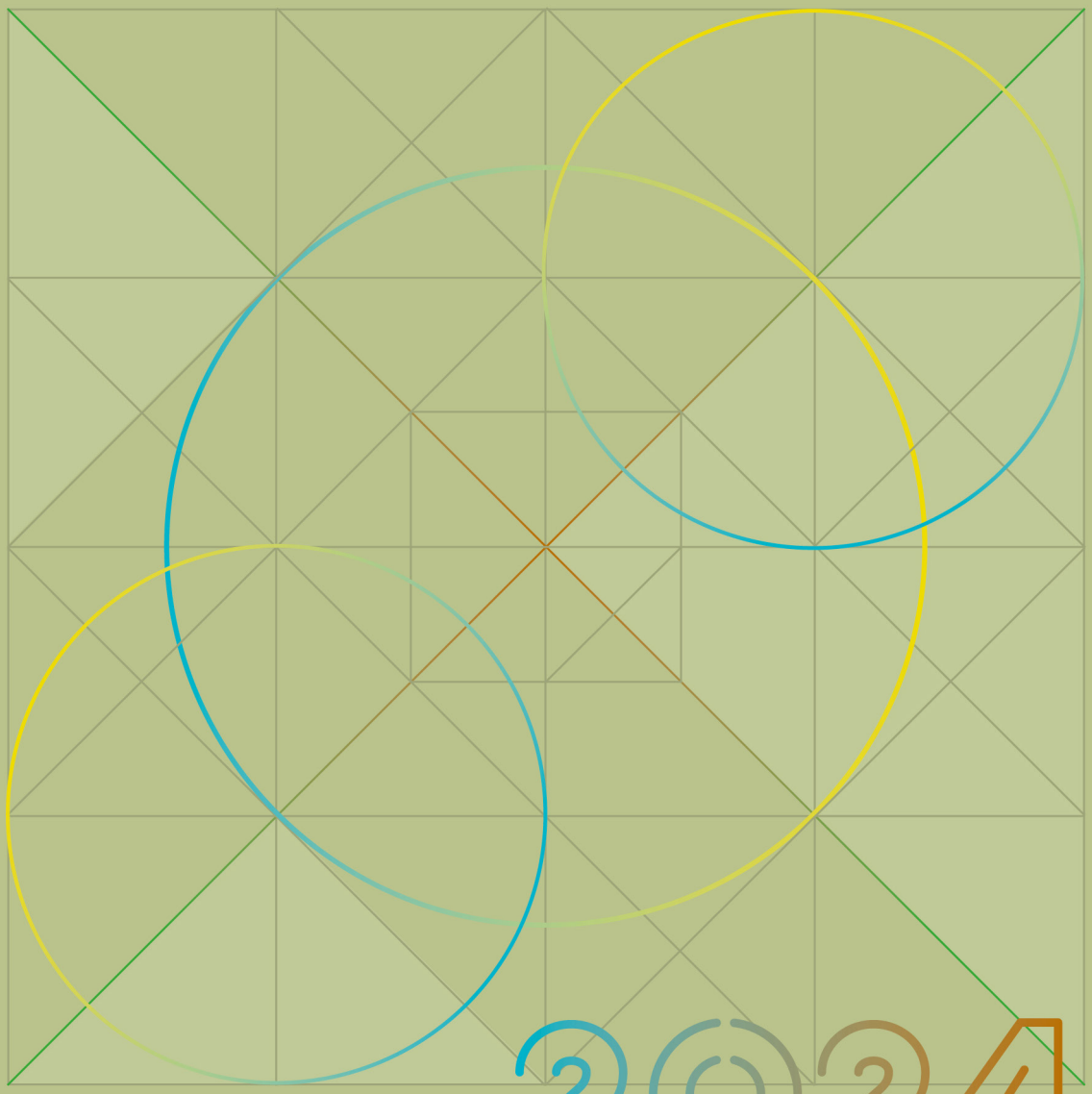
RTE

REGIONAL EUTHANASIA REVIEW COMMITTEES



ANNUAL REPORT 2024

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FOREWORD

As in previous years, 2024 saw a significant rise in the number of euthanasia cases: the RTEs received 9,958 notifications of euthanasia, a 10% increase compared with 2023. The number of notified cases of euthanasia as a percentage of the total number of deaths rose from 5.4% to 5.8% in 2024. A study into the reasons for this growth, promised to the House of Representatives by the Minister of Health, Welfare and Sport (VWS), should provide a better insight into these figures. At present, all that can be said is that there is no reason to assume that the gradual increase seen in recent years will soon come to a halt.

In 2024 the RTEs reviewed 932 fewer notifications than they received. This backlog was caused by the fact that the RTEs received almost 900 more notifications than in the previous year, combined with a shortage of secretaries due to a relatively high turnover, illness and maternity leave. The secretariat is now back to full capacity and most of the backlog has been cleared. The processing time – the average time between a notification being received and the findings being sent to the physician – is now also back at an acceptable level. Although all cases were still reviewed within the statutory time limit, I regret the fact that in 2024 physicians were left in uncertainty for longer than usual as they waited for the findings on whether they had fulfilled the due care criteria. Many physicians find this period of uncertainty distressing.

I would like to thank the secretariat staff in particular. They made a huge effort to guarantee the continuity and quality of the review procedure in this period, while at the same time training new colleagues. That was not an easy task.

Six cases notified to the RTEs were found not to have been handled with due care this year. Chapter 3 gives summaries of the findings in these cases. These cases are a very small percentage of the total, and the conclusion is therefore once again that in the Netherlands the procedures relating to euthanasia are carried out with great care.

My term as coordinating chair of the RTEs ended on 1 February 2025 and I have decided, for personal reasons, not to serve a second term. As of that date, Mariëtte Moussault, chair of region 1, has been serving as interim coordinating chair, pending the arrival of a successor. It has been a great pleasure to be involved in shaping the important work of the RTEs over the past four years. I have devoted a great deal of attention to critical external views. Euthanasia must never be taken for granted.

The RTEs are open to criticism and are always willing to reassess their methods and ask themselves: are we still fulfilling our task properly? Society as a whole must also continue to take account of new developments with regard to euthanasia.

I am therefore pleased to see the public debate on euthanasia for young people with a psychiatric disorder, although it was not easy to find the right form for such a discussion. Debate leads to reaffirmation or adaptation of social norms. It invites parties to express and account for their views, and therefore helps prevent euthanasia from being taken for granted. Chapter 2 provides the figures the RTEs have for this special category of cases. The findings in one of these cases is included in Chapter 3, under the heading 'Psychiatric disorders'.

The statutory standards for euthanasia and the reviews by the RTEs are good examples of the capacity of our democracy under the rule of law to bridge significant social divisions and arrive at a broadly supported solution to a fundamental dilemma. Such a solution is by its very nature a compromise. The challenge is to ensure that compromise does not become set in stone, but instead to let it evolve. The open norms in the legislation allow for this, within the strict parameters set by that same legislation. The RTEs' task is to ensure a balance in this respect, and they have done so since their inception. I have every reason to be optimistic about the future.

JEROEN RECOURT
Coordinating chair

SUMMARY

The number of euthanasia cases in the Netherlands increased significantly in 2024: the RTEs received 9,958 notifications, which is 10% more than in 2023. The number of notified cases of euthanasia as a percentage of the total number of deaths rose from 5.4% to 5.8% in 2024.

In 2024 the RTEs reviewed 932 fewer notifications than they received. This backlog was caused by the fact that the RTEs received 890 more notifications than in 2023, combined with a temporary staffing shortage at the RTE secretariat.

The vast majority of euthanasia notifications (86.29%) involved patients with common somatic conditions, such as cancer, neurological disorders, pulmonary disease and/or cardiovascular disease. There were 427 cases of euthanasia involving patients with a form of dementia. There were 219 euthanasia notifications that concerned patients whose suffering was (largely) caused by one or more psychiatric disorders. The RTEs received 397 notifications concerning patients with multiple geriatric syndromes. Lastly, there were 232 notifications in the category 'other conditions'.

The RTEs found in six cases that the physician had not fulfilled the due care criteria in performing euthanasia. In two of these cases the physician had not consulted an independent physician or had not done so in the correct manner. One case concerned the particular caution the physician must exercise when the request for euthanasia is based (largely) on suffering caused by a psychiatric disorder. In the other three cases the 'Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide' had not been followed when complications arose during the euthanasia procedure.

In 2024, the RTEs further investigated the possible risk that the patient might be in an insufficiently deep coma and thus be aware of the effects of the muscle relaxant in the event that a second dose of muscle relaxant is administered without first administering a second dose of the coma-inducing substance. In cases where a period of 30 minutes or more has elapsed between the administration of the coma-inducing substance and the administration of the last dose of muscle relaxant, the RTEs will always find that due medical care has not been exercised. In such cases the RTEs no longer consider the assessment of the depth of the coma to be sufficiently reliable.

INTRODUCTION

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

Another aim of the annual report is to give physicians and other interested parties insight into the way in which the committees 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.

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. On 1 January 2024 the total number of committee members was 53.

The committees assess the notifications they receive on the basis of the detailed report produced by the physician who performed euthanasia (i.e. the completed model reporting form), the independent physician's report and other relevant documentation, such as medical records, letters from specialists and/or an advance directive.

STRAIGHTFORWARD AND NON-STRAIGHTFORWARD NOTIFICATIONS

The committees distinguish between two categories of notification: straightforward notifications (which account for some 95% of cases) and notifications that raise questions (around 5% of cases). Committee members review straightforward notifications digitally, and can consult with one another via a secure digital network. Straightforward notifications are not reviewed at in-person committee meetings. Nevertheless, if any questions arise during the digital review process, the committee members may agree to change the status of the notification to non-straightforward. Non-straightforward notifications are discussed at a committee meeting. Whether a particular notification is

straightforward or not depends on the questions it raises. For instance, the case may be particularly complex, or the information provided by the physician could be insufficiently clear.[1]

COMMITTEES

All notifications, regardless of whether they are considered straightforward or non-straightforward, are reviewed by a committee consisting of a lawyer, a physician and an ethicist. 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 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. The secretaries attend committee meetings in an advisory capacity and are coordinated by the general secretary.

TERMINOLOGY AND FURTHER INFORMATION

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.

Wherever mention is made of 'the physician', this refers to the physician who has performed euthanasia and notified the committee. The term 'SCEN physician' refers to physicians who are consulted as independent physicians.

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, Diagrams 1, 2 and 3 for a schematic overview of the review procedures.*

CHAPTER 1
COMMITTEE PROCEDURES – DEVELOPMENTS

1 DUE MEDICAL CARE

In 2021, the Royal Dutch Medical Association (KNMG) and the Royal Dutch Association for the Advancement of Pharmacy (KNMP) updated their guidelines on performing euthanasia and assisting suicide (*KNMG/KNMP Richtlijn Uitvoering euthanasie en hulp bij zelfdoding,* available in Dutch only). 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.

In 2024 the RTEs further investigated the possible risk to the patient, in terms of awareness, of administering a second dose of muscle relaxant without first administering a second dose of the coma-inducing substance; it also investigated the risks associated with a long period of time elapsing between the administration of the coma-inducing substance and the administration of the muscle relaxant. They also consulted on the subject with members of the KNMG's guidelines committee.

The conclusion was that if a period of 30 minutes or longer has elapsed between the administration of the coma-inducing substance and the administration of the last dose of muscle relaxant, there is too great a risk that the patient might be aware of the effect of the muscle relaxant. The assessment of the depth of the coma is then no longer sufficiently reliable. The RTEs will therefore always find that due medical care has not been exercised in cases where a period of 30 minutes or more has elapsed between the administration of the coma-inducing substance and the administration of the last dose of muscle relaxant.

The RTEs will apply this new policy in assessing notifications as of 1 July 2025. Until then they will endeavour to communicate this change to physicians.

The RTEs consider it important for physicians who perform euthanasia and SCEN physicians to act in accordance with the most recent Guidelines. If a patient does not respond sufficiently to the administered euthanatic, the Guidelines state that the physician must assume they missed the vein when injecting the euthanatic. This is not always visible as a subcutaneous swelling. That means that if the administered euthanatic does not work, the physician must carry out the entire procedure 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).

2 IMPROVING COMMUNICATION TO PHYSICIANS

In 2024 the RTEs made improvements to how it informs notifying physicians. We have set out below the changes made.

DELAY NOTICES

The Act requires a committee to review a euthanasia notification within six weeks. The committee can extend that time period once by six weeks.

The previous annual report noted that the RTEs had received a complaint from a physician because the review of his notification had been delayed. He felt that he had been poorly informed about the delay. This physician's complaint contributed to changes being made to our procedure. In June 2024, the RTEs began sending delay notices to physicians whose notification was categorised as non-straightforward. That categorisation means that the notification will be discussed at an in-person meeting, and as a result the physician will not receive the findings within six weeks.

The delay notice reads as follows:

> **Review of your euthanasia notification**
> Your notification will be discussed at a committee meeting on [date]. This means that the committee will not be able to complete its review of your notification within six weeks. The committee is therefore extending the time period for the review by six weeks. This means that in principle you will receive the committee's findings no later than 12 weeks after the day on which the committee received your notification.

Starting in the summer of 2024, the secretariat of the RTEs was severely short-staffed. This caused a backlog,[2] and it became clear that the RTEs would not be able to complete the review of the received notifications within six weeks. The RTEs therefore decided to temporarily send all notifying physicians the following delay notice:

> In principle your notification will be reviewed within the statutory time period of six weeks – which can be extended by six weeks if necessary. Due to a temporary staffing shortage at the secretariat of the review committees, it is likely that the review of your notification will not be completed within the initial time period of six weeks If you have any questions, please contact the undersigned. Please quote the reference number in your correspondence.

2 *The secretariat is now back to full capacity. The RTEs have worked hard to make up the backlog, and at the time of writing they have largely succeeded.*

Sometimes a committee will decide to ask the physician to provide additional information, orally or in writing. In such cases the committee is not always able to complete the review within 12 weeks. The physician is informed accordingly, in the same letter as the request for further explanation. The passage reads as follows:

> **Review of your euthanasia notification**
> You were previously informed by the committee that the statutory time limit for completing the review of your notification was to be extended by six weeks. Since you have now been invited to provide a[n] [written/oral] explanation, your notification will be discussed at a subsequent committee meeting. As a result the committee will not be able to complete its review of your notification within the statutory time period of 12 weeks. The committee understands that this means a longer period of uncertainty for you, and offers its sincere apologies for the delay.

PRIOR NOTICE OF PEER CONSULTATION

In order to safeguard the quality of the practice of euthanasia, a committee may decide to provide a physician or SCEN physician with feedback in the form of peer consultation. The physician sitting on the committee phones the physician or SCEN physician for that purpose. The RTEs have received reports that some physicians and SCEN physicians felt taken by surprise when they received an unannounced phone call from a committee member. They said that in some cases they were on the road or did not have the documentation to hand, which made for an awkward situation.

It was therefore decided in 2024 that committee members would always first send an email to make an appointment to speak on the phone, so that this can be done at a time that is convenient for the physician.

Sometimes the secretariat may contact a physician or SCEN physician because certain factual information is missing, which the committee needs in order to review the euthanasia notification. This will be done by email if possible, so that the physician can reply at their convenience. Sometimes a phone call will still be necessary, for instance if there is only little time before the committee meeting.

CHANGES IN THE WORDING OF THE ABRIDGED FINDINGS REPORT

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

language and was therefore rewritten in 2024. The text now reads as follows:

> Dear [name of physician],
>
> On [date] the Regional Euthanasia Review Committee ('the Committee') received your notification of euthanasia concerning [name of patient]. The committee reviewed your notification on [date of findings].
>
> **Due care criteria fulfilled**
> The committee finds that you fulfilled the due care criteria laid down in section 2 (1) of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act. This means that:
> - you could be satisfied that the patient's request was voluntary and well considered;
> - you could be satisfied that the patient's suffering was unbearable, with no prospect of improvement;
> - you informed the patient about their 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;
> - you exercised due medical care in performing euthanasia.

The RTEs may sometimes issue an abridged findings report concerning a notification where the suffering that gave rise to the patient's request for euthanasia was caused wholly or partly by a psychiatric disorder. In this case the following paragraph is added to the report:

> **Explanatory note**
> The documents show that the patient's request for euthanasia was (wholly or partly) based on suffering caused 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 the assessment of 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 principle, the RTEs consider that the physician must always seek psychiatric expertise for this category of patients. You fulfilled this requirement.
>
> The committee has established that both you and the physician(s) you consulted were of the opinion that the patient was decisionally competent with regard to their request for euthanasia, that the patient was suffering without prospect of improvement, and that there was no reasonable alternative in their situation.

3 NEW PUBLICATION POLICY

The RTEs used to publish a selection of abridged and full reports of findings. As of June 2024, all full reports of findings are published on the website. In addition, the RTEs will continue to publish a monthly selection of abridged findings reports, including both common and more exceptional types of notifications. This policy is consistent with the RTEs' aim of providing maximum transparency.

The secretariat's staffing issues mentioned above have caused a publication backlog. We expect to have cleared that backlog by the end of 2025.

CHAPTER 2
FIGURES IN 2024

NUMBER OF NOTIFICATIONS

In 2024 the RTEs received 9,958 notifications of euthanasia.[3] The total number of deaths in the Netherlands was 172,049.[4] That means that 5.8% of the total number of deaths were by euthanasia. In 2023 there were 9,068 deaths by euthanasia, which was 5.4% of the total number of deaths in that year.

The RTEs cannot review all notifications in the calendar year in which they receive them. Notifications received at the end of the year are generally reviewed at the beginning of the following calendar year. Due to the staffing shortage at the secretariat, there were more notifications than usual that the RTEs were unable to review in 2024; 932 notifications received in 2024 will be reviewed in 2025. As a result, some of the figures in this annual report are incomplete. Where that is the case, an explanation has been added.

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 – 1,013 notifications
Region 2: Overijssel, Gelderland, Utrecht and Flevoland – 2,637 notifications
Region 3: North Holland – 1,992 notifications
Region 4: South Holland and Zeeland – 1,919 notifications
Region 5: North Brabant and Limburg – 2,397 notifications

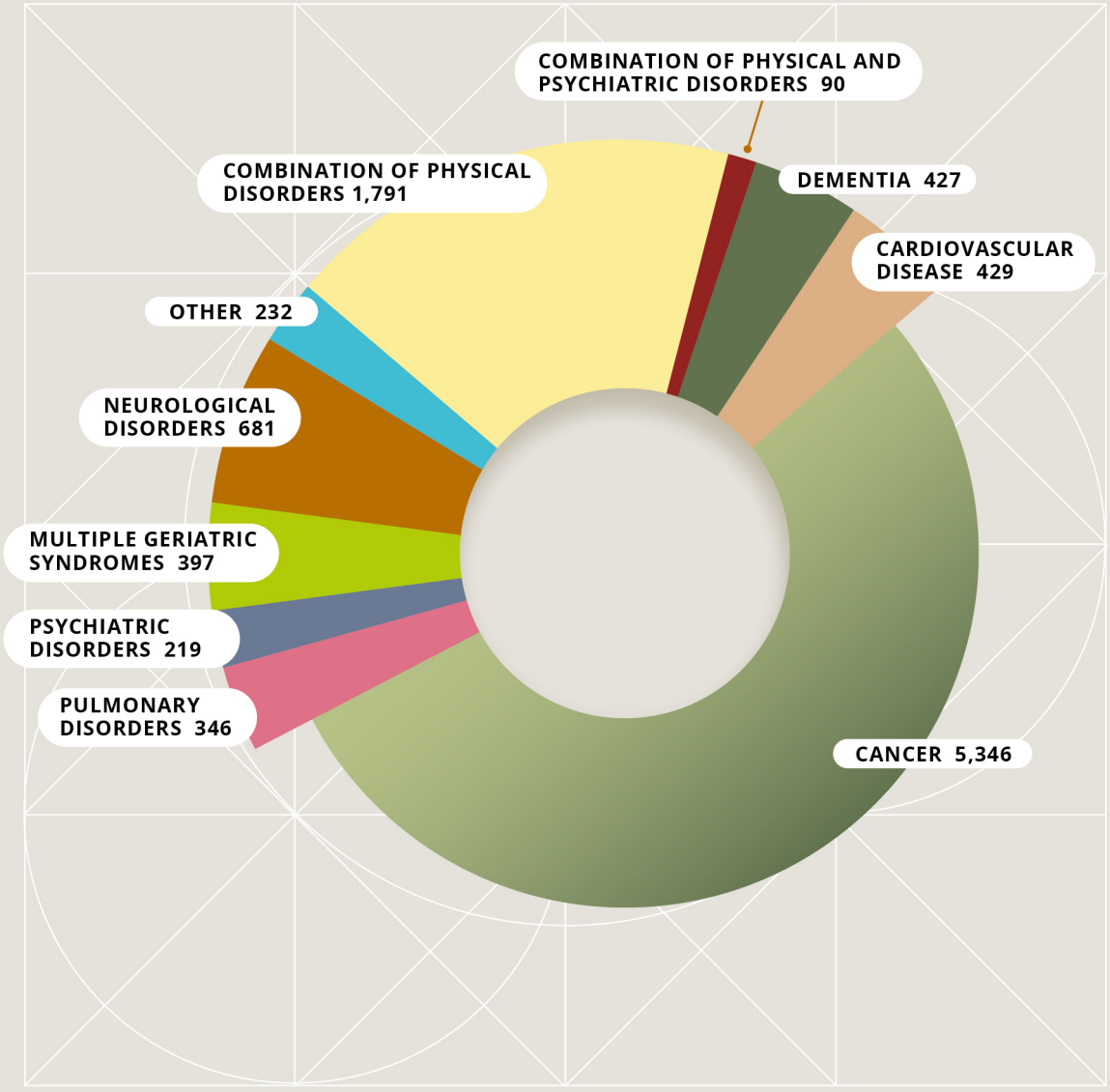
MALE/FEMALE RATIO

As in previous years, the number of notifications concerning men and women were almost the same: 4,996 men (50.2%) and 4,962 women (49.8%).

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 2023. Some of the notifications received in 2024 will only be reviewed in 2025. The annual figures also include a number of notifications that were received at the end of 2023, but could not be included in the previous annual report.*

4 *Source: Statistics Netherlands (CBS)*

NATURE OF CONDITIONS



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

There were 9,753 notifications of termination of life on request (97.94% of the total), 187 notifications of assisted suicide (1.88%) and 18 notifications involving a combination of the two (0.18%). 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 the termination of life on request by intravenously administering a coma-inducing substance, followed by a muscle relaxant.

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

CONDITIONS INVOLVED

COMMON SOMATIC CONDITIONS

In 2024, 8,593 (86.29%) notifications received by the RTEs involved patients with:

- cancer (5,346);
- neurological disorders such as Parkinson's disease, multiple sclerosis and motor neurone disease (681);
- cardiovascular disease (429);
- pulmonary disorders (346);
- a combination of somatic conditions (1,791).

DEMENTIA

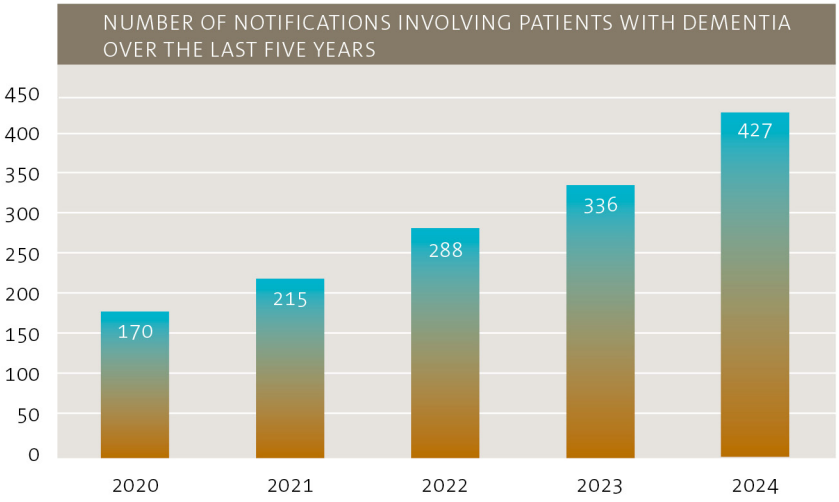
There were 427 cases of euthanasia involving patients with a form of dementia; 346 of these notifications were reviewed in 2024. Of these patients, 340 were still decisionally competent with regard to their request for euthanasia. These patients still had insight into their condition and its symptoms, such as spatial and temporal disorientation, and personality changes.

Six notifications reviewed in 2024 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 these cases their advance directive took the place of an oral request for euthanasia. All of these notifications have been published on the website of the RTEs.

Eighty-one notifications involving patients with a form of dementia that were received in 2024 have not yet been reviewed. It is not known how many of these patients were decisionally competent. The figures concerning the numbers of decisionally competent and decisionally

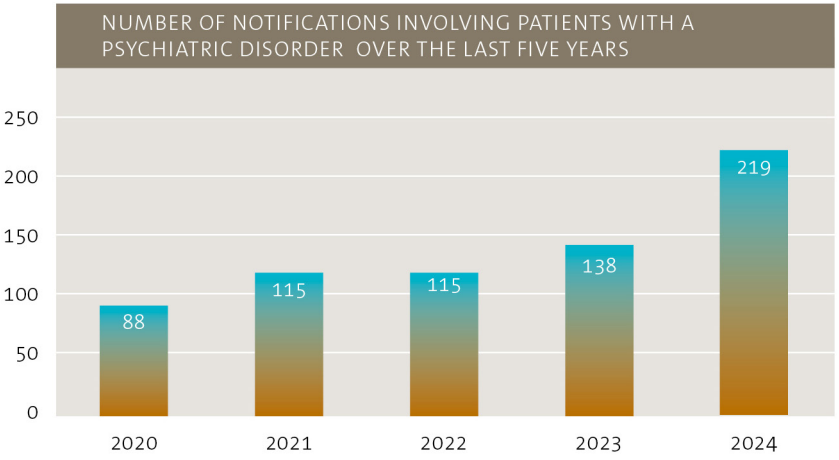
incompetent patients are therefore incomplete. The examples presented in Chapter 3 include one case involving a patient who was decisionally competent and one involving a patient who was decisionally incompetent.

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



PSYCHIATRIC DISORDERS

In 2024, 219 euthanasia notifications concerned patients whose suffering was (largely) caused by one or more psychiatric disorders. In 60 cases the physician performing euthanasia was a psychiatrist, in 55 cases a general practitioner and in 26 instances a specialist (including elderly-care specialists). In the other 78 cases the physician fell into the category 'other physician'. In 126 cases the physician performing euthanasia was affiliated with the Euthanasia Expertise Centre (EE).



There were 90 notifications in 2024 of cases where a combination of one or more psychiatric disorders and at least one somatic disorder gave rise to the request for euthanasia. This is the first time that this specific combination of psychiatric and somatic disorders has been mentioned separately in the annual report.

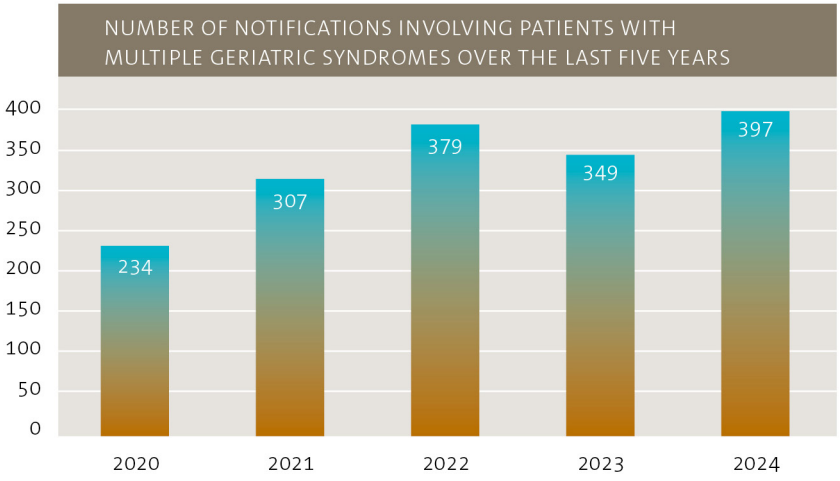
If a patient requests euthanasia because they are suffering from one or more psychiatric disorders, the physician must exercise 'particular caution'. This means that the physician must seek psychiatric expertise. An example of such a case is described in Chapter 3.

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

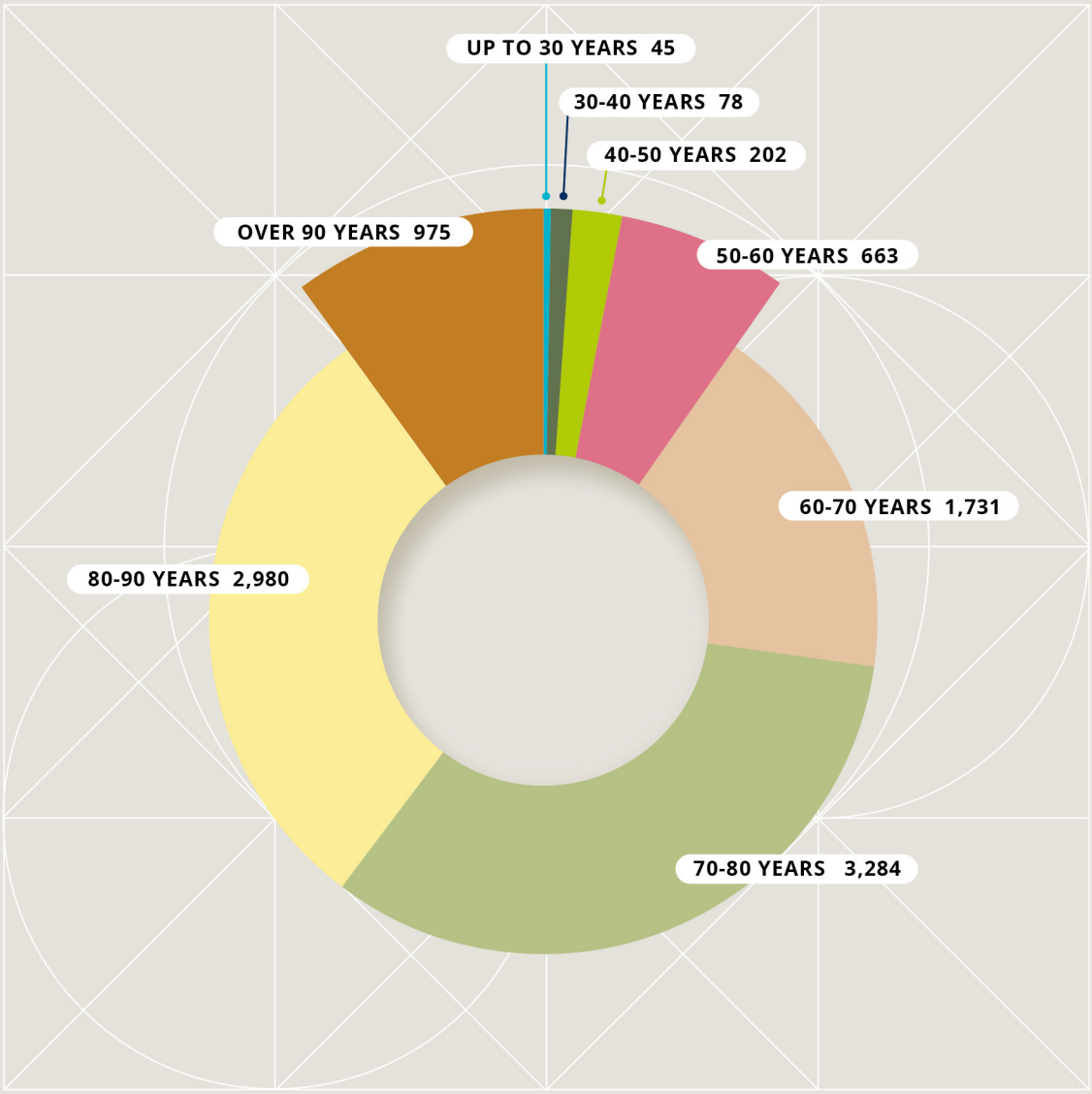
MULTIPLE GERIATRIC SYNDROMES

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 the patient may experience as unbearable and without prospect of improvement. In 2024 the RTEs received 397 notifications of euthanasia that fell into this category. An example of such a case is described in Chapter 3.

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



AGE


UP TO 30 YEARS 45
30-40 YEARS 78
40-50 YEARS 202
50-60 YEARS 663
60-70 YEARS 1,731
70-80 YEARS 3,284
80-90 YEARS 2,980
OVER 90 YEARS 975

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 232 such cases in 2024.

AGE

The highest number of notifications of euthanasia involved people in their seventies (3,284 cases), followed by people in their eighties (2,980 cases) and people in their sixties (1,731 cases). There were 975 notifications concerning people aged over 90, 663 notifications concerning people in their fifties, 202 concerning people in their forties and 78 concerning people in their thirties. The lowest number concerned people younger than 30 (45 cases).

In 2024 the RTEs reviewed three notifications of euthanasia involving a minor between the ages of 12 and 18. Two of these notifications had been received in 2023. They concerned patients who had requested euthanasia due to suffering caused by psychiatric disorders. The notification received in 2024 concerned a patient who had requested euthanasia due to suffering caused by a somatic disorder.

In the category 'dementia' (427 cases), the highest number of notifications involved people in their eighties (194 cases), followed by people in their seventies (149 cases). This was different in 2023, when the highest number of such notifications involved people in their seventies.

In the category 'psychiatric disorders' (219 cases), there were 111 notifications involving people aged between 30 and 60, and 78 involving people aged 60 or over. Lastly, there were 30 notifications concerning people aged between 18 and 30.

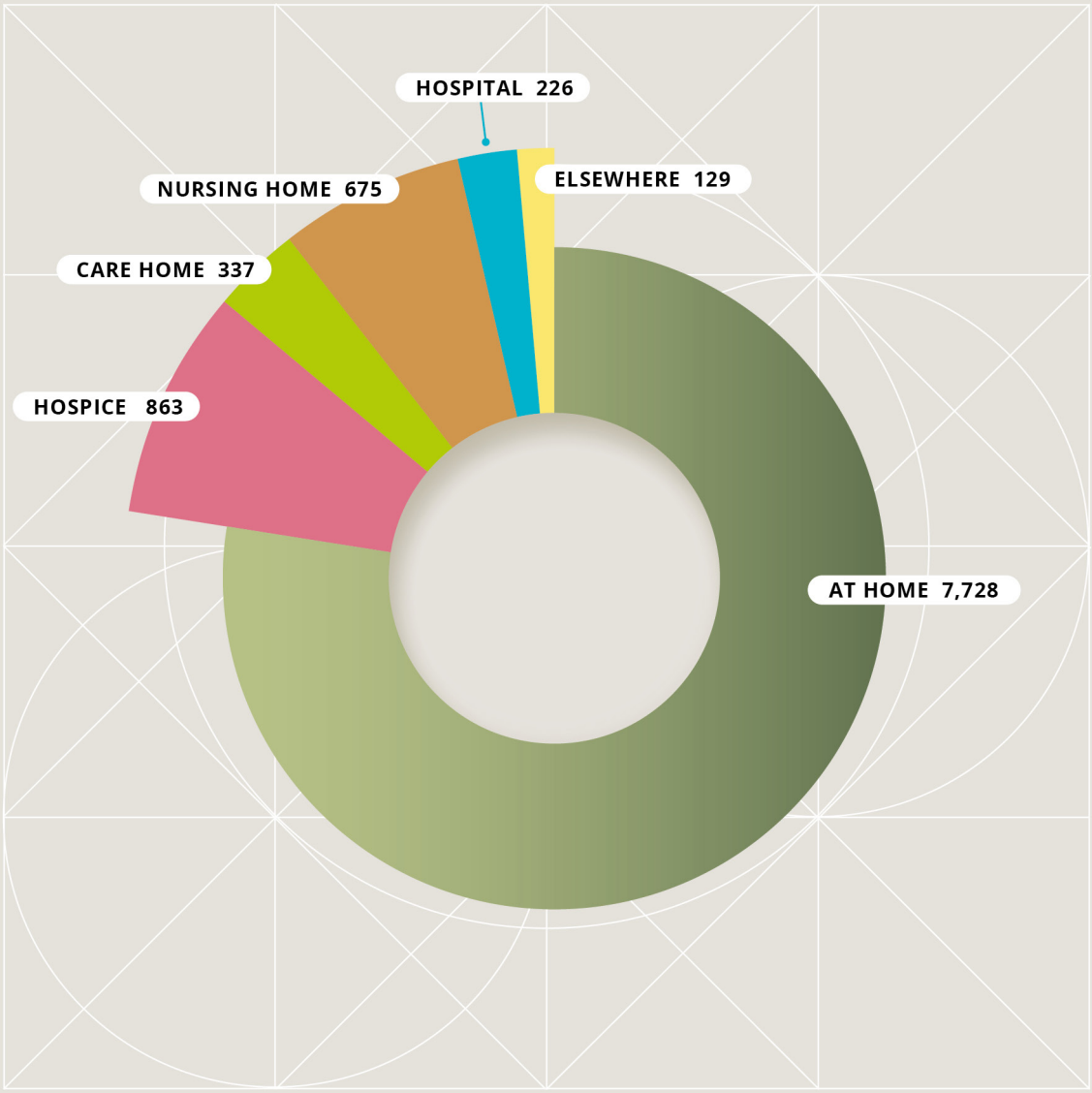
In the category 'multiple geriatric syndromes' (397 cases) most of the notifications concerned people aged 90 or older (244 out of 397 cases).

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

LOCATIONS

As in previous years, patients in the vast majority of cases died at home (7,728 cases). Other locations were a nursing home or care home (1,012), a hospice (863), a hospital (226) or elsewhere, for instance at the home of a family member or in a convalescent home (129).

LOCATIONS


HOSPITAL 226
ELSEWHERE 129
NURSING HOME 675
CARE HOME 337
HOSPICE 863
AT HOME 7,728

NOTIFYING PHYSICIANS

The vast majority of cases were notified by a general practitioner (7,913). The other notifying physicians were elderly-care specialists (424), psychiatrists (72), other specialists (282), registrars (157) and 'other physicians' (1,110).[5]

NOTIFICATIONS INVOLVING THE EUTHANASIA EXPERTISE CENTRE

The number of notifications by physicians affiliated with the Euthanasia Expertise Centre (EE) (1,417) increased by 140 compared to 2023, when there were 1,277 notifications by this group. That is an increase of 11%. 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: 126 out of 219 notifications (57.5%). This is a higher percentage than in 2023: 70 out of 138 notifications (50.7%). Of the 427 notifications of cases in which the patient's suffering was caused by a form of dementia, 149 (34.9%) came from EE physicians. Of the 397 notifications involving patients with multiple geriatric syndromes, 140 (35.3%) came from EE physicians. This is a lower percentage than in 2023 (43.3%).

ORGAN AND TISSUE DONATION AFTER EUTHANASIA

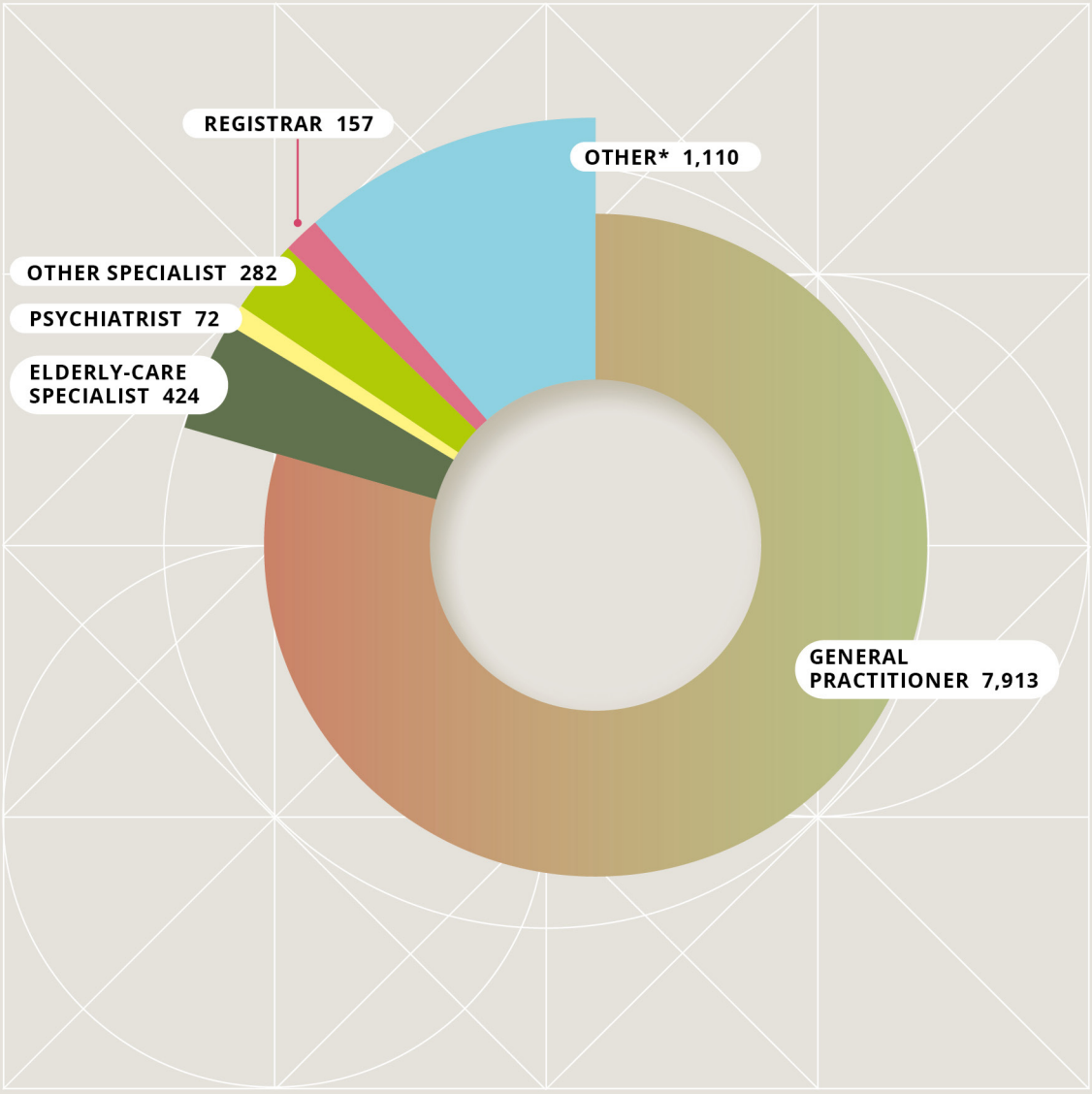
Euthanasia does not preclude organ and tissue donation. The *Richtlijn Orgaandonatie na euthanasie* (Guidelines on organ donation after euthanasia) published by the Dutch Foundation for Transplants provides a step-by-step procedure for such cases.[6] If a patient wishes to donate their organs, euthanasia must be performed in hospital. For tissue donation, this is not necessary.

In 2024 the RTEs received 28 notifications that mentioned specifically that organ and/or tissue donation had taken place after euthanasia. In 2023, this figure was 24. However, there may also have been other cases where organ and/or tissue donation took place, but this was not mentioned specifically in the case file.

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

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

NOTIFYING PHYSICIANS



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

'DOUBLE EUTHANASIA'

If two people request that they receive euthanasia simultaneously and both requests are granted, the RTEs register this as 'double euthanasia'. Before 2024, this always involved couples. The year under review saw the first ever notifications of double euthanasia involving not couples but close family members. In 2024, double euthanasia occurred 54 times (108 patients). The number of notifications received in 2024 concerning double euthanasia was 107. This is because one notification was received in 2023, and was therefore added to the figures for that year. Of course, the due care criteria set out in the Act must be satisfied in each case separately. Each patient must be visited by a different SCEN physician in order to safeguard the independence of the assessment of their requests.

For more information see the Euthanasia Code 2022, p. 30.

DUE CARE CRITERIA NOT COMPLIED WITH

In six of the notified cases in 2024, 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 three cases the euthanasia procedure was not carried out with due medical care and in two cases the due care criterion of consulting an independent physician had not been fulfilled. One case concerned the particular caution physicians must exercise when a request for euthanasia is based (largely) on suffering caused by a psychiatric disorder.

CATEGORISATION OF NOTIFICATIONS

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

The secretary of the RTE first provisionally categorises the case as a non-straightforward case (VO) or a straightforward case (NVO). This is not a finding by the committee, but a provisional decision. The committee then reviews the notification. A non-straightforward notification is always reviewed at an in-person meeting of the committee. A straightforward notification is generally reviewed at an online meeting. In that case all members read the case file and can indicate individually whether in their opinion the physician acted with due care. If any of the members have questions after reading the case file, the committee assesses whether the questions can be asked in writing or whether an in-person meeting is required. Usually the notification is then discussed at an in-person meeting.

In 2024, 94.46% of the notifications reviewed were categorised as straightforward by the secretary. In the end, 42 of these cases were discussed at an in-person meeting. This procedure is illustrated in diagram 3 of Annexe I.

Of all the notifications received, 5.54% were immediately categorised as non-straightforward (see diagram 2 of Annexe I). Some categories of notification are by definition non-straightforward. They include cases in which the suffering that gives rise to the request for euthanasia is caused wholly or partly by a psychiatric disorder, cases involving patients with advanced dementia, and cases involving minors. A notification can also turn out to be non-straightforward if questions arise about one of the due care criteria, or because the case file submitted by the physician who performed euthanasia contained insufficient information for the committee to review the notification.

DIFFERENT TYPES OF WRITTEN REPORTS OF FINDINGS

If a notification is completely straightforward, the committee writes an abridged findings report. The report informs the physician of the committee's finding, based on the notification, that the physician has complied with all the due care criteria. Chapter 3 includes examples of straightforward notifications, for which the physician received an abridged findings report.

If a notification is non-straightforward, it is discussed at an in-person meeting. Often, the committee will then decide not to write an abridged findings report, but a full report of findings. That means that the committee will specifically address the elements of the notification that prompted questions. In its report, the committee explains the considerations that led to the finding that the physician had or had not complied with the due care criteria.

WRITTEN AND ORAL QUESTIONS PUT BY THE COMMITTEES

In some cases the reports and documents submitted with the notification do not provide enough information for the committee to be able to review the notification. In that case the committee may decide to ask the physician or SCEN physician for a further explanation.

In 2024 the RTEs asked the physician for a further written explanation in 29 cases.

In 16 cases the committee invited the physician (and in one case the independent physician as well) to answer questions in person at a committee meeting, sometimes after having first put written questions to the physician. These included the above-mentioned six cases in which the committee ultimately found that the due care criteria had not been complied with. Simple and factual questions are generally dealt with by phone or email.

PROCESSING TIME

In 2024 the average time that elapsed between the notification being received by the RTEs and the findings being sent to the physician was 40 days. This is within the maximum time period of two times six weeks laid down in section 9 (1) of the Act.

This overall average figure does not provide the full picture, however. The processing time increased to 60-70 days in the autumn due to staffing issues at the secretariat.

THE RTES' VIRTUAL DISCUSSION SPACE

Some cases are so complex that all the RTE members and secretaries should be able to gives their views. This leads to intensive consultations between the committees, which take place in a virtual discussion space. 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 this 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 2024, 20 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 retrospectively in the periodic meetings of, respectively, lawyers, physicians and/or ethicists.

CHAPTER 3
CASES

3

1 INTRODUCTION

Essentially, the RTEs' work consists of reviewing physicians' notifications concerning euthanasia performed by them. This chapter discusses a selection of the committees' findings. Section 3.2 describes several cases in which the RTE found that the due care criteria had been complied with, including both common and more exceptional cases. Section 3.3 describes all cases in which the committee found that the physician had failed to fulfil one or more of the due care criteria.

A physician who has performed euthanasia has a statutory duty to report this to the municipal pathologist. The municipal pathologist 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 written request for euthanasia (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 KNMG.

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

The due care criteria say that the physician must:

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

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

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 these three due care criteria, the physician has a certain amount of discretion in making the assessment. In its review, the committee examines how the physician investigated the facts and how they substantiated their decision-making, and how they therefore could reasonably be satisfied that these three due care criteria had been fulfilled. The independent physician's report often contributes to that substantiation.

Section 2 of this chapter is divided into three subsections. In subsection 2.1 we present five straightforward cases that are representative of the vast majority of notifications received by the RTEs. These are often cases involving patients with 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 the 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 non-straightforward cases of euthanasia involving patients who fall into a special category: patients with a psychiatric disorder, patients with multiple geriatric syndromes and patients with dementia.

Section 3 describes the cases in which the RTEs found that the due care criteria had not been met. There were six such cases in 2024.

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.

CANCER

Breast cancer, metastasised to bones, risk of paraplegia

The patient, a woman in her sixties, had been diagnosed four years before her death with breast cancer which had metastasised to her bones and liver. Her condition was already incurable at that time. The patient underwent three different types of palliative systemic therapy (hormone treatment and chemotherapy) in order to slow the progression of the disease. When it became apparent after the third course of treatment that the bone tumours had actually metastasised further, she decided against a fourth course of treatment and only wanted her symptoms to be treated. She could no longer walk and was at risk of becoming paraplegic due to the metastases in her bones.

The patient's suffering consisted of increasing pain and complete dependence on others, as she had become bedridden. Her energy was depleted and she could no longer take an interest in anything. She had always been an independent woman, engaged in lots of activities such as volunteer work and looking after her grandchildren. She found it unbearable that she could no longer do anything at all and had to ask for help with everything, while knowing that her situation was only going to deteriorate.

At an earlier stage of illness, the patient had already discussed the possibility of euthanasia with the physician, who was her general practitioner. More than two weeks before her death, the patient asked the physician to perform euthanasia.

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 physician who was also a SCEN physician. The independent physician saw the patient two weeks before her death and came to the conclusion that the due care criteria had been fulfilled.

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.

NEUROLOGICAL DISORDER

Huntington's disease, EE-affiliated independent physician

The patient, a man in his forties, was suffering from Huntington's disease, an incurable hereditary disease. He had known since 2010 that he carried the gene that causes the disease, and he was diagnosed in 2019. The patient knew how the disease would affect his life, as he had seen it happen to his father and brother. Since 2019, he had spoken regularly to his general practitioner about his disease, his suffering and the limits of what was bearable to him, as well as his wish for euthanasia at a later stage.

The patient increasingly suffered from chorea (sudden, involuntary, twitching movements) which resulted in him having more falls, eventually no longer being able to eat without assistance and no longer being able to take care of himself. This loss of independence, combined with the knowledge of how the disease would progress, made his suffering unbearable to him. He asked the physician to perform euthanasia.

The physician requested a consultation with the Euthanasia Expertise Centre.

The physician realised how difficult it was for the patient, knowing for so long that he carried the gene and then developing symptoms that became increasingly severe and ultimately meant he could no longer function independently.

The physician was satisfied that the patient was suffering unbearably with no prospect of improvement, and that there was no reasonable alternative. The patient's request for euthanasia was voluntary and well considered. The SCEN physician consulted by the physician agreed.

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.

PULMONARY DISEASE

Respiratory infections, COVID-19

The patient, a man in his sixties, had suffered from recurring respiratory infections, including COVID-19, in the two years before his death. He had been admitted to hospital with COVID-19. He then developed pneumonia and deteriorated rapidly. He had great difficulty coughing up phlegm. Several courses of antibiotics, inhalation medication, prednisolone and Fluimucil were initially fairly effective, but the symptoms kept returning. His lung function and his general condition had deteriorated sharply.

Assisted coughing techniques were applied, but with diminishing effect. The patient stayed in a rehabilitation centre for about a week. It was concluded that he was not expected to make an adequate recovery. His suffering was caused by the persistent cough, the coughing up of phlegm and shortness of breath. In addition, his condition was deteriorating, he suffered from fatigue and was dependent on the support of his partner and carers. Some weeks before his death, he became bedridden.

The patient asked his general practitioner to perform euthanasia. The physician was convinced that the suffering was unbearable to the patient and that there was no prospect of improvement. It had proven impossible to alleviate the patient's suffering.

The physician consulted an independent physician who was also a SCEN physician. The independent physician spoke with the patient. The conversation proceeded haltingly, because of the phlegm which the patient was unable to rid himself of. His partner helped him cough by applying pressure to his diaphragm several times when he exhaled. 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.

CARDIOVASCULAR DISEASE

End-stage heart failure, comfort care

The patient, a woman in her eighties, was suffering from end-stage heart failure. On the last occasion that she was admitted to hospital, attempts to stabilise her situation had failed. It was decided to let the patient go home and not to admit her to hospital any more. The doctors and the patient agreed that she would only be made comfortable.

The patient was constantly severely fatigued. She had to be supported in everything she did, and she was unable to even take two steps. This made her suffering unbearable to her. She asked her general practitioner to perform euthanasia. The physician considered her suffering to be palpable. He knew the patient to be an enterprising woman.

The physician concluded that the request was voluntary and well considered. The patient had repeated her request several times. She had also drawn up a written request for euthanasia, both in 2020 and recently. She was able to explain clearly the pros and cons of her request, as well as the consequences of her disease. The physician considered her decisionally competent.

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.

COMBINATION OF CONDITIONS

Breast cancer, lung cancer and COPD

The patient, a woman in her eighties, had suffered from COPD for 15 years before her death and had been treated for breast cancer in the four years before her death. In the two years before her death, she suffered vertebral compression fractures caused by osteoporosis and brain damage due to several falls. Six months before her death, doctors diagnosed her with lung cancer, for which she did not receive treatment because her poor health did not allow it.

The patient lived in a nursing home and could only walk very short distances, with difficulty, using a rollator. She suffered from back pain, was severely fatigued, and very short of breath after any exertion. Due to her suffering, the patient could do very little for herself and became increasingly dependent on the care staff. She could only get out of bed for a very short time and could not therefore really enjoy having visitors. Other things she used to enjoy were no longer possible, such as doing puzzles, going outside by herself to smoke, and going places with family members.

A month and a half before her death, the patient asked an elderly-care registrar to perform euthanasia. The physician discussed the request with his supervisor and talked with the patient about her wish for euthanasia, both with and without his supervisor.

The physician concluded that the request for euthanasia was voluntary and well considered. The physician was also satisfied that the patient's suffering was unbearable to her and with no prospect of improvement according to prevailing medical opinion. For her there were no longer any acceptable ways to alleviate her suffering. The case file made it clear that the physician had given her information about her situation and prognosis.

The physician consulted an independent physician who was also a SCEN physician. The SCEN physician saw the patient three weeks before her death and came to the conclusion that the due care criteria had been fulfilled.

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.

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. The non-straightforward 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 questions in certain situations. A physician cannot grant a request for euthanasia made by another person on behalf of the patient. It must always be clear that the request has been made by the patient personally (see Euthanasia Code 2022, p. 18).

In cases involving patients with dementia, it is necessary to exercise great caution when considering whether the statutory due care criteria have been met. This is especially true of the criterion relating to the voluntary and well-considered nature of the request. As a patient's dementia progresses, their decisional competence will decline (see Euthanasia Code 2022, p. 47).

VOLUNTARY AND WELL-CONSIDERED REQUEST

Dementia, decisionally competent patient, independent physician consulted had doubts

The patient, a man in his seventies, was diagnosed with Alzheimer's disease four years before his death. A year before his death he was also diagnosed with parkinsonism.

In the years prior to his death, the patient suffered from memory defects and lost the capacity to use his initiative. He increasingly needed help with everyday tasks and activities. His cognitive skills and ability to process information declined, and holding a conversation became increasingly difficult. He had difficulty finding words, and his vision and mobility also deteriorated. He was afraid of losing control of his life, of deteriorating further and of having to wear a nappy. The patient was also very focused on his wish for euthanasia and had put it in writing because he was afraid that he would be unable to express his wish when he felt the time had come.

Eight months before his death, the patient discussed his wish for euthanasia with his general practitioner (GP). At first, the patient's GP was willing to grant the request for euthanasia. He consulted an elderly-care specialist in order to be able to assess the patient's decisional competence. This specialist concluded after speaking twice with the patient that the patient was decisionally incompetent regarding his wish for euthanasia. According to the specialist, the patient was unable to substantiate his wish for euthanasia sufficiently. The GP subsequently did not feel comfortable continuing the euthanasia process with the patient, and referred him to the Euthanasia Expertise Centre (EE).

The patient's first conversation with the EE physician took place about three months before his death. During this conversation, the patient requested euthanasia. He repeated the request in three subsequent conversations.

A SCEN physician saw the patient about a month before his death. The SCEN physician noted in his report that, due to the dementia and parkinsonism, the patient was unable to express his request in clear, full sentences, but that he was explicit about his wish and was able to express it in short sentences. He had no doubt whatsoever about the patient's decisional competence with regard to his request for euthanasia.

The physician also consulted an independent expert, an elderly-care specialist, to assess the patient's decisional competence. The independent expert saw the patient about a month and a half before his death. The patient was able to describe his symptoms clearly and explain why he wanted euthanasia; he knew what the alternative was, understood what euthanasia entailed and what the consequence would be.

The physician had had conversations with the patient while they went for walks. During the walks in particular, good communication was possible with the patient. The patient made it known to the physician in different ways and in different words that he wanted to die by means of termination of life on request. He understood that granting his request for euthanasia would lead to his death. The patient was able to explain clearly what his suffering consisted of and why he wanted to die: he said he was no longer able to do anything and knew that his condition would only deteriorate. The knowledge of the man he used to be and so badly still wanted to be also led to intense feelings of powerlessness and frustration.

The committee found that the physician had exercised great caution when assessing the patient's decisional competence with regard to his request for euthanasia. The physician had assessed and established the patient's decisional competence in various ways and on several occasions. In addition, the physician's conclusion was supported by the findings of the SCEN physician and the independent expert. The committee found that the physician had substantiated sufficiently that the patient's request was voluntary and well considered. The committee found that the other due care criteria had also been fulfilled.

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

The Euthanasia Code 2022 gives the following explanation of these due care criteria: '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 for 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' (see 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, we will discuss them 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

Combination of conditions, advice of independent physician

The patient, a woman in her eighties, had been suffering from poly-articular osteoarthritis (osteoarthritis in several joints) for 15 years, and this had become worse in the last few years. She had a great deal of pain in her hands, shoulders, back and legs. In addition, the patient suffered from irritable bowel syndrome, with many symptoms including nausea, terrible abdominal pain, and alternating constipation and faecal incontinence. The nausea was exacerbated by the pain medication, and as a result she hardly ate anything. The patient was deteriorating physically and was fatigued, had increasing difficulty walking and was at great risk of falling. She became less and less self-reliant and more and more dependent on care. In the end she mostly lay in bed, because then the pain and nausea affected her the least.

The patient had discussed euthanasia with her general practitioner before, as a future possibility. Three weeks before her death, the patient asked the physician to perform euthanasia. The physician asked an independent physician from the Euthanasia Expertise Centre for advice, particularly to gain better insight into the unbearable nature of the patient's suffering. The independent physician visited the patient together with the physician.

After speaking with the patient, the physician was satisfied that the suffering was unbearable to her. Over the past 15 years she had had to give up more and more activities, because she was no longer able to do them. At first she had tried to make the best of it. But now that she could no longer do anything and had become completely dependent on others, it was clear to the physician that she was suffering unbearably. In addition, the physician was satisfied that the patient was suffering without prospect of improvement, because there were no treatment options left that could improve her situation.

The physician consulted an independent physician who was also a SCEN physician. The SCEN physician saw the patient five days before her death and came to the conclusion that the due care criteria had been fulfilled.

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

NO REASONABLE ALTERNATIVE

Multiple geriatric syndromes, cochlear implant as an option

The patient, a man in his eighties, was deteriorating physically. He was deaf and suffered from tinnitus, increasing tremor and dizziness. The patient was short of breath after the slightest exertion, and therefore could hardly do anything. Even a conversation was too much. He lost more and more of his contacts, became more dependent, and was no longer able to help others.

His hearing aids had little effect. The ear, nose and throat specialist told him that a cochlear implant was the only option left. The patient saw no point in that, in view of his age and the risk of complications. An elderly-care specialist was consulted, but in their opinion no improvement was possible.

The patient was suffering unbearably due to his symptoms. He discussed euthanasia with his general practitioner several times. The physician considered the patient's suffering to be palpable, in view of the patient's personality, and saw no further options for alleviating his suffering. This was supported by the SCEN physician's conclusion.

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

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 reasonable alternatives 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

Due care criteria not yet fulfilled at the time of first visit

The patient, a woman in her sixties, had been diagnosed with lung cancer. She was extremely fatigued, coughed, had trouble breathing and was short of breath, and had various pain symptoms. The pain could be treated effectively with fentanyl, but the other symptoms were practically untreatable.

The patient asked her general practitioner to perform euthanasia. According to the physician, the patient's suffering was without prospect of improvement, because there was no chance of her getting any better and her condition would only deteriorate. He consulted an independent physician, a SCEN physician, who spoke with the patient.

During that conversation, the patient's condition was still relatively good. She was experiencing some improvement due to a high dose of prednisolone. The patient said that for the time being she still wanted to live, but she predicted that her wish for euthanasia would become relevant at a later date. Before she was given the higher dose of prednisolone, she had already experienced what it was like to lose all of her energy.

The independent physician concluded that the patient's request was voluntary and well considered, that there was no reasonable alternative in her situation and that she had been given information about her situation and prognosis. The independent physician also concluded that the patient was not yet suffering unbearably without prospect of improvement.

Just over three weeks later, the patient's condition had sharply deteriorated. The physician again consulted the independent physician, by phone. The patient indicated that she could feel her strength ebbing away, and that she wanted euthanasia soon. The independent physician concluded that all due care criteria for euthanasia had now been fulfilled.

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

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).

DUE MEDICAL CARE

IV cannula not positioned correctly, entire procedure restarted

The patient, a man in his seventies, was suffering unbearably without prospect of improvement due to a lung condition, and asked his general practitioner to perform euthanasia. Complications occurred during the euthanasia procedure.

An IV cannula had been inserted and the physician began the procedure by administering the coma-inducing substance: 2000mg of thiopental. However, the patient did not go into a coma. The physician saw that this was because the IV cannula was not positioned correctly. The physician then inserted a new IV cannula and administered a new dose of 2000mg of thiopental, via the new cannula. He checked the depth of the coma and thus adequately determined that the patient's consciousness had been sufficiently reduced. It is important for the patient's consciousness to be sufficiently reduced, because otherwise they might be aware of the effects of the muscle relaxant.

The physician then administered the muscle relaxant: 150mg of rocuronium. The patient then died.

The KNMG/KNMP 'Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide' state that the physician must assume that the IV cannula is not positioned correctly if the patient does not go into a coma after the coma-inducing substance has been administered. In that case the physician must repeat the entire procedure, including the insertion of a new IV cannula. The physician in this case did so and thus acted in accordance with the Guidelines.

The committee found that the physician had fulfilled the due care criteria.

2.3 FOUR EXAMPLES OF CASES INVOLVING PATIENTS WITH PARTICULAR CONDITIONS

In this subsection we describe four cases involving patients in a special category. 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 (largely) 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. The independent psychiatrist must assess whether the patient is decisionally competent regarding their request, whether the patient's suffering is without prospect of improvement and whether there are no reasonable alternatives. The independent psychiatrist may give advice on treatment if necessary (see Euthanasia Code 2022, pp. 45-47).

PSYCHIATRIC DISORDER

Non-straightforward notification, patient is a minor, autism spectrum disorder

The patient, a young man aged between 16 and 18, had been diagnosed around four-and-a-half years before his death with an autism spectrum disorder with anxiety and mood-related problems. Even as a young child he had feelings of depression and no longer wanted to live. From about four years before his death he constantly had suicidal thoughts. Two years before his death he made a serious suicide attempt.

The patient described his life as 'joyless'. He felt very lonely, was deeply unhappy and derived no enjoyment from anything. He was unable to connect with peers and find where he fit in in society, and felt misunderstood by others. He was troubled by the fact that he could see his peers developing while he was unable to put his capabilities to use, and had reached a dead end. Every day was an ordeal he had to get through. As he was oversensitive to stimuli and unable to regulate his emotions, he was very limited in what he could do. He could hardly leave his house at all, because without his mother's stabilising influence he became overstimulated too quickly and suffered angry outbursts or panic attacks. Life was a constant struggle for him, with no prospects whatsoever. In the final weeks before his death, he lay in bed the whole time.

About a year before his death, the patient had registered with the Euthanasia Expertise Centre (EE). Due to the long waiting time at EE, he and his parents contacted a paediatric psychiatrist, to put the request for euthanasia to him. The physician decided to assess the patient's request for euthanasia. Five months before the patient's death the physician spoke to him for the first time, on which occasion the patient asked him to perform euthanasia. He repeated this request during each subsequent conversation. The physician consulted an independent psychiatrist with specific expertise in the area of paediatric psychiatry, and an independent physician who was a SCEN physician. He also consulted with the patient's parents, practitioners who were treating him or had done so previously, fellow paediatric psychiatrists, professional associations of physicians, professors with specific expertise in this area, and multidisciplinary experts. He held a moral deliberation session with three practitioners, two experts, the patient's parents and one other family member to discuss the question of whether the patient's request for euthanasia should be granted. He also conducted additional research, by consulting academic sources concerning the possibility that the patient's suffering might be alleviated in time as his brain matured.

VOLUNTARY AND WELL-CONSIDERED REQUEST

Despite the patient's young age, the physician had no doubts whatsoever about his decisional competence with regard to the request for euthanasia. He was able to assess the situation and understood the consequences of euthanasia for himself and his loved ones. He was able to clearly describe his suffering and his considerations and had also explained his wish in a written request for euthanasia. His wish for euthanasia was long-standing and consistent. The physician was also satisfied there was no pressure from those around him. On the contrary, both those close to him and his healthcare providers had long tried to persuade him to change his mind, but to no avail. The physician was also satisfied that the patient's wish for euthanasia was not a direct consequence of his autism spectrum disorder, but was rooted in years of suffering due to the consequences of the disorder. The physician concluded that the patient's request was voluntary and well considered. This conclusion was supported by the independent psychiatrist, the SCEN physician and the participants in the moral case deliberation session.

UNBEARABLE SUFFERING AND ABSENCE OF A REASONABLE ALTERNATIVE

The case file showed that the patient had undergone an extensive process of treatment and counselling over the past 10 years. From early childhood, he had received counselling from school and had play therapy. He received psychoeducation, cognitive behavioural therapy, emotion regulation therapy and systemic therapy. The last three years before his death, he received individual talking therapy on a weekly basis. In addition, he had EMDR in order to process distressing events. The patient also received counselling in connection with his giftedness, and recovery-oriented interventions were implemented such as special education, an adapted programme at school, and a daytime activity group. The patient had also been treated with medication, including antidepressants and an atypical antipsychotic. Although he had put effort into all the treatments they did not have the desired effect and his suffering was not alleviated.

The patient's attending psychiatrist had discussed the patient's situation several times during peer supervision meetings with colleagues and had sought contact with institutions to ascertain whether an alternative or more intensive form of therapy was possible. No suitable treatment was found, either within the region or elsewhere. As a last resort he suggested an intensive intervention (admission to psychiatric hospital or referral to a centre of expertise for autism).

Given the process that had been followed, the physician was satisfied that the patient was suffering without prospect of improvement. He did not expect the current or any future treatments to improve the patient's

quality of life. The patient's wish to die was expected to remain, with a high risk that he would make another attempt at suicide if his wish for euthanasia were not granted.

The independent psychiatrist noted that a certain type of antidepressant (tricyclic) had not yet been tried for the patient's mood-related problems. Other treatments from the depression protocol had not yet been tried either, such as electroconvulsive therapy (ECT) and ketamine. As these treatments would have little to no effect on the patient's autistic spectrum disorder, which was the cause of his problems and the basis for his request for euthanasia, the physician did not expect these treatments to be of any help to the patient. They could only be carried out if the patient were admitted, which would mean having to leave his familiar surroundings and becoming unsettled.

The committee found that the physician could be satisfied that the patient was suffering without prospect of improvement and that there was no reasonable alternative in his situation. The patient's practitioners and the independent psychiatrist and independent physician consulted all supported this conclusion.

The committee was of the opinion that the physician had exercised particular caution and had fulfilled the due care criteria discussed above, as well as the other due care criteria.

This notification has been published on the website (2024-037).

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, visually impaired, joint pain

The patient, a woman aged over 100, was increasingly suffering due to visual impairment, severe hearing impairment and pain from wear and tear in the joints in her back, hands, knees and shoulder. She had discussed euthanasia several times with the elderly-care specialist in the nursing home where she lived.

Over the past few years the physician had tried various ways to alleviate the patient's suffering. The patient was admitted to the nursing home, adjustments were made to her bed and chair, and she received medication and physiotherapy. Eventually the patient became so tired and was in so much pain that she spent almost the entire day in bed. As a result, her wish for euthanasia became relevant.

The physician considered the patient's suffering to be palpable and saw no options for alleviating the suffering. The SCEN physician was brought in, who agreed with the physician.

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

DEMENTIA

In cases involving patients with dementia, the physician must exercise particular caution when considering whether the statutory due care criteria have been met. This is especially true of the criteria that require the request to be voluntary and well considered and the patient's suffering to be unbearable. 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 decline in cognitive ability and functioning that these patients are already experiencing, their suffering is also caused 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 a written request for euthanasia when still decisionally competent. Section 2 (2) of the Act states that a written request for euthanasia can replace an oral request and that the same due care criteria apply (see Euthanasia Code 2022, pp. 48-49).

At the very least, the written request for euthanasia 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, the written request for euthanasia must also state 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 a written request.

DECISIONALLY COMPETENT PATIENT WITH DEMENTIA

Straightforward notification, dementia

The patient, a woman in her sixties, had difficulty remembering names around two years before her death. A year before her death she was examined at the hospital's memory clinic. Mild cognitive disorders were discovered. Six months before her death, she found she was deteriorating. She was diagnosed with dementia, which progressed rapidly.

At the time of her referral to the memory clinic, the patient had already told her general practitioner that she had had unpleasant experiences in the past when family members had been diagnosed with dementia. She did not want to become like them and wanted euthanasia if it turned out she had dementia too. She repeated this several times. According to the general practitioner, the patient was very determined in this respect. She absolutely did not want to go into a nursing home.

The patient noted she was deteriorating rapidly. She was given sedatives because she suffered from anxiety attacks and angry outbursts. The patient wanted to prevent further deterioration and asked her general practitioner to perform euthanasia.

The physician also consulted an independent expert, an elderly-care specialist, in order to be able to assess the patient's decisional competence. According to the independent expert, the patient was decisionally competent with regard to her wish for euthanasia.

The physician was satisfied that this suffering was unbearable to her and that there was no prospect of improvement. She consulted an independent physician who was also a SCEN physician. The patient told the independent physician that she experienced severe stress when people talked to her about things she could not remember. She also said that 'her head could no longer keep up with her'. The patient expressed her wish to die several times to the independent physician, who concluded that the patient was well aware of her disease and the prognosis. The independent physician considered the patient to be fully decisionally competent regarding her request for euthanasia.

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

PATIENT WITH DEMENTIA WHO WAS NO LONGER DECISIONALLY COMPETENT

Non-straightforward notification, mixed dementia, advance directive, contraindication.

The patient, a man in his eighties, was diagnosed seven years before his death with mixed dementia involving Alzheimer's disease and vascular dementia. Six-and-a-half years before his death, the patient drew up an advance directive, which included a request for euthanasia with a detailed explanation. The patient had discussed his written request for euthanasia with his physicians and family on several occasions. During these conversations, he was decisionally competent regarding his request for euthanasia. In the years that followed, the patient reaffirmed his written request for euthanasia several times; the last time was over a year and a half before his death.

VOLUNTARY AND WELL-CONSIDERED REQUEST

When the request for euthanasia became relevant, the patient turned to his general practitioner. The general practitioner considered the reason for the request for euthanasia palpable, and supported the patient's request, but was not willing to perform euthanasia personally. The patient's family therefore registered the patient with the Euthanasia Expertise Centre (EE). An EE physician took over the euthanasia process.

However, the first EE physician withdrew after she had established that the patient had become decisionally incompetent. A second EE physician saw the patient for the first time about seven months before his death. This physician saw him another eight times. During each of these visits the physician tried to have a conversation with the patient, but was unsuccessful every time. It was clear to the physician that meaningful communication was no longer possible with the patient and that the patient was no longer decisionally competent with regard to his request for euthanasia. The physician also spoke on several occasions with the attending elderly-care specialist, the nursing and care team, and the patient's family. The physician decided to proceed with the termination of life on the basis of the patient's written request for euthanasia.

The committee found that the physician could be satisfied that the patient was decisionally competent when he drew up his advance directive. The committee also found that the physician could be satisfied that the patient was no longer decisionally competent at the time the termination of life was carried out. The circumstances described by the man in his advance directive indeed existed. The committee therefore found that the patient's advance directive could take the place of an oral request.

The committee considered that the physician was alert to contraindica-

tions that would preclude the performance of euthanasia. When, during a visit from the physician around a month before the patient's death, the patient said that he would 'not take a jab' that would cause him to die, the physician temporarily halted the process in order to assess whether this comment should be considered a contraindication. To this end, the physician consulted with the attending elderly-care specialist, the nursing and care team, the independent expert, the independent physician and the patient's family. In addition, a multidisciplinary consultation for reflection purposes was held within the EE. After extensive consultation and reflection the physician concluded that the patient's comment had been a one-off occurrence and not a consistent and clear form of behaviour or expression. The committee found that there was thus no contraindication.

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

A year before the patient's death, the moment came when he could no longer stay at home. Contrary to what he had affirmed before, he decided to move to an assisted-living facility. He hated being dependent on care and he experienced a great deal of agitation and frustration, while his dementia made it impossible for him to cope with this situation. He was verbally and physically aggressive to other residents and the care staff. He started to wander about in the assisted-living facility. He developed urinary and faecal incontinence and often refused to be changed, as a result of which he regularly soiled himself. He did not eat well, and therefore lost weight and became weaker. The patient became increasingly dependent on care, but often would not allow anyone to provide assistance and care. Increasingly there were times when the patient showed fear, sadness, anger, despair, anguish, incomprehension, shame and frustration. Eventually there were hardly any moments when the patient was calm, content or happy.

In addition the physician was of the opinion that the patient's suffering could not be ended. This opinion was based on extensive consultation with the practitioners, the nursing and care team and the patient's family. According to the physician, all palliative treatment options had been implemented, but had proven unsuccessful. For instance, a behavioural expert was brought in to try and alleviate the patient's agitation as much as possible. The patient received one-on-one assistance with activities and took his meals alone in his room. Medication did not alleviate his feelings of agitation, but did have side-effects due to which the patient sat in his room waiting apathetically to be collected.

The committee noted that the independent expert and the independent physician also concluded that there was no reasonable alternative in the patient's situation.

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

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

In 2024, the RTEs found in six cases that the physician had not acted in accordance with the due care criteria in performing euthanasia. Two cases concerned consulting an independent physician and one case concerned the particular caution the physician must exercise when the request for euthanasia is based (largely) on suffering caused by a psychiatric disorder. In three cases due medical care was not exercised. 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 refers to the fact that the Act states that this physician must be independent. The concept of independence refers to their relationship with both the physician and the patient. The independent physician must be in a position to form their own opinion. There must be no personal, organisational, hierarchical or financial relationship with the physician.

If an independent physician provides support that goes beyond general advice or information, that may jeopardise their independence. In the following case, no independent consultation took place, because the physician and the independent physician spoke to the patient together.

Sometimes, both members of a couple may make simultaneous requests for euthanasia. This is referred to as ‘double euthanasia’. In such cases the physician must consult a different independent (SCEN) physician for each patient. This is necessary to ensure that the two cases are assessed separately. This safeguards the independence of the assessment. If a SCEN physician were to visit the second partner after having seen the first partner, the independent physician would no longer be deemed independent at the time of the second visit. They could come under pressure to reach the same conclusion for the second partner, i.e. that the due care criteria for euthanasia had been fulfilled. In addition, both independent physicians must be satisfied that neither of the partners is exerting undue pressure on the other in relation to their request for euthanasia (see Euthanasia Code 2022, p. 30).

CONSULTING AN INDEPENDENT PHYSICIAN

Parkinson's disease, SCEN physician involved previously as adviser

The patient, a woman in her seventies, was suffering from Parkinson's disease. She had discussed euthanasia several times with the physician, an elderly-care specialist. About two weeks before her death, she asked the physician to actually perform euthanasia. The physician consulted an independent SCEN physician. The independent physician visited the patient together with the physician. A week before the patient's death, the independent physician visited the patient a second time, without the physician.

The physician had spoken to the independent physician on the phone, saying that the patient was hesitating between euthanasia or stopping eating and drinking.

The physician thought the patient might like the physician and the independent physician to speak to her together. It was more difficult for the patient to talk to a stranger about her wish to die. As the physician remembered it, it was the independent physician who suggested he be present during the conversation between the physician and the patient. The physician thought he probably did this so that there would be a familiar person present when they met, and in this way the patient would already have undergone part of the consultation process. The physician assumed the independent physician would have told her if this was not the correct way to proceed.

During the conversation with the physician and the patient, the independent physician did not really give any advice. The independent physician asked what the operation entailed and why the patient did not want it.

The committee considered that the physician should have realised that the statutory requirement to consult an independent physician automatically means that the patient is confronted with an unfamiliar outsider. The independent physician sees and speaks with a patient they have not previously seen or spoken with, and gives an unbiased and independent opinion.

The committee found that, to all intents and purposes, the physician and the independent physician had worked together. In the physician-patient dialogue, they jointly fulfilled the role of physician. After the first conversation, it was possible that the independent physician's assessment had been influenced, as a result of which he was no longer able to

make a free and unbiased assessment during the second conversation, which he and the patient held alone. The patient, for her part, may have no longer felt free to change her mind and decide against euthanasia, because the independent physician had also been present during the first conversation.

The committee was of the opinion that the physician had therefore not fulfilled the due care criterion concerning consultation of at least one other, independent, physician who sees the patient and gives a written opinion on the due care criteria.

The committee found that the physician had fulfilled the other due care criteria.

This notification has been published on the website (2024-001).

ONLY ONE INDEPENDENT PHYSICIAN FOR DOUBLE EUTHANASIA

Double euthanasia, multiple geriatric syndromes, failure to consult two different SCEN physicians

The patient, a woman in her nineties, was suffering from osteoporosis, polyarticular osteoarthritis (osteoarthritis in several joints), vertebral compression fractures, kidney failure and progressive allodynia, a condition in which involves extreme sensitivity to touch.

The patient suffered severe pain due to her conditions. The osteoporosis caused pain in her ribs and lower back, spreading to her legs. Analgesics did not work or were not possible due to the patient's poor kidney function. She could no longer bear the pain and was afraid it would increase. She also suffered due to her loss of autonomy and the lack of prospects for improvement. She absolutely did not want to deteriorate further and become dependent on care. She asked her general practitioner to perform euthanasia.

The patient preferably wanted to die together with her husband, who was also seriously ill and had asked the same physician to perform euthanasia. The couple had been together for more than 70 years. Over the past several years, despite her pain issues, the patient had looked after her husband, who needed more and more care. She kept going because she did not want her husband to stay behind on his own. Her husband's rapid deterioration and his wish for euthanasia meant that there was ultimately no longer any reason for her to keep fighting the pain.

The patient had discussed euthanasia with the physician before. Eleven years before her death she had drawn up a written request for euthanasia. Six months before her death, she spoke to a colleague of the physician about her current wish for euthanasia. The physician subsequently visited the patient and discussed her wish for euthanasia with her. In the following months the patient continued to repeat her wish for euthanasia. Her pain increased to a level that was unbearable for her. A month and a half before her death, the patient asked the physician to actually perform the procedure to terminate her life.

The physician consulted an independent SCEN physician who visited the patient twice. During the first visit, three weeks before the patient's death, the independent physician spoke with the patient's husband, during which conversation the patient was present in the background. The independent physician could not assess the patient's request for

euthanasia at that time, because he did not yet have her medical records. After he received the medical records, he visited the patient again, two weeks before her death, and spoke to her about her situation and her request for euthanasia (in her husband's presence).

The committee noted that the physician had consulted the same independent physician for both spouses in this case of double euthanasia. It therefore decided to invite the physician and the independent physician to give an oral explanation.

It emerged from that explanation that neither the physician nor the independent physician was aware of the fact that in a case of double euthanasia the physician must consult two different independent physicians. The independent physician acknowledged that he was no longer independent when he assessed the patient's request for euthanasia. He had concluded that her husband's request for euthanasia, which was connected to her wish for euthanasia, fulfilled the statutory due care criteria. This meant that the two cases were no longer being assessed separately and he could no longer make a free and unbiased assessment as to whether her request for euthanasia also fulfilled the statutory due care criteria.

The committee found that the physician had not fulfilled the due care criterion concerning consultation of at least one other, independent physician per patient. The physician had fulfilled the other due care criteria.

This notification has been published on the website (2024-006).

EXERCISING PARTICULAR CAUTION IN CASES INVOLVING PATIENTS WITH PSYCHIATRIC DISORDERS

If a request for euthanasia is based (largely) 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 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 (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.

NO INDEPENDENT PSYCHIATRIST CONSULTED

Obsessive compulsive disorder and vertebral fracture, no psychiatric expertise requested

The patient, a woman in her seventies, had been suffering from obsessive compulsive disorder for more than 50 years. She had been admitted to hospital several times and also underwent outpatient treatment on many occasions. The compulsion had not gone away; it had in fact increased. Her obsessive compulsive disorder took the form of germophobia and obsessive cleaning. She had tried various treatments. Over a year before her death, the patient suffered a vertebral fracture. As a result, she developed severe back pain and could no longer give in to her cleaning compulsion. This caused her unbearable stress.

About eight years previously, the patient had expressed a wish for euthanasia to her general practitioner. She had repeated that wish on several later occasions. About one month before her death, the patient asked the physician to actually perform euthanasia.

The physician consulted an independent physician who was a SCEN physician but not a psychiatrist. The physician did not consult an independent psychiatrist to assess whether the patient was decisionally competent, whether she was suffering without prospect of improvement and whether there were any reasonable treatment options.

The committee noted that the patient's request for euthanasia was based largely on suffering caused by a psychiatric disorder, i.e. obsessive compulsive disorder. In addition there was physical suffering due to a vertebral fracture.

The physician indicated that the obsessive compulsive disorder had existed for several decades. The problems caused by the vertebral fracture took away her ability to cope with the obsessive compulsive disorder. The physician was satisfied that the patient's request was voluntary and well considered. He had known her for 30 years. In the physician's opinion, the patient was able to understand the implications of her request. The physician therefore did not consider consulting a psychiatrist. He did, however, ask the independent physician whether they considered additional diagnostics necessary. The independent physician indicated this was not necessary and concluded that the due care criteria had been fulfilled. The physician had relied entirely on the independent physician's conclusion.

In its findings, the committee explained that it expects a physician to exercise particular caution if a request for euthanasia is based on a psychiatric disorder. The physician should have consulted a psychiatrist because the patient's suffering was caused by her psychiatric disorder. Neither the physician nor the independent physician had specific expertise on psychiatric disorders. As no independent psychiatrist was consulted, the necessary particular caution was not exercised.

The committee also noted that the independent physician should have pointed out to the physician that no independent psychiatrist had been consulted yet, and that this needed to be done. However, it is the physician who is responsible for the euthanasia process and who should familiarise themselves with the relevant legislation and guidelines.

The committee found that the physician had not fulfilled the due care criteria that require that he could be satisfied that the request was voluntary and well considered, that the patient was suffering without prospect of improvement and that there was no reasonable alternative in the patient's situation.

The physician had fulfilled the other due care criteria.

This notification has been published on the website (2024-015).

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 (in Dutch only; referred to below as the Guidelines). The Guidelines advise physicians and pharmacists on practical and effective methods of performing euthanasia and assisting with suicide. They list preferred substances, and also explicitly advise against using certain other substances (Euthanasia Code 2022, p. 34).

Page 17 of the Guidelines states the following: 'If a patient does not respond sufficiently to the dose of thiopental or propofol, it must be assumed that the substance has missed the vein. This is not always visible as a swelling. A new IV cannula will then have to be inserted, and the procedure carried out again. If the IV cannula is positioned correctly, there will be a flashback of blood when the syringe is drawn up.'

Page 20 of the Guidelines states: 'The muscle relaxant may be administered only if the patient's consciousness is sufficiently reduced. If there is the slightest doubt about this, the patient's consciousness must be reduced sufficiently by administering (more of) a coma-inducing substance intravenously. The muscle relaxant is to be administered immediately after establishing that the patient's consciousness is sufficiently reduced. Waiting any longer risks the patient's consciousness not being sufficiently reduced when the muscle relaxant is administered, and the patient being aware of the effects of the muscle relaxant.' After it has been administered intravenously, the dose of muscle relaxant mentioned in these Guidelines causes full paralysis of all striated muscle, except that in the heart, within minutes. As a result, the patient stops breathing and death by anoxaemia ensues.

In the RTEs' view, the physician has adequately established that the patient's consciousness is sufficiently reduced if the patient shows no protective reflexes (such as the eyelash reflex and the corneal reflex) or no response to a pain stimulus (heavy pressure on the nail bed or pinching the trapezius muscle) (Euthanasia Code 2022, p. 35).

PROCEDURE NOT CARRIED OUT IN ACCORDANCE WITH GUIDELINES

Cancer, depth of coma not adequately checked in procedure with complications

The patient, a man in his eighties, was diagnosed around two months before his death with extensive liver metastasis with no known primary tumour. Complications occurred during the euthanasia procedure.

The physician had indicated on the model reporting form, in a written explanation and in an oral explanation that the procedure to terminate the patient's life had not been without problems. The physician had first administered the usual dose of a coma-inducing substance. When this did not result in the patient going into a coma, the physician administered another dose of the coma-inducing substance via the same IV cannula, followed by a dose of muscle relaxant.

Although the physician established that the patient was in a sufficiently deep coma after the second dose of the coma-inducing substance had been administered, the patient did not die after the physician subsequently administered the first dose of muscle relaxant.

The physician phoned the ambulance service and had a new IV cannula inserted. He then administered a second dose of muscle relaxant, without establishing again, as the Euthanasia Code prescribes, whether the coma was still sufficiently deep. The patient died immediately after. The entire procedure took about 60 minutes.

The committee noted that the physician did not act in accordance with the Guidelines when performing euthanasia. After establishing that the patient was not responding sufficiently to the first dose of the coma-inducing substance, he did not immediately insert a new IV cannula (or have this done by someone else) before he injected the second dose of the coma-inducing substance. The physician explained that at that point he did not have any doubts about the IV cannula.

After the second dose of the coma-inducing substance, and before the first dose of muscle relaxant, the physician established adequately that the patient's consciousness was sufficiently reduced. In the committee's opinion there was therefore no real risk of the patient being aware of the effects of the first dose of muscle relaxant. Not inserting a new IV cannula before administering a second dose of the coma-inducing substance is not in accordance with the Guidelines, and the committee emphasised the importance of acting in accordance with the Guidelines.

Nevertheless the committee found that the physician did not fail to exercise due medical care in this respect.

The same is not true, however, with regard to the phase after the new IV cannula had been inserted. When death did not ensue after the first dose of muscle relaxant had been administered, and the physician began to have doubts about the IV cannula, the Guidelines state that the physician should have repeated the entire procedure. The physician had a new IV cannula inserted, but then did not administer a new dose of the coma-inducing substance before administering the second dose of muscle relaxant, nor did he adequately check the depth of the patient's coma as described in the Euthanasia Code 2022. Due to the long period (about 30 minutes) between the last time the physician checked the depth of the patient's coma and the moment when he administered the second dose of muscle relaxant, it cannot be established with sufficient certainty that the patient was still in a sufficiently deep coma.

The physician stated that he constantly monitored and assessed the patient. He was convinced that the patient was not aware of any part of the procedure, with the exception of the phase between the two doses of the coma-inducing substance. However, in the committee's opinion, that did not sufficiently minimise the risk of the patient being aware of the effects of the second dose of muscle relaxant. The physician must at all times avoid the risk of the patient being aware that the muscle relaxant is being administered.

Because it could not be established with sufficient certainty that the patient was not aware of the effects of the second dose of muscle relaxant, the committee had no other choice but to find that the physician failed to exercise due medical care when performing the procedure to terminate the patient's life.

The physician had fulfilled the other due care criteria.

This notification has been published on the website (2024-005).

FAILURE TO EXERCISE DUE MEDICAL CARE

Cancer, emergency set not complete, patient left alone

The patient, a woman in her sixties, had been diagnosed with metastasised cancer. Her condition was incurable. She suffered from nausea, pain and her increasing dependence on others, while knowing that she would continue to deteriorate. She asked her general practitioner to perform euthanasia. Complications occurred during the euthanasia procedure.

On the day euthanasia was to be performed, the physician had inserted a butterfly IV cannula. She checked whether the cannula was unobstructed. When the euthanasia procedure began, the physician checked again whether the cannula was unobstructed. The physician noticed that the patient was somewhat slow to fall asleep after the coma-inducing substance had been administered. She checked the depth of the coma and then injected the muscle relaxant without any problems. The patient was in a deep coma, but did not die.

The emergency set of substances contained the coma-inducing substance, but no muscle relaxant; the latter was in the refrigerator at the practice. The physician went herself to collect the muscle relaxant, because the practice was closed that day so there was nobody there who could bring it. She left the patient and her family by themselves for about five minutes. However, she had given them her phone number so that the family could contact her directly. After she returned, the physician inserted a new cannula and then immediately administered the muscle relaxant without first administering a new dose of the coma-inducing substance. The patient then died after three minutes. The physician considered the insertion of the cannula to be a pain stimulus. There was more than an hour between the moment the first set of euthanatics was administered and the moment the second dose of muscle relaxant was administered.

When it became apparent the patient had not died, the physician did insert a new cannula, but did not inject a new dose of the coma-inducing substance before administering the muscle relaxant. As a result, in view of the amount of time that elapsed, there is a chance that the patient was aware of the effects of the muscle relaxant. Checking the depth of the coma is also important in that respect. What is more, the physician left the patient and her family by themselves, which meant that the physician could not respond in the event of an unexpected situation.

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.

This notification has been published on the website (2024-004).

PROCEDURE NOT CARRIED OUT IN ACCORDANCE WITH GUIDELINES FOR CHECKING DEPTH OF COMA

The patient, a woman in her eighties, had been diagnosed with metastasised cancer. She was deteriorating rapidly and was suffering unbearably from pain, nausea, shortness of breath and loss of independence. She asked her general practitioner to perform euthanasia. Complications occurred during the euthanasia procedure.

After the physician had checked the cannula by drawing up blood, he was able to inject the coma-inducing substance without any problems. The patient fell asleep, but responded to an eyelash reflex test and to a pain stimulus. There was no swelling near the cannula. After a while the physician administered dormicum to relax the patient so that she could fall into a coma. However, this did not happen. The physician repeated the pain stimulus several times, but the patient kept responding.

After 40 minutes the physician decided to have the registrar who was with her go and collect the emergency set of substances from the refrigerator at the practice. Together they prepared the injections for use. After this, the patient proved to be in a deep coma and no longer responded to the eyelash reflex test or the pain stimulus. By now it was about 80 minutes since the coma-inducing substance had been administered. When the physician subsequently checked the IV cannula, it was obstructed. She then phoned the ambulance service, which inserted a new IV cannula 20 minutes later. The patient did not respond to this.

Immediately after this, the physician injected the muscle relaxant. She did not administer an extra dose of the coma-inducing substance, because she was convinced the patient was in a deep coma. Due to the hectic process and the fact that she had been constantly checking the depth of the patient's coma throughout the process, the physician could not remember whether she had also checked this immediately before administering the muscle relaxant. She also considered the insertion of the IV cannula as a pain stimulus. The patient died four minutes after the muscle relaxant was administered.

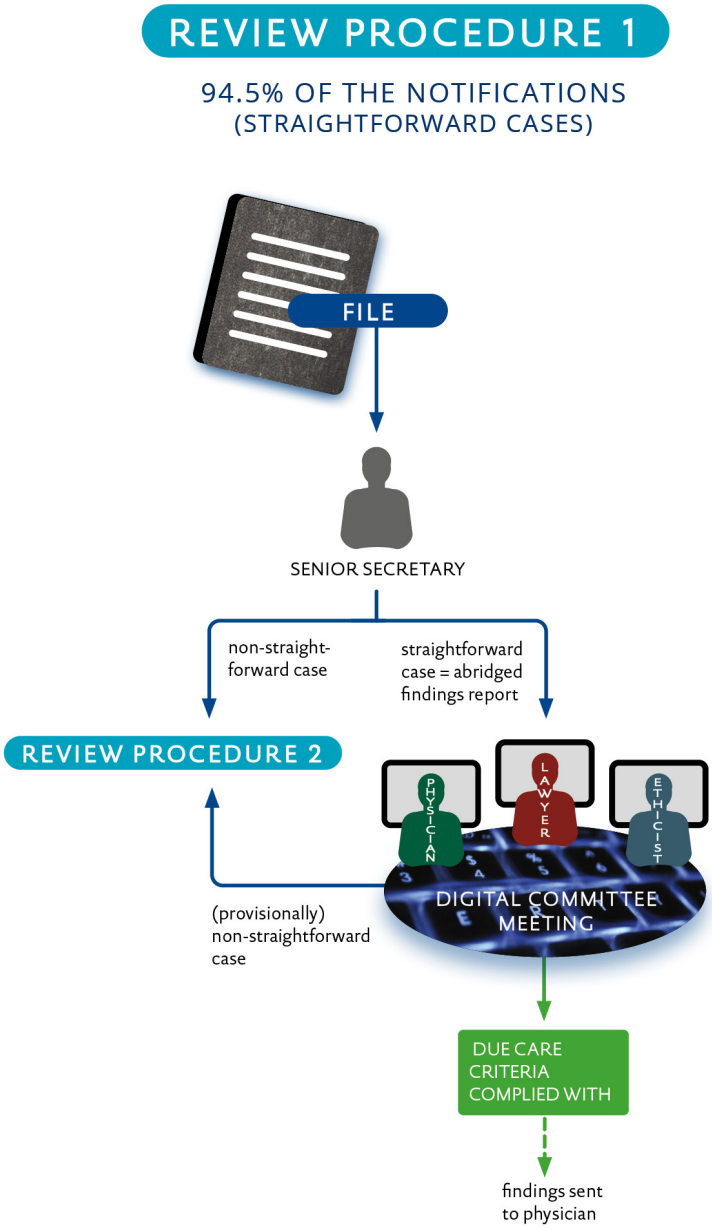
It is not sufficiently certain that the patient could not be aware of the effect of the muscle relaxant, given the long time between administering the coma-inducing substance and administering the muscle relaxant, and because it is not certain that the depth of the coma was checked immediately before the muscle relaxant was administered.

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.

This notification has been published on the website (2024-049).

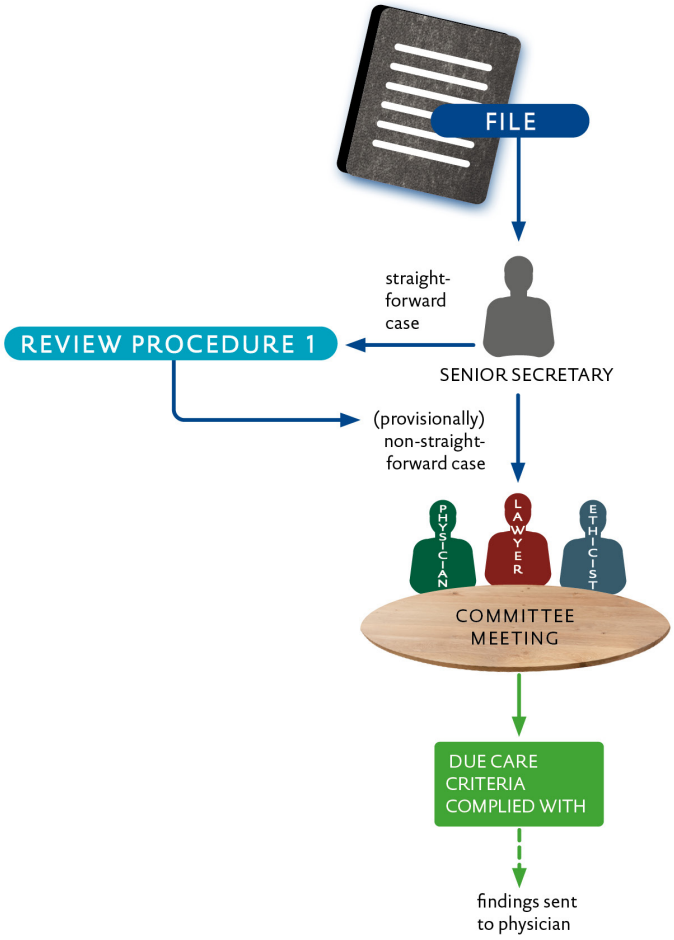
ANNEXE I

DIAGRAMS OF THE STRAIGHTFORWARD AND NON-STRAIGHTFORWARD ROUTES DIAGRAMS 1, 2 AND 3



REVIEW PROCEDURE 2

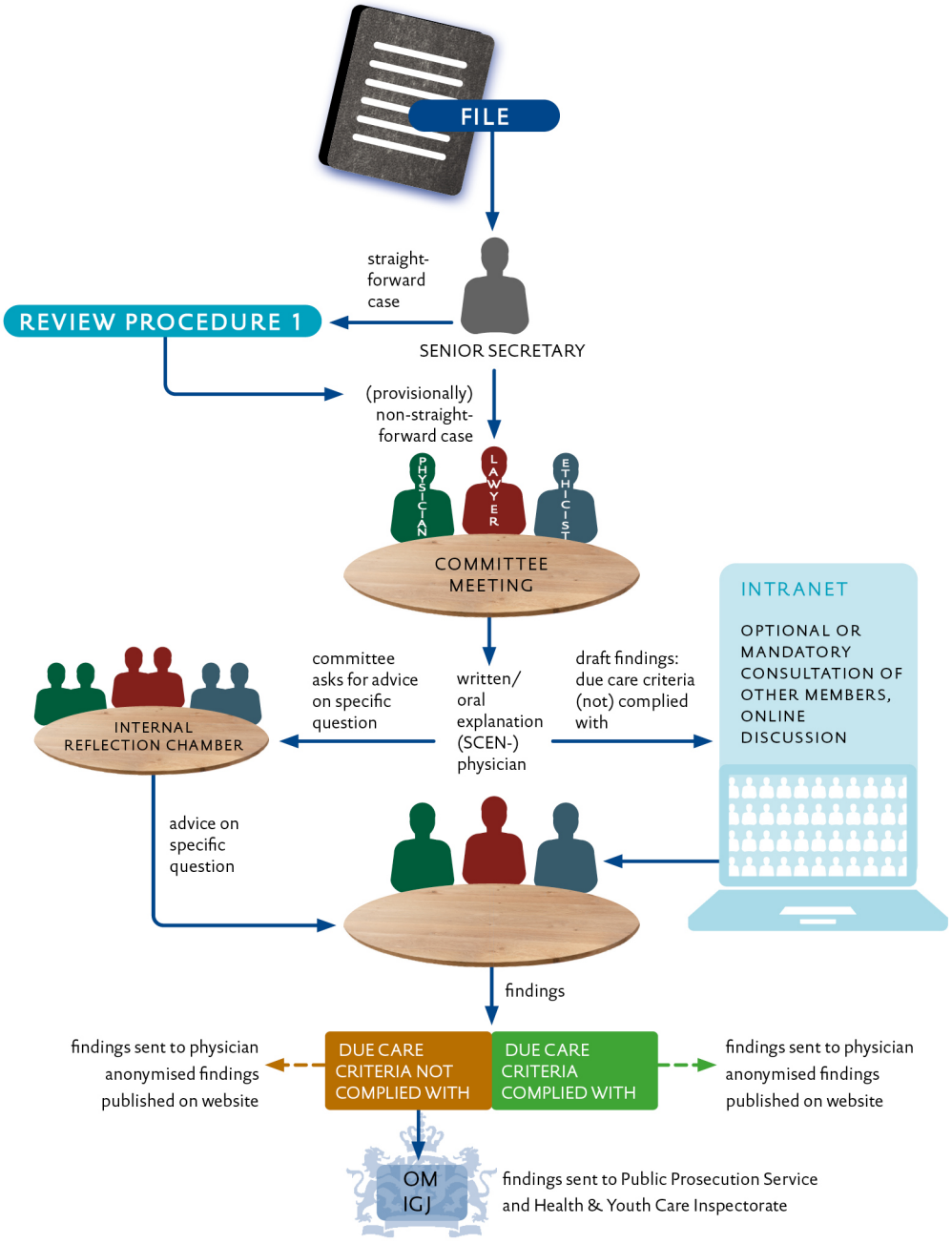
5.5% OF THE NOTIFICATIONS
(NON-STRAIGHTFORWARD CASES)



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)

March 2025

In the event of any inconsistencies, the Dutch version of this annual report prevails over the translation.