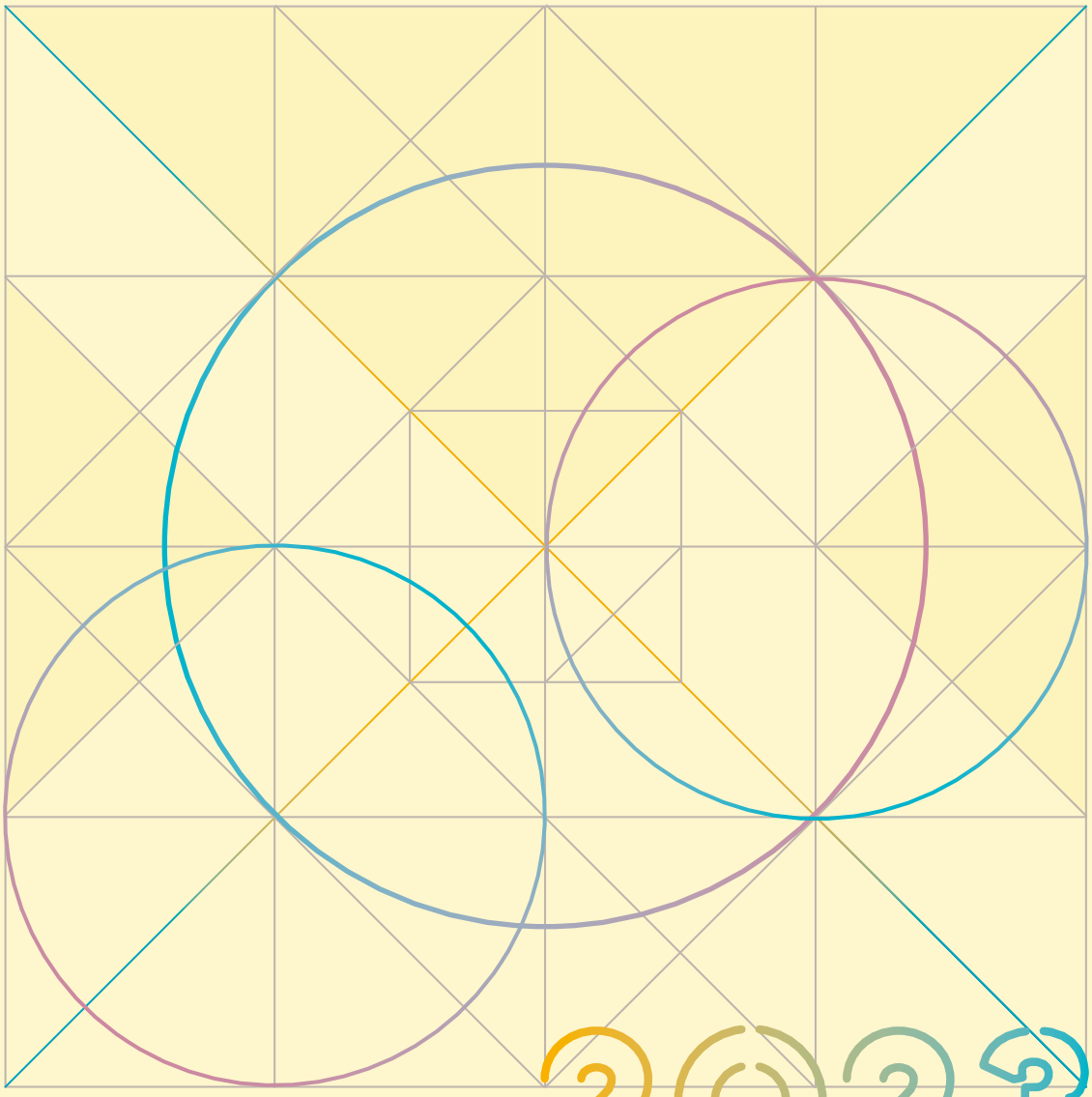
RTE

REGIONAL EUTHANASIA REVIEW COMMITTEES



ANNUAL REPORT 2023

CONTENTS

CHAPTER 3 CASES

FOREWORD

In 2023 the Regional Euthanasia Review Committees (RTEs) marked their 25th anniversary. The order establishing the five committees, with the aims of ensuring legal certainty, enabling public scrutiny and safeguarding the quality of the processes, entered into force on 1 November 1998. An additional aim specified in the order was to create more distance between criminal law and the process, in order to increase physicians' willingness to report euthanasia.

The RTEs would appear to be contributing to achieving those aims. Every year, the RTEs have been able to report that euthanasia procedures are generally carried out with great care, and this year has been no exception. The periodic evaluations of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act ('the Act'), and by extension the evaluation of the RTEs themselves, have also all come to the same conclusion. The degree of willingness among physicians to report euthanasia remains high. The RTEs' functioning has received positive assessments, including in the most recent evaluation which was carried out in July 2023. The only recommendation given specifically to the RTEs in that evaluation – to make the internal criteria for the categorisation of notifications more transparent – was taken on board and carried out.

The RTEs do what they are meant to do: reviewing, in a timely manner, notifications of euthanasia carried out by physicians. Of course this does not mean that there is nothing left to achieve or that the RTEs are not faced with any challenges. Leaving aside the steady increase in the number of notifications – in 2023 there was a 4% increase in notifications compared with the previous year – matters that require constant attention include the quality and consistency of the findings, the staffing of the RTEs and the relationship between the RTEs and physicians – both those who perform euthanasia and SCEN physicians. In addition, a conference was held in December 2023 to mark the RTEs' 25th anniversary, featuring many expert speakers, with a view to gaining insight into issues that might arise in the future.

In 2023 the RTEs received 9,068 notifications of euthanasia. The numbers thus continue to rise, though less than in the previous year. This annual report is the first to include diagrams showing the development in the number of notifications per medical category. On the whole, there are no noteworthy differences in the numbers per category.

In five cases this year it was found that the due criteria had not been complied with. This is again a very small percentage of the total number. Chapter 3 gives summaries of the findings in these cases. Chapter 1 of this report refers to a number of cases in which the 'Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide' of the Royal Dutch Medical Association (KNMG) and the Royal Dutch Association for the Advancement of Pharmacy (KNMP), published in 2021, were not adhered to. As these cases were reviewed in 2024, they will be discussed in the next annual report.

In the second half of the year under review, the RTEs recruited nine additional members, and a tenth extra member will follow in the first half of 2024. This expansion will enable the RTEs to keep pace with the steady growth in the number of notifications of euthanasia. The precise reasons for this increase remain unknown. However, patient autonomy appears to play a role, with regard to both deciding to request euthanasia and choosing when euthanasia is performed. In the 25 years of the RTEs' existence, views on patient autonomy in healthcare have changed, and that automatically includes patients' autonomy at the end of their lives. The Act, which is worked out in greater detail in the Euthanasia Code 2022, provides scope for this development. It is a fine example of the slow dynamics between law and practice, as embodied in the work of the RTEs.

JEROEN RECOURT
Coordinating chair

INTRODUCTION

In this annual report the Regional Euthanasia Review Committees ('RTEs')[1] report on their work over the past calendar year. They thus account – to society, government and parliament – for the way in which they fulfil their statutory task of reviewing notified cases of termination of life on request and assisted suicide on the basis of the due care criteria laid down in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act ('the Act'). This report uses the term 'euthanasia' to refer to both forms of termination of life. The distinction between termination of life on request and assisted suicide is made only where necessary.

Another aim of the annual report is to give physicians and other interested parties insight into the way in which the committees review and assess specific notifications. That is why the annual report discusses various notifications, both common and more exceptional cases, as well as all cases in which it was found that the due care criteria had not been complied with.

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

For more information on the outlines of the Act, the committees' procedures, etc., see the Euthanasia Code 2022 and the website of the RTEs: https://english.euthanasiecommissie.nl.

1 *See Annexe I for more information on how the RTEs are organised.*

CHAPTER 1
COMMITTEE PROCEDURES – DEVELOPMENTS

1 ABRIDGED FINDINGS REPORT FOR EUTHANASIA NOTIFICATIONS INVOLVING PATIENTS WITH A PSYCHIATRIC DISORDER

One of the developments in the RTEs' procedures in 2023 was the introduction of an 'abridged findings report' for a number of cases in which the request for euthanasia was based on suffering caused entirely or in part by a psychiatric disorder.[2] Previously, the findings concerning such cases had always been written out in a full report discussing the specific aspects of the case and the committee's considerations. This is not done in abridged findings reports. Experience has shown over the past few years that some notifications in this category do not raise any extra questions with the committee, as can also be the case with euthanasia notifications involving patients with somatic conditions, and that it is clear in these cases that the physician has complied with the due care criteria.

Abridged findings reports are issued in cases where the following three conditions have been met:

- *the physician has consulted an independent psychiatrist (who may or may not also be the independent (SCEN) physician consulted);*
- *the physician and the independent psychiatrist and independent (SCEN) physician consulted by the physician all agree on the diagnosis or diagnoses, the patient's decisional competence with regard to the request for euthanasia, the absence of reasonable treatment options and the absence of reasonable alternatives;*
- *no questions arose with the committee as to whether the physician complied with all the due care criteria.*

If a notification in which the request for euthanasia was based on suffering caused entirely or partly by a psychiatric disorder does raise extra questions with the committee, or if there is a reason to make known specific considerations set out by the committee, a full report of findings will be issued, as was previously always the case for notifications in this category. If there is only one consideration of the

2 *This includes notifications involving patients with both somatic conditions and a psychiatric disorder.*

committee, this may be added to the standard text of the abridged findings report. Notifications of cases in which the request for euthanasia was based on suffering caused entirely or partly by a psychiatric disorder are still always discussed in a committee meeting.

Every month at least one abridged findings report for a case in which the request for euthanasia was based on suffering caused entirely or partly by a psychiatric disorder will be written out in full and published on our website.

THE TEXT OF THE ABRIDGED FINDINGS REPORT

The documents have shown that the patient's request for euthanasia *was (largely) based on suffering caused by one or more psychiatric disorders / was based on suffering caused partly by one or more somatic conditions and partly by one or more psychiatric disorders.* In such cases, the physician must exercise particular caution with regard to the request for euthanasia. That particular caution especially concerns assessing the patient's decisional competence with regard to their request for euthanasia, the absence of any prospect of improvement, and the lack of a reasonable alternative.

The physician must rule out that the patient's powers of judgment have been impaired by their psychiatric disorder(s). If the patient is not decisionally competent with regard to their request for euthanasia, that request cannot be regarded as voluntary and well considered. The physician must take particular note of whether the patient is able to grasp relevant information, understands their disease and is unequivocal in their deliberations (see Euthanasia Code 2022, p. 45).

As regards suffering with no prospect of improvement and the absence of a reasonable alternative, the physician must carefully explore the possibility of other options that could end or reduce the patient's suffering. If the patient refuses a reasonable alternative, they cannot be said to be suffering with no prospect of improvement. At the same time, patients are not obliged to undergo every conceivable form of treatment or intervention (see Euthanasia Code 2022, p. 45).

The RTEs' basic principle is that for this category of patients the physician must always seek psychiatric expertise. The purpose of seeking psychiatric expertise is for the physician to ensure they are well informed and can reflect critically on their own convictions. The independent psychiatrist may give advice on treatment if necessary. The physician can decide whether to consult an independent psychiatrist in addition to an independent (SCEN) physician or an independent (SCEN) physician who is also a psychiatrist (see Euthanasia Code 2022, pp. 46-47).

(If an independent psychiatrist is consulted in addition to a SCEN physician:)
The committee has established that you consulted an independent psychiatrist,

who examined the patient and gave their expert opinion on the patient's decisional competence with regard to their request for euthanasia, the absence of any prospect of improvement, and the lack of a reasonable alternative.

In addition you consulted an independent SCEN physician (who is also a psychiatrist). The independent physician saw the patient and gave their opinion in writing as an independent physician with regard to the due care criteria set out in section 2 (1) (a) to (d) of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

(If an independent psychiatrist is consulted as a SCEN physician:)
The committee has established that you consulted an independent SCEN physician who is also a psychiatrist. The independent physician saw the patient and gave their opinion as an independent physician in writing with regard to the due care criteria set out in section 2 (1) (a) to (d) of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act. This included an assessment of the patient's decisional competence with regard to the request for euthanasia, the absence of any prospect of improvement, and the lack of a reasonable alternative.

The committee has established that **[select as appropriate:]** you, the independent psychiatrist and the independent physician were of the opinion that the patient was decisionally competent with regard to their request for euthanasia, that the request was voluntary and well considered, that there were no longer any reasonable treatment options and the patient was therefore suffering without prospect of improvement, and that there was no reasonable alternative in their situation.

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

2 ORAL EXPLANATION NO LONGER ALWAYS NECESSARY AFTER EUTHANASIA ON THE BASIS OF A WRITTEN REQUEST

In 2017, the RTEs decided to always invite the physician to give an oral explanation at a committee meeting if the physician submitted a notification concerning euthanasia performed on the basis of a written request (also referred to as an 'advance directive'). As these 'section 2 (2)' notifications occurred very rarely and the RTEs therefore had little experience with them, the physician was asked to explain in detail the procedure they had followed.

Since then, the RTEs have gained more experience with this particular category of notifications and there is greater clarity as to how the statutory due care criteria should be interpreted in relation to euthanasia based on a written request. Experience in the past few years has shown that for some of these notifications, the information provided by the physician in the case file is sufficient for the committee to form an opinion. In these cases the RTEs will therefore no longer as a rule invite the physician to give an oral explanation. Sometimes however it may still be necessary to ask the physician for a written explanation.

Due to the nature of the notifications in this particular category, they will always be discussed in a committee meeting. When assessing whether the physician complied with the due care criteria, in some cases it is not particularly useful – and would place a disproportionate burden on the physician – to ask for an oral explanation if the committee does not have any specific questions.

All findings in response to notifications of euthanasia performed on the basis of a written request are published on our website.

3 SPECIAL COMMITTEE PROCEDURE WITH REGARD TO DUE MEDICAL CARE

In 2021, the KNMG and the KNMP updated their guidelines on performing euthanasia and assisting with suicide (*KNMG/KNMP Richtlijn Uitvoering euthanasie en hulp bij zelfdoding*). The RTEs refer to the Guidelines in assessing whether the physician has exercised due medical care (see Euthanasia Code 2022, p. 34). If a physician deviates from the Guidelines, they must give sufficient reasons for doing so.

It emerged in 2023 that there was a risk of inconsistency in the RTEs' findings with regard to the conditions under which a physician may deviate from the Guidelines in the event that the administered euthanatic does not have the desired effect. The notifications in question were put on hold pending the outcome of internal consultations.

This prevented legal inequality, but it also resulted in a delay of several months in dealing with a number of notifications. First and foremost, this was distressing for the physicians who had to wait a long time to receive the RTEs' findings on their notifications. It also led to the RTEs finding in January 2024 that in two of the cases the due care criteria had not been complied with, whereas without the delay the findings would have been issued in 2023. Lastly, one of the physicians who experienced this delay submitted a complaint about this and other matters.

The internal consultations were completed at the end of November 2023, after which the RTEs resumed reviewing notifications in which physicians had deviated from the Guidelines. The RTEs will further investigate the possible risk to the patient of administering a second dose of muscle relaxant without first administering a second dose of the coma-inducing substance; it will also investigate the risks associated with a long time elapsing between the administration of the different euthanatics. The results are expected in 2024 and will be discussed in the 2024 annual report. For now we would emphasise that the RTEs consider it important for physicians who perform euthanasia and SCEN physicians to be familiar with the most recent Guidelines. The RTEs also stress that the preferred course of action is to adhere to the Guidelines. If a patient does not respond sufficiently to the administered euthanatic, it must be assumed that the euthanatic has missed the vein. This is not always visible as a subcutaneous swelling. That means that if the administered euthanatic does not work, the entire procedure must be carried out again, from inserting a second IV cannula, administering a coma-inducing substance and adequately establishing whether the patient's consciousness is sufficiently reduced, to administering a muscle relaxant (see pp. 15-17 of the Guidelines).
This reduces the risk of further complications and of a third set of euthanatics having to be delivered.

CHAPTER 2
FIGURES IN 2023

NUMBER OF NOTIFICATIONS

In 2023 the RTEs received 9,068 notifications of euthanasia.[3] This is 5.4% of the total number of people who died in the Netherlands in that year (169,363).[4] The number of notifications increased by 4% compared with 2022 (8,720). Below is an overview of the number of notifications received by each of the five regional committees.

Region 1: Groningen, Friesland, Drenthe and the Caribbean Netherlands – 929 notifications.
Region 2: Overijssel, Gelderland, Utrecht and Flevoland – 2,351 notifications.
Region 3: North Holland – 1,844 notifications.
Region 4: South Holland and Zeeland – 1,763 notifications.
Region 5: North Brabant and Limburg – 2,181 notifications.

MALE/FEMALE RATIO

As in previous years, the number of notifications concerning men and women were almost the same: 4,603 men (50.8%) and 4,465 women (49.2%).

RATIO OF CASES OF TERMINATION OF LIFE ON REQUEST TO CASES OF ASSISTED SUICIDE

There were 8,860 notifications of termination of life on request (97.7% of the total), 190 notifications of assisted suicide (2.1%) and 18 notifications involving a combination of the two (0.2%). A combination of the two occurs if, in a case of assisted suicide, the patient ingests the potion handed to them by the physician, but does not die within the time agreed on by the physician and patient. The physician then performs termination of life on request by intravenously administering a coma-inducing substance, followed by a muscle relaxant.

For points to consider regarding due medical care, see pages 34 ff of the Euthanasia Code 2022.

3 *As is the case in all the annual reports of the RTEs, a number of these notifications concerned euthanasia performed in the previous year, in this case 2022. Some of these notifications will only be reviewed in 2024. The annual figures also include a number of notifications that were received at the end of 2022, but could not be included in the previous annual report.*
4 *Source: CBS Statistics Netherlands, 21 February 2024, deaths per week, by gender and age.*

CONDITIONS INVOLVED

COMMON SOMATIC CONDITIONS

In 2023, 8,042 (88.7%) notifications received by the RTEs involved patients with:

- cancer (5,105);
- neurological disorders such as Parkinson's disease, multiple sclerosis and motor neurone disease (605);
- cardiovascular disease (393);
- pulmonary disorders (340);
- a combination of conditions, usually somatic (1,599).

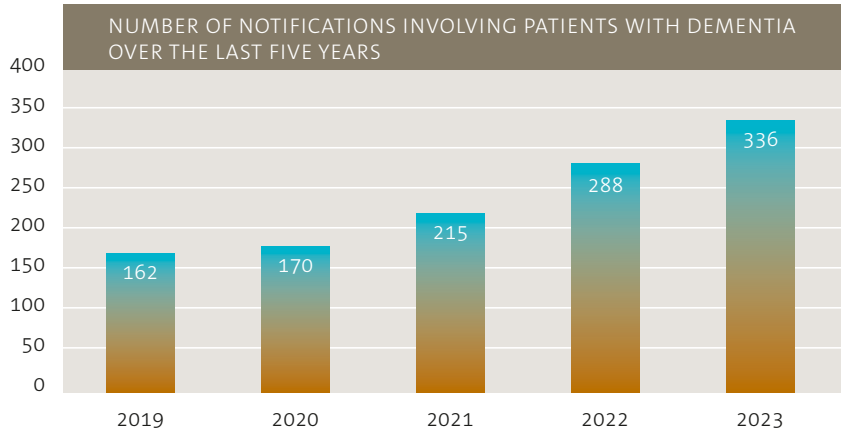
DEMENTIA

There were 328 cases of euthanasia involving patients with a form of dementia who were still decisionally competent with regard to their request for euthanasia. These patients still had insight into their condition and its symptoms, such as spatial and temporal disorientation, and personality changes. Case 2023-074, described in Chapter 3, is an example.

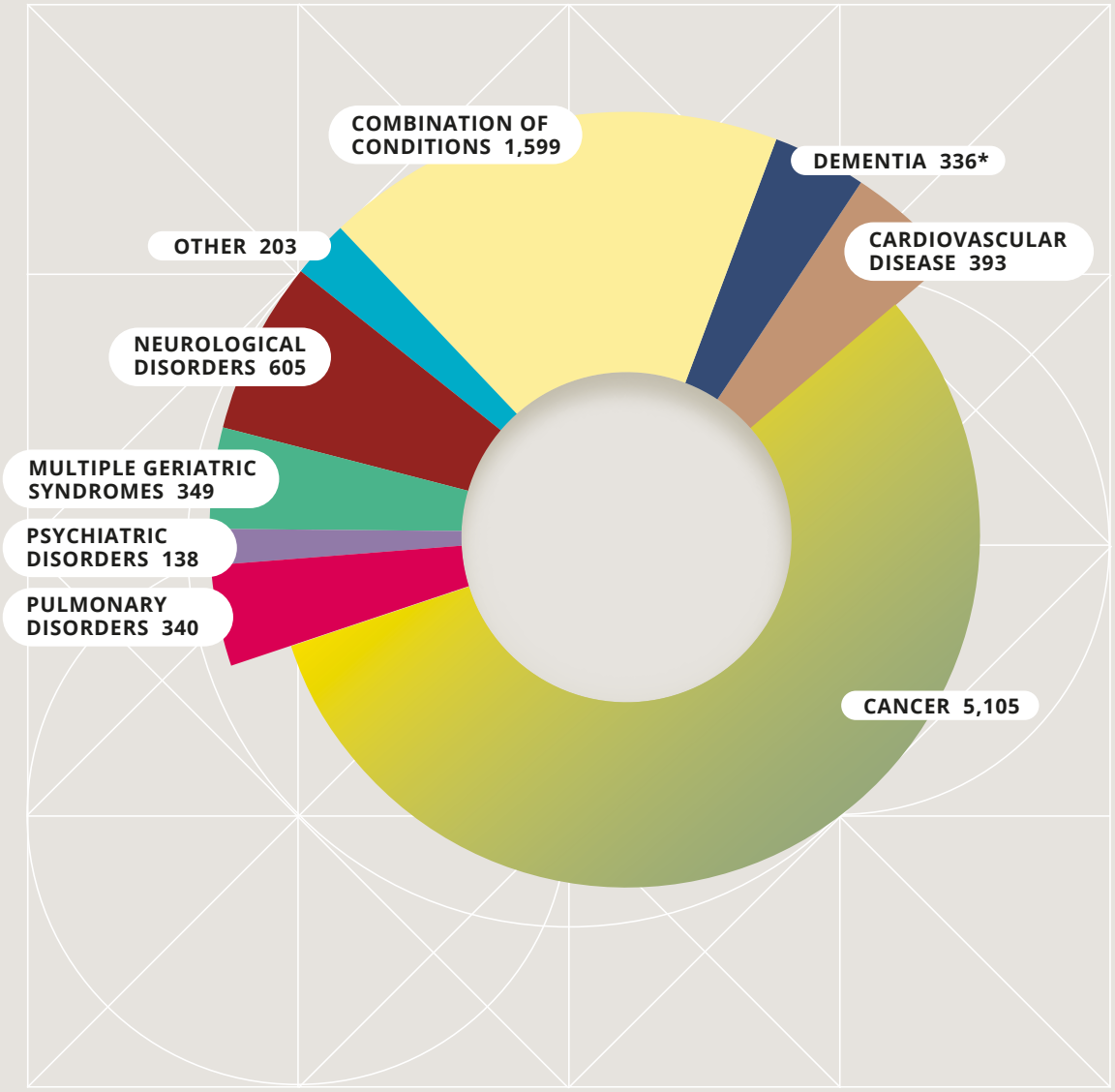
Eight notifications reviewed in 2023 involved patients in an advanced stage of dementia who were no longer decisionally competent with regard to their request for euthanasia and no longer able to communicate meaningfully regarding their request. In their cases the advance directive was considered to be their request for euthanasia. One of these cases (2023-065) is described in Chapter 3 of this report. All of these notifications have been published on the website of the RTEs.

In 2023 there was one other case in which euthanasia was performed on the basis of an advance directive. The patient in question was not suffering from dementia, but was no longer decisionally competent as the result of a stroke.

For points to consider regarding patients with dementia, see pages 47 ff of the Euthanasia Code 2022.



NATURE OF CONDITIONS



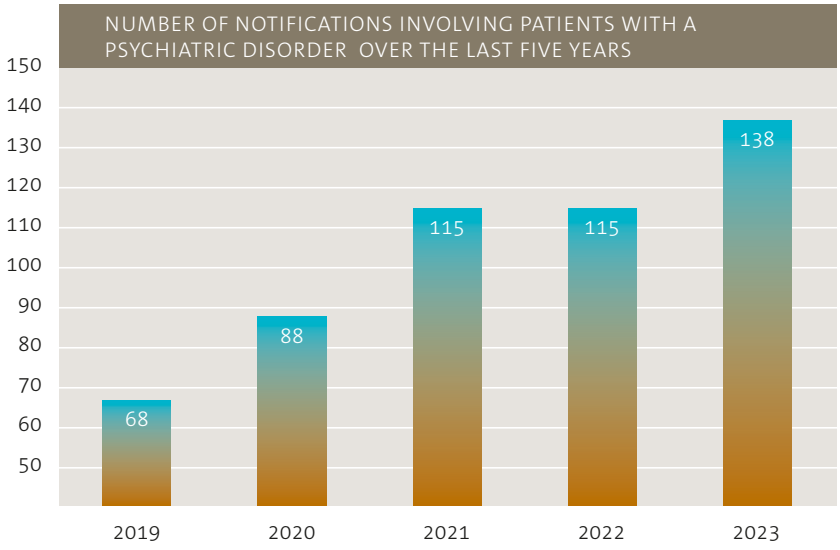
* *patient decisionally competent: 328*
patient not decisionally competent: 8

PSYCHIATRIC DISORDERS

In 2023, 138 euthanasia notifications concerned patients whose suffering was (largely) caused by one or more psychiatric disorders. In 56 cases the physician performing euthanasia was a psychiatrist, in 35 cases a general practitioner and in 10 instances a consultant (including elderly-care specialists). In the other 37 cases the physician fell into the category 'other physician'.[5] In 70 cases the physician performing euthanasia was affiliated with the Euthanasia Expertise Centre (EE).

If a patient requests euthanasia because they are suffering from one or more psychiatric disorders, the physician must exercise particular caution. An example of such a case is described in Chapter 3 (2023-004).

For points to consider regarding patients with a psychiatric disorder, see pages 45 ff of the Euthanasia Code 2022.

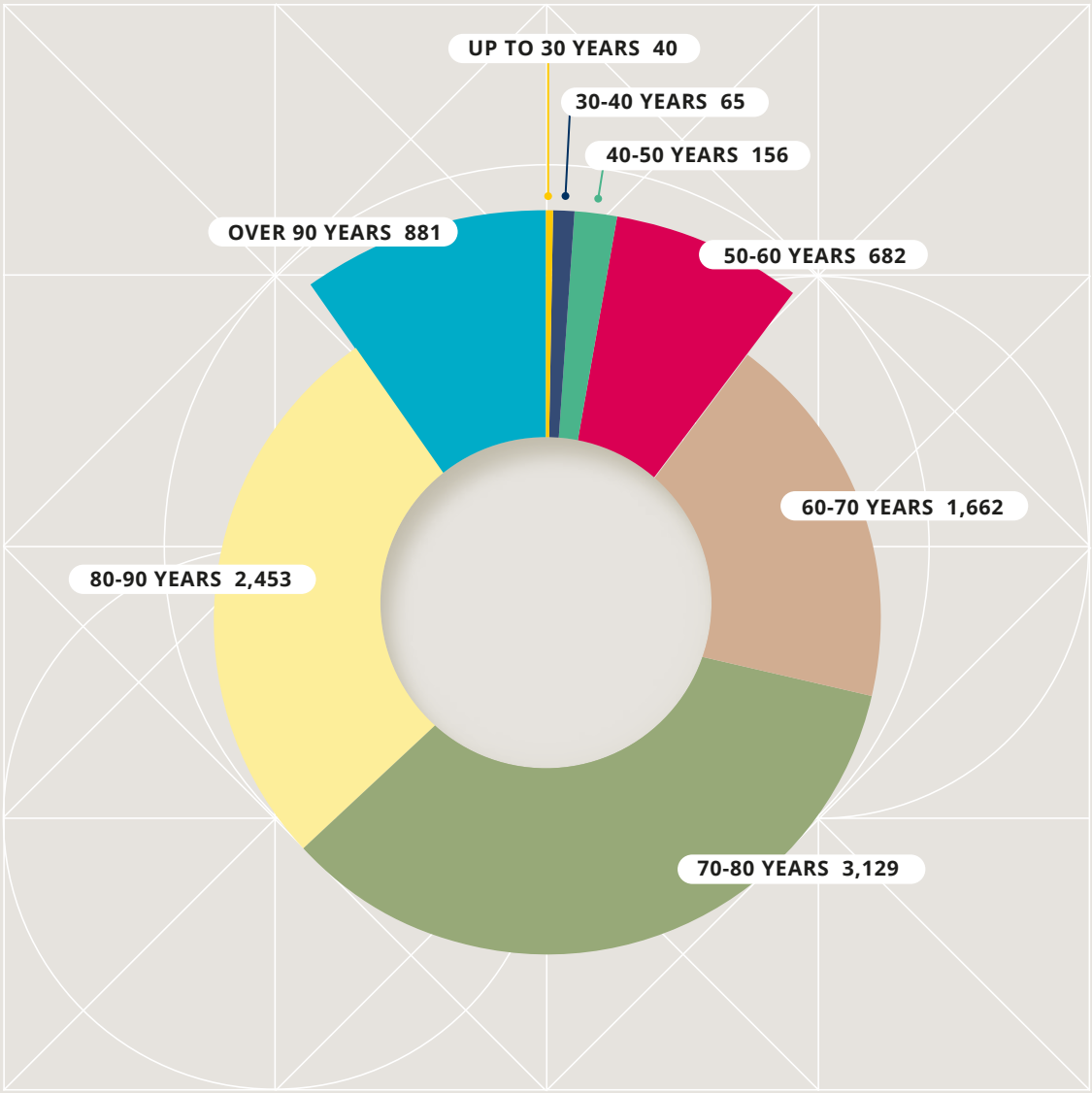


MULTIPLE GERIATRIC SYNDROMES

Multiple geriatric syndromes – such as sight impairment, hearing impairment, osteoporosis and its effects, osteoarthritis, balance problems or cognitive decline – may cause unbearable suffering without prospect of improvement. These syndromes generally develop in older age, and can lead to an accumulation of symptoms. In conjunction with the patient's medical history, life history, personality, values and stamina, they may give rise to suffering that that patient may experience as unbearable and without prospect of improvement. In 2023 the RTEs

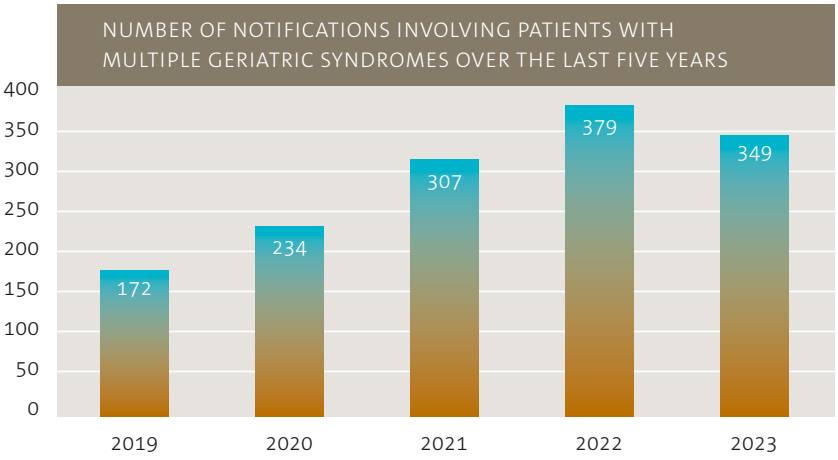
5 *In this context, 'other physician' may mean, for instance, a peripatetic physician, a medical manager, a non-practising physician, a registrar, or a junior doctor.*

AGE


UP TO 30 YEARS 40
30-40 YEARS 65
40-50 YEARS 156
OVER 90 YEARS 881
50-60 YEARS 682
60-70 YEARS 1,662
80-90 YEARS 2,453
70-80 YEARS 3,129

received 349 notifications of euthanasia that fell into this category. An example of such a case is described in Chapter 3 and has been published on the website (2023-043).

For points to consider regarding multiple geriatric syndromes, see page 22 of the Euthanasia Code 2022.



OTHER CONDITIONS

Lastly, the RTEs register cases involving conditions that do not fall into any of the above categories, such as chronic pain syndrome, rare genetic disorders, kidney failure, blindness, severe fractures or long COVID, as 'other conditions'. There were 203 such cases in 2023.

AGE

The highest number of notifications of euthanasia involved people in their seventies (3,129 cases), followed by people in their eighties (2,453 cases) and people in their sixties (1,662 cases).

There were 682 notifications concerning people in their fifties, 156 concerning people in their forties and 65 concerning people in their thirties. The lowest number concerned people aged below 30 (40 cases).

In 2023 the RTEs received two notifications of euthanasia involving a minor between the ages of 16 and 18.[6] These notifications will be reviewed in 2024.

In 12 cases the patient was over 100 years of age; the oldest was aged 104.

There were 105 notifications concerning people aged between 18 and 40.

6 *For points to consider regarding minors, see pages 44-45 of the Euthanasia Code 2022.*

In 52 of these cases, the patient's suffering was caused by cancer and in 22 cases it was caused by a psychiatric disorder.

In the category 'dementia', the highest number of notifications involved people in their seventies (141 cases), followed by people in their eighties (131 cases).

In the category 'psychiatric disorders', there were 27 notifications involving people in their fifties and 27 involving people in their sixties.

In the category 'multiple geriatric syndromes' most of the notifications concerned people aged 90 or older (224 out of 349 cases).

LOCATIONS

In 2023, as in previous years, patients in the vast majority of cases died at home (7,151 cases). Other locations were a nursing home or care home (897), a hospice (688), a hospital (211) or elsewhere, for instance at the home of a family member or in a convalescent home (121).

NOTIFYING PHYSICIANS

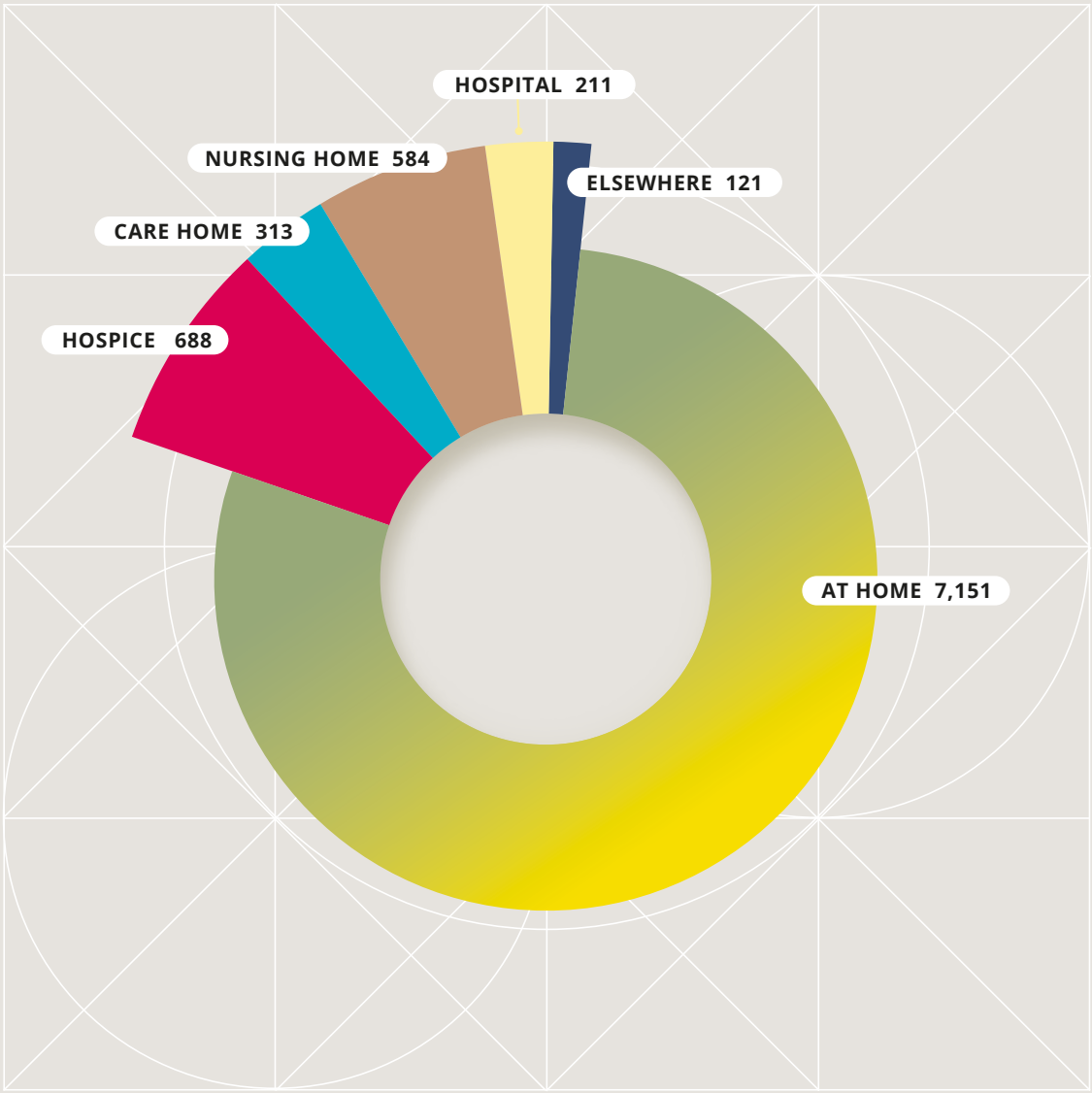
The vast majority of cases were notified by a general practitioner (7,249). The other notifying physicians were elderly-care specialists (365), psychiatrists (62), other specialists (327), registrars (124) and 'other physicians' (941).[7]

NOTIFICATIONS INVOLVING THE EUTHANASIA EXPERTISE CENTRE

The number of notifications by physicians affiliated with the EE (1,277; 14.1% of the total number) increased by 36 compared to 2022, when there were 1,241 notifications by this group. EE physicians are often called upon if the attending physician considers a request for euthanasia to be too complex. Physicians who do not perform euthanasia for reasons of principle or who will only perform euthanasia if the patient has a terminal condition also sometimes refer patients to the EE. In some cases, rather than being referred by an attending physician, the patients themselves or their families contact the EE. Around half of the notifications involving patients with a psychiatric disorder came from EE physicians: 70 out of 138 notifications (50.7%). This is a slight decline in relative terms compared with 2022: 65 out of 115 notifications (56.5%). Of the 336 notifications of cases in which the patient's suffering was caused by a form of dementia, 134 (39.9%) came from EE physicians. Of the 349 notifications involving patients with multiple geriatric syndromes, 151 (43.3%) came from EE physicians.

7 *'Other physicians' in this context include a peripatetic physician, a medical manager, a non-practising physician, or a junior doctor.*

LOCATIONS


HOSPITAL 211
NURSING HOME 584
ELSEWHERE 121
CARE HOME 313
HOSPICE 688
AT HOME 7,151

ORGAN AND TISSUE DONATION AFTER EUTHANASIA

Euthanasia does not preclude organ and tissue donation. The *Richtlijn Orgaandonatie na euthanasie* (Guidelines on organ donation after euthanasia) published by the Dutch Foundation for Transplants provides a step-by-step procedure for such cases.[8] If a patient wishes to donate their organs or tissue, euthanasia must be performed in hospital.

In 2023 the RTEs received 24 notifications that mentioned specifically that organ and/or tissue donation had taken place after euthanasia. That is an increase compared with last year, when six such notifications were received. It is not always specified clearly in the case file whether organ or tissue donation has taken place, so there are no precise figures.

'DOUBLE EUTHANASIA'

If both members of a couple make simultaneous requests for euthanasia and both requests are granted, the RTEs register this as 'double euthanasia'. This occurred 33 times in 2023 (66 notifications). Of course, the due care criteria set out in the Act must be satisfied in each case separately. Each partner must be visited by a different independent physician in order to safeguard the independence of the assessment of their requests.[9]

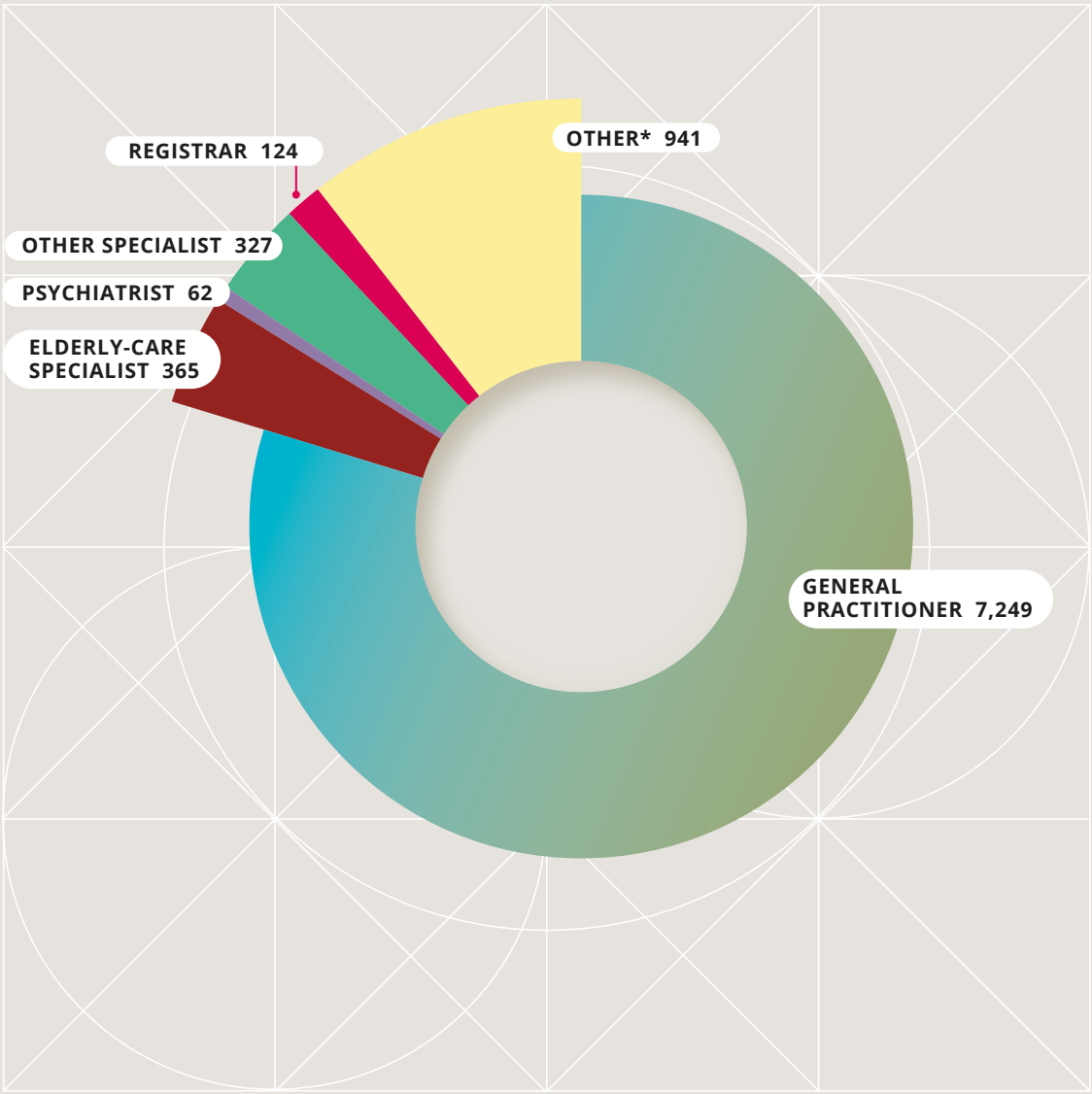
DUE CARE CRITERIA NOT COMPLIED WITH

In five of the notified cases in 2023, the RTEs found that the physician who performed euthanasia did not comply with all the due care criteria set out in the Act. All of these cases are discussed in Chapter 3. In one of these cases the independent physician was registered as a patient in the practice of the general practitioner who performed euthanasia. The committee therefore found that the two physicians could not be considered independent in relation to one another. In three cases the physician had not exercised the necessary particular caution with regard to a patient whose suffering was caused by a psychiatric disorder or a combination of a somatic condition and a psychiatric disorder. And in one case the physician had left the medication with the patient prior to performing euthanasia. The committee therefore found that the physician had not exercised due medical care.

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

9 *See Euthanasia Code 2022, p. 30.*

NOTIFYING PHYSICIANS



* *For example, physicians affiliated with the Euthanasia Expertise Centre or a junior doctor.*

CATEGORISATION OF NOTIFICATIONS

Since 2012, notifications received by the RTEs have been processed as follows (see also the diagrams in the annexes).

The secretary of the RTE first provisionally categorises the case as a non-straightforward case (VO) or a straightforward case (NVO), after which the committee reviews the notification.

In 2023, 95.6% of the notifications received were categorised as straightforward by the secretary. These notifications are reviewed digitally by the RTE, as can be seen in diagram 1 of Annexe 2. The committee decides whether it agrees with the secretary's provisional view that the notification is straightforward or whether on the contrary it considers it to be non-straightforward.

In the latter case the committee categorises the notification as non-straightforward and discusses it at a meeting. In 2023 this occurred in 65 cases. This procedure can be seen in diagram 3 of Annexe 2.

Of all the notifications received, 4.4% were immediately categorised as non-straightforward (see diagram 2 of Annexe 2) because, for example, they involved patients with a psychiatric disorder, patients with advanced dementia or minors, there were questions about how euthanasia had been performed, or because the case file submitted by the notifying physician did not contain enough information for the committee to reach a conclusion.

DIFFERENT TYPES OF WRITTEN REPORTS OF FINDINGS

If a notification is completely straightforward, the physician always receives an abridged findings report, informing the physician of the committee's finding, based on the notification, that the physician has complied with all the due care criteria.

Cases 2023-031, 2023-015, 2023-013, 2023-021 and 2023-029 are included in Chapter 3 as examples of straightforward notifications, for which the physician received an abridged findings report. For the purpose of this annual report, summaries have been given of these cases. Similar descriptions of some of the straightforward cases are published (in Dutch) on the website of the RTEs (https://www.euthanasiecommissie.nl). The abridged findings reports sent to the physicians do not include such a summary.

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

As of this year, a new abridged findings report has been introduced for certain cases in which the request for euthanasia was based on suffering caused entirely or in part by a psychiatric disorder. This was explained in Chapter 1. In 2023, 122 of these abridged findings reports were sent to physicians.

WRITTEN AND ORAL QUESTIONS PUT BY THE COMMITTEES

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

In 21 cases, the committee asked the notifying physician after its meeting for a further written explanation.

In 16 cases the committee invited the notifying physician (and in one case the independent physician) to answer the committee's questions in person at a committee meeting, sometimes after having first put written questions to the physician. These included the five cases in which the committee ultimately found that the due care criteria had not been complied with. If the committee has a question about a simple, factual matter, it may also be asked by phone or email.

PROCESSING TIME

In 2023 the average time between the notification being received and the notification being reviewed was 31 days. This is within the maximum time limit of two times six weeks laid down in section 9 (1) of the Act. It is also shorter than in 2022, when the average time was 34 days.

NOTIFICATIONS IN THE RTES' VIRTUAL DISCUSSION SPACE

Some cases are considered to be so complex that all the RTE members and secretaries should be able to have a say in the matter. This leads to intensive consultations between the committees. The standard practice is that when a committee believes a particular notification does not meet the due care criteria, it makes the case file and its draft findings available to all the committee members and secretaries in a virtual discussion space. Notifications of cases in which a physician granted a request for euthanasia by a decisionally incompetent patient on the basis of their advance directive are always handled this way. The committee reaches a final conclusion after studying the comments from other committee members.

The same is done in other cases where the committee feels it would benefit from an RTE-wide consultation. The aim is to ensure the quality of the review is as high as possible and to achieve maximum uniformity in the findings.

In 2023, 26 cases were discussed in this way. This includes the cases in which it was found that the due care criteria had not been complied with. In some cases the findings are also discussed afterwards in the periodic meetings of, respectively, chairpersons, physicians and/or ethicists.

REFLECTION CHAMBER

At the request of the national consultative committee of chairpersons, the reflection chamber considered in 2023 whether changes were necessary to the assessment framework set out in the Euthanasia Code 2022 for euthanasia requests on the basis of suffering caused by a combination of one or more somatic conditions and one or more psychiatric disorders (section 4.3). The reflection chamber expects to issue its advisory report on this matter in 2024.

CHAPTER 3
CASES

1 INTRODUCTION

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

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

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

The due care criteria say that the physician must:

a. be satisfied that the patient's request is voluntary and well considered;
b. be satisfied that the patient's suffering is unbearable, with no prospect of improvement;
c. have informed the patient about their situation and their 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 the patient's suicide.

The RTEs review notifications in the context of the Act, its legislative history, the relevant case law and the Euthanasia Code 2022, which was drawn up on the basis of earlier findings of the RTEs. They also take the decisions of the Public Prosecution Service and the Health and Youth Care Inspectorate into account.

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

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

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

In subsection 2.2 we examine the various due care criteria, focusing in turn on (a) a voluntary and well-considered request, (b) unbearable suffering without prospect of improvement, (d) the joint conclusion that there is no reasonable alternative, (e) consultation of an independent physician and (f) due medical care.

There is no explicit reference here to due care criterion (c): informing the patient about their prognosis. This criterion is generally closely connected with other due care criteria, particularly the criterion that the physician must be satisfied that the request is voluntary and well considered. This can only be the case if the patient is well aware of their health situation and their prognosis.

In subsection 2.3 we describe four cases of euthanasia involving patients who fall into specific, complex categories: patients with a psychiatric disorder, patients with multiple geriatric syndromes and patients with dementia.

Section 3 deals with the five cases in which the RTEs found this year that the due care criteria had not been met.

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

2 PHYSICIAN ACTED IN ACCORDANCE WITH THE DUE CARE CRITERIA

2.1 FIVE EXAMPLES OF THE MOST COMMON NOTIFICATIONS

As stated in Chapter 2, many euthanasia cases involve patients with cancer, neurological disorders, cardiovascular disease, pulmonary disease or a combination of conditions. The following five cases, all straightforward notifications and therefore reviewed digitally by the RTEs, are examples. They give an impression of the types of notification that the RTEs receive most frequently.

The findings are set out in most detail for the first case, to show that the committees examine all the due care criteria. The findings for the other cases focus mainly on the patient's suffering, unless there was an exceptional aspect relating to one of the other due care criteria.

CANCER

Rare type of cancer, patient in a great deal of pain due to an open wound

The patient, a woman in her forties, was diagnosed with oropharyngeal cancer (a type of head and neck cancer) over two years before her death. Various treatments had not had sufficient effect. The cancer had metastasised and the patient's condition was incurable.

The patient had a rapidly growing open wound in her neck, which caused her a great deal of pain. When she was able to eat, the food would often come back out via the wound. As a result, the patient rapidly lost weight and strength, and was constantly hungry. In addition, she was hardly able to speak. The patient did not consider this a dignified existence.

The patient had discussed euthanasia with the physician previously, and more than a week before her death she asked the physician to perform the procedure to terminate her life.

The physician concluded that the request was voluntary and well considered. The physician was also satisfied that this suffering was unbearable to the patient and with no prospect of improvement according to prevailing medical opinion. There were no alternative ways to alleviate her suffering that were acceptable to her. The case file made it clear that the physician had given her information about her situation and prognosis.

The physician consulted an independent SCEN physician, who saw the patient four days before her death. The independent physician was satisfied that the due care criteria had been complied with.

The physician performed the euthanasia using the method, substances and dosage recommended in the KNMG/KNMP's 'Guidelines for the Practice of Euthanasia and Physician-assisted Suicide' of 2021.

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

Number 2023-031 on the website.

NEUROLOGICAL DISORDER

Rare brain disease, patient dependent on care

The patient, a woman in her seventies, had been suffering from neurodegenerative problems for several years before her death. About a year before her death she was diagnosed with progressive supranuclear palsy (PSP), a rare brain disease with symptoms similar to those of Parkinson's disease, causing problems with balance and movement, and cognitive issues.

The patient had frequent falls, and speaking and swallowing were increasingly difficult for her. She was completely dependent on the care provided in the nursing home where she was living. This was unbearable to her.

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

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

Number 2023-015 on the website.

PULMONARY DISEASE

Rare pulmonary disease, Euthanasia Expertise Centre, existing wish for euthanasia

The patient, a woman in her eighties, was diagnosed with lymphangioleiomyomatosis (LAM) about nine years before her death. This disease causes scarring in the lungs, which damages the lung tissue. Shortly before the patient's death, her symptoms were similar to those of severe COPD.

The patient was constantly short of breath, and this became progressively worse. She was dependent on extra oxygen. The disease made her dependent on care and her world grew smaller and smaller. As she had previously been an independent woman, this was unbearable to her.

The patient had no rapport with her general practitioner, so she contacted the Euthanasia Expertise Centre (EE). At the time of her registration with the EE, the patient regularly expressed her wish for euthanasia, but usually added that she still found her suffering bearable and therefore did not want euthanasia to be performed yet. For that reason, she had another 18 conversations with the physician over the course of three years. Over a month before her death, the patient asked the physician to perform the procedure to terminate her life.

The physician was satisfied that the 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 physician consulted an independent SCEN physician. The independent physician visited the patient three times, on account of her inconsistent wish for euthanasia. The last visit took place just over a week before the patient died. The independent physician was satisfied that the due care criteria had been complied with.

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

Number 2023-013 on the website.

CARDIOVASCULAR DISEASE

Thrombosis in cerebral artery, patient no longer able to speak

The patient, a man in his fifties, suffered from thrombosis (a blood clot) in one of his cerebral arteries. This caused paralysis in all four of his limbs. After rehabilitation, the patient remained paralysed on one side.

He had always been independent, but he became completely dependent on others. He could no longer speak and developed a swallowing disorder, as a result of which he was at risk of choking. The patient had a tracheostomy tube inserted into his windpipe to ensure he could breathe. This tube needed to be suctioned several times a day. He could no longer eat or drink without help. In addition, the patient was ashamed of the extreme emotions that sometimes suddenly flared up due to his condition.

The physician concluded that the request was voluntary and well considered. Although the patient was no longer able to speak, he could communicate well by using gestures, moving his head, pointing and using a speech-generating device. In this way he was able to convey his request clearly.

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

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

Number 2023-021 on the website.

COMBINATION OF CONDITIONS

Alcohol addiction, various somatic conditions, independent psychiatrist

The patient, a man in his forties, had suffered from alcohol addiction from a young age. Multiple stays in a rehabilitation clinic had not helped. His addiction was considered untreatable and was causing physical decline. The patient suffered from chronic pancreatitis and shortly before his death his existing lung problems suddenly worsened. There was a strong suspicion of COPD and polyneuropathy (pain and problems with movement and sensation due to nerve damage).

The patient had become emaciated and physically weakened, and he was often short of breath. He had very little energy and as a result could not go outside. He mainly spent his days in bed or in a chair. The patient also suffered from chronic pain and had become incontinent, which was very unpleasant for him.

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

The physician consulted an independent psychiatrist who concluded that at the time of the assessment the patient was not suffering from any depressive, manic or psychotic symptoms which might have influenced the patient's wish for euthanasia. The independent psychiatrist considered the patient to be decisionally competent regarding his request for euthanasia. The independent physician (a SCEN physician) agreed.

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

Number 2023-029 on the website.

2.2 FIVE CASES ILLUSTRATING THE DUE CARE CRITERIA IN THE ACT

In this subsection five cases are described with a focus on one of the following five due care criteria: the physician must be able to conclude that (a) the patient's request is voluntary and well considered and (b) the patient's suffering is unbearable, with no prospect of improvement; (d) the physician and the patient together must be satisfied that there is no reasonable alternative; the physician must also (e) consult an independent physician and (f) exercise due medical care and attention in terminating the patient's life. All but one of the cases described below were non-straightforward notifications. This means that these notifications were discussed at a committee meeting.

VOLUNTARY AND WELL-CONSIDERED REQUEST

The Act states that the physician must be satisfied that the patient's request is voluntary and well considered. The patient must make the request personally.

This due care criterion may raise further questions in certain situations. In the following case, the question arose as to whether the patient had herself made the request for euthanasia to be performed. A request for euthanasia made by another person on behalf of the patient cannot be granted. It must always be clear that the request has been made by the patient personally (see Euthanasia Code 2022, p. 18).

VOLUNTARY AND WELL-CONSIDERED REQUEST

Pancreatic head carcinoma, authorised partner, oral explanation by physician

The patient, a woman in her seventies, was diagnosed with pancreatic cancer two and a half years before her death. Six months before her death, the cancer had returned, and metastasised to the liver. Her condition was incurable.

About four months before her death, the patient discussed euthanasia with the physician for the first time. In subsequent conversations they discussed it again. Shortly before her death, the patient had not yet made an immediately relevant request for euthanasia. She hoped that she would go into a coma, so that she herself would not have to make a decision about the end of her life.

The physician wrote in his report that termination of the patient's life was requested 'through an authorised partner', and he also noted: 'Specifically leaving the decision to the partner'. It was unclear to the committee what exactly had transpired in the period shortly before the patient's death. The committee therefore decided to ask the physician for an explanation.

The physician stated that the patient had struggled greatly with her request for euthanasia. She always thought more about her loved ones than about herself. She also kept postponing her request because of her children's and grandchildren's holidays and birthdays. The patient did not want her death to affect celebrations. She also always found something positive in the day, something that would give her the strength to carry on a little longer. On the day euthanasia was performed, the physician asked the patient whether she wanted and was able to go on living. The patient shook her head. When the physician asked the patient if she wanted to die, the patient nodded. The patient was completely exhausted and at times drowsy from the medication. Then, knowing that the patient wanted to die, the physician agreed on a time when euthanasia would be performed with the patient's partner.

It became clear to the committee that the physician could be satisfied that the patient's request was voluntary and well considered. Over a long period of time, the patient had discussed her eventual wish for euthanasia with the physician on several occasions, and was at the time fully aware of the situation. Despite the fact that in the end the patient was no longer able to properly put her request into words, she was able to confirm her request and the physician was able to conclude that the patient's request for euthanasia was now immediately relevant. The other due care criteria had also been fulfilled, in the committee's view.

Number 2023-109 on the website.

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

'A patient is regarded as suffering with no prospect of improvement if the disease or disorder causing the suffering is incurable and there are no means of alleviating the symptoms so that the suffering is no longer unbearable. [...] There is no prospect of improvement if there are no curative or palliative treatment options that could end the patient's suffering. It is thus clear that the assessment of the prospect of improvement is closely linked to determining whether there is a reasonable alternative that would alleviate or end the suffering. [...] It is sometimes hard to establish whether suffering is unbearable, for this is a subjective notion. What is bearable for one patient may be unbearable to another. This depends on the individual patient's perception of their situation, their life history and medical history, personality, values and physical and mental stamina. It must be palpable to the physician, also in light of what has happened so far, that this particular patient's suffering is unbearable' (Euthanasia Code 2022, pp. 23-24).

Although due care criteria (b) 'unbearable suffering without prospect of improvement' and (d) 'no reasonable alternative' are connected and therefore often assessed together, they will be discussed in separate cases below. The first case focuses on unbearable suffering without prospect of improvement and the second case on the joint conclusion of the physician and patient that there was no reasonable alternative.

UNBEARABLE SUFFERING WITHOUT PROSPECT OF IMPROVEMENT

Hip fracture, short time between request and death

The patient, a man in his nineties, had lived independently until he fell and broke his hip. He discussed the options for hip surgery with the surgeon. He had obtained information about the surgery options and, partly in view of his age and the experiences of people he knew, he did not want a hip operation. After a short period in hospital, the patient moved to a hospice. In the hospice, the patient immediately asked the physician for euthanasia. The physician was willing to help the patient with this.

The case file showed that the period between the patient's fall and his death was only two weeks. For that reason, the committee questioned, among other things, whether the physician could be sufficiently certain that the patient was suffering with no prospect of improvement, because the patient had not yet had time to get used to the new situation. The physician stated that before the fall the patient's life was acceptable and that he was able to function independently. Due to his broken hip, he would lose a lot of his independence. It was unlikely that he would be able to walk again and regain his independence. Almost immediately after the fall, the patient had tried to end his own life, but did not succeed. The physician stated that, despite the short time between the fall and the request for euthanasia, the patient was certain that he wanted to die as soon as possible.

The committee noted that the patient had always lived an independent life. Over the years it had become increasingly difficult for him to walk, but he still enjoyed his life and his independence. After he fell and broke his hip, the patient lost all his independence. He was suffering from his increasing dependency on other people. The committee came to the conclusion that due to this disability the patient was no longer able to give purpose to his life.

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

Number 2023-120 on the website.

NO REASONABLE ALTERNATIVE

General practitioner still considered there were treatment options, nursing home admission

The patient, a woman in her seventies, was suffering from various somatic conditions. She suffered pain due to polyarticular osteoarthritis (wear and tear in several joints) and abdominal pain due to fibromyalgia (pain in muscles and connective tissue). She also suffered from vertebral compression fractures due to osteoporosis and severe itching due to eczema. Because of her symptoms the patient was exhausted, which led to self-neglect. She had always had an active social life, but was now a shadow of her former self.

The case file showed that the patient's general practitioner had not been fully convinced that there was no reasonable alternative that would alleviate the patient's suffering. He also felt the patient was inconsistent in expressing her suffering. This gave the general practitioner reason not to accept the patient's request for euthanasia. The patient then contacted a physician at the Euthanasia Expertise Centre.

This physician spoke with the patient on four occasions, during which the patient repeated her request several times. The physician spoke with the patient about other solutions that had been proposed by the general practitioner, namely going into a nursing home or having treatment to manage the itching. At first the patient had thought moving into a nursing home might be a good idea, but by now she no longer had the energy for such a move. This was therefore no longer a reasonable alternative for her. Furthermore, she would still have the pain and the itching, for which she was already receiving the best available support and medication.

The physician consulted an independent psychiatrist because there were doubts concerning a possible personality disorder. The independent psychiatrist concluded that there were no severe psychiatric problems. The patient did exhibit signs of an avoidant personality disorder, as a result of which she was less able to deal with her physical complaints. However, the patient did not want any treatment to help her accept this. In addition the psychiatrist concluded that the patient was decisionally competent regarding her request for euthanasia.

It became clear to the committee that the patient's request was based on her somatic conditions and that these were causing extra suffering because the patient had difficulty coping with them. In the committee's opinion, the physician had clearly explained how he had come to the conclusion that there was no reasonable alternative. This was supported by the independent physician (a SCEN physician) and the independent psychiatrist.

The committee therefore found that the physician could come to the conclusion, together with the patient, that there was no reasonable alternative in her situation. The other due care criteria had also been fulfilled, in the committee's view.

Number 2023-121 on the website.

CONSULTATION

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

The Act requires consultation with at least one other, independent physician. The independent physician must be in a position to form their own opinion. The concept of independence refers to their relationship with both the physician and the patient. It is therefore important that the independent physician and the physician explain their relationship with each other and with the patient in their reports. The independence of the independent physician in relation to the patient implies among other things that there is no family relationship or friendship between the independent physician and the patient, and that the independent physician is not currently treating the patient, and has not done so in the recent past. Contact on a single occasion in the capacity of locum need not present any problem, although this will depend on the nature of the contact and when it occurred (see Euthanasia Code 2022, pp. 29-30).

CONSULTATION

Independent physician recently involved in treatment, independence in relation to patient

The patient, a man in his sixties, suffered from an autism spectrum disorder, bipolar disorder and recurrent depression. He also had persistent somatic problems. The patient had received extensive counselling and treatment for many years, including more than 100 sessions of electroconvulsive therapy (ECT).

The physician consulted an independent physician who was a SCEN physician and also a psychiatrist. This independent physician had seen the patient regularly for the ECT sessions in the period between 10 and 3 years before the patient's death. He stated in his report that he had never had an actual treatment relationship with the patient and that his part in the treatment sessions was mainly limited to a 'technical role'. The patient had never been in the independent physician's consultation room and the independent physician had never seen him other than lying in a hospital bed. The independent physician had never been jointly responsible for the needs assessment or the evaluation of the ECT treatment, nor did he know anything about the patient's life history or personal situation.

The committee noted that the independent physician had been (jointly) responsible for administering ECT in the period between 10 and 3 years before the patient's death and had also been responsible for dealing with any complications during or immediately after the ECT. It noted that, during that period, the independent physician was therefore one of the patient's attending physicians. The independent physician's role as attending physician was limited, however, to administering medical treatment as part of a broader treatment plan. Three years before the patient's death, the ECT was halted because it was not having sufficient effect and the patient was experiencing severe memory problems. Since then, the independent physician had not been involved in the patient's treatment in any way.

The committee therefore found that there was no recent, intensive treatment relationship between the independent physician and the patient and that the independent physician therefore had sufficient distance from the patient to be able to form an independent opinion. The other due care criteria had also been fulfilled, in the committee's view.

Number 2023-110 on the website.

DUE MEDICAL CARE

The physician must exercise due medical care in performing euthanasia. Two aspects of this are the substances and doses administered, and appropriate checks to determine the patient's level of consciousness. In assessing compliance with this due care criterion, the committees refer to the KNMG/KNMP 'Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide' of 2021. According to the Guidelines, the physician must have an emergency set of substances available in case something goes wrong with the first set (see Euthanasia Code 2022, pp. 34-36).

Straightforward notification, IV cannula not positioned correctly, entire procedure restarted

The patient, a woman in her seventies, was suffering from metastasised pancreatic cancer. Her condition was incurable. Complications occurred during the procedure to terminate her life. The following became clear from the physician's notification form.

On the day when euthanasia was performed, various health professionals made several attempts to insert an IV cannula. After these attempts failed, it was decided that the patient would be taken to hospital, so that an IV cannula could be inserted under ultrasound guidance. This was successful and the patient was able to go home. The euthanasia procedure was scheduled for the end of the afternoon.

During the euthanasia procedure, lidocaine (a painkiller) was administered, followed by a coma-inducing substance. This went smoothly and painlessly. The physician was also able to flush the cannula with a saline solution without any problems. However, after the coma-inducing substance had been administered, the patient remained awake. Although there were no obvious signs, the physician suspected the cannula was not correctly positioned, as the patient did not go into a coma. The physician contacted the hospital's A&E department and the duty anaesthesiologist to discuss the situation. They agreed that a new IV cannula would be inserted at the hospital.

The patient was then taken to hospital by ambulance. There, again under ultrasound guidance, a cannula for continuous infusion was inserted, to increase the chance of it continuing to function properly.

At the hospital the physician organised an extra emergency set of euthanatics, so as to have both a first set and an emergency set again. The physician carried out the entire procedure again at the patient's home. This time the administering of the coma-inducing substance, followed by the muscle relaxant, was uneventful. The patient passed away peacefully.

The committee noted that the physician had halted the procedure after he had concluded that the cannula was not working properly. By having a new cannula inserted, the physician acted adequately and in accordance with the Guidelines. The physician then proceeded to carry out the entire procedure again from the start. The physician sought advice from an anaesthesiologist about the best course of action. During the procedure, the physician remained calm and supported the patient and her family in a competent manner. In the committee's view, the other due care criteria were also fulfilled.

Number 2023-119 on the website.

2.3. FOUR EXAMPLES OF CASES INVOLVING PATIENTS WITH PARTICULAR CONDITIONS

This subsection describes four cases involving patients with particular conditions. The first concerns a patient with a psychiatric disorder, the second a patient with multiple geriatric syndromes. The third and fourth cases involve patients with dementia.

PSYCHIATRIC DISORDER

If a request for euthanasia is based (mainly) on suffering caused by a psychiatric disorder, physicians are expected to exercise particular caution. In line with this principle, the RTEs review whether the physician consulted an independent psychiatrist and whether the latter assessed the patient's decisional competence with regard to their request for euthanasia, whether the patient was suffering unbearably and whether there were no reasonable alternatives. The independent psychiatrist may give advice on treatment if necessary (see Euthanasia Code 2022, pp. 45-47).

PSYCHIATRIC DISORDER

Non-straightforward, obsessive-compulsive disorder, no reasonable alternatives

The patient, a woman aged between 18 and 30, had suffered from obsessive-compulsive disorder (OCD) from a young age. This disorder took the form of germophobia and perfectionism, and contributed to the onset of an eating disorder. In addition, a year before the patient's death it was found that she exhibited signs of an autism spectrum disorder.

Due to her psychiatric disorders, the patient had difficulty giving purpose to her life and was unable to enjoy activities. She could never meet the high standard of perfection she demanded of herself due to the OCD, and she punished herself by self-harming. The patient had difficulty processing her day-to-day experiences and in making and maintaining social contacts. She suffered from the enormous, unremitting pressure she felt, and did not want to suffer any longer.

The physician established that the patient had a realistic perception and understanding of her illness and her prospects, and was aware of the implications of her request for euthanasia. The independent psychiatrist and the independent physician (a SCEN physician) consulted by the physician both found that the patient was decisionally competent regarding her request for euthanasia.

The case file showed that the patient had undergone many psychiatric treatments throughout most of her life. These did not succeed in helping her to deal with her obsessive thoughts and compulsive behaviour, nor did they provide any prospect of recovery. The independent psychiatrist concluded that neither the treatments aimed at reducing the symptoms nor the palliative care the patient received had been able to alleviate her suffering. On the contrary, over time and due to the various treatment attempts the symptoms had only worsened. According to the independent psychiatrist there were no more treatment options left. The independent physician shared that opinion.

Due to the patient's young age, the physician discussed the request for euthanasia in a moral case deliberation session and also consulted various practitioners at some length. Since the conclusion was that deep brain stimulation was still a treatment option, it was assessed whether this could be a reasonable option for the patient. It was found that the patient could no longer summon the necessary motivation to go through this lengthy and intensive treatment.

The committee was of the opinion that the physician had exercised particular caution. In the committee's opinion, the physician could be satisfied that the patient's request for euthanasia was voluntary and well considered, that her suffering was unbearable and without prospect of improvement, and that the physician and the patient together could be satisfied that there was no reasonable alternative in the patient's situation. The other due care criteria had also been fulfilled, in the committee's view.

Number 2023-004 on the website.

MULTIPLE GERIATRIC SYNDROMES

For a patient's request for euthanasia to be considered, their suffering must have a medical dimension. However, it is not a requirement that there be a life-threatening medical condition. Multiple geriatric syndromes – such as sight impairment, hearing impairment, osteoporosis, osteoarthritis, balance problems or cognitive deterioration – may cause unbearable suffering without prospect of improvement. These syndromes, which are often degenerative in nature, generally occur in elderly patients, and a combination of these syndromes and the related symptoms can cause suffering. For these patients, the suffering and its unbearable nature are connected to matters such as life history, personality and stamina (see Euthanasia Code 2022, p. 22).

MULTIPLE GERIATRIC SYNDROMES

Straightforward notification, patient aged over 100, various conditions, mood-related problems

The patient, a woman aged over 100, suffered from multiple geriatric syndromes. She had high blood pressure, which caused problems with her blood vessels and kidneys. She also suffered from a hearing impairment, with tinnitus, and a sight impairment. The patient slept badly, and was therefore constantly tired, and she had great difficulty moving. She had been independent up to an advanced age, but had recently become dependent on care for her everyday activities. The patient was also suffering cognitive decline and her comprehension had deteriorated. This made her anxious, and she suffered from low spirits.

A month and a half before her death the patient discussed euthanasia with the physician for the first time. On that occasion she requested euthanasia. According to the physician, her request for euthanasia was voluntary and well considered. However, the physician asked an independent psychiatrist to assess the patient's symptoms of low spirits. The psychiatrist found that these symptoms were caused by the patient's physical condition. She was not depressed. This was supported by the independent physician (a SCEN physician).

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

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

Number 2023-043 on the website.

DEMENTIA

In cases involving patients with dementia, the physician is required to exercise particular caution when considering whether the statutory due care criteria have been met. This is especially true of the criteria relating to the voluntary and well-considered nature of the request, and unbearable suffering. In the early stages of dementia, the normal consultation procedure (consulting a SCEN physician) is generally sufficient. If there are any doubts as to the patient's decisional competence, it is wise for the physician to seek the advice of another physician with relevant expertise (see Euthanasia Code 2022, p. 48).

In nearly all the cases notified to the committees concerning patients with dementia, the patient still has sufficient understanding of their situation and is decisionally competent with regard to their request for euthanasia. Besides the current decline in cognitive ability and functioning, these patients' suffering is often partly determined by their fear of further decline and the negative impact on their autonomy and dignity (see Euthanasia Code 2022, p. 48).

It is still possible to grant a request for euthanasia if dementia has progressed to such an extent that the patient is no longer decisionally competent with regard to their request, provided the patient drew up an advance directive containing a request for euthanasia when still decisionally competent. Section 2 (2) of the Act states that an advance directive can replace an oral request and that the due care criteria apply *mutatis mutandis* (see Euthanasia Code 2022, p. 48).

At the very least, the advance directive must always describe that the patient requests euthanasia in those situations in which they are no longer capable of expressing their will with regard to euthanasia. If the patient also wants their request to be granted in the event that their unbearable suffering is not of a physical nature, it must also be apparent from the advance directive that the patient considers their expected suffering in this situation to be unbearable to them and that this is the basis for their request (see Euthanasia Code 2022, p. 39).

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

DECISIONALLY COMPETENT PATIENT WITH DEMENTIA

Straightforward notification, Alzheimer's disease, organ donation

The patient, a man in his sixties, was diagnosed with Alzheimer's disease a few months before his death. His memory was deteriorating rapidly, and he was becoming increasingly clumsy and short-tempered. His life was dominated by the fear of having to go into a nursing home. He was therefore determined that his request for euthanasia should be made in good time.

Almost a year before his death, the patient discussed euthanasia with the physician for the first time. A month and a half before his death, the patient asked the physician to carry out the euthanasia procedure.

According to the physician, despite his dementia the patient had a realistic perception and understanding of his illness and there was no doubt whatsoever that his request for euthanasia was voluntary and well considered. The physician was also satisfied that this suffering was unbearable to him and that there was no prospect of improvement. There were no alternative ways to alleviate his suffering that were acceptable to him. The physician also gave the patient sufficient information about his situation and prognosis.

The physician consulted an independent SCEN physician, who saw the patient around a month before his death. The independent physician was satisfied that the due care criteria had been complied with. As the patient had said he wanted to donate his organs after his death, the euthanasia procedure was carried out in hospital. The physician followed the Guidelines on organ donation after euthanasia, issued by the Dutch Foundation for Transplants in July 2023.

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

Number 2023-074 on the website.

PATIENT WITH DEMENTIA WHO WAS NO LONGER DECISIONALLY COMPETENT

Non-straightforward notification, Alzheimer's disease, advance directive, Euthanasia Expertise Centre, patient in a secure unit

The patient, a man in his eighties, was diagnosed with Alzheimer's disease about 10 years before his death. As his illness prevented him from living at home, he was living in a secure unit of a residential care facility, on the basis of a court order. After the patient was diagnosed with Alzheimer's disease, he drew up an advance directive and discussed it with his general practitioner. He updated the advance directive twice: eight years and five years before his death.

VOLUNTARY AND WELL-CONSIDERED REQUEST

When the patient drew up his advance directive after being diagnosed with Alzheimer's disease, he was decisionally competent with regard to his wish for euthanasia. The advance directive was voluntary and well considered and the patient had discussed it with his general practitioner and his family. Over the years, the advance directive was updated twice.

The patient had indicated in his advance directive that he did not want to be in a situation in which he would lose his personal dignity, suffer unbearably or without prospect of improvement, or in which further distress and humiliation were to be expected. He wrote, in his own words, that he wanted euthanasia if as a result of dementia he became incontinent, had to go into a nursing home, became aggressive, no longer recognised his loved ones, went into a coma, had a stroke, could no longer eat, drink or breathe independently, became incapable, could no longer read or watch television, and if he became anxious.

The patient contacted the Euthanasia Expertise Centre (EE). During the first three conversations with the EE team, the patient's decisional competence fluctuated. The physician concluded that at that point the patient was not yet suffering unbearably and there was no current wish for euthanasia yet. A few months later, around three months before the patient's death, the patient spoke with the physician for the fourth time, at his wife's request. After that there were another five conversations, during which the patient was no longer decisionally competent.

The patient's mental and physical condition deteriorated rapidly in the residential care facility. Together with the patient's wife and children and other physicians involved in the case, the physician came to the conclusion that the patient's present circumstances corresponded with those he had described in his advance directive. The patient had been aggressive towards

people around him on several occasions. He was also very agitated, confused and frustrated because he could no longer deal with the situation. He often failed to recognise people around him, meaningful communication was no longer really possible and his memory was deteriorating rapidly.

The committee noted that when euthanasia was performed, the circumstances described by the patient in his advance directive as being unbearable suffering for him indeed existed.

The committee also concluded that the patient's advance directive met the two essential requirements: it followed from the advance directive that the patient wanted euthanasia if he became decisionally incompetent due to dementia, and the suffering resulting from the dementia was the basis of his request.

The committee further noted that when visiting the patient the physician had not observed any verbal utterances or behaviour that conflicted with his request for euthanasia (contraindications).

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

As regards the unbearable nature of the patient's suffering, in the committee's view the physician had assessed this carefully during the visits. The patient was very agitated, visibly frustrated and on several occasions shouted that he no longer wanted to live. He was aggressive and would suddenly hit another person. He was receiving medication for this, but that caused him to fall more frequently. The patient could also no longer eat, drink or function independently. He no longer recognised his loved ones and whenever he realised his memory was failing he was sad, frustrated and helpless. The physician found the patient's situation to be distressing and humiliating, and his suffering palpably unbearable. Other physicians involved in the case, as well as the independent expert and the independent physician, shared his opinion. The current unbearable suffering was due to the agitation and anger caused by the patient's illness.

During the physician's first visit, the patient was (partly) decisionally competent and during the last conversations he was decisionally incompetent. For that reason, the physician had not been able to discuss reasonable alternatives at any length with the patient. However, the patient had indicated that he was aware that his condition would only get worse, as had been the case with his brother and sister who also suffered from Alzheimer's disease. The patient had a fairly realistic picture of how the disease would progress. Previously, when he was still decisionally competent, he had also discussed this with his general practitioner, attending physicians and family. As regards the patient's suffering and the lack of a reasonable

alternative, the physician based his conclusion on his own observations and on reports by and consultations with other practitioners who had treated the patient. The independent expert and the independent physician also concluded that there were no reasonable alternatives that would alleviate his suffering. There was no longer any way to relieve the patient's agitation and anger outbursts in a dignified manner.

INFORMED ABOUT THE SITUATION AND PROGNOSIS

It was clear from the case file that, at the time of the diagnosis and when drawing up his advance directive, the patient had been fully informed by his attending physicians about his condition and the prognosis. In that period, the patient was still decisionally competent and he was very familiar with course of the disease, as he had seen it with his brother and sister. When the physician became involved, the patient was at times still decisionally competent with regard to his request for euthanasia. The committee found that at the time he drew up his advance directive, the patient had been aware of his disease and its progression.

CONSULTATION

The independent physician, a psychiatrist, spoke with the physician and studied all the relevant information, including the advance directive. He visited the patient, with whom meaningful communication was by then no longer possible, and spoke with his wife. The independent physician was satisfied that the due care criteria had been complied with.

The physician consulted an elderly-care specialist as an independent expert, who visited the patient and tried to have a conversation with him. The independent expert also spoke with various people who were involved with the patient and studied all the information, and on that basis came to the conclusion that the due care criteria had been complied with.

PERFORMANCE OF EUTHANASIA

In view of the patient's agitated behaviour, and possible outbursts of anger, frustration and physical aggression, it was decided in consultation with everyone involved to administer a sedative before euthanasia was performed. This caused the patient to fall asleep. The physician then carried out the euthanasia procedure in accordance with the Guidelines, in the presence of the patient's wife and children.

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

Number 2023-065 on the website.

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

In the year under review, the RTEs found in five cases that the physician had not fulfilled the due care criteria in performing euthanasia. One case concerned the due care criterion of consulting an independent physician, two cases concerned the particular caution that must be exercised if the request for euthanasia is based (mainly) on suffering caused by a psychiatric disorder, one case involved a patient with a combination of somatic conditions and a psychiatric disorder, which also required particular caution to have been exercised, and in one case the euthanasia procedure was not carried out with due medical care. The findings are set out below; more detailed descriptions can be found on the website.

CONSULTING AN INDEPENDENT PHYSICIAN

The Act states that physicians must consult at least one other, independent physician, who must see the patient and give a written opinion on whether due care criteria (a) to (d) have been fulfilled. The Euthanasia Code 2022 also refers to the fact that the Act states that this physician must be independent. The independent physician must be in a position to form their own opinion. The concept of independence refers to their relationship with both the physician and the patient. The requirement of independence on the part of the independent physician in relation to the physician means that there must be no personal, organisational, hierarchical or financial relationship between the two. For instance, if the independent physician is from the same medical practice or partnership, if there is a financial or other relationship of dependence with the physician (for instance, if the independent physician is a registrar), or if there is a family relationship between them, that person cannot act as the independent physician. Nor can the independent physician be the physician's patient (see Euthanasia Code 2022, pp. 29-30).

In the following case, no independent physician was consulted, because the physician in question was registered as a patient in the practice of the physician performing euthanasia.

CASE 2023-025

In this case the physician consulted a SCEN physician as the independent physician. Regarding the relationship between the independent physician and himself, the physician wrote the following in his report: *'I only know the independent physician as a patient registered in my practice, and until we came into contact via the organisation I did not know he was a SCEN physician.'* In his report, the independent physician wrote: *'I have known the physician for a year because he is my own general practitioner. I have only met him once. I feel able to give an independent and professional opinion.'*

It became apparent during the oral explanation to the committee that the physician and the independent physician had come into contact through the roster of SCEN physicians. When the physician and the independent physician spoke on the phone, they were both aware of the fact that the independent physician had been registered as a patient in the physician's practice for the past year. They had seen each other briefly at the physician's surgery for an introductory appointment. When they discussed this, they came to the conclusion that this would not preclude the consultation.

The physician and the independent physician both said they were not familiar with the text of the Euthanasia Code 2022, from which it is clear that a physician who is a patient of the physician performing euthanasia cannot act as an independent physician. The physician and the independent physician did not realise that a different independent physician should have been consulted.

In the committee's view it is not appropriate for a physician who is registered as a patient of the physician performing euthanasia to be consulted as the independent physician. The physician knew that the independent physician was registered as a patient in his practice. Even though he had met the independent physician only once, during an introductory appointment, he should have consulted a different independent physician in order to guarantee their independence of each other.

The committee therefore found that no independent physician had been consulted. The physician had fulfilled the other due care criteria.

EXERCISING PARTICULAR CAUTION IN CASES INVOLVING PATIENTS WITH PSYCHIATRIC DISORDERS

If a request for euthanasia is based (mainly) on suffering caused by a psychiatric disorder, the physician is expected to exercise particular caution. That particular caution especially concerns assessing the patient's decisional competence with regard to their request for euthanasia, the absence of any prospect of improvement, and the lack of a reasonable alternative. The RTEs' basic principle is that for these patients the physician must always seek psychiatric expertise. The purpose of seeking psychiatric expertise is for the physician to ensure they are well informed and can reflect critically on their own convictions (see Euthanasia Code 2022, pp. 46-47).

In the following case, the requirement to consult an independent psychiatrist was not fulfilled. As a result, the physician did not exercise the required particular caution.

CASE 2023-002

This case concerns a woman in her seventies who suffered from tinnitus. Her symptoms were examined by various physicians, but no clear somatic cause was found. In the past the patient had been treated for post-traumatic stress disorder (PTSD); the symptoms had improved but had not disappeared completely. Several months before her death, the patient attempted suicide and was subsequently treated by a psychiatrist, who established that the patient was suffering from a somatoform disorder and a depressive disorder. On the advice of the psychiatrist, the patient was referred to an audiology centre and to the tinnitus clinic at a university hospital. There it was established that she had perceptive hearing loss (damage to the inner ear), but it was concluded that there was no need for specific help, as psychological counselling was already being provided. In addition to tinnitus, the patient also suffered from palpitations and lightheadedness. Various treatments provided by the mental health services had no effect on the patient's symptoms. The attending psychiatrist concluded that there were no further treatment options left.

The physician consulted an independent SCEN physician, who did not have any psychiatric expertise. The physician did not consult an independent psychiatrist.

During the oral explanation to the committee, the physician stated that seeking independent psychiatric expertise hardly ever leads to new insights. He did not want to burden the patient unnecessarily with an assessment, because in his opinion there were no realistic treatment options that would alleviate her suffering. He said that an assessment by an independent psychiatrist would have been too much of a burden for her. All the patient wanted was an end to her suffering by means of euthanasia. The physician considered this a good reason not to seek psychiatric expertise. He also considered consulting an independent psychiatrist unnecessary because, according to him, tinnitus is considered to be a somatic condition, albeit a largely misunderstood one.

In the committee's opinion, the physician should have exercised particular caution, because a somatoform disorder should be considered a psychiatric disorder, even though the cause may be somatic. In addition, by not seeking psychiatric expertise, the physician was unable to reflect sufficiently on the patient's mood-related problems, her recent attempt at suicide and her current PTSD symptoms. The physician's explanation as to why he had not sought psychiatric expertise did not convince the committee. The physician also did not ascertain whether the patient would be open to a conversation with an independent psychiatrist. The committee was not convinced that

requesting an independent psychiatric assessment would in this case have placed a disproportionate burden on the patient.

As the physician had not consulted an independent psychiatrist, the committee found that the physician could not be sufficiently satisfied that the patient's request was voluntary and well considered, that she was suffering without prospect of improvement and that there was no reasonable alternative in her situation. The physician had fulfilled the other due care criteria.

In the following case the physician did consult an independent psychiatrist, but the psychiatrist did not assess the lack of prospect of improvement or the lack of a reasonable alternative. There was also no clear diagnosis.

CASE 2023-038

This case concerns a woman in her sixties who had had mood-related problems since early childhood. More than 50 years before her death, according to the patient, she had been diagnosed with depression, for which she underwent many treatments, including medication and admission to a psychiatric hospital. This was such a long time ago that there was no documentation on this diagnosis and treatment. In addition to her mood-related problems, more than 50 years before her death the patient had had a brain injury, which caused fatigue, slowness and reduced concentration.

According to the physician, who was the patient's general practitioner, the patient's request for euthanasia was based on suffering caused by her mood-related problems. The physician had known the patient for years and described the problems as chronic depression. The physician was aware that, given the patient's psychiatric disorder, she was required to seek psychiatric expertise by consulting an independent psychiatrist. The physician wanted to rule out the possibility of the patient's psychiatric disorder affecting her decisional competence in this regard.

The independent psychiatrist concluded that during his visit to the patient there were no signs of low spirits or a depression affecting her decisional competence. In his report the psychiatrist only gave his opinion on the patient's decisional competence and did not comment on whether her suffering was without prospect of improvement or whether there were any reasonable alternatives. His report did not contain a clear psychiatric diagnosis, nor did he confirm the diagnosis given by the physician.

The physician consulted an independent physician who was also a SCEN physician, who concluded that the due care criteria had been complied with. However, the independent physician did not have sufficient knowledge in the field of psychiatry.

In her oral explanation, the physician stated that she had been involved in the patient's treatment for years and that the patient had been expressing a wish to die for all that time. According to the physician, it was clear to everyone that the patient was suffering from untreatable chronic depression, but she could not say who had diagnosed the condition nor how the patient

had been treated for it. The treatments proposed by the physician were refused by the patient.

As the independent psychiatrist had not given a clear diagnosis in his report and had only discussed the patient's decisional competence, the committee concluded that the physician was insufficiently able to reflect critically on her own convictions. The committee found that the physician could not be sufficiently satisfied that the patient's request was well considered, nor that she was suffering without prospect of improvement. In addition, the physician could not be sufficiently satisfied that there were no reasonable alternatives in the patient's situation and she was unable to inform the patient sufficiently about her prognosis.

The physician had fulfilled the other due care criteria.

COMBINATION OF SOMATIC CONDITIONS AND PSYCHIATRIC DISORDERS

If a patient suffers from a combination of one or more somatic conditions and one or more psychiatric disorders, the physician must also exercise particular caution when dealing with their request for euthanasia. If the psychiatric disorder contributes to the patient's suffering, the physician must consult an independent psychiatrist, who must assess whether the patient is decisionally competent with regard to their request, whether the patient is suffering without prospect of improvement and whether there is no reasonable alternative (see Euthanasia Code 2022, pp. 46-47).

In this case the physician had taken over the euthanasia process from another physician, who had consulted a geriatrician as an independent expert. The expert recommended consulting a psychiatrist and a neurologist. The physician who performed euthanasia disregarded the geriatrician's advice, but did not give sufficient reasons for doing so.

CASE 2023-003

This case concerns a woman in her seventies who suffered from focal epilepsy (epileptic seizures arising from a specific part of the brain), possibly caused by strokes. However, a conversion disorder (psychological distress converted into physical symptoms by the brain) was not ruled out. The patient also suffered from pain and a gait disorder.

Two physicians had previously been involved in the patient's euthanasia process, following each other in quick succession due to personal circumstances. The first physician involved in the case had doubts about the medical dimension, whether the suffering was without prospect of improvement, to what extent some of the patient's problems had a psychiatric cause and whether there were still treatment options available. For that reason, a geriatrician was consulted as an independent expert. The geriatrician recommended having the patient assessed by a psychiatrist, due to her mood-related problems and in order to obtain an assessment of her decisional competence. The geriatrician also recommended having the patient assessed by a neurologist in connection with the unusual seizures associated with focal epilepsy, the reduced strength in the left side of her body and her mobility problems.

The second physician was only briefly involved in the case and, due to personal circumstances, handed the case over to the physician who performed euthanasia. The latter only spoke with the patient once about the substance of her request for euthanasia. He did not follow the recommendations of the consulted expert.

During his oral explanation to the committee, the physician stated that he believed the geriatrician's recommendations were unnecessary. Although he had only discussed the substance of the request once with the patient, he was convinced that the patient's request was not related to a psychiatric disorder. The physician also did not want to burden the patient unnecessarily with extra assessments. He had made an attempt to contact the patient's neurologist, but the neurologist was on holiday, and the physician made no further attempts to contact them. The physician said that, in practice, seeking independent psychiatric expertise seldom if ever leads to new treatment options or other ways to alleviate the suffering. He said that he had years of experience working as a geriatrician and considered the patient's seizures to be entirely caused by focal epilepsy, and not (in part) by a psychiatric disorder.

Both the first physician involved in the case and the independent geriatrician had doubts about whether the patient's request for euthanasia stemmed

from a psychiatric disorder. Further assessment by and advice from a psychiatrist and a neurologist was therefore desirable. The physician did not follow this advice and did not give sufficient reasons for doing so. The committee was also not convinced that further assessment would have placed too great a burden on the patient.

In the committee's opinion, the physician had been insufficiently able to reflect critically on his own convictions with regard to the patient's decisional competence, the possible psychiatric cause of part of her problems and possible treatment options, as he had disregarded the advice to consult a neurologist and psychiatrist about this. The physician could therefore not be sufficiently satisfied that the patient's request was voluntary and well considered, that the patient was suffering with no prospect of improvement, and that there was no reasonable alternative in the patient's situation. The physician thus did not exercise the required particular caution.

The physician had fulfilled the other due care criteria.

DUE MEDICAL CARE

In assessing whether the physician has exercised due medical care, the RTEs refer to the KNMG/KNMP 'Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide' of 2021. The Guidelines state (page 50) that the pharmacist must give the physician instructions on how to safely store the euthanatics (the medication used in the euthanasia procedure) from the time they are dispensed until euthanasia is performed.

The physician is not allowed to leave the euthanatics with the patient prior to the euthanasia procedure. This is to prevent the patient or another person from being able to administer or ingest the euthanatics in the physician's absence (see Euthanasia Code 2022, p. 35.)

In this case, the physician left the euthanatics with the patient and his family, because the euthanasia procedure was postponed until later that day.

CASE 2023-108

This case concerns a man in his forties who suffered from metastasised kidney cancer. His condition was incurable.

Prior to the euthanasia procedure the physician left the euthanatics in the patient's home for some time. The physician had collected the euthanatics from the pharmacist. At the arranged time he took the euthanatics to the patient's home and inserted an IV cannula. The patient wanted to postpone the euthanasia procedure until later that day, because a family member was on their way to say goodbye to him and could arrive at any minute. The physician and the patient agreed that they would wait until the family member had been to say goodbye. The physician went back to his practice and expected to return to the patient soon. In consultation with the patient's family, the physician decided to leave the euthanatics at the man's home, in a sealed box.

During his oral explanation to the committee, the physician said he had been aware that there was no need to leave the euthanatics with the patient. He could and should have taken the euthanatics, which were ready for use, back with him to the practice. The physician's expectation that he would return to the patient soon and the physician's trust in the patient and his family were factors in his decision, but in hindsight he agreed that these were not good reasons.

The committee therefore concluded that the physician had no good reason to leave the euthanatics at the patient's home. By leaving the euthanatics behind, the physician took the risk of the patient or his family administering the euthanatics to the patient (or someone else) in the physician's absence. The committee therefore found that the physician had not exercised due medical care in performing euthanasia.

The physician had fulfilled the other due care criteria.

ANNEXES

ANNEXE I

THE ORGANISATION

There are five regional RTEs. Each region has at least three lawyers, who serve as the committee chairs. One of them is also the regional chair. Each region also has at least three physicians and three ethicists. In view of the increasing number of notifications, the RTEs agreed an expansion of the number of committee members with the Ministry of Health, Welfare and Sport and the Ministry of Justice. As of 1 January 2024 the total number of committee members is 53.

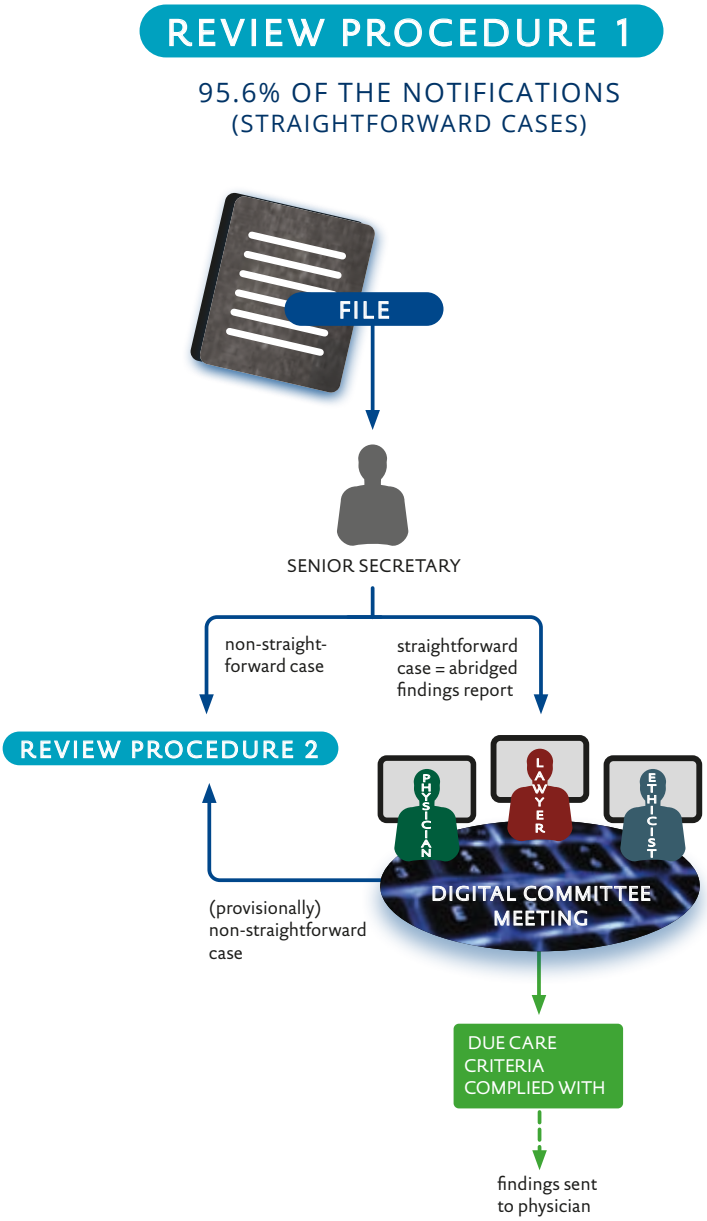
The committee members are publicly recruited and appointed for a term of four years by the Minister of Health, Welfare and Sport and the Minister of Justice and Security, on the recommendation of the committees. They may be reappointed once.

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

The coordinating chair of the RTEs presides over the policy meetings of the committee chairs, at which the physicians and ethicists are also represented. The RTEs are assisted by a secretariat consisting of approximately 20 staff members: the general secretary, secretaries (who are also lawyers) and administrative assistants (who provide process support). The secretaries attend committee meetings in an advisory capacity and are coordinated by the general secretary.

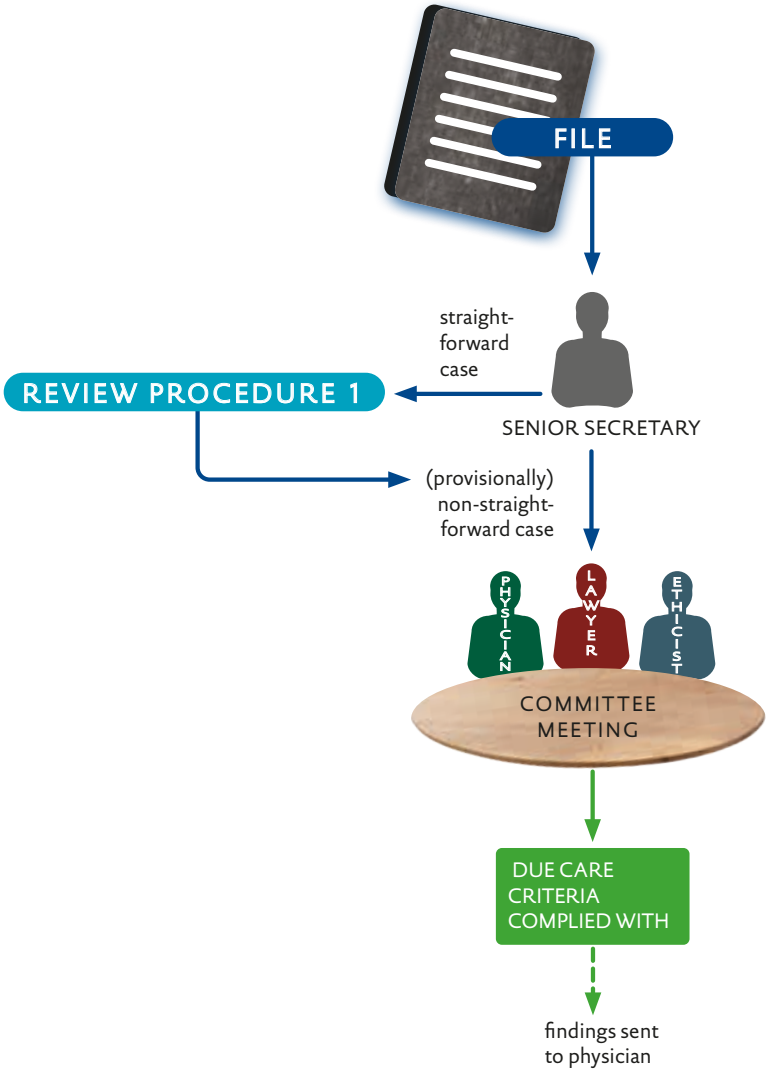
ANNEXE II

DIAGRAMS OF THE STRAIGHTFORWARD AND NON-STRAIGHTFORWARD ROUTES



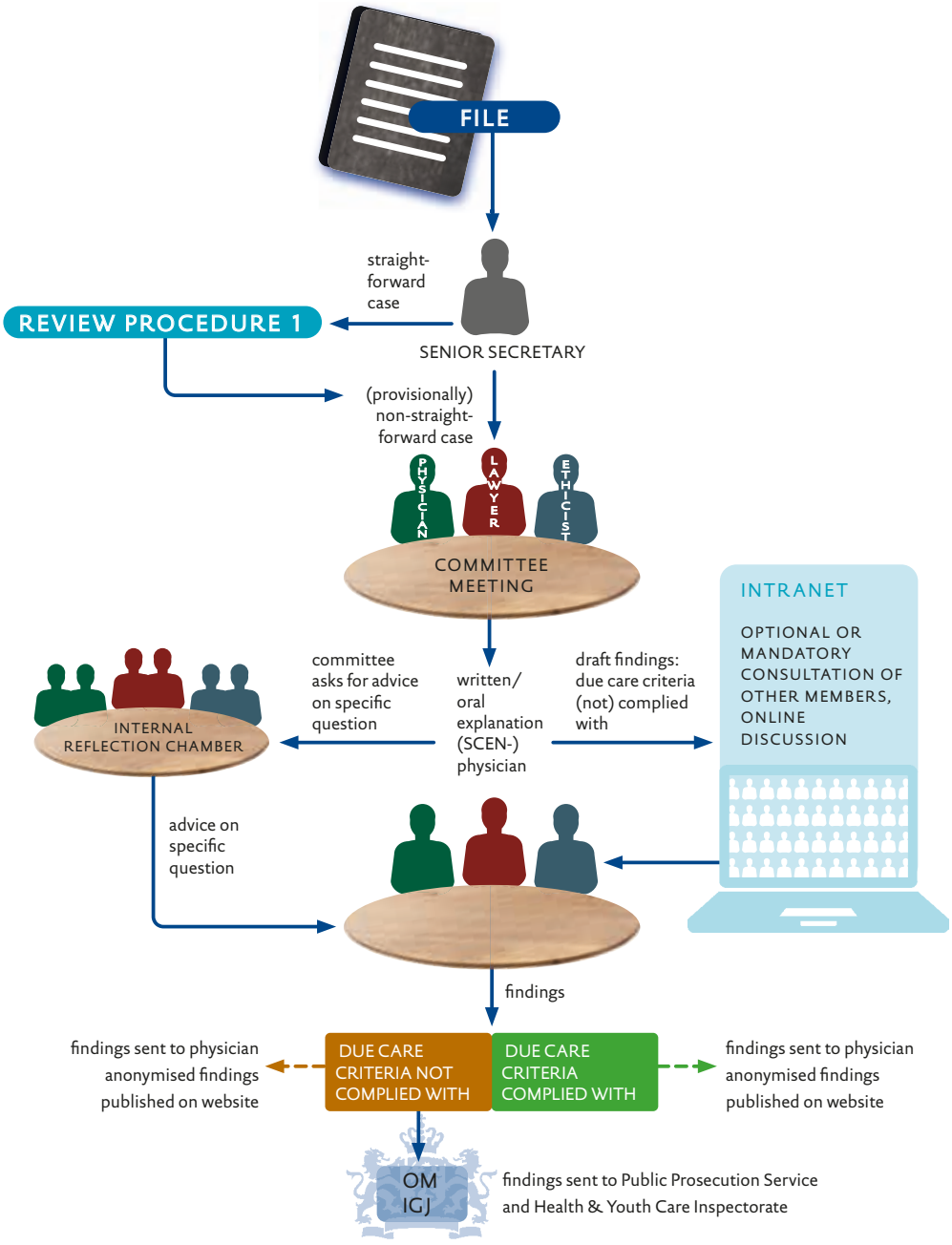
REVIEW PROCEDURE 2

4.4% OF THE NOTIFICATIONS
(NON-STRAIGHTFORWARD CASES)



REVIEW PROCEDURE 3

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



PUBLICATION DETAILS

Published by:
Regional Euthanasia Review Committees
www.euthanasiecommissie.nl

Design:
Inge Croes-Kwee
(Manifesta idee en ontwerp)

April 2024