Regional euthanasia review committees: 2007 annual report

Contents

Annexes

Overview of notifications: region by region (not included)

A. Groningen, Friesland and Drenthe region

B. Overijssel, Gelderland, Utrecht and Flevoland region

C. North Holland region

D. South Holland and Zeeland region

E. North Brabant and Limburg region

II The Termination of Life on Request and Assisted Suicide (Review Procedures) Act (not included)

Foreword

I hereby present the 2007 annual report of the five regional euthanasia review committees. The structure of the report has changed slightly compared with previous years, but the approach is essentially the same. The core of the report once again consists of case material (with all identifying details removed) relating to each of the due care criteria. The cases found not to have been handled with due care are also mentioned. In 2007 there were three such cases, out of a total of just over 2,100 notifications.

On 1 July 2007 I succeeded Ms Reina de Valk-van Marwijk Kooy as coordinating chair of the committees. My predecessor turned the committees and their secretariats into a very well-organised system during their pioneering years. She was also the driving force behind the regular meetings of committee chairs. On behalf of the committees, I would like to thank her for all her work.

Two things stood out in 2007. First, a review of how Dutch euthanasia legislation works in practice was published in May. Second, the number of notified life-terminating procedures was 10% higher than in 2006 (2,120 as against 1,923). Both items are briefly discussed below.

The review contains a wealth of information and proposals. Among other things, physicians are now clearly more willing to notify cases. The review also includes a number of recommendations for the committees. We entirely agree with these recommendations (see later in this report). The review rightly emphasises the importance of uniform procedures and assessments of compliance with the due care criteria.

Some of the recommendations concern the standard report form. Like the authors of the review, we hope the new form will soon be available, for it is urgently needed.

The number of notifications continues to be a matter of public interest. We have looked at possible reasons for the 10% increase (which is not evenly distributed over the regions, and mainly reflects an increase in notifications by general practitioners). However, we are unable to draw any firm conclusions, and can only speculate. Since the review committees were set up in late 1998, there have been fairly large fluctuations within the 1,800-2,100 range (from 1,815 in 2003 to 2,123 in 2000). The only conclusion to be drawn at this stage is that the choices made at the end of people’s lives are still in a state of flux. In view of all this, another national review should probably be carried out in 2010.

The committees greatly welcome any feedback you may wish to provide.

The Hague, April 2008

J.J.H. Suyver
Coordinating chair of the regional euthanasia review committees
e-mail: eh.dekkers@toetscie.nl

Introduction

In 2007, the committees received 2,120 notifications of termination of life on request or assisted suicide, as against 1,923 in 2006.[1] In each case the committees examined whether the physician who had performed the procedure had acted in accordance with the due care criteria set out in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act ('the Act'). In three cases the committees found that the physician had not acted in accordance with the criteria.[2]

The findings of the review of the Act were published in 2007. Both the Act and the committees were found to be functioning satisfactorily. However, the review did point out some areas for further improvement.

The committees have read the findings with great interest, and agree with its conclusions and recommendations. They see the government's response to the review as supportive of their work. This will be discussed further in Chapter I.

[1] The figures – total and region by region – are given in an annexe to the full report.
[2] See cases 5 (in full report), 11 and 12.

Chapter I

Developments in 2007

The main developments in 2007 were the publication of the review of the Act and the responses to it. Some of the findings and responses will be discussed below. Other findings are mentioned in the discussions of cases in Chapter II and also in Chapter III, which deals with committee activities.

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

Willingness to notify

The review of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act was published in May 2007.[3] Its purpose was to shed light on developments in medical decisions at the end of life, as well as the effectiveness and side effects of the Act. It was in many respects similar to earlier large-scale studies in 1990, 1995 and 2001.[4]

In general, the review found that the Act is functioning satisfactorily. The goals of the Act, including greater transparency in euthanasia procedures, are largely being attained. Among other things, the review indicated that the rate of notification had risen from 54% in 2001 to 80% in 2005. The main reason not to notify was that the physician did not consider he had performed a life-terminating procedure. In the cases that were not notified, the most frequently used substances were morphine and sedatives. In cases where physicians did consider they had performed a life-terminating procedure, they almost always used the appropriate euthanatics.[5] The review indicated that a full 99% of the cases in which such euthanatics were used were notified.

---

[3] Philipsen, Van der Heide *et al., Evaluatie van de Wet toetsing levensbeëindiging en hulp bij zelfdoding (WTL)* ('Review of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act').

[4] Van der Maas, P.J., Van Delden, J.J.M., Pijnenborg, L., and Remmelink, J. *Medische beslissingen rond het levenseinde* ('Medical decisions at the end of life'), The Hague, Sdu Uitgevers, 1991, Van der Wal, G. and Van der Maas, P.J., *Euthanasie en andere medische beslissingen rond het levenseinde* ('Euthanasia and other medical decisions at the end of life'), The Hague, Sdu Uitgevers, 1996, and Van der Wal, G. *et al.*, *Medische besluitvorming aan het einde van het leven*, ('Medical decision-making at the end of life'), Utrecht, De Tijdstroom, 2003.

[5] See Royal Dutch Pharmaceutical Society, *Standaard Euthanatica: toepassing en bereiding* ('Standard for euthanatics: application and preparation'), The Hague, 2007.

Functioning of the review committees

The review found that the review committees are generally functioning in accordance with the intentions of the Act, but that they should continue to monitor the quality of their work, particularly as regards assessment procedures and the appraisal of certain aspects of the due care criteria. The committees are aware that frequent coordination is needed to ensure that notifications are assessed in a consistent manner. They already have various procedures for this purpose, including meetings of committee chairs and a rule that all cases suspected of having been handled 'without due care' must be discussed with all five committees. There is frequent coordination between committee secretaries, and the medical members of the committees consult each other in appropriate cases.

The review committees can find that cases have been handled either 'with due care', i.e. in accordance with the statutory criteria, or 'without due care'. If they find that a case has been handled 'without due care', they refer it to the Public Prosecution Service and the Health Care Inspectorate (besides notifying the physician concerned). A second recommendation in the review was that the Act should give the committees specific powers whereby cases found to have been handled 'with due care' can still be referred to the Inspectorate.

In its response to the review, the government took the view that the existing Act already gave the committees enough scope to reach appropriate conclusions on individual notifications.[6] According to the review, this was confirmed by interviews with committee members. The government also felt it was undesirable, and potentially detrimental to physicians' legal certainty, for cases to be referred to the Inspectorate despite having been handled 'with due care'.

However, the government does feel that review committees should notify the Inspectorate of any failings that come to light when assessing a notification, such as inadequate institutional protocols. Such failings should not relate to the actual case or to the notifying physician.

This proposal is entirely in line with the committees' existing custom of drawing the attention of establishments (or their boards) to outdated or inadequate protocols.

The review also recommended that committee members' terms of office be limited to two four-year periods. If members were replaced more often, there would be less risk of the

[6] Letter of 14 November 2007, ref. PG/E-2808432.

decision-making procedure becoming routine. A shorter term of office would also be more in keeping with practice elsewhere.

The government supports the proposal to limit the term of office to two four-year periods (rather than two six-year periods as at present). In accordance with the coalition agreement, the review committees will adopt the recommended term of office without the Act having to be amended.

According to the review, the review committees' annual reports and the publication of their findings on their website (with all identifying details removed) make for greater transparency and public awareness. It was recommended that the committees gain further experience of publishing notified cases on their website. There is a potential conflict between the need to protect patients' privacy and the wish to provide valuable information on specific cases. The review stated that this issue should be specifically addressed in the committees' reports and in future reviews. Findings began to be published in 2006 in order to make the assessment procedure more transparent. Notified cases of termination of life on request will therefore continue to be published (without identifying details) on the website. The government agrees with the authors of the review that published findings must constantly be monitored to ensure that patients' privacy is protected.

The committees are aware of the potential conflict referred to, and their procedures are specifically designed to ensure that patients' privacy is protected.

Standard report form

The review and the government's response to it also commented on the standard report form for use by notifying physicians. The form is being amended in the light of these comments. The amended form will make it even clearer that the review committees are competent to assess all cases of termination of life on request and assisted suicide involving patients aged 12 or older. They are not competent to assess notifications if there has been no request to terminate the patient's life or assist in his suicide.[7]

If a physician has terminated the life of a patient without the patient having explicitly requested it, the municipal pathologist must refer the case directly to the public prosecutor.

[7] See Article 1, paragraph 2 of the guidelines on the working procedures of the regional euthanasia review committees, adopted on 21 November 2006.

The committees are not competent to assess cases in which the life of a patient under 12 years of age has been terminated. Nor are they competent in cases involving normal medical procedure. The review procedure set out in the Act is not intended for such cases. Examples of normal medical procedure include ceasing or not commencing treatment that serves no medical purpose, ceasing or not commencing treatment at the patient's request, or administering treatment needed to alleviate the patient's severe suffering which leads to the patient's death. Normal medical procedure does not fall within the scope of criminal law and does not need to be reported.

The committees consider it important that the standard report form be amended so as to eliminate existing ambiguities and resulting misunderstandings by notifying physicians.

Chapter II

Due care criteria

Due care criteria: general

The committees assess whether the notifying physician has acted in accordance with all the statutory due care criteria. These criteria, as referred to in Article 293, paragraph 2 of the Criminal Code, are as follows.

Physicians must:

(a) be satisfied that the patient's request is voluntary and well-considered;

(b) be satisfied that the patient's suffering is unbearable, with no prospect of improvement;

(c) inform the patient about his situation and prognosis;

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

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

(f) exercise due medical care and attention in terminating the patient's life or assisting in his suicide.

The information provided by notifying physicians is of crucial importance to the committees' assessments.

The cases described in this annual report give an idea of the notifications assessed by the committees. In practically every case, the committees found that the physician had acted in accordance with the due care criteria. By far the majority of notifications gave no grounds for further discussion by the committees. Case 1 is an example of such a notification. Some notifications gave grounds for further discussion by the committees, and if necessary the physician was asked to provide additional information either orally or in writing. Case 2 and

those that follow are examples of cases that gave grounds for such questions or for further discussion.

Case 1

The information provided by the notifying physician – including the independent physician's written report – satisfied the committee that the patient's suffering was palpably unbearable.

The patient, a man between 30 and 40 years of age, had been diagnosed in his youth with the progressive muscular disease Duchenne muscular dystrophy (DMD). There was no prospect of cure. His life had always been difficult and had to be strictly regulated, but he had always managed to keep control of things and, given the circumstances, had been content. Over the past eight years, fatigue had forced him to spend more and more time in bed. All activities of daily living took him a long time, and he found talking and thinking extremely tiring. He was suffering because he was no longer able to do anything at all and his physical and mental resources were exhausted. He was also suffering because his situation was hopeless and his quality of life was nil. This suffering was unbearable to him. A week before his life was terminated, he specifically asked the physician to agree to his request for euthanasia.

The physician consulted an independent physician who was a fellow general practitioner and was also a SCEN physician (see below). The independent physician saw the patient a week before his life was terminated.

In his report, the independent physician stated that he had found an emaciated man in a wheelchair, with totally atrophied muscles. It was clearly a great effort for the patient to talk. During the interview he began tossing his head more and more violently. According to the independent physician, the patient's thought processes were lucid and coherent. He did not appear to be suffering from depression. He said he found his suffering unbearable because recently he had been living simply in order to stay alive.

As far as he could see, all he could now do was stay in bed and slowly waste away. He said that in the last five years he had needed considerable self-discipline to eat, urinate and defecate properly, and that he felt he could no longer keep up the effort. At first the independent physician found it hard to accept a request for euthanasia from such a young man, but during the interview he felt admiration for this patient who had fought for so long to

keep going with what little life had to offer him. The independent physician felt the patient's suffering was palpable and understandable. The patient did not feel he was a burden to others: he did not feel forced to request euthanasia to relieve his carers.

The independent physician concluded that the due care criteria had been fulfilled. The committee found that the notifying physician had acted in accordance with the criteria.

Due care criteria: specific

(a) Voluntary and well-considered request

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

The physician must be satisfied that the patient's request is voluntary and well-considered. This emphasises the notion of euthanasia as a *process*, rather than the moment at which life is actually terminated. Key elements in this process between the physician and the patient include willingness to discuss the (possibly imminent) end of the patient's life, the patient's wishes, and ways in which they can or cannot be fulfilled. A number of elements are crucial here.

First, the request for euthanasia must have been made by the patient himself. Second, it must be voluntary. The physician must be certain that the patient has not made the request under pressure from those around him. In making their assessment, the committees consider when and how the patient made the request. Third, in order to make a well-considered request, the patient must have a full understanding of his disease, the situation he is in, the prognosis and any other ways of improving the situation.

In order to make a voluntary, well-considered request, the patient must be capable of making an informed decision. If, for example, a patient is suffering from depression, this may adversely affect his ability to make such a decision. Where there is any doubt, a psychiatrist is often consulted in addition to the independent physician. The attending physician must thus ascertain, or obtain confirmation, that the patient is decisionally competent. If other medical practitioners have been consulted, it is important to make this known to the committees. In some cases, after weighing everything up, a physician may decide neither to consult an additional medical practitioner, nor to call in for a second time one who has been consulted earlier. Such information is also of relevance to the committees' assessment: if the

physician gives an account of the entire decision-making process in his initial notification, he may not be required to answer further questions later on.

Some notifications concern termination of life on request or assisted suicide involving patients suffering from dementia. They are in the incipient stages of the disease and still have insight into it and its symptoms (loss of bearings and personality changes). They are deemed capable of making an informed decision because they can fully grasp the implications of their request. They feel their suffering is unbearable because they are aware that their personality, functions and skills are already starting to disintegrate and that the process will only get worse, eventually leading to utter dependence and total loss of self. The committees act on the principle that requests for euthanasia from patients suffering from dementia should normally be treated with great caution, and therefore advise physicians to take extra care when assessing such situations.

The physician must take the stage of the disease and the other specific circumstances of the case into account when reaching his decision. Patients at a more advanced stage of the disease will rarely be decisionally competent. If a physician believes that a patient is in the initial stages of dementia, it is therefore important to consult one or more experts in addition to the independent physician.

Apart from whether or not the request is voluntary and well-considered, the question of whether the patient is suffering unbearably, with no prospect of improvement, also means that the physician must make an extremely careful assessment.

Advance directive

The following needs to be said about advance directives. The Act requires the physician to be satisfied that the patient has made a voluntary and well-considered request. The request is almost always made during a conversation between the physician and the patient, and hence is made orally. What matters most is that the physician and the patient should be in no doubt about the patient's request. Even if the patient is capable of making an informed decision and can request termination of life, a written advance directive can help eliminate any uncertainty and confirm the oral request.

By recording details of any general discussion of a patient's wish for euthanasia and the decision-making process concerning the end of his life in the patient's records, the physician can also help eliminate any uncertainty. This may, for example, be of help to locums and others involved in reaching a decision.

Contrary to popular belief, the Act does not require an advance directive to be drawn up. In practice, the existence of such a directive makes it easier to assess the case, but the committees wish to emphasise that it is not mandatory, if only to ensure that people are not put under unnecessary pressure to draw up such a directive, sometimes very shortly before they die.

The Act does mention advance directives, but in a different context – that of a patient suffering unbearably with no prospect of improvement who is no longer capable of expressing his wishes when the time comes to consider ending his life. Although the existence of an advance directive does not automatically lead to euthanasia or assisted suicide in cases where the patient is decisionally incompetent, some recommendations can still be made. It is in any case advisable to draw up the directive in good time and update it at regular intervals and, where possible, describe the specific circumstances in which the patient wishes to have his life terminated. The clearer and more specific the directive is, the firmer the basis it provides for the physician's decision. A handwritten directive by the patient in which he describes the circumstances in his own words often provides additional personal confirmation.

Case 2 (voluntary and well-considered request: dementia)

In the following case, the patient made her request for termination of life when she was in the incipient stages of dementia. The case shows how the physician enabled the patient to keep control of how her life would end. By consulting various experts in good time, he was able to satisfy himself that the patient had made a voluntary and well-considered request.

In autumn 2006, after two years of worsening symptoms such as noticeable slowness of mind and difficulty with basic arithmetic, the patient, a woman aged between 70 and 80 years of age, had been diagnosed with incipient Alzheimer's disease. Her awareness of her disease and prognosis caused her great suffering, as did her growing dependence on others, her decreasing ability to communicate and make social contact, and her resulting isolation. She was losing control of her life. This suffering was unbearable to her.

Three months after the diagnosis, she had told the physician that she wanted euthanasia when the time came. She wanted to keep control over how her life would end. A few weeks before she died, she had specifically asked the physician to terminate her life.

Because the patient's initial memory problems some years earlier had made the physician suspect she might be suffering from depression, and in order to respect her wish to keep control of her life, the physician had asked a geriatric psychologist to make a first independent assessment some time before the specific request was made. The independent physician gave the patient a psychological examination to ascertain whether her request was due to depression. He found he could well understand the patient's wish for euthanasia and felt it was in keeping with her view of life and her background. It was not due to depression.

Then, two months before the patient requested that her life be terminated, the physician had asked a SCEN physician to make a second independent assessment. During an interview with this second independent physician, the patient said that, given the protracted nature of the disease, she was afraid she no longer had any real future and would become isolated. She said she preferred to stay in bed in the mornings because she no longer felt able to do anything. She described the despair she felt as she carried out her activities of daily living. It took her a very long time to get anything done. She had had to give up all her hobbies and stop reading and watching television, as she could no longer concentrate. She also said she regularly felt physical discomfort, although she was unable to describe the feeling in detail. The despair she felt in her daily life made the world seem menacing to her. Her suffering had become virtually unbearable to her, which the independent physician found understandable. He concluded that her request had been voluntary and well-considered. The patient said she was not yet ready to have the procedure performed.

The second independent physician saw the patient a second time, two weeks before her life was terminated and after she had specifically requested euthanasia.

This time the attending physician had asked the independent physician to focus on whether the patient was capable of making an informed decision. The independent physician was satisfied that she was, and concluded that all the due care criteria had been fulfilled.

Finally, the attending physician consulted a third independent physician, a clinical geriatrician, and again asked him to assess the patient's decisional competence. This independent physician saw the patient two weeks before her life was terminated.

The third independent physician's report stated that the patient had sometimes had trouble expressing herself, but that she had made reasonably clear what she wanted to say. She repeatedly indicated that she could no longer cope with her current situation and with having

to live with Alzheimer's disease. She was expected to live about six more years, and saw this as a heavy and intolerable burden. The independent physician found that, despite having Alzheimer's disease, she could still provide a reasonable justification for her request for euthanasia. She could grasp the implications of her decision, and did not feel that any of the alternatives would improve the quality of her life. The independent physician could see no reason not to grant her request. The patient had been decisionally competent when she made the request.

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

Case 3 (not included here)

Case 4 (not included here)

(b) Unbearable suffering with no prospect of improvement

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

The physician must find the patient's suffering to be palpably unbearable, and must convince the committee of this. The committees are well aware that the question of suffering can sometimes be a difficult one for physicians to answer, and have therefore focused on it in more detail in this report.

Suffering is a complex experience, like pain, love, hope or despair. It is a fundamental part of human life, and can often be recognised as such more readily than it can be put into words. Any description of suffering is therefore a reconstruction of components of suffering to form as complete a picture as possible, based on what the suffering patient says and on observations of the patient. In that sense, suffering is an 'intersubjective experience' which can to some extent be communicated, and hence assessed. As the Royal Dutch Medical Association has stated, assessments by physicians are based on the assumption that suffering is to some extent palpable.

To understand and communicate suffering in connection with the end of life, we often use a conceptual framework based on the notion of 'the person in medicine', in which people are seen as physical, mental, social and spiritual/existential beings. Suffering is then classified according to whether it has a physical, a mental or an existential cause. People's differing

perceptions of suffering caused by similar factors are described as ‘subjective’, which usually implies that they are beyond other people’s ability to comprehend. Reflecting on what suffering means also involves facing the fact that the most frequently used conceptual framework has its limitations. The medical concept of the human being is in itself sufficiently broad and abstract to identify the most common symptoms of disease and abnormal behaviour, but is too limited to help us understand all the main elements of a phenomenon as complex as suffering. Finding a definition of suffering means describing an experience that involves a threat to intact existence and the decay or disintegration of the personality.

It should also be remembered that all suffering is existential, regardless of the cause, because people who suffer are existential beings. The perception of pain is based on a mind that can perceive it, and in that sense all suffering – even suffering that has a physical cause – is mental suffering. Without a mind to perceive suffering, human beings cannot suffer. This means that human suffering is not ‘subjective’ in the sense described above, but it is linked to a subject or person. It is thus by definition personal: bodies do not suffer, people do.

Besides the physical, mental, social and existential aspects, this concept of the individual includes the notion of man as a being with a perception of time and expectations of the future, a being whose life is informed by a need for meaning or meaningfulness. And it is these very aspects, such as the loss of future prospects and the perception that life no longer has any meaning, that are reflected in many requests for euthanasia when patients indicate why life is now unbearable to them.

The requirement that the patient’s suffering be ‘unbearable with no prospect of improvement’, does not make it easier to reach a conclusion, but it does not make it impossible. All the aspects of a particular person’s suffering can be brought together to form a whole that in its totality is unbearable to him. Of course, this is always a difficult task, but successive notifications have proved over and over again that a clear enough picture can be obtained to make the prior assessment and carry out the subsequent review.

The phrase ‘with no prospect of improvement’ requires some further comment. It has at least two meanings that are of relevance when assessing a patient’s suffering. First, there is *no prospect of improvement* if there is no realistic means of treatment. The disease or condition that is causing the suffering is incurable and there is no realistic prospect of alleviating the symptoms. It is up to the physician to decide whether this is the case, in the light of the diagnosis and the prognosis. ‘Realistic prospect’ means that the improvement that can be achieved by palliative care or other treatment must be in reasonable proportion to the burden

such care or treatment places on the patient. In this sense, ‘with no prospect of improvement’ refers to the disease and its symptoms. Second, the phrase has a meaning that relates to the patient as an individual. Patients use it to indicate that the balance between present and future symptoms has tipped against them to a degree they find unacceptable, and that they want their suffering to end. In that sense, it is part of what makes suffering unbearable.

This makes it harder to decide whether suffering is *unbearable*, for this is an open-ended, complex notion. Suffering is usually caused by a disease and is manifested by symptoms and loss of function. This is the aspect that can be objectively determined. However, the question of whether the symptoms of suffering become unbearable, and if so when, ultimately depends on the person who is suffering, and hence is an individual matter. Whether suffering is unbearable is determined by the patient’s personality, his physical and mental stamina as an expression of his previous history and experience of life, and his perception of the future. What is still bearable to one patient may be unbearable to another.

Notifications often describe unbearable suffering in terms of physical symptoms such as pain, nausea and shortness of breath – all based on the patient’s own statements – and perceptions such as exhaustion, increasing humiliation and dependence, and loss of dignity. As already indicated, perceptions of such symptoms and circumstances will differ, because they are linked to particular individuals. A crucial factor when the committees make their assessments is whether the physicians – both the attending physician and the independent physician – found the patient’s suffering to be palpably unbearable.

Unbearable suffering in special cases

As already indicated in the section on voluntary and well-considered requests, requests for euthanasia from patients suffering from dementia should normally be treated with great caution. The question of capacity to make an informed decision has already been discussed.

A key issue is whether dementia patients can be said to be suffering unbearably. Being aware of his disease and the prognosis may cause the patient great suffering. In that sense, ‘fear of future suffering’ is in fact a realistic assessment of the prospect of further deterioration. Here again, the specific circumstances of the case will determine whether the physician feels the patient’s suffering to be palpably unbearable.

A second key issue is whether comatose patients can be said to be suffering unbearably. The general medical opinion is that deeply comatose patients are not conscious, do not

suffer and hence do not suffer unbearably. For comparison, if a patient is sedated to combat unbearable symptoms, the purpose of the treatment is to induce loss of consciousness so that the patient is no longer aware of suffering. Cases involving comatose patients usually lead the committees to ask further questions. The committees examine the specific facts and circumstances. On this basis, a committee may find in a specific case that the physician has acted in accordance with the due care criteria. The following factors need to be considered here.

If a patient is in a shallow rather than a full coma and still displays outward symptoms of suffering, the physician may indeed be satisfied that the patient is suffering unbearably. Despite this latitude for assessment between shallow and full comas, the committees feel that physicians should adopt a cautious approach to patients who can no longer communicate.

Termination of life in the case of patients who can no longer communicate is sometimes complicated by the fact that the physician has already made promises to the patient without allowing for the possibility that the patient may go into a coma. If a physician has made such a promise and is later confronted with what may be a sudden change in the situation whereby the patient is no longer suffering unbearably (for example, because the patient has gone into a spontaneous coma), the physician faces a dilemma, owing to the conflict between his promise to the patient and the fact that the ‘unbearable suffering’ criterion is no longer fulfilled. In such cases, the patient’s relatives may also remind the physician of his promise and insist that the procedure be carried out, making him feel he is under moral pressure to proceed. It is therefore advisable for physicians to refrain from making unqualified promises to patients and to point out the possibility that they may go into a coma, at which point the life-terminating procedure cannot normally be continued.

Not infrequently, the attending physician consults an independent physician who does not yet find that the patient is suffering unbearably. In many cases, the independent physician often indicates that he expects further deterioration to lead to unbearable suffering within a given period of time. In such cases, it is advisable for the physician to consult the independent physician again at a later stage, and to make this known to the committee. This is discussed in more detail in the section on independent assessment.

Palliative sedation

Another relevant issue in connection with unbearable suffering is palliative sedation, whereby the patient's consciousness is deliberately reduced in order to eliminate untreatable suffering in the final stage of his life. Palliative sedation can only be considered if the patient is expected to die soon.[8]

The possibility of palliative sedation does not always rule out euthanasia, for two reasons. First, palliative sedation is not an appropriate way to eliminate unbearable suffering in patients who are likely to remain alive for a relatively long time. For example, patients suffering from multiple sclerosis, heart failure or serious lung conditions may be suffering unbearably even though they are not in a terminal stage. Given the likely duration of the disease, the fact that there is no prospect of improvement may contribute to making their suffering unbearable. Second, there are patients who expressly refuse palliative sedation and indicate that they wish to remain conscious to the very end.

Case 5 (not included here)

Case 6 (not included here)

Case 7 (not included here)

Case 8 (not included here)

Case 9 (not included here)

(c) Informing the patient

Physicians must inform the patient about his situation and prognosis.

In assessing fulfilment of this criterion, the committees determine whether, and in what way, the physician has informed the patient about his disease and prognosis. In order to make a well-considered request, the patient must have a full understanding of his disease, the diagnosis, the prognosis and the possible forms of treatment. It is the physician's responsibility to ensure that the patient is fully informed and to verify this. This criterion did not raise problems in any of the reported cases.

[8] See the Royal Dutch Medical Association's guidelines on palliative sedation (December 2005).

(d) No reasonable alternative

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

It must be clear that there is no realistic alternative available to the patient other than euthanasia. The focus is on treating and caring for the patient and on limiting and where possible eliminating the suffering, even if therapy is no longer possible or the patient no longer wants it. The emphasis in medical decisions at the end of life must be on providing satisfactory palliative care. However, this does not mean that the patient has to undergo every possible form of palliative care or other treatment. A patient who is suffering unbearably with no prospect of improvement can refuse palliative care or other treatment. Refusal of treatment is an important subject of discussion between physicians and patients.

One factor that can lead a patient to refuse palliative or other treatment is that it may have side effects which he finds hard to tolerate and/or unacceptable. In that case, the effect of the treatment does not outweigh its disadvantages.

There are also patients who refuse further palliative care (in the form of an increased dose of morphine) because of a fear of becoming drowsy or losing consciousness, which they definitely do not want. In order to ensure that the patient is properly informed, the question of whether this fear is justified must always be discussed with him, for such feelings of drowsiness and confusion usually pass quickly.

Since decisions on such matters must be reached jointly by the patient and the physician, the physician will be expected to indicate in his report to the committee why other alternatives were not deemed reasonable or acceptable in this specific case.

(e) Independent assessment

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

A second, independent physician must see the patient and indicate in writing whether the due care criteria have been fulfilled. In this capacity, the second physician must make an

independent assessment. Failure to consult an independent physician will lead the committees to find that the physician did not act in accordance with the due care criteria.

The second physician must be independent of the attending physician and the patient. In the case of the physician this means, for example, that there is no family or working relationship between the two physicians and that they are not members of the same group practice.

In practice, the committees are confronted with a number of different arrangements in which general practitioners work under the same roof. They are not members of a group practice who care for patients jointly, but they do share facilities; for example, they may rent the same premises, share computer systems or share electronic patient files. It is not easy to decide beforehand which particular arrangements will jeopardise a physician's independence, for such information is not usually available in advance. In cases of doubt, the committees will therefore always ask further questions when such working arrangements are involved.

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

This situation arose in Case 10. The committee explicitly directed the two physicians to stop working together in this way. Since both physicians said they would comply and now clearly understood what was at stake, the committee found that the due care criteria had been fulfilled in this case. The committees feel that, if a physician always consults the same independent physician, the latter's independence may eventually be jeopardised. It is vital to avoid anything that may suggest the physician is not independent.

A notifying physician and an independent physician may also know each other privately, or as members of a peer supervision group. The fact that they know each other privately does not automatically rule out an independent assessment, but it does call the physician's independence into question. The fact that they know each other as members of a group that meets to discuss medical cases – a professional activity – need not call the physician's independence into question; whether it rules out an independent assessment will depend on how the group is organised. What matters is that the notifying physician and independent physician should be aware of this and make it clear to the committee how they reached an opinion on the matter.

In the case of the patient, there must, for example, be no family relationship or friendship, the physician must not be helping to treat him (and must not have done so in the past) and he must not have come into contact with him in the capacity of locum. In Case 11, the physician's independence was jeopardised because he was related to the patient's husband. In this case the committee found that he did not qualify as an independent physician.

Not only is the independence requirement literally set out in section 2, subsection 1 (e) of the Act, but at various points during the preparatory work on the Act it was specifically stated that a physician who is thinking about terminating a patient's life must consult an independent physician.

When the bill was debated in the House of Representatives (*Parliamentary Papers*, 1999-2000 session, 26691, no. 6, p. 16), the requirement that an independent physician be consulted was seen as a means of ensuring that decisions were as careful and complete as possible. During the same debate (*ibid*., p. 60) it was stated that, in cases involving hospital patients, the independent physician must likewise be independent of both the attending physician and the patient.

The Royal Dutch Medical Association's 2003 Position Paper on Euthanasia also explicitly stated (p. 15) that the physician's independence must be guaranteed. This meant that a member of the same group practice, a registrar, a relative or a physician who was otherwise in a position of dependence in relation to the physician who called him in could not normally be deemed independent. The need to avoid anything that might suggest the physician was not independent was once again emphasised.

In Case 12, the 'independent' physician again did not qualify as such, for he had already attended the patient as a locum. The committee found that the notifying physician had not acted in accordance with the due care criteria. One factor that led to this finding was that the two physicians had told the committee they had been aware that the second physician was not independent of the patient, but had gone ahead regardless. They had also said they would do the same thing again in similar circumstances.

The independent physician's report is of great importance when assessing notifications.[9] A report describing the patient's situation when seen by the physician and the way in which the patient talks about the situation and his wishes will give the committees a clearer picture.

The independent physician must give his opinion on whether the due care criteria set out in (a) to (d) have been fulfilled. He should also specifically mention his relationship to the attending physician and the patient.

The independent physician is responsible for his own report. However, the attending physician bears final responsibility for performing the life-terminating procedure and for fulfilling all the due care criteria. If there is a difference of opinion between the two physicians, the attending physician must ultimately reach his own decision (even if he takes extensive account of the independent physician's findings), for it is his own actions that the committees will be assessing.

Sometimes an independent physician concludes on seeing the patient that one of the due care criteria has not yet been fulfilled. It is not always clear to the committees what exactly happened after that. In such cases they ask the notifying physician further questions. If the independent physician is called in at an early stage and finds that the patient is not yet suffering unbearably or that a specific request for euthanasia has not yet been made, he will usually have to see the patient a second time. If he has indicated that the patient's suffering will very soon become unbearable and has specified what he believes that suffering will entail, a second visit will not normally be necessary, but it may still be advisable for the two physicians to consult by telephone or in some other manner. If a longer period of time is involved or if the prognosis is less predictable, the independent physician will have to visit the patient a second time.

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

The Euthanasia in the Netherlands Support and Assessment Project (SCEN) trains physicians to make independent assessments in such cases. In most cases it is SCEN physicians who are called in as independent physicians. SCEN physicians also have a part to play in providing support, for example by giving advice.

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

Case 10 (not included here)

Case 11 (independent assessment)

The 'independent' physician was related to the patient's husband and was therefore not independent of the patient. The committee found that the notifying physician had not acted in accordance with the due care criteria.

The patient, a woman between 50 and 60 years of age, was diagnosed with a carcinoid tumour in summer 2006, and underwent surgery. The condition proved incurable. She was suffering unbearably, with no prospect of improvement. A specialist was called in as an independent physician. He saw the patient one day before her life was terminated and on the day itself, after being informed about her by the notifying physician. According to the independent physician's report, the patient had said at the time of the diagnosis that she wanted euthanasia if her condition proved incurable. Both before and after a second operation, the patient confirmed her wish while fully conscious.

The notifying physician was asked to provide additional oral information, because the written report had raised questions among members of the committee. On paper the whole procedure appeared to have been carried out very quickly, and it was not altogether clear what role the two physicians had played. The notifying physician provided the requested oral information.

He outlined the patient's case history as follows. She had developed abdominal symptoms in 2006. He had known her for a very long time, and became her attending physician. After the diagnosis she underwent surgery. She indicated that she wanted to recover, but that she wanted euthanasia if things went wrong. As she put it, she did not want to 'drain the cup to the dregs'. The physician promised not to abandon her to her fate.

In late 2006 her symptoms became much worse and she was readmitted to hospital, where it was decided to operate a second time. The patient expressly stated that she did not want to come round if the condition proved inoperable. During the operation it became clear that the prognosis was negative, but the patient came round nevertheless. The attending physician found her with her relatives all around her. A second physician was also present, but he was a cousin of the patient's husband and so was not truly independent. The attending physician said things had proceeded in this way because it was impossible to find a SCEN physician

on that day. The patient made it abundantly clear that this was a situation she had not wanted to find herself in, and made a very well-considered request for euthanasia. The second physician took the view that the patient's suffering was contrary to her wishes. He drew up a written report the day after the procedure was performed, but now stated his opinion orally in the attending physician's presence.

In consultation with a registrar at the hospital, the patient was sent home, where the attending physician terminated her life in the presence of those closest to her.

The whole procedure had indeed been carried out very quickly, but was entirely in accordance with the patient's wishes. She had always been promised she would not have to suffer unbearably. During her illness she had made clear what she did and did not want. The physician had also made a well-considered decision to perform the procedure, though he was aware that not everything was strictly in accordance with the rules.

In the light of these facts and circumstances and the additional oral information provided by the notifying physician, the committee found he could be satisfied that the request had been voluntary and well-considered. Regarding the question of whether the patient had been suffering unbearably, with no prospect of improvement, the committee considered the following factors.

Before undergoing surgery, the patient had clearly and repeatedly emphasised that she did not want to come round from the anaesthetic if her condition proved inoperable. The physician had been aware of this express wish. Those who performed the surgery had not fulfilled it. The patient and her relatives had assumed the request would be granted. The committee understood why those who performed the surgery could not fulfil the patient's wish. It would have been better if the surgeon had made clear to the patient that her request could not be granted in this way, so as to avoid giving the patient and her relatives false expectations.

The committee found that the physician could be satisfied that, after the surgery, the patient was in a situation she found unbearable, with no prospect of improvement.

Regarding the question of independent assessment, the committee considered the following factors.

The second physician was a relative of the patient's husband. The patient was in a pitiful state and had to be taken home, where in view of her situation euthanasia would be performed immediately. On the day in question it would certainly have taken some time to find a truly independent physician.

Under the circumstances, the two physicians decided it would be best if the second physician drew up a brief report confirming that the patient was suffering unbearably, with no prospect of improvement, and that she had made an explicit request for euthanasia.

However, the committee could not overlook the fact that, whatever good reasons there had been to proceed in this way, the second physician was a cousin of the patient's husband and hence did not qualify as an independent physician.

The committee therefore had no choice but to find that the 'independent assessment' criterion had not been fulfilled in this case. This meant that the physician had not acted in accordance with the due care criteria.

The committee stated that, particularly in the light of the detailed oral information provided by the physician, they were convinced that both physicians had acted with the best of intentions, given the circumstances they were in and the promises that had been made to the patient from the outset.

However, understandable though all this was, they should have endeavoured – especially as the whole situation was so sensitive – to arrange an independent assessment, rather than an assessment by a cousin of the patient's husband who just happened to be visiting her. The committee found that the physician had not acted in accordance with the due care criteria. The case was referred to the Board of Procurators General and the Health Care Inspectorate. The Board of Procurators General decided that the physician should not be prosecuted. After interviewing the two physicians, the Inspectorate closed the case.

Case 12 (independent assessment)

The 'independent' physician had already attended the patient as a locum, and so was not truly independent. The committee found that the notifying physician had not acted in accordance with the due care criteria.

The patient, a man between 50 and 60 years of age, was diagnosed with a metastasised melanoma in mid-2006. He was suffering unbearably, with no prospect of improvement. He first made a specific request for euthanasia in early 2007. The 'independent' physician first saw him as a locum, a few days before his life was terminated, and saw him again as an 'independent' physician on the day the procedure was performed. He supported the patient's request.

The committee asked the notifying physician to provide additional written information as to why he had sought an independent assessment from a physician who had in fact already attended the patient as a locum. He was asked why he had not consulted a SCEN physician instead. In a letter, he said he was surprised to learn that the fact that the physician had already attended the patient as a locum could prevent him from making an independent assessment. He added that he had not consulted a SCEN physician because of a bad experience with one on a previous occasion. He had felt that the SCEN physician was trying to take over his role as attending physician. He believed that the independent physician should play an unobtrusive role and avoid interfering in the therapeutic relationship between the attending physician and the patient.

The 'independent' physician was asked to provide additional written information about his reasons for concluding that the due care criteria had been fulfilled in this case. Despite repeated requests, the 'independent' physician did not submit an additional report.

The two physicians were invited to appear before the committee to provide additional information in person. On the day before the committee met, the 'independent' physician sent it a fax with additional information concerning his very cursory written report. Despite this information, it was still not clear to the committee why the notifying physician had consulted an 'independent' physician who had in fact already attended the patient as a locum.

At the meeting, the 'independent' physician said he had felt that a note stating that the due care criteria had been fulfilled would be sufficient. He had seen no need for additional details. If he said that the criteria had been fulfilled then 'that was the case'. He had seen no need, for example, to use the checklist drawn up by the SCEN project. However, because the committee had repeatedly asked for additional information, he had finally provided it.

During the interview, the notifying physician stated that he had not been the patient's own general practitioner. The GP had been on holiday. The notifying physician had attended the patient several times as a locum, and the patient had said he wanted to be seen by him if his

own GP was away. He had known the patient for a year. The 'independent' physician had attended the patient as a locum when the notifying physician – himself a locum for the patient's own GP – was away, because the patient's condition had deteriorated. In this capacity he concluded that no further palliative treatment was possible. The patient then asked him to perform euthanasia. As a locum, he told the patient to ask the notifying physician instead.

When the notifying physician later commenced the euthanasia procedure, he deliberately asked this locum to act as the 'independent' physician because it was convenient – the locum already knew the patient and his situation. The 'independent' physician (who had already seen the patient as a locum) confirmed this, and said he would do the same thing again in similar circumstances. He had been able to see that the patient's condition had deteriorated in a matter of days – something another independent physician could not have seen.

The notifying physician was asked whether he had considered waiting until the patient's own general practitioner returned from holiday. He said he had not been able to bring himself to do so, in view of the patient's condition. Waiting had not been an option. The patient had also requested his own GP to perform euthanasia. The 'independent' physician said that he knew he should not have acted in that capacity after having seen the patient as a locum, but that he had gone ahead regardless.

Regarding the question of independent assessment, the committee considered the following factors.

The notifying physician had deliberately consulted an 'independent' physician who had in fact already attended the patient as a locum. The 'independent' physician was also aware that he should not have acted in that capacity after having seen the patient a few days earlier as a locum.

The notifying physician had not wanted to consult a SCEN physician because of a previous bad experience, and had not considered any other way of arranging an independent assessment. Although both physicians were aware of the statutory due care criteria, they had deliberately acted as described above. During the interview with the committee, they also indicated that they did not in any way regret what they had done and would do it again in similar circumstances.

The committee felt that the need for independent assessment had been all the more pressing since the notifying physician had himself been acting as a locum for the patient's own GP. The committee was also disturbed by the two physicians' assertion that they would do the same again in similar circumstances.

Since there had been no independent assessment in this case, the committee found that the due care criteria had not been fulfilled. The case was referred to the Board of Procurators General and the Health Care Inspectorate. The Board reported that it saw no reason to prosecute.

(f) Due medical care

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

Euthanasia or assisted suicide is normally carried out using the method, substances and dosage set out in the Royal Dutch Pharmaceutical Society's advisory report.[10] The recommended method involves administration of a coma-inducing substance, followed by administration of a muscle relaxant. The report recommends the use of 'first-choice' substances (those with which physicians have the most experience). 'Second-choice' (alternative) substances are recommended for use in emergencies. The report also lists substances that are *not* recommended for inducing comas. It thus makes a distinction between first-choice substances, second-choice substances and substances that should not be used at all. If a physician does not use a first-choice substance, the commission may ask further questions to ascertain what made him decide which method, substances or dosage to use. The use of second-choice substances is not necessarily wrong, but they are substances with which physicians currently have less, or less satisfactory, experience.

The committees note the increasingly frequent use – contrary to the advice given in the report – of midazolam (sometimes in combination with opiates), particularly when inducing a coma. The committees consider this undesirable, and recommend the use of substances with proven effectiveness in inducing a coma. This is not always the case with benzodiazepines. The use of non-recommended substances may prove very distressing for both the patient and any relatives who are present. This can be avoided by using the appropriate substances.

[10] *Standaard Euthanatica: toepassing en bereiding* ('Standard for euthanatics: application and preparation'), 2007.

The committees note that Dormicum (brand name of midazolam) is sometimes used as pre-medication before euthanasia is performed. The prescribed coma-inducing substances are also administered in such cases. There is then no objection to the use of Dormicum or similar substances as pre-medication. Before performing euthanasia, physicians are advised to discuss with the patient and his relatives what effect the substances will have. In line with the Royal Dutch Pharmaceutical Society's recommendations, it is important to fulfil patients' personal wishes.

The following unusual situation occurred in Case 13. After the physician administered a coma-inducing substance (thiopental), the patient's breathing immediately became irregular and stopped after five minutes. The physician did not administer an additional muscle relaxant. Since thiopental can induce such a deep coma, with absence of reflexes, that it can even lead to death, and since the patient's breathing immediately became irregular and stopped after five minutes, the committee found the physician had been right to wait and see what effect it would have, rather than administer a muscle relaxant at once.

In the case of euthanasia, i.e. termination of life on request, the physician actively terminates the patient's life by administering euthanatics, usually by intravenous injection. In the case of assisted suicide, the patient ingests the euthanatics himself. He does so by drinking a barbiturate potion.[11] In principle, the physician must remain with the patient until the patient is dead. He must not leave the patient alone with the euthanatics. This is because the patient may vomit, in which case the physician may perform euthanasia. Furthermore, leaving such substances without medical supervision may pose a hazard to people other than the patient.

In exceptional cases different arrangements may be made in advance, but only for good reasons. The physician must always be on hand to intervene quickly if the euthanatics do not have the desired effect.

Euthanasia must always be performed by the physician himself. In Case 14, it was performed by a trainee general practitioner, and the committee asked further questions about this. Since the trainee was supervised by a general practitioner in the practice where he worked, and particularly since the general practitioner was present when euthanasia was performed, the committee found that the physician had exercised due medical care.

[11] Usually a 100-millilitre potion containing 9 grams of pentobarbital sodium or secobarbital sodium.

In practice, physicians are occasionally uncertain about their role in the euthanasia procedure. For example, if a case of euthanasia is reported by a physician who did not actually perform the procedure, the physician who performed the procedure must also sign the notification and will be deemed by the committees to be the notifying physician.[12]

Case 13 (not included here)

Case 14 (not included here)

[12] See Article 3, paragraph 1 of the guidelines on the working procedures of the regional euthanasia review committees, adopted on 21 November 2006.

Chapter III

Committee activities

Statutory framework

Termination of life on request and assisted suicide are criminal offences in the Netherlands (Articles 293 and 294 of the Criminal Code). The only exception is when the procedure is performed by a physician who has fulfilled the statutory due care criteria and has notified the municipal pathologist. If the physician satisfies both conditions, the procedure he has performed is not treated as a criminal offence. The aforementioned articles of the Criminal Code identify them as specific grounds for exemption from criminal liability. The due care criteria are set out in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act ('the Act'), and the physicians' duty to notify the municipal pathologist is dealt with in the Burial and Cremation Act.

Under the Act, notifications of termination of life on request and assisted suicide must be reviewed by regional euthanasia review committees ('committees'). The committees carry out their main task on the basis of the Act. They review notifications of termination of life on request and assisted suicide, and assess whether the physician has fulfilled the statutory due care criteria. Termination of life on request means that the physician administers the euthanatics to the patient. Assisted suicide means that he prescribes substances to be ingested by the patient himself.

Role of the committees

When a physician has terminated the life of a patient on request, or assisted in his suicide, he notifies the municipal pathologist. When doing so, he submits a detailed report showing that he has complied with the due care criteria.[13] The pathologist performs an external examination and ascertains how the patient died and what substances were used to terminate his life. He then establishes whether the physician's report is complete. The report by the independent physician and, if applicable, the advance directive drawn up by the deceased are added to the file.

The pathologist notifies the committee, submitting all the required documents and any other relevant documents provided by the physician, such as the patient's medical file and letters from specialists. Once the committee has received the documents, both the pathologist and

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

the physician are sent an acknowledgement of receipt. The committees assess the physician's actions, examining whether he has acted in accordance with the statutory due care criteria. If a committee has any questions, the physician in question will be informed. Physicians are often asked to respond in writing to additional questions.[14] The committees sometimes contact physicians by telephone if they need extra information. If the information thus provided by the physician is insufficient, he may then be invited to provide further information in person. This gives him an opportunity to explain in more detail what took place in this particular case.

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

The multidisciplinary committees issue their findings on the notifications they assess. In almost every case they conclude that the physician has acted in accordance with the due care criteria. In such cases, only the notifying physician is informed.

In 2007, three physicians were found not to have acted in accordance with the criteria. In such cases, the findings are not only sent to the notifying physician, but are also referred to the Board of Procurators General and the Health Care Inspectorate. The Board decides whether or not the physician in question should be prosecuted. The Inspectorate decides in the light of its own tasks and responsibilities whether any further action should be taken. This may range from interviewing the physician to disciplinary action. The committees hold consultations with the Board of Procurators General and the Inspectorate every year.

There are five regional euthanasia review committees. The place of death determines which committee is competent to assess the case in question. Each committee comprises three members: a lawyer, who is also the chair, a physician and an ethicist. They each have an alternate. Each committee also has a secretary, who is also a lawyer, with an advisory vote at committee meetings. It should be emphasised that the committees act as committees of experts. The secretaries and support staff form the secretariats, which are responsible for assisting the committees in their work. For organisational purposes the secretariats form part of the Central Information Unit on Health Care Professions (CIBG) in The Hague, which is an executive organisation of the Ministry of Health, Welfare and Sport. The secretariats have offices in Groningen, Arnhem and The Hague, and the committees meet there every month.

[14] In 2005, according to the review of the Act, this happened in some 6% of notified cases.

The committees help the Euthanasia in the Netherlands Support and Assessment Project (SCEN) train physicians to perform independent assessments.

The committees see all the reports by the independent physicians consulted by the notifying physicians, and they alone have an overall picture of the quality of these reports. Although this is generally improving, they feel it should be constantly monitored, as too many independent physicians are still submitting substandard reports. The committees' general findings are forwarded to SCEN each year.

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

Annexe I

Overview of notifications: total

1 January 2007 to 31 December 2007

Notifications

The committee received 2,120 notifications in the year under review.

Euthanasia and assisted suicide

There were 1,923 cases of euthanasia, 167 cases of assisted suicide and 30 cases involving a combination of the two.

Physicians

In 1,886 cases the notifying physician was a general practitioner, in 157 cases a medical specialist working in a hospital, in 76 cases a physician working in a nursing home and in 1 case a physician being trained as a specialist.

Conditions involved

The conditions involved were as follows:

Cancer	1,768
Cardiovascular disease	40
Neurological disorders	105
Other conditions	128
Combination of conditions	79

Location

In 1,686 cases patients died at home, in 147 cases in hospital, in 82 cases in a nursing home, in 89 cases in a care home and in 116 cases elsewhere (e.g. in a hospice or at the home of a relative).

Competence and findings

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

Length of assessment period

The average time that elapsed between the notification being received and the committee's findings being sent to the physician was 28 days.