to find that the physician did *not* act in accordance with one or more due care criteria, the physician is invited for an interview with the committee.

The committees issue written findings on the notifications they review. In principle, the physician will receive the committee's findings within the statutory period of six weeks. This period may be extended by a further six weeks. These periods may be longer in cases where the committee requires further oral or written explanation or information from the notifying physician or the independent physician. In addition, further internal consultations for the purpose of *harmonisation* (discussed below) sometimes lead unavoidably to extension of these periods. The notifying physician is informed of this possibility in the confirmation of receipt of the notification, which states that the notification will, in principle, be dealt with within the statutory period of 6 (or 12) weeks.

If the committee finds that the physician has complied with all the due care criteria, the review procedure ends. The case has then been disposed of de facto.

If the committee finds that the physician did *not* act in accordance with one or more of the due care criteria, the findings and the relevant file are sent to the Board of Procurators General and the Health Care Inspectorate, as well as to the physician (section 9 (2) of the Act). The Board will decide, possibly after an interview with the physician, whether criminal charges will be brought. The Inspectorate will decide, again possibly after an interview with the physician, whether or not to institute a disciplinary case or take other measures.

The notifications of the Public Prosecution Service (the Board of Procurators General) and the Health Care Inspectorate and the considerations in those notifications are included in the committees' annual report.

The coordinating chair, the deputy coordinating chair and the general secretary of the committees consult annually with the Board and the Inspectorate.

Composition and organisation of the committees

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. The basic principle is that a committee has two alternate members for each discipline. That means there are a total of nine committee members for each region. Each member can and does serve as an alternate member for other regions, both in the digital review of notifications and in discussing and reviewing notifications at the monthly committee meetings. Each committee is assisted by a secretary (a lawyer) who makes the preparations for the monthly committee meeting and attends the meetings in an advisory capacity.

The secretariats provide support to the committees. They have offices in Groningen, Arnhem and The Hague, which is where the committees meet. The secretariats are incorporated in the Disciplinary Boards and Review Committees Secretariats Unit (ESTT), which also comprises the secretariats of the Healthcare Disciplinary Boards. The secretariats are organised separately so as to guarantee the impartiality of review by the committees.

Harmonisation

If a committee intends to find that a physician has *not* acted in accordance with one or more due care criteria, it always submits those findings and the accompanying file – digitally – to all members and alternate members of the committees for their advice and comments. The draft findings in complex cases stating that the physician *has* acted in accordance with the due care criteria are usually submitted to all members and alternate members of the committees as well. In very exceptional cases, after all the arguments submitted have been considered, draft findings are submitted to the national consultative council for an authoritative opinion. Even then, the final decision falls to the competent committee.

Every year a meeting is held on a complex and current topic for all members and secretaries, often inviting external experts to attend. The national consultative council meets at least four times a year. Their meetings are also attended by the general secretary and the committee secretaries. The physician members meet separately at least once a year, as do the ethicists on the committees. This helps ensure harmonisation and consistency of assessment and decision-making.

Transparency and communication

To provide physicians and other interested parties with a good, up-to-date overview of the committees' findings and to make their interpretation of the due care criteria more accessible, the committees published a Code of Practice in 2015 which can be consulted online, like their annual reports.

The committees' Publication Committee, established in 2013, is tasked with publishing findings that are deemed important for the development of standards in an accessible way on the committees' website. They in any case publish findings of all cases in which the committees found that the physician had *not* complied with one or more of the due care criteria. Their publication on the committees' website has priority.[13]

The committees also fulfil their duty to inform[14] by giving presentations to municipal health services, associations of general practitioners, foreign delegations and so on. In these presentations, the committee members and secretaries discuss the statutory due care criteria and the review procedure, often using examples from practice.

The committees also help the KNMG's Euthanasia in the Netherlands Support and Assessment Programme (SCEN) to train physicians to perform independent assessments. At the request of SCEN physicians, members of the committees attend peer supervision meetings in their regions. The importance of good reporting by SCEN physicians is also a topic of discussion at these meetings. To help them draw up their report, the SCEN has published a Guideline for the independent physician's report.[15]

The committees' findings with regard to independent physicians' reports are generally forwarded directly to the physician in question and sometimes in general terms, and therefore anonymised, to the SCEN organisation.

ANNEXE 1 (NOT INCLUDED HERE)

13 www.euthanasiecommissie.nl

14 See article 4 (2) of the Decree establishing rules regarding the committees referred to in section 19 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

15 Leidraad Verslag van een SCEN-arts [Guideline for the independent physician's report], www.KNMG.nl/diensten/SCEN/richtlijn-en-downloads.htm

ANNEXE 2

RELEVANT STATUTORY PROVISIONS

Bulletin of Acts and Decrees 2001, no. 194
Act of 12 April 2001, containing review procedures for the termination of life on request and assisted suicide and amending the Criminal Code and the Burial and Cremation Act (Termination of Life on Request and Assisted Suicide (Review Procedures) Act)[16]

TERMINATION OF LIFE ON REQUEST AND ASSISTED SUICIDE (REVIEW PROCEDURES) ACT

CHAPTER I. DEFINITIONS

Section 1

For the purposes of this Act, the following definitions apply:

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

CHAPTER II. DUE CARE CRITERIA

Section 2

1. In order to comply with the due care criteria referred to in article 293, paragraph 2 of the Criminal Code, the physician must:
   a. be satisfied that the patient's request is voluntary and well considered;
   b. be satisfied that the patient's suffering is unbearable, with no prospect of improvement;
   c. have informed the patient about his situation and his prognosis;
   d. have come to the conclusion, together with the patient, that there is no reasonable alternative in the patient's situation;
   e. have consulted at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled;
   f. have exercised due medical care and attention in terminating the patient's life or assisting in his suicide.
2. If a patient aged sixteen or over who is no longer capable of expressing his will, but before reaching this state was deemed capable of making a reasonable appraisal of his own interests, has made a written declaration requesting that his life be terminated, the physician may comply with this request. The due care criteria in subsection 1 apply *mutatis mutandis*.

16 For an account of the proceedings in Parliament, see: Parliamentary Papers, House of Representatives, 1998/1999, 2000 2001, 26 691. Proceedings of the House of Representatives, 2000/2001, pp. 2001-2072; 2107-2139; 2202-2223; 2233-2260; 2372-2375. Parliamentary Papers, Senate, 2000/2001, 26 691 (137, 137a, 137b, 137c (reprint), 137d, 137e, 137f, 137g, 137h). Proceedings of the Senate, 2000/2001, see session of 10 April 2001.

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

CHAPTER III. REGIONAL REVIEW COMMITTEES FOR THE TERMINATION OF LIFE ON REQUEST AND ASSISTED SUICIDE

Division 1: Establishment, composition and appointment

Section 3

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

Section 4

1. The chair, the members and the alternate members are appointed by Our Ministers for a period of six[17] years. They may be reappointed once for a period of six years.
2. A committee has a secretary and one or more deputy secretaries, all of whom must be legal experts appointed by Our Ministers. The secretary attends the committee's meetings in an advisory capacity.
3. The secretary is accountable to the committee alone in respect of his work for the committee.

Division 2: Resignation and dismissal

Section 5

The chair, the members and the alternate members may tender their resignation to Our Ministers at any time.

Section 6

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

17 Pursuant to an agreement concluded in 2007 by the review committees and the Minister of Health, Welfare and Sport and the Minister of Security and Justice, as of 1 January 2008 the appointment period is set at four years. Members may be reappointed once for a period of four years.

Division 3: Remuneration

Section 7

The chair, the members and the alternate members are paid an attendance fee and a travel and subsistence allowance in accordance with current government regulations, in so far as these expenses are not covered in any other way from the public purse.

Division 4: Duties and responsibilities

Section 8

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

Section 9

1. The committee notifies the physician of its findings in writing within six weeks of receiving the report referred to in section 8, subsection 1, giving reasons.
2. The committee notifies the Board of Procurators General and the regional health care inspector of its findings:
   a. if the physician, in the committee's opinion, did not act in accordance with the due care criteria set out in section 2; or
   b. if a situation occurs as referred to in section 12, last sentence of the Burial and Cremation Act.
   The committee notifies the physician accordingly.
3. The time limit defined in the first subsection may be extended once for a maximum of six weeks. The committee notifies the physician accordingly.
4. The committee is empowered to explain its findings to the physician orally. This oral explanation may be provided at the request of the committee or the physician.

Section 10

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

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

2° for the purposes of a criminal investigation

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

Division 6: Procedures

Section 11

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

Section 12

1. The committee adopts its findings by a simple majority of votes.
2. The committee may adopt findings only if all its members have taken part in the vote.

Section 13

The chairs of the regional review committees meet at least twice a year in order to discuss the methods and operations of the committees. A representative of the Board of Procurators General and a representative of the Health Care Inspectorate, which falls under the public health inspectorates, will be invited to attend these meetings.

Division 7: Confidentiality and disqualification

Section 14

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

Section 15

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

Section 16

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

Division 8: Reporting requirements

Section 17

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

Section 18

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

Section 19

1. On the recommendation of Our Ministers, rules are laid down by order in council on:
   a. the number of committees and their powers;
   b. their locations.
2. Further rules may be laid down by Our Ministers by or pursuant to order in council with regard to:
   a. the size and composition of the committees;
   b. their working methods and reporting procedures.

CHAPTER III A. BONAIRE, ST EUSTATIUS AND SABA

Section 19a

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

Section 19b

1. For the purposes of:
   - section 1 (b), 'article 294, paragraph 2, second sentence of the Criminal Code' is replaced by: 'article 307, paragraph 2, second sentence of the Criminal Code of Bonaire, St Eustatius and Saba'.
   - section 1 (f), 'a regional review committee as referred to in section 3' is replaced by: 'a committee as referred to in section 19c';
   - section 2, subsection 1, opening words, 'article 293, paragraph 2, second sentence' is replaced by: 'article 306, paragraph 2, second sentence of the Criminal Code of Bonaire, St Eustatius and Saba';
   - section 8, subsection 1, 'section 7, subsection 2 of the Burial and Cremation Act' is replaced by: 'section 1, subsection 3 of the Death Certificates (Bonaire, St Eustatius and Saba) Act';
   - section 8, subsection 3, 'or the relevant care providers' lapses;
   - section 9, subsection 2, opening words, 'the Board of Procurators General' is replaced by 'the Procurator General'.

2. Section 1 (e) does not apply.

Section 19c

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

Section 19d

The chair of the committee referred to in section 19c takes part in the meetings referred to in section 13. The Procurator General or a representative appointed by him and a representative of the Health Care Inspectorate also take part.

CRIMINAL CODE

Article 293

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

Article 294

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

BURIAL AND CREMATION ACT

Section 7

1. The person who conducted the post-mortem examination issues a death certificate if he is satisfied that the death was due to natural causes.
2. If death was the result of the termination of life on request or assisted suicide as referred to in article 293, paragraph 2 or article 294, paragraph 2, second sentence of the Criminal Code respectively, the physician does not issue a death certificate and immediately notifies the municipal pathologist or one of the municipal pathologists of the cause of death by completing a report form.
   The physician encloses with the form a substantiated report on compliance with the due care criteria set out in section 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.
3. If the physician decides, in cases other than those referred to in subsection 2, that he is unable to issue a death certificate, he immediately notifies the municipal pathologist or one of the municipal pathologists accordingly by completing a report form.

Section 9

1. The form and layout of the models for the death certificates to be issued by the physician and the municipal pathologist are laid down by order in council.
2. The form and layout of the models for the notification and the detailed report as referred to in section 7, subsection 2, for the notification as referred to in section 7, subsection 3 and for the forms referred to in section 10, subsections 1 and 2 are laid down by order in council on the recommendation of Our Minister of Justice and Our Minister of Health, Welfare and Sport.

Section 10

1. If the municipal pathologist decides that he is unable to issue a death certificate, he immediately notifies the public prosecutor by completing a form and immediately notifies the Registrar of Births, Deaths and Marriages.
2. Without prejudice to subsection 1, the municipal pathologist, if notified as referred to in section 7, subsection 2, will report without delay to the regional review committees referred to in section 3 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act by completing a form. He will enclose a detailed report as referred to in section 7, subsection 2.

Section 81

Anyone who
1° infringes the provisions laid down by or pursuant to sections (...) 7, subsections 1 and 2 (...) is liable to a term of imprisonment not exceeding one month or a second-category fine.

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