X. PAÍSES BAJOS

X.1. LA CONSTITUCIÓN DEL REINO DE LOS PAÍSES BAJOS (2002)*

CAPÍTULO 1. Derechos fundamentales

Artículo 10

1. Todos tienen derecho, salvo las limitaciones que se establezcan por o en virtud de la ley, al respeto de su intimidad personal y familiar.

2. La ley establecerá normas para proteger la intimidad personal y familiar en relación con el registro y el suministro de datos personales.

3. La ley regulará los derechos de las personas a tomar conocimiento de los datos registrados sobre ellas y del uso que se hace de los mismos, así como a la rectificación de dichos datos.

Artículo 11

Todos tienen derecho a la integridad física, salvo las limitaciones que se establezcan por o en virtud de la ley.

Artículo 20

1. [...]

2. La ley regulará los derechos a la seguridad social.

3. [...]

Artículo 22

1. Los poderes públicos tomarán medidas para promover la salud pública.

2. [...]

3. [...]

IX.2. LEGISLACIÓN

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

This Act entered into force on April 1, 2002 –

Review procedures of termination of life on request and assisted suicide and amendment to the Penal Code (Wetboek van Strafrecht) and the Burial and Cremation Act (Wet op de lijkbezorging)

We Beatrix, by the grace of God, Queen of the Netherlands, Princess of Oranje-Nassau, etc., etc. etc.

Greetings to all who shall see or hear these presents! Be it known:

Whereas We have considered that it is desired to include a ground for exemption from criminal liability for the physician who with due observance of the requirements of due care to be laid down by law terminates a life on request or assists in a suicide of another person, and to provide a statutory notification and review procedure;

We, therefore, having heard the Council of State, and in consultation with the States General, have approved and decreed as We hereby approve and decree:

Chapter I. Definitions of Terms

Article 1

For the purposes of this Act:

a. Our Ministers mean the Ministers of Justice and of Health, Welfare and Sports;

b. assisted suicide means intentionally assisting in a suicide of another person or procuring for that other person the means referred to in Article 294 second pragraph, second sentence of the Penal code;

c. the physician means the physician who according to the notification has terminated a life on request or assisted in a suicide;

d. the consultant means the physician who has been consulted with respect to the intention by the physician to terminate a life on request or to assist in a suicide;

e. the providers of care mean the providers of care referred to in Article 446 first paragraph of Book 7 of the Civil Code (Burgerlijk Wetboek);

f. the committee means a regional review committee referred to in Article 3;

g. the regional inspector means the regional inspector of the Health Care Inspectorate of the Public Health Supervisory Service.

Chapter II. Requirements of Due Care

Article 2

1. The requirements of due care, referred to in Article 293 second paragraph Penal Code mean that the physician:

a. holds the conviction that the request by the patient was voluntary and wellconsidered,

b. holds the conviction that the patient's suffering was lasting and unbearable,

c. has informed the patient about the situation he was in and about his prospects,

d. and the patient hold the conviction that there was no other reasonable solution for the situation he was in,

e. has consulted at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts a - d, and

f. has terminated a life or assisted in a suicide with due care.

2. If the patient aged sixteen years or older is no longer capable of expressing his will, but prior to reaching this condition was deemed to have a reasonable understanding of his interests and has made a written statement containing a request for termination of life, the physician may this request. The requirements of due care, referred to in the first paragraph, apply mutatis mutandis.

If the minor patient has attained an age between sixteen and eighteen years and may be deemed to have a reasonable understanding of his interests, the physician may cant' out the

* Fuente: Publicación del Ministerio del Interior y de Relaciones del Reino.- División de Asuntos Constitucionales y Legislación.- www.minbzk.nl

** Fuente: http://www.nvve.nl/assets/nvve/english/euthlawenglish. pdf

patient's request for termination of life or assisted suicide, after the parent or the parents exercising parental authority and/or his guardian have been involved in the decision process.

4. If the minor patient is aged between twelve and sixteen years and may be deemed to have a reasonable understanding of his interests, the physician may cant' out the patient's request, provided always that the parent or the parents exercising parental authority and/or his guardian agree with the termination of life or the assisted suicide.

The second paragraph applies mutatis mutandis.

Chapter III. The Regional Review Committees for Termination of Life on Request and Assisted Suicide

Paragraph 1: Establishment, composition and appointment

Article 3

1. There are regional committees for the review of notifications of cases of termination of life on request and assistance in a suicide as referred to in Article 293 second paragraph or 294 second paragraph second sentence, respectively, of the Penal Code.

2. A committee is composed of an uneven number of members, including at any rate one legal specialist, also chairman, one physician and one expert on ethical or philosophical issues'. The committee also contains deputy members of each of the, categories listed in the first sentence.

Article 4

1. The chairman and the members, as well as the deputy members are appointed by Our Ministers for a period of six years. They may be re-appointed one time for another period of six years. 'philosophical issues' — in the original text the Dutch word 'zingevingsvraagstukken' is used to describe the discussion on the prerequisites for a meaningful life.

2. A committee has a secretary and one or more deputy secretaries, all legal specialists, appointed by Our Ministers. The secretary has an advisory role in the committee meetings.

3. The secretary may solely be held accountable by the committee for his activities for the committee.

Paragraph 2: Dismissal

Article 5

Our Ministers may at any time dismiss the chairman and the members, as well as the deputy members at their own request.

Article 6

Our Ministers may dismiss the chairman and the members, as well as the deputy members for reasons of unsuitability or incompetence or for other important reasons.

Paragraph 3: Remuneration

Article 7

The chairman and the members, as well as the deputy members receive a holiday allowance as well as a reimbursement of the travel and accommodation expenses according to the existing government scheme insofar as these expenses are not otherwise reimbursed from the State Funds.

Paragraph 4: Duties and powers

Article 8

1. The committee assesses on the basis of the report referred to in Article 7 second paragraph of the Burial and Cremation Act whether the physician who has terminated a life on request or assisted in a suicide has acted in accordance with the requirements of due care, referred to in Article 2.

2. The committee may request the physician to supplement his report in writing or verbally, where this is necessary for a proper assessment of the physician's actions.

3. The committee may make enquiries at the municipal autopsist, the consultant or the providers of care involved where this is necessary for a proper assessment of the physician's actions.

Article 9

1. The committee informs the physician within six weeks of the receipt of the report referred to in Article 8 first paragraph in writing of its motivated opinion.

2. The committee informs the Board of Procurators General and the regional health care inspector of its opinion:

a. if the committee is of the opinion that the physician has failed to act in accordance with the requirements of due care, referred to in Article 2; or

b. if a situation occurs as referred to in Article 12, final sentence of the Burial and Cremation Act.

The committee shall inform the physician of this.

3. The term referred to in the first paragraph may be extended one time by a maximum period of six weeks. The committee shall inform the physician of this.

4. The committee may provide a further, verbal explanation on its opinion to the physician. This verbal explanation may take place at the request of the committee or at the request of the physician.

Article 10

The committee is obliged to provide all information to the public prosecutor, at his request, which he may need:

1. for the benefit of the assessment of the physician's actions in the case referred to in Article 9 second paragraph;or

2. for the benefit of a criminal investigation.

The committee shall inform the physician of any provision of information to the public prosecutor.

Paragraph 6: Working method

Article 11

The committee shall ensure the registration of the cases of termination of life or assisted suicide reported for assessment. Further rules on this may be laid down by a ministerial regulation by Our Ministers.

Article 12

1. An opinion is adopted by a simple majority of votes.

2. An opinion may only be adopted by the committee provided all committee members have participated in the vote.

Article 13

At least twice a year, the chairmen of the regional review committees conduct consultations with one another with respect to the working method and the performance of the committees. A representative of the Board of Procurators General and a representative of the Health Care Inspectorate of the Public Health Supervisory Service are invited to attend these consultations.

Paragraph 7: Secrecy and Exemption

Article 14

The members and deputy members of the committee are under an obligation of secrecy to keep confidential any infor-

mation acquired in the performance of their duties, except where any statutory regulation obliges them to divulge this information or where the necessity to divulge information ensues from their duties.

Article 15

A member of the committee that serves on the committee in the treatment of a case exempts himself and may be challenged if there are facts or circumstances that may affect the impartiality of his opinion.

Article 16

A member, a deputy member and the secretary of the committee refrain from rendering an opinion on the intention by a physician to terminate a life on request or to assist in a suicide.

Paragraph 8: Report

Article 17

1. Not later than 1 April, the committees issue a joint annual report to Our Ministers on the activities of the past calendar year. Our Ministers shall lay down a model for this by means of a ministerial regulation.

2. The report on the activities referred to in the first paragraph shall at any rate include the following:

a. the number of reported cases of termination of life on request and assisted suicide on which the committee has rendered an opinion;

b. the nature of these cases;

c. the opinions and the considerations involved.

Article 18

Annually, at the occasion of the submission of the budget to the States General, Our Ministers shall issue a report with respect to the performance of the committees further to the report on the activities as referred to in Article 17 first paragraph.

Article 19

1. On the recommendation of Our Ministers, rules shall be laid down by order in council regarding the committees with respect to

a. their number and their territorial jurisdiction;

b. their domicile.

2. Our Ministers may lay down further rules by or pursuant to an order in council regarding the committees with respect to

a. their size and composition;

b. their working method and reports.

Chapter IV. Amendments to other Acts

Article 20

The Penal Code shall be amended as follows:

A

Article 293 shall read:

Article 293

1. Any person who terminates another person's life at that person's express and earnest request shall be liable to a term of imprisonment not exceeding twelve years or a fifthcategory fine.

2. The act referred to in the first paragraph shall not be an offence if it committed by a physician who fulfils the due care criteria set out in Article 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, and if the physician notifies the municipal pathologist of this act in accordance with the provisions of Article 7, paragraph 2 of the Burial and Cremation Act.

B

Article 294 shall read:

Article 294

1. Any person who intentionally incites another to commit suicide shall, if suicide follows, be liable to a term of imprisonment not exceeding three years or a fine of the fourth-category fine.

2. Any person who intentionally assist another to commit suicide or provides him with the means to do shall, if suicide follows, be liable to a term of imprisonment not exceeding three years or a fourth-category fine. Article 293, paragraph 2 shall apply *mutatis mutandis*.

C

In Article 295, the following is inserted after '293': first paragraph.

D

In Article 422, the following is inserted after '293': first paragraph.

Article 21

The Burial and Cremation Act shall be amended as follows:

A

Article 7 shall read:

Article 7

1. A person who has performed a postmortem shall issue a death certificate if he is convinced that death has occurred as a result of a natural cause.

2. If the death was the result of the application of termination of life on request or assisted suicide as referred to in Article 293 second paragraph or Article 294 second paragraph second sentence, respectively, of the Penal Code, the attending physician shall not issue a death certificate and shall promptly notify the municipal autopsist or one of the municipal autopsists of the cause of death by completing a form. The physician shall supplement this form with a reasoned report with respect to the due observance of the requirements of due care referred to in Article 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) act.

3. If the attending physician in other cases than referred to in the second paragraph believes that he may not issue a death certificate, he must promptly notify the municipal autopsist or one of the municipal autopsists of this by completing a form.

B

Article 9 shall read:

Article 9

1. The form and the set-up of the models of the death certificate to be issued by the attending physician and by the municipal autopsist shall be laid down by order in council.

2. The form and the set-up of the models of the notification and the report referred to in Article 7 second paragraph, of the notification referred to in Article 7 third paragraph and of the forms referred to in Article 10 first and second paragraph shall be laid down by order in council on the recommendation of Our Minister of Justice and Our Minister of Health, Welfare and Sports.

C

Article 10 shall read:

Article 10

1. If the municipal autopsist is of the opinion that he cannot issue a death certificate, he shall promptly report this to the public prosecutor by completing a form and he shall promptly notify the registrar of births, deaths and marriages.

2. In the event of a notification as referred to in Article 7 second paragraph and without prejudice to the first paragraph,

the municipal autopsist shall promptly report to the regional review committee referred to in Article 3 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act by completing a form. He shall enclose a reasoned report as referred to in Article 7 second paragraph.

D

The following sentence shall be added to Article 12, reading: If the public prosecutor, in the cases referred to in Article 7 second paragraph, is of the opinion that he cannot issue a certificate of no objection against the burial or cremation, he shall promptly inform the municipal autopsist and the regional review committee referred to in Article 3 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act of this.

E

In Article 81, first part, '7, first paragraph' shall be replaced by '7, first and second paragraph'.

Article 22

The General Administrative Law Act (Algemene wet bestuursrecht) shall be amended as follows:

At the end of part d of Article 1:6, the full stop shall be replaced by a semicolon and the following shall be added to the fifth part, reading:

e. decisions and actions in the implementation of the Termination of Life and Assisted Suicide (Review Procedures) Act.

Chapter V. Final Provisions

Article 23

This Act shall take effect as of a date to be determined by Royal Decree.

Article 24

This Act may be cited as: Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

We hereby order and command that this Act shall be published in the Bulletin of Acts and Decrees and that all ministerial departments, authorities, bodies and officials whom it may concern shall diligently implement it.

Done

The Minister of Justice,

The Minister of Health, Welfare and Sports.

Upper House, parliamentary year 2000-2001, 26 691, no 137

X.3. DOCUMENTOS

Termination of Life on Request and Assisted Suicide Euthanasia: the Netherlands' new rules

• *«Termination of Life on Request and Assisted Suicide» informe realizado por el Ministry of Health, Welfare and Sport by researchers from Vrije Universiteit Amsterdam's medical centre, Erasmus MC, AMC and UMC Utrecht, in collaboration with Statistic Netherlands(CBS)»* para evaluar la aplicación de la ley desde su entrada en vigor en el año 2002.

Por su interés recogemos las conclusiones del informe publicadas en mayo de 2007.

Evaluation – Summary

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

[...]

Research (see chapter 1, §12.2.1 and appendices in the original report)

The Termination of Life on Request and Assisted Suicide (Review Procedures) Act (Wtl) came into force in 2002. This Act makes it compulsory for physicians to report the administering of euthanasia or assisting in suicide to the municipal forensic pathologist. One of five regional euthanasia review committees (RTe's) subsequently determines whether the legally-established requirements of due care[1] have been complied with. The RTe's only forward cases to the legal prosecutor when the requirements for careful practice have not been met. Research has been carried out in connection with the evaluation of the Wtl so as to provide insight into practical developments in medical decision-making at the end of life and into the efficacy and side effects of the Wtl. In order to achieve this objective, a number of sub-studies have been carried out, each with its own terms of reference and design. A distinction has been made between a legal investigation oriented towards the juridical aspects of the evaluation of the Act, and a practical investigation that concentrates more on studying medical decisions and terminal care in practice. Each of these two parts has been further divided into a number of sub-studies as shown in Box 1. Most of the practical investigation is comparable to previous nation-wide investigations that were conducted in 2001, 1995 and 1990.

Box 1: Sub-studies on the evaluation of the Wtl

Sub-study I. Legal investigation

Ia Literature study
Ib Interviews with relevant parties
Ic Research into views held by organisations
Id Research into RTe files
Ie Interviews with RTe members

Sub-study II. Practical investigation

IIa Death certificate study
IIb Physicians' study
IIc Research into guidelines, conducted at institutions and among physicians
IId Focus group research

[1] The requirements for due care: a voluntary and well-considered request of the patient; unbearable suffering without prospect of improvement; having informed the patient about his situation and prospects; no more reasonable alternatives; having consulted at least one other, independent physician; having terminated the patient's life or provided assistance with suicide with due medical care and attention

Practice

Box 2: Estimated frequencies of medical end-of-life decisions and continuous deep sedation in the Netherlands in 2005 and 2001 (death certificate study)

	2005		2001	
	Abs.	%*	Abs.	%*
Medical decisions on end of life:				
Euthanasia	2,325	1.7	3,500	2.6
Physician-assisted suicide	100	0.1	300	0.2
Ending of life without an explicit request of the patient	550	0.4	950	0.7
Intensified alleviation of pain or symptoms with hastening of death as a possible side effect	33,700	25	29,000	21
Abandoning potentially life-prolonging treatment	21,300	16	28,000	20
Continuous deep sedation:				
With medical end-of-life decisions†	9,700	7.1	8,500	6.0
Without medical end-of-life decisions	1,500	1.1	‡	

* Percentage of all deaths
† Cases of continuous deep sedation in which a medical decision was taken with the shortening of the patient's life as a possible or intended consequence were, depending on the answers given by the physician, classified as abandoning life-prolonging treatment, intensifying the alleviation of pain or symptoms, or (rarely) as ending of life. These cases should therefore not be added to the total number of medical end-of-life decisions.
‡ Unknown for 2001

Medical decision-making at the end of life (chapters 5, 6, 7, §12.2)

Box 2 gives the major frequency estimations of medical end-of-life decisions in 2005 and 2001. Cases were classified as euthanasia when the physician had indicated that decease was caused by a medicine administered at the explicit request of the patient with the explicit intention of hastening the end of the patient's life. One of the most remarkable findings in the practical investigation is the decrease in euthanasia and assistance in suicide in 2005 compared to 2001 and 1995. The number of requests for euthanasia 'in due course' (from 34,700 in 2001 to 28,600 in 2005) and 'within the foreseeable future' (from 9,700 in 2001 to 8,400 in 2005) also have decreased. This decline is linked to a number of other developments. First of all, the absolute number of deaths in 2005 was less than in 2001, whereas the proportion of persons aged 80 and over (euthanasia and assistance in suicide occur relatively infrequently in this age group) was actually greater. Secondly, an increase was found in other methods of controlling the symptoms of patients in the terminal phase of their lives, such as continuous deep sedation. In addition, the majority of the physicians thought there is a clear connection between improvements in palliative care and the decrease in life-terminating action taken by physicians. And finally, the decrease in the number of cases of euthanasia can probably partly be explained in part by changes in knowledge and opinions on the effects of morphine, which means that physicians are probably less inclined to attribute a life-shortening result to morphine. This has resulted in a decrease in the number of cases of life termination using morphine. We note here that in such cases, it is rather a question of a different appreciation of physicians of their own actions than an actual change in behaviour.

As in the preceding years of research, euthanasia and assistance in suicide appear to be carried out predominantly by general practitioners, on patients with cancer and patients younger than 80 years of age. The most frequently-cited reasons for administering euthanasia and assistance in suicide (besides the patient's own request for life termination: their hopeless situation, loss of dignity and the presence of serious symptoms) and the degree of estimated shortening of patients' lives are also comparable with previous years. Life termination in the case of patients suffering from dementia who possess a euthanasia advance directive, elderly people who were «tired of life», and life termination at the request of minors took place very seldom in 2005.

Knowledge and attitudes towards the law (chapters 8, 9, 10, §12.3)

A majority of physicians are of the opinion that the Wtl has improved their legal certainty and contributes to the carefulness of life-terminating acts. Although nine out of every ten physicians have indicated that they are sufficiently au fait with the content of the Wtl, their knowledge regarding a number of details appeared to be insufficient.

Physicians almost always adhere to the due care requirements during decision-making on a request for euthanasia, while 25% occasionally experience problems with the assessment of the due care requirements, particularly with regard to the requirements that a patient must suffer unbearably and hopelessly and that the patient must have made a voluntary and well-considered request.

In 2005, the percentage of cases reported was approximately 80%, which is a marked increase compared to 54% in 2001. The major reason for failure to report is that the physician does not regard the course of action as a life-terminating act. This is strongly related to the drugs used. In cases where physicians use drugs that are typical for euthanasia or assisted suicide (barbiturates and/or muscle relaxants), the percentage of cases reported is 99%, whereas this is only 2% if morphine is used.

More than two-thirds of the health care institutions in the Netherlands have a written policy on euthanasia and assistance in suicide, in which euthanasia is usually permissible under certain conditions. About one-quarter of these institutions do

not as a general rule acquaint all the physicians and nurses employed at their institutions with this policy view. The majority of the physicians working at institutions is interested in practical guidelines for euthanasia. Six out of every ten institutions have indeed devised guidelines for euthanasia and assistance in suicide, and two thirds of the guidelines were adjusted since the Wtl came into force in 2002. About one-third of the guidelines devised or revised since 2002 were actually stricter than the law as regards content. Moreover, the information contained in the guidelines was not always comprehensive, e.g. with regard to advance euthanasia directives, to the way in which the due care requirements should be applied, and to the part to be played by the nursing staff.

RTe's, the Public Prosecution and the Health Care Inspectorate (chapters 10, 11, §12.4)

The five regional euthanasia review committees (RTe's) assess about 2,000 reported cases of euthanasia and assistance in suicide annually. The verdict of non compliance was given in 15 cases during the years 2003, 2004 and 2005. In approximately 6% of all reported cases, RTe's asked for further information from the physician or consultant in attendance because there was uncertainty or doubt regarding one or more of the due care requirements. The requirement that most frequently involved doubts was that concerning unbearable suffering. Generally speaking, the RTe's performance seems to conform to the intentions of the law. The effectiveness of reviewing is probably mainly due to the fact that physicians' knowledge of how to act in cases of (requests for) euthanasia is continually increasing.

The Public Prosecution only receives the cases assessed by the RTe's as being non compliant. In principle, the prosecution guideline published at the end of 2003 means that prosecution will only be instituted if substantive due care requirements (unbearable and hopeless suffering, voluntary and well-considered request) have not been complied with. This regulation helps ensure physicians' legal certainty. Generally speaking, the Public Prosecution performance is in keeping with the intentions of the law. The way in which the Inspectorate fulfils its duties – geared in particular to a professional approach and professional conduct on the part of the physician – was also found to be adequate.

The law

Are the objectives of the law achieved?(chapters 2, 3, 4, 8, 10, 11, §12.5, §12.8, §12.9)

The legislature had three objectives in mind when drawing up the Wtl: legal certainty, transparency/societal control and quality improvement. The underlying basic assumption is the protection of life together with recognition of other values. It has transpired that each of these objectives has been achieved to a greater or lesser extent.

Legal certainty

In most cases, the system of reporting and reviewing is predictable, and this is also regarded as such by physicians and physicians' organisations. This can also be seen in the increased percentage of reports made. Legal certainty is more limited in border-line cases: this is primarily because the law works with a number of open global concepts (e.g. 'unbearable suffering') with regard to the due care requirements. However, this does not constitute a problem for the vast majority of standard cases. There is less legal certainty for the patient. Also under the Wtl, the patient does not have a right on euthanasia, even though there are sometimes misunderstandings in this regard; the public should be better informed on this point. This does not alter the fact that rejection of a request for euthanasia in a situation where the patient could reasonably expect otherwise in view of the law can pose a real problem. In fact, with regard to the patient's position, it is also important that a clear organisational policy (including guidelines) exists and that adequate information on this policy is given.

Transparency/societal control

In view of the percentage of cases reported (80% in 2005), transparency of practice has further increased since 2001, although this does not alter the fact that approximately 20% of all cases of life termination upon request are not reported. Non-reporting of cases is largely connected with the use of morphine as a means of life termination; in view of the willingness to report cases, societal control is properly carried out insofar as this is possible.

Quality improvement

The degree in which this objective is achieved is linked to the degree in which physicians comply with the law and are willing to be assessed. From the increasing percentage of cases reported and the due care taken by physicians in reported cases, it transpires that quality is improving. A number of factors contribute to quality improvement: professionalisation of the compulsory consultation before complying with a request, reviewing by the RTe's afterwards, publication of the verdicts, and information provided by the RTe's.

If the RTe's see fit to do so, they may invite physicians for an 'instructive' talk, even if their actions have been assessed as 'careful' on balance. In addition, they sometimes consider that such cases should be passed on to the Inspectorate: a clear basis for this should be included in the law.

Incorporating into criminal law and relationship with other legislation (chapters 2, 3, 4, §12.6)

A problem that might arise as a result of incorporating the Wtl into criminal law is potential tension between a penal and a medical approach. The evaluation shows that there is indeed a problem due to the various interpretations of the same rulings concerning life termination, particularly in border-line cases in which the nature and dosage of the medicines used give rise to questions in view of the patient's situation. Further elucidation of the boundary between life termination and normal medical treatment is of special importance. Professional organisations and institutions can contribute to this with the aid of guidelines and protocols. One possibility is to include a clause in the Criminal Code (as was already put forward at the time by the Dutch State Commission on Euthanasia) stating that indicated and proportional use of medicines to alleviate suffering does not constitute life termination but is regarded as normal medical treatment.

In order to invoke statutory defence in Article 293 paragraph 2 of the Criminal Code, physicians are now required by law to report euthanasia or assistance in suicide. This puts non-reporting of life termination on an equal footing with its actual carrying out. Criticism of this situation is extended by proposals to implement the punishability of non-reporting in a different way.

Performing euthanasia or assisting with suicide with due medical care and attention is also required in order to invoke statutory defence. However, disciplinary rules are more suitable than criminal law for sanctioning insufficient medical care when terminating life upon request. For this reason, it has been proposed to eliminate due medical care and attention as a condition for invoking statutory defence.

No inconsistencies have been found between the Wtl and other Dutch legislation. The main issue in the relationship between the Wtl and treaty law is the relationship vis-à-vis the European Convention on Human Rights (ECHR). Here, the compatibility of the law plays a part with the right to life (Article 2 ECHR) on the one hand, and with the criminal principle that nobody is obliged to cooperate in bringing about his or her own conviction on the other hand (nemo tenetur principle; Article 6 ECHR). We may assume that the Wtl does not contravene the right to life, although only the European Court may pronounce judgement on this. With regard to compatibility with the nemo tenetur principle, there is more cause for doubt as to whether the law can stand up to the Strasbourg test.

Due care requirements, advance euthanasia directives and the position of minors (chapters 2, 3, 4, 8, 11 §12.7)

Due care requirements

The fact that physicians and RTe's occasionally encounter problems in the application of material due care requirements (especially with regard to unbearable suffering and the existence of other reasonable solutions) does not in itself constitute a reason to modify these requirements. The requirements have been purposely formulated in an open manner in the law, the idea being that further content will be given to these requirements in case law and in the verdicts given by the RTe's. Physicians do not encounter many problems when interpreting the procedural due care requirements; the RTe's occasionally encounter problems when assessing the independent consultant's actual independence, particularly in hospitals. These problems do not constitute grounds for modification of the requirements because the RTe's can state an opinion on these points in the relevant cases. Moreover, these problems will presumably decrease if more consultations are held in hospitals using SCEN (Support and Consultation on Euthanasia in the Netherlands).

Written advance euthanasia directives

The Wtl states that a previously-drafted advance euthanasia directive by a patient who has meanwhile become incapable of performing legal acts may be regarded as a request. The applicability of the other due care requirements in such a situation has come in for some criticism. The legislature has attempted to overcome this problem by giving the RTe's extra scope to ascertain – all things considered - whether due care and attention has been employed under the circumstances governing the relevant case. There appears to be support among physicians in favour of the advance euthanasia directive scheme, although at the same time, the scheme is applied restrictively in practice. In this connection, there is also a risk that advance euthanasia directives may erroneously raise patients' expectations that euthanasia will be administered as a matter of course if the situation stated in the directive arises.

Minors

The Wtl has adopted a system of age limits when dealing with euthanasia requests from minors. Although this type of system is attended by certain restrictions, the regulation seems to work in practice.

The law's ability to stand the test of time (chapters 3 and 4, §12.10)

Since the Wtl has adopted an open system of broad-based rules in which the RTe's are able to refine the standards and develop them further by assessing border-line cases, the law allows scope for views developing in society.

Recommendations

All things considered, the above gives a positive picture: the law has achieved its objectives well, generally speaking. The frequency of euthanasia and assistance in suicide has decreased and the percentage of cases reported has increased; there does not seem to be any question of a slippery slope with regard to life termination, either with or without the request of the patient. Therefore, there is very little incentive for actual substantial law or policy amendments.

This does not alter the fact that there is a basis for improving the effect of the law in practice. The evaluation study has brought a number of recommendations to light, which can be divided into the following: recommendations pertaining to the law, recommendations for improving law-related procedures, recommendations concerning training and provision of information, recommendations with regard to guidelines and organisational policies, and other recommendations.

The law

– We recommend to consider explicit inclusion of the following clause in the Criminal Code: life termination should not be taken to mean indicated and proportional use of medicines to alleviate suffering, even if this means that the physician is hastening the death of the patient. (12.6.1)

– We recommend implementing the punishability of failure to report life termination upon request or assistance in suicide in another way, thereby amending Article 293 paragraph 2 of the Criminal Code in such a way that invoking statutory defence as stated in this regulation no longer requires the physician to report the case of euthanasia or assistance in suicide to the municipal forensic pathologist. (12.6.2)

– We recommend sanctioning insufficient medical care taken when terminating life upon request or giving assistance in suicide using other means than those provided under criminal law, thereby amending Article 293 paragraph 2 in such a way that complying with the requirement for acting with due care is no longer necessary to be able to invoke statutory defence as stated in this regulation (12.6.2).

– It should be explicitly laid down in the law that RTe's have the option of handing over a case to the Health Care Inspectorate, even if this case is assessed as having been handled with due care (12.8.2).

Law-related procedures

– We recommend that the RTe's monitor the quality of their own performance with regard to matters such as the assessment procedure and the methods used when assessing certain aspects of the due care requirements. (12.4.2)

– We recommend to consider limiting the RTe's term of office to a maximum of two periods of four years. (12.4.2)

– We recommend a uniform policy line for all regions governing the way in which the Public Prosecution Service deals with reports of euthanasia made by the municipal coroner. (12.4.3)

– We recommend extending the model for physicians' reports with the question of why there was no other reasonable solution to the relevant case (if there were any other possible forms of treatment that were rejected by the patient). (12.7.1)

– The 'Nota Bene' in the model for physicians' reports (regarding psychological suffering or patients who may have a diminished ability to express a well-considered request) should be deleted. (12.7.1)

– We recommend rounding off the improving of the model for physicians' reports (Ministerial working group established in 2003) as soon as possible and also examining what alterations to the other forms would be advisable. (12.8.1)

– More experience concerning the database containing reported cases should be acquired (including the area of tension between the guarantee of anonymity and the informative value of published cases) before drawing any conclusions. Attention should nevertheless be devoted to this point in the review committees' reports and in future evaluations. (12.8.2)

Training and provision of information

– Physicians should be further educated on the effects and side effects of morphine and benzodiazepines so that they can select the correct medicines if life termination is the envisaged objective. (12.2, 12.3 , 12.5)

– More attention should be devoted to the content of the Wtl at medical faculties in order to augment physicians' knowledge of the Act. (12.3.1)

– We advise improving information for physicians regarding the interpretation of the due care requirements and the requirements governing the compiling of reports. (12.3.1)

– In order to avoid misunderstandings, we advise the provision of information to physicians and the public alike concerning the options and restrictions attaching to advance directives. (12.7.3)

Guidelines and organisational policy

– Health care institutions must always acquaint professionals in their employment with their organisational policy regarding euthanasia and assistance in suicide. (12.3.2)

– More attention should be devoted to the position of nursing staff in guidelines for health care institutions. (12.3.2)

– Health care institutions should have at their disposal high-quality, up-to-date guidelines for euthanasia, which accurately state the boundaries of the law. In order to support institutions in this, it is advisable to devise a national model guideline for such institutions; umbrella organisations can be of assistance in this regard. (12.3.2 and 12.9.2)

– Guidelines and protocols for institutions and professional medical organisations can contribute to physicians' legal certainty by devoting attention to the boundaries between life termination and other types of terminal care, to the significance of the physician's intention and to the medicines to be administered. (12.5.1 en 12.6.1)

– The Health Care Inspectorate should incorporate institutional policy on euthanasia and assistance in suicide, and the quality of the guidelines devised in this regard, into the regular supervision of institutions. (12.4.4)

Other recommendations

– Terminal care should be given continual attention in health care policy, medical training and research. (12.2)

– Periodic research whereby insight is also acquired into non-reported cases of euthanasia and grey areas is an important addition to the reporting and reviewing system, since this is the only way of keeping track of cases that have not been reported by physicians. (12.5.2)

– The government must ensure that SCEN (Support and Consultation on Euthanasia in the Netherlands) physicians are employed in hospitals as soon as possible. (12.7.2)

– We recommend that further research be carried out into the course of events appertaining to rejection of requests for euthanasia or assistance in suicide. (12.9.2)

• **Euthanasia: the Netherlands' new rules** (Documentation, 8 April 2002)
The Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

Documento publicado por el the Ministry of Health, Welfare and Sport and the Ministry of Justice con el fin de divulgar los contenidos de la Ley y la aplicación de la misma.

http://www.minvws.nl/en/folders/ibe/euthanasia_the_netherlands_new_rules.asp

[...]

1 What is euthanasia?

In the Netherlands, euthanasia is understood to mean the termination of life by a doctor at the patient's request, with the aim of putting an end to unbearable suffering with no prospect of improvement. It includes suicide with the assistance of a doctor. The voluntary nature of the patient's request is crucial: euthanasia may only take place at the explicit request of the patient. This Dutch definition of euthanasia contrasts with the definitions used in some countries, where it is sometimes interpreted as meaning termination of life by a doctor without the consent of the patient.

Withdrawing or refraining from medical treatment at a patient's request is not a form of euthanasia. Any time a patient refuses treatment, their doctor is obliged to respect their wishes. Nor is it euthanasia when a doctor decides against treatment that would be futile. This is accepted medical practice. A doctor may also attempt to relieve pain using ever stronger medication, even if this has the side effect of hastening death.

This too should be distinguished from euthanasia.

2 Why do people ask for euthanasia?

Most requests for euthanasia come from patients who are suffering unbearably with no prospect of improvement and see death as the only way out. They do not request euthanasia because of inadequate terminal care or palliative care (i.e. care to relieve suffering). It is almost always possible to provide terminal patients with a high standard of care, even if there is no cure for their condition. In nearly all cases, the patient's suffering is physical. More than eighty percent of these requests for euthanasia come from cancer patients in the final stages of their illness.

The other requests for euthanasia come from people who want to make arrangements 'just in case'. These people – and their number is growing – are concerned about the future, when they might find themselves in situations in which they now

believe their suffering would be unbearable, with no prospect of improvement. For instance, a brain haemorrhage could leave them paralysed and mute. Since they would then be unable to make their wishes known, they discuss the matter with their family doctor now or put their request for euthanasia in writing. This is called an advance directive or living will (specifically, it is a euthanasia directive) and the new Act recognises it as a legitimate request for euthanasia. This becomes especially important when patients cannot make an oral request. If the situation described in the advance directive actually arises, the family doctor is required to find out whether the patient still wants euthanasia. Furthermore, the doctor is required to fulfil the same due care criteria that apply in the case of an oral request (see question 6).

The new Act deals solely with requests for euthanasia by people who are still completely lucid at the moment of the request.

3 Are doctors obliged to comply with requests for euthanasia?

No. Doctors have two distinct duties to their patients. The first is to relieve suffering and the second is to preserve life. Because honouring a request for euthanasia conflicts with this second duty, doctors are allowed to refuse. Nurses may also refuse to assist in performing euthanasia or preparing for it. Neither doctors nor nurses can ever be censured for failing to comply with requests for euthanasia. The new Act is intended to ensure that doctors and nurses will never have to compromise their personal principles. Doctors are under no obligation to perform euthanasia, and patients have no right to it. If a doctor refuses to perform euthanasia, however, he must refer the patient to another doctor who may be willing to grant the request.

4 Is every request for euthanasia eventually granted?

No. Two-thirds of the requests for euthanasia that are put to doctors are refused. Often, treatment still offers some hope of improvement or there are ways of relieving a patient's suffering, such as effective pain control. Patients may choose to pursue one of these alternatives. Sometimes, they find sufficient peace of mind in the knowledge that the doctor is prepared to perform euthanasia. Many patients die before a decision has been reached on their request for euthanasia.

5 Can a minor request euthanasia?

Yes. Minors of twelve and over may request termination of life or assisted suicide. The decision, however, is not made without the parents. Like existing rules on the medical treatment of minors, the Act divides this group into two age categories. Patients between twelve and fifteen need the consent of their parents or guardian. Sixteen and seventeen-year-olds have the right to decide for themselves, but their parents must be consulted. The same general conditions apply: the minor in question must be suffering unbearably with no prospect of improvement. And of course, the doctor must comply with the statutory due care criteria.

6 What criteria do doctors have to fulfil when performing euthanasia?

A doctor who is willing to perform euthanasia first has to investigate the background to the request. He must make a medical assessment of the patient's physical and psychological suffering and obtain a second opinion from an independent doctor. Their joint conclusion should have a firm medical basis and conform with accepted rules of medical ethics.

The new Act on euthanasia does not change the legal status of termination of life on request or assisted suicide. They are still offences under the Criminal Code. Doctors are exempt from prosecution, however, if they comply with the statutory criteria for due care and notify the municipal pathologist of their actions. The pathologist then notifies one of the five regional review committees.

The due care criteria are as follows. Doctors must:

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

Note: This means that the request must not be made owing to pressure from or influence by other people or as the result of a mental disorder. The patient must fully understand the nature of his condition, his prospects and the types of treatment available. He must also have repeatedly expressed the wish to die;

b. be satisfied that the patient's suffering is unbearable, and that there is no prospect of improvement;

c. inform the patient about his situation and further prognosis;

d. discuss the situation with the patient and come to the conclusion that there is no reasonable alternative;

e. consult at least one other physician with no connection to the case, who must then see the patient and state in writing that the attending physician has satisfied the due care criteria listed in a. to d. above; and

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

Note: The doctor must perform euthanasia himself. He may not have someone else do it. In cases of assisted suicide, the doctor must remain with or near the patient until death occurs. Doctors who do not fulfil (or may not have fulfilled) these criteria or do not report their actions (see question 7) may be prosecuted.

7 How is it possible to tell whether a doctor has satisfied the due care criteria?

After the death of the patient, the doctor who performed euthanasia completes a report. He must also immediately notify the municipal pathologist of this instance of death from non-natural causes. The pathologist then performs an autopsy to determine how euthanasia was performed and what means were used. He also compiles a report on his findings.

The two reports and any annexes (such as the patient's advance directive, if there is one) are sent to the review committee for the region where the doctor terminated the patient's life or assisted in his suicide. There are five such committees in the Netherlands, located in Groningen, Arnhem, Haarlem, Rijswijk and 's-Hertogenbosch. The pathologist also sends his findings to the public prosecutor, who must give consent for burial.

Each regional review committee has an odd number of members and includes a legal expert (who acts as chair), a doctor and an expert on ethical issues. The members are appointed by the Minister of Justice and the Minister of Health, Welfare and Sport for a term of six years.

The committee assesses whether the doctor met the statutory due care criteria. If it finds that he did so, he will not be prosecuted. If it finds that he failed to do so, or may have failed to do so, it notifies the Board of Procurators General of the Public Prosecution Service and the regional health care inspec-

tor of its findings. The Public Prosecution Service then determines whether an offence has been committed and whether or not to prosecute. The inspector decides whether or not the case should come before a disciplinary tribunal.

8 Is euthanasia always lawful?

No. Termination of life and assisted suicide are still offences under the Criminal Code. Taking the life of another person is prohibited by law, even if it is done at that person's explicit request.

The essence of the new Act on euthanasia is that it introduces a single exception: doctors (and only doctors) may perform euthanasia if they fulfil the statutory due care criteria. If the doctor did not fulfil (or might not have fulfilled) the criteria, he may be prosecuted. The Public Prosecution Service may open an investigation on the basis of allegations or suspicion of unlawful conduct on the part of the municipal pathologist, the review committee or relations of the deceased.

The new Act codifies long-established practices. It brings the issue of euthanasia out into the open and enables more effective review of euthanasia cases. It also reflects the expectation that, now that clear legal rules have been established, doctors will henceforth report every case of euthanasia.

9 Does the new Act apply to all cases of termination of life and assisted suicide?

No. The Act, which came into effect on 1 April 2002, applies only to euthanasia – in other words, termination of life or assistance in suicide by a doctor at a patient's explicit request (see also question 1). There have been cases where a doctor terminated the life of a patient who had not asked him to do so. Some of these cases involved newborn babies who were severely handicapped and not expected to live long, or patients in coma. These are not considered euthanasia cases, and the Public Prosecution Service decides whether or not to prosecute, not the regional review committees.

10 Are doctors allowed to perform euthanasia on patients suffering from dementia?

No, not as a rule. Dementia does not justify terminating a patient's life or assisting in suicide. Els Borst, Minister of Health, in a response to questions from the Dutch parliament, has said that dementia can create an unbearable situation for the person suffering from it. An Alzheimer's patient's awareness that his personality is changing might for instance be unbearable.

The prospect of dementia, in particular the loss of personality and dignity once the condition reaches an advanced stage, leads some people to draw up a euthanasia directive (a kind of advance directive or living will). In this directive, they establish in advance that, under certain circumstances (advanced dementia, for example) which they believe would be unbearable and offer no prospect of improvement, they want their life to be terminated. People may draw up directives of this kind or discuss the matter with their doctor. The doctor may only perform euthanasia if the patient has drawn up a euthanasia directive and the doctor believes that the patient's suffering is unbearable and without any prospect of improvement.

11 Can patients from other countries come to the Netherlands for euthanasia?

No. This cannot happen because a close doctor-patient relationship is required. Under the new Act, the patient's suffering must be unbearable, with no prospect of improvement, and his request for euthanasia must be voluntary, carefully considered and repeated. To assess these criteria, a doctor has to know a patient well. This means that the patient needs to have been seeing the doctor for some time already.

[....]

X.4. ESTADÍSTICAS

Statistical Yearbook of the Netherlands 2004
Statistics*

Deaths and medical decisions to end life

	1990	1995	2001
	Absolute		
Without medical decision to end life	78,513	78,689	79,354
With medical decision to end life of which:	50,311	56,986	61,024
not starting and/or ending treatment, taking into account the probability that life will be shortened	11,956	9,404	10,610
treating pain and/or symptoms, taking into account the probability that life will be shortened	19,010	21,589	25,793
treating pain and/or symptoms, with the aim to shorten life as well	4,851	3,784	2,055
not starting and/or ending treatment, with the explicit aim to shorten life	11,113	18,038	17,902
providing medication with the explicit aim to shorten life of which:	3,381	4,171	4,664
euthanasia	2,163	3,020	3,444
aid in suicide	242	238	283
action shortening life without explicit request to do so	976	913	938
Total	128,824	135,675	140,377

	1990	1995	2001
		%	
Without medical decision to end life	60.9	58.0	56.5
With medical decision to end life of which:	39.1	42.0	43.5
not starting and/or ending treatment, taking into account the probability that life will be shortened	9.3	6.9	7.6
treating pain and/or symptoms, taking into account the probability that life will be shortened	4.8	15.9	18.4
treating pain and/or symptoms, with the aim to shorten life as well	3.8	2.8	1.5
not starting and/or ending treatment, with the explicit aim to shorten life	8.6	13.3	12.8
providing medication with the explicit aim to shorten life of which:	2.6	3.1	3.3
euthanasia	1.7	2.2	2.5
aid in suicide	0.2	0.2	0.2
action shortening life without explicit request to do so	0.8	0.7	0.7
Total	100	100	100

* Fuente: http://www.cbs.nl/nr/rdonlyres/3c60b3e9-09e0-491f-87f2-99b8e54936a1/0/a32004.pdf

X.5. DIRECCIONES WEB

Ministry of Health, Welfare and Sport
http://www.minvws.nl/en/

Dutch Ministry of Justice
http://english.justitie.nl/

Dutch Ministry of Foreign Affairs
http://www.minbuza.nl/es/home

Statistics Netherlands
http://www.cbs.nl/en-GB/default.htm

Federation of Patients and Consumer Organisations in the Netherlands (NPCF) http://www.npcf.nl/?id=252

The Dutch Voluntary Euthanasia Society (NVVE)
www.nvve.nl