REGIONALE TOETSINGSCOMMISSIES EUTHANASIE

Judgment 2020-118, careful, general practitioner, dementia, hopeless and unbearable suffering, voluntary and well-considered request, no reasonable other solution, independent doctor consulted, medically careful execution, information to the patient

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Great caution in advanced dementia, performance of euthanasia on the basis of a written living will in accordance with Article 2 paragraph 2 WTL with due observance of the conclusions in the judgment of the Supreme Court of 21 April 2020 (ECLI: NL: HR: 2020: 712)

There is advanced dementia. In view of the patient's incapacity to give consent, the physician relied on the advance directive in accordance with Article 2, paragraph 2 of the WTL. This living will was general in nature, but the patient had explained this further to the doctor when she was still decisively. Based on the physician's own observations and information from relatives, the physician explained the patient's living will at the final request in accordance with the patient's intention. After the first consultant consulted had given a negative advice, the doctor consulted a second consultant. The doctor and the second consultant consulted concluded from their own observations that the patient's suffering was unbearable and hopeless and - contrary to the conclusion of the first consultant consulted - there was no reasonable alternative for the patient. The physician had consulted a specialist in geriatric medicine, but not in the capacity of an independent expert. In view of the doctor's contacts with a

psychiatrist, a specialist in geriatric medicine, and the peer consultation with a doctor from the Euthanasia Expertise Center, the Committee is of the opinion that the doctor nevertheless exercised the necessary extra caution. Taking into account that the formulation of the Supreme Court in the judgment of 21 April 2020 offers some scope for this.

The committee invited the doctor for an oral explanation. A report has been made of the oral explanation. The doctor has been given the opportunity to correct any factual inaccuracies in the report.

Introduction to the case

Three years before death, the patient, a woman aged 70-80, was diagnosed with Alzheimer's disease on the basis of long-standing complaints. The patient's cognitive decline was such that she eventually no longer recognized her own children and became completely dependent on the care of others. In addition, there was a loss of decorum and a permanent state of inner unrest, in which the patient expressed grief and impotence. The patient was no longer able to express what was bothering her.

Almost a year and a half before her death, the patient switched to the doctor's practice, because her relationship with her previous GP had become disrupted. During the introductory meeting approximately sixteen months before her death, the doctor and patient discussed euthanasia and also referred to the living will drawn up by her five years before her death. After this conversation, the doctor had asked an independent psychiatrist to assess the patient's decisiveness. In the months that followed, the patient still had good moments, but as time went on her situation deteriorated further. One month before the patient's death, the patient's husband asked the doctor to grant the patient's request as laid down in her living will, because the patient was no longer able to do so herself.

The physician consulted two independent SCEN physicians as consultants. The first consultant visited the patient three and a half weeks before death. According to the patient's family, this conversation had gone off in an unpleasant way and neither she nor the doctor felt satisfied from this consultation. For this reason, and in the absence of the consultant's report, the physician consulted

the second consultant, who visited the patient nine days before death. In the period between the two consultations, the doctor had asked an independent specialist in geriatric medicine to form an opinion on the possible options for reducing the patient's suffering on the basis of the medical file and the other documents.

The assessment framework in general

Section 2, subsection 1, of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act (hereinafter: WTL) contains the six due care criteria that a doctor must meet when applying for termination of life on request or assisted suicide. The text of Article 2, first paragraph, of the WTL can be found here.

The assessment framework focused on the case

This case concerns a patient with advanced dementia, where the doctor relied on the patient's advance directive. In this situation, as much as actually possible in the given situation, all due care requirements, Article 2, paragraph 1, WTL apply mutatis mutandis.

In patients with dementia, the doctor must take extra care to check whether the statutory due care criteria have been met, in particular the requirements regarding the voluntary and well-considered nature of the request, the hopelessness and unbearability of the suffering and the lack of a reasonable other solution. The circumstance that a patient can no longer express his will will usually prompt the doctor to consult - in addition to the regular consultant - a second independent doctor with specific expertise in the matter (such as a geriatrician, a specialist geriatric medicine or an internist geriatric medicine).). In addition, in this case the Committee has explicitly considered the other due care requirements regarding information about the situation and prospects, consultation and implementation.

On April 21, 2020, the Supreme Court set out basic principles about the possibility for a doctor to comply with a written request for euthanasia from a

patient suffering from advanced dementia. The committee based itself - partly - on the judgment (ECLI: NL: HR2020: 712) of the Supreme Court.

Considerations

On the basis of the facts and circumstances derived from the file and insofar as relevant, the Committee considers as follows.

Voluntary and Informed Request

Considerations

The execution of a euthanasia request in the phase in which the process of dementia has progressed to such an extent that the patient is no longer competent and can no longer communicate (or only through simple expressions or gestures) is possible in cases where the patient, while still was competent, has drawn up a living will. Article 2, second paragraph, WTL stipulates that a written living will can replace an oral request and that the due care criteria referred to in Article 2, first paragraph, WTL apply mutatis mutandis.

The doctor must have come to the conviction that the patient had drawn up the advance directive voluntarily and deliberately at the time. The doctor will have to base this on his own assessment of the medical file and the concrete situation of the patient, consultation with other care providers who have or had a treatment relationship with the patient and consultation with family and relatives, now verbal verification of the wishes of the patient. the patient is not possible. In addition, the doctor must establish that the current situation of the patient corresponds with the situation outlined by the patient in his advance directive. First of all, this requires determining the content of the advance directive. In its judgment of 21 April 2020, the Supreme Court ruled that the advance directive must be interpreted with a view to ascertaining the patient's intention. In doing so, the doctor must pay attention to all circumstances of the case and not just the literal wording of the request. There is therefore room for interpretation of the advance directive.

In the aforementioned ruling, the Supreme Court also determined that the advance directive must at least always include that the patient requests euthanasia in a situation where he can no longer express his will. If the patient also wants his request granted if there is no unbearable suffering as a result of physical suffering, the advance directive must also show that the patient regards his (expected) suffering from this situation as unbearable and that he or she does so. on the basis of his request.

Taking the above into account, the Committee considers as follows. Approximately four and a half years before her death, the patient had drawn up a living will at a civil-law notary, which also included a request for euthanasia and a special clause 'dementia' accompanying the euthanasia request. On the basis of the documents, the Committee comes to the conclusion that at the time the patient drew up her living will there was no reason to assume that she was already incapable of giving consent. The Committee takes into account that the diagnosis of Alzheimer's had not yet been made and it follows from the living will itself that she stated before a civil-law notary that she was in possession of her full intellectual capacities. It is also taken into account that the doctor during the introductory meeting with the patient,

In her living will the patient had formulated her euthanasia request as follows.

“When I find myself in a situation in which I suffer without hope, and / or in which there is no reasonable prospect of a return to a state of life worthy of me and / or my further deterioration can be foreseen, I explicitly request my doctor to grant serve or provide to end my life.
(...)
This euthanasia request will remain in full force regardless of the time that may have passed since it was signed. It is completely clear to me that I can withdraw this euthanasia request. By signing this euthanasia request, I therefore consciously accept the possibility that a doctor will accept the request, about which I might have started to think differently if I was consciously aware of it.
(...)
I have carefully considered this euthanasia request, I have been well informed about it and I am in possession of my full mental capacities at the time of signing it.

This written euthanasia request has legal force and expressly applies as a valid and legally recognized written statement from me in the event that, for whatever reason, I can no longer make a decision about my medical situation as referred to in this statement.
(...)
Special clause 'dementia' belonging to the euthanasia request
If I am no longer able to do so myself, my authorized representative will fully represent my interests in the medical field and thereby strive for the realization of the advance directives filled in and signed by my attending physician (s). In this regard, my proxy will bring my advance directives to the attention of my treating physician (s) and ensure that my request for termination of life will be seriously assessed by my doctor and, if possible, granted and the treatment prohibition included in the advance directives will be fully respected . ”

The Committee has established that the patient's living will has been drawn up in general terms. For example, it is not made concrete what the patient understood by hopeless suffering, a dignified state of life or tarnishing. When asked, the doctor stated that she also found the patient's living will very general and that is why she asked the patient during the introductory meeting to explain what would be hopeless suffering for her. The patient stated very emphatically that she did not want to be admitted to a nursing home. Her frame of reference was a close family member who lived angry in a nursing home for years after a stroke. She wanted to prevent this for herself. According to her, there was also a question of tarnishing if she were completely dependent on others, would no longer be able to be independent or to undertake things independently and no longer recognize her children. During this introductory meeting, the patient had also stated that she still fully supported her living will. The physician concluded that although the patient had cognitive impairment at the time, the understanding was intact and she could still clearly indicate what she did and did not want. However, the patient did not yet have a current request. In the months that followed, the patient's situation deteriorated further and ultimately meaningful communication with the patient was no longer possible. On the basis of the documents, the Committee holds that the patient was no longer legally competent at the time of the request by her husband.

De commissie overweegt dat patiënte vierenhalf jaar voor het overlijden een levenstestament had opgesteld, dat zij tijdens het gesprek met de arts, ongeveer zestien maanden voor het overlijden, nader heeft toegelicht. Uit de stukken volgt voorts dat de arts na dit kennismakingsgesprek ongeveer elke zes tot acht weken met patiënte heeft gesproken. Hieruit komt een beeld naar voren van een patiënte die gaandeweg steeds verwarder raakte, maar bij gesloten vragen toch kon aangeven dat zij niet naar een verpleeghuis wilde. De gedachte bij haar veilige baken, zijnde haar echtgenoot, weg te moeten maakte haar onrustig en angstig.

From the documents and the conversation with the doctor it follows that the patient was no longer able to take care of herself for about three months before death. She could no longer dress or undress herself, wash herself and also had to be helped with the toilet. The patient needed help from her husband in everything, showed constant restless behavior and was unaware of her loss of decorum. The patient could not always clean herself for defecation and then panicked. The home situation had become very precarious and admission to a nursing home was threatening, even though the patient had explicitly indicated that she did not want this. The patient no longer showed any recognition towards her children and even became restless when she was in their presence without her husband. A month before the patient's death, the patient's husband indicated to the doctor that the patient could no longer enjoy benefits and that she would never have wanted this situation. The patient's daughter also stated this to the doctor when asked.

Furthermore, the doctor turned to the patient's treating case manager for dementia. She had visited the patient three and a half weeks before her death and stated that the patient was a different woman than four months before. The patient had become completely dependent on care, introverted, constantly restless and very mood sensitive. The case manager, who had supervised the patient for more than a year and a half, said that this was precisely the situation in which the patient did not want to find herself and why she had her living will drawn up at the time.

On the basis of all the data, the Committee has become convinced that at the time of the execution of the life termination there were the circumstances that the patient had described in her living will, or to which the patient referred in her

living will. It is true that the patient had not made concrete in her living will what she understood by a dignified state of life or tarnishing, but it is certain that she could no longer communicate meaningfully, needed help with everyday things, no longer had a grip on her thinking and acting and now and then there was was of stool incontinence, loss of decorum and no longer recognized her children. The doctor herself spoke with the patient when she was still decisively and in which she indicated that she did not want to be completely dependent on others or that she wanted to go to a nursing home and she feared that she would no longer recognize her loved ones. In addition, the doctor spoke with the patient's relatives who confirmed that the patient did not want to end up in this situation. This is also endorsed by the patient's case manager.

In the Committee's opinion, the physician took this course of action to interpret the living will in accordance with the patient's intentions. It has thus become sufficiently clear to the Committee that there was a situation in which the patient no longer had a dignified state of life, and further tarnishing could be foreseen now that there was a threat of admission to a nursing home, which the patient absolutely did not want. In addition, the Committee notes that, seen in conjunction with the associated special clause 'dementia' as included in the patient's living will, it follows from the euthanasia request that she requested euthanasia if she had become incapacitated by the dementia and that she suffered from her request for had laid the foundation.

According to the Euthanasia Code 2018 (No longer mentally competent in the matter), the doctor must check whether the incapacitated patient shows clear signs that he does not want to end his life. The Supreme Court has confirmed this in the aforementioned ruling. The Supreme Court held that the patient's statements could no longer be interpreted as an expression of will explicitly aimed at withdrawing or adjusting the previous request. However, verbal or other utterances by the patient can be essential, both in assessing possible contraindications and in assessing the patient's current suffering.

The Committee notes that the physician has made several attempts to contact the patient in order to investigate whether she could indicate verbally or non-verbally that she no longer wanted euthanasia. It has become clear from the file that there have been no such statements. The conversations with the doctor, the second consultant and the case manager for dementia show that several times

there are indications that indicate that the patient still had a request for euthanasia. The doctor stated that during the conversations the patient made comments such as 'I don't want this' or 'I don't want anymore'. Although the physician found these statements difficult to weigh in view of her incapacity to give consent, she concluded that the patient in any case did not show any contradictory statements.

In the Committee's opinion, the physician exercised extra caution in determining whether the request was voluntary and well-considered. In doing so, the Committee takes into account that the physician himself had several conversations with the patient, studied extensively the patient's medical situation, spoke extensively with family and the patient's case manager. She has also taken note of the living will. In addition, the doctor consulted an independent psychiatrist who, fifteen months before her death, determined that some communication with the patient was possible, but that her spontaneous speech was sparse and she was persevering regularly. The independent psychiatrist found that the foreground aphasia made it impossible to assess to what extent the patient can still oversee the situation, reason abstractly and make decisions. Since there was no current request from the patient, she did not further assess her competence. She did, however, establish in retrospect that the patient could be deemed competent at the time of drawing up the living will.

The Committee considers that although this psychiatrist has not further assessed the patient's decisional competence, it does not consider that to be insurmountable in this specific situation. After all, in the Committee's opinion it is established that at the time of the actual request, more than a year after the psychiatrist had spoken to the patient, the patient was no longer able to express her will. In addition, it is taken into account that the second consultant confirms the physician's conclusion that the performance of the euthanasia was in accordance with the patient's advance directive and not contradictory to her statements.

In view of the foregoing, the physician could conclude that the performance of the euthanasia was in line with the patient's advance directive and that there were no contraindications for this.

In view of the foregoing, the Committee is of the opinion that the doctor could come to the conviction that there was a voluntary and well-considered request from the patient, which could be replaced by the written euthanasia request as referred to in Article 2, second paragraph, of the WTL. of the oral request.

Hopeless and unbearable suffering and no reasonable other solution

Hopeless suffering
The Committee states first of all that the hopelessness of the suffering, given the nature of the disorder, is evident and does not require further motivation.

Unbearable suffering
At the time of the performance of the euthanasia, there must be a situation in which it is likely that the patient is experiencing unbearable suffering. There may be current unbearable suffering due to physical ailments, but there may also be current unbearable suffering if the patient finds himself in the situation that he has designated in his advance directive as (expected) unbearable suffering. The mere circumstance that the patient is in the situation described in the advance directive is not sufficient for the conclusion that there is actual unbearable suffering. The doctor will always have to establish in a careful and verifiable manner that the patient is actually suffering from current unbearable suffering. The doctor can base this on his own assessment of the medical file and the concrete situation of the patient, consultation with other care providers who have or had a treatment relationship with the patient and consultation with family and loved ones. The determination of whether there is in fact hopeless and unbearable suffering is a medical professional judgment and therefore reserved for the doctor. The retrospective assessment of whether the doctor could come to the conviction that there was unbearable suffering amounts to a marginal assessment of whether the doctor could reasonably conclude that there was unbearable suffering (Supreme Court 21 April 2020; ECLI: NL: HR: 2020: 712). The determination of whether there is in fact hopeless and unbearable suffering is a medical professional judgment and therefore reserved for the doctor. The retrospective assessment of whether the doctor could come to the conviction that there was unbearable suffering amounts to a marginal assessment of whether the doctor could reasonably conclude that there was unbearable suffering (Supreme Court 21 April 2020; ECLI: NL: HR: 2020: 712). The determination of whether there is in fact hopeless and unbearable suffering is a

medical professional judgment and therefore reserved for the doctor. The retrospective assessment of whether the doctor could come to the conviction that there was unbearable suffering amounts to a marginal assessment of whether the doctor could reasonably conclude that there was unbearable suffering (Supreme Court 21 April 2020; ECLI: NL: HR: 2020: 712).

The Committee takes into account in its opinion that the file and the oral explanation have shown that the doctor has thoroughly studied the patient's situation. The doctor examined step by step whether there was any current unbearable suffering of the patient. In addition, the doctor spoke several times with the patient, her family and case manager, but also consulted other colleagues. As a result of these conversations and observations of the patient, the physician eventually concluded that the patient was suffering unbearably. The doctor describes that the patient had always been a neat, well-groomed woman who did not want to be dependent on others. The suffering that the patient had seen in her immediate environment made the patient very firm in her desire not to go to a nursing home. Due to the dementia, the patient was eventually no longer able to express herself properly and indicate what she wanted. In addition, the patient was no longer able to take care of herself and had to be helped with everyday things. She could no longer dress and undress or wash herself. She also no longer knew what she liked to eat, nor could she make a choice in the food and drink that was served to her. The patient was also regularly lost in her own home and had to be accompanied everywhere by her husband. There was also inner turmoil in which there were expressions of grief (crying, not compulsive), impotence and wandering behavior. The doctor determined that this (previously) well-groomed woman lost her decorum. During the various visits to the patient, she regularly saw powerlessness and grief in her. Eventually, the patient was no longer able to enjoy life's small pleasures, such as a cup of coffee or a glass of rosé in her garden, which she was able to do before. The patient repeatedly indicated 'I don't want this', where the sentence is often spoken loosely, so not in response to a question or action. The doctor concluded that the patient was no longer happy in the situation she found herself in and was suffering from her dementia.

However, the first consultant concluded that there was no unbearable suffering. She established that the films of the patient and the descriptions of her family

and involved practitioners showed that there was sadness and discomfort. However, the patient's behavior is described and sometimes interpreted without providing a clear description of the suffering, such as fear, grief or pain. During the visit, the consultant saw that the patient was not happy when she cried and searched around the house. She found that disconcerting and suspected that this was the disgrace to which the patient referred in her living will. However, the consultant did not have the impression during her visit that the patient was suffering unbearable. Under these circumstances, according to the first consultant, there was no question of unbearable suffering. The doctor was forced to consult another consultant. According to the family, the conversation with the first consultant had proceeded in an unpleasant manner, whereby the treatment of the consultant towards the patient was experienced as 'unkind'. During the oral explanation, the physician stated that this consultant (apparently) showed a great resemblance to the previous GP of the patient with whom the relationship had become disrupted. The patient had been upset for days after the consultant's visit, the doctor said. A few days after the visit, the consultant voluntarily contacted the patient's husband by telephone to discuss the course of the conversation and to apologize. During the oral explanation, the doctor stated that she was not looking for a positive advice from a consultant. She would have taken a negative advice from the second consultant to heart. The consultation with the second consultant arose from the way in which the conversation with the first consultant had gone, so that the patient's family and the doctor did not feel satisfied after this consultation and there was no longer any confidence in the first consultant. During the visit of the second consultant, no report from the first consultant was available. The consultation with the second consultant arose from the way in which the conversation with the first consultant had gone, so that the patient's family and the doctor did not feel satisfied after this consultation and there was no longer any confidence in the first consultant. During the visit of the second consultant, no report from the first consultant was available. The consultation with the second consultant arose from the way in which the conversation with the first consultant had gone, so that the patient's family and the doctor did not feel satisfied after this consultation and there was no longer any confidence in the first consultant. During the visit of the second consultant, no report from the first consultant was available.

The second consultant concluded that there was unbearable suffering. The patient could no longer make this verbally clear, but according to the second consultant this was shown by her impotence and incapacity. The second consultant observed this impotence during his visit and he was able to deduce from the available video images and diary entries of her husband. The Committee also takes into account in its assessment that the same picture was outlined by the dementia case manager and the supervisors of the care farm where the patient had a trial run a few months before death. When asked, the case manager stated in writing that she saw grief only in the face, eyes and posture of the patient. The patient was completely withdrawn. This while the patient was still cheerful four months earlier and could enjoy small things. During the observations on the care farm it was also observed that the patient was very anxious and restless and even tried to climb over the fence to get away. The general impression was that the patient could not express her anger and without her beacon of safety, being her husband, and without her own environment, she lost control of her life.

In the Committee's opinion, it follows from all of the foregoing that the physician considered at length the question of whether the patient's suffering was unbearable for her, despite the fact that the patient was no longer able to adequately verbally express her suffering. As a result of the fact that the unbearable nature of the suffering was not palpable to the first consultant, the doctor gave further justification at the end of her model report. The Committee considers that in the model report and during the oral explanation, the physician has extensively motivated her decision-making process. In doing so, the doctor was guided by her own observations, the video images made by her family, the conversations with the immediate relatives of the patient and the written statements of the case manager, and employees of the care farm. The physician was also confirmed by the second consultant in her conclusion that there was unbearable (current) suffering for the patient. In view of this course of action, the doctor not only reflected extra, but also provided an insightful motivation for setting aside the assessment of the first consultant. The Committee also takes into account that the first consultant during her visit also observed that the patient wandered around the house and occasionally had to cry and was unhappy at those moments. Although she did not qualify this as unbearable suffering, the doctor, the second consultant and the dementia case manager did.

In view of this course of action, the doctor not only reflected extra, but also provided an insightful motivation for setting aside the assessment of the first consultant. The Committee also takes into account that the first consultant during her visit also observed that the patient wandered around the house and occasionally had to cry and was unhappy at those moments. Although she did not qualify this as unbearable suffering, the doctor, the second consultant and the dementia case manager did. In view of this course of action, the doctor not only reflected extra, but also provided an insightful motivation for setting aside the assessment of the first consultant. The Committee also takes into account that the first consultant during her visit also observed that the patient wandered around the house and occasionally had to cry and was unhappy at those moments. Although she did not qualify this as unbearable suffering, the doctor, the second consultant and the dementia case manager did. The Committee also takes into account that the first consultant during her visit also observed that the patient wandered around the house and occasionally had to cry and was unhappy at those moments. Although she did not qualify this as unbearable suffering, the doctor, the second consultant and the dementia case manager did. The Committee also takes into account that the first consultant during her visit also observed that the patient wandered around the house and occasionally had to cry and was unhappy at those moments. Although she did not qualify this as unbearable suffering, the doctor, the second consultant and the dementia case manager did.

As already considered under the heading 'The assessment framework geared to the case', the circumstance that the patient can no longer express his will will usually give rise to consult a second independent doctor with specific expertise in the matter (such as a geriatrician, a specialist geriatric medicine or a geriatric internist). This expert must give an opinion - where necessary based on his own research - about, among other things, the unbearable and hopelessness of the patient's suffering and any reasonable alternatives. In this way a guarantee is created that all reasonable efforts have been made in order to draw conclusions from the expressions of a patient that are sometimes difficult to interpret that relate directly to the will to, or awareness of, termination of life. The Committee has established that it was sufficient for the doctor to consult two independent consultants. These were irrelevant experts, as indicated above.

The Committee was thus faced with the question of whether the physician had also observed the said extra caution with regard to determining the unbearable nature of the suffering. The Committee took the following circumstances into account in this consideration. The doctor asked the dementia case manager to comment on the patient's condition at that time. When asked, this case manager stated in writing that she had been involved with the patient for over a year and a half and had spoken to her regularly. During the first conversations with the patient, she was still able to articulate her euthanasia request and was able to clearly indicate what she did and did not want. In the following period she had also remained consistent in her views, albeit that more and more often she could only indicate these with 'yes' or 'no'. In the conversations with the patient, the patient was often attentive and she was able to make a pertinent little comment every now and then, although participating in the conversation gradually became more difficult. She could still enjoy company, have a cup of tea together and still had a sparkle in her eyes. However, during the last visit of the case manager, about a month before the death, he found that the patient had become a different woman from the one she was a few months earlier. The patient's face had sunk in, she was almost the entire time inward-looking, staring ahead at an indefinable point on the floor. In addition, the patient was very restless all the time: she sat up, stood and sat up again and visibly tightened her abdominal muscles all the time. When asked, the patient made a few more comments such as 'I don't like it anymore, it's not fun anymore' and 'I am so very tired, so very tired all the time', after which she also fell into tears. The case manager concluded that the patient's previous cheerfulness and sparkle had disappeared and was replaced by sadness. Sadness observed by the case manager in the patient's face, eyes, and posture. The Committee therefore concludes that the doctor was confirmed not only by the second consultant but also by the case manager that he was suffering from current excruciating suffering. The case manager concluded that the patient's previous cheerfulness and sparkle had disappeared and was replaced by sadness. Sadness observed by the case manager in the patient's face, eyes, and posture. The Committee therefore concludes that the doctor was confirmed not only by the second consultant but also by the case manager that he was suffering from current excruciating suffering. The case manager concluded that the patient's previous cheerfulness and sparkle had disappeared and was replaced by sadness. Sadness observed by the case manager in the patient's face, eyes, and posture. The Committee

therefore concludes that the doctor was confirmed not only by the second consultant but also by the case manager that he was suffering from current excruciating suffering.

Although no expert was consulted with this, as is generally considered to be customary in the case of a patient with advanced dementia, the Committee ultimately concluded that the doctor carefully examined and substantiated the unbearable nature of the suffering. It is considered decisive in this regard that the physician was able to closely monitor and record the course of the patient's suffering himself. The dementia case manager, who had been involved with the patient for a long time, also provided an extensive and detailed report on the course of the patient's dementia. In addition, the second consultant was well oriented and was able to interpret his impressions partly through conversations with the patient's loved ones, the dementia case manager and the doctor, as well as by studying the available video images. Finally, the Committee considers that the doctor has discussed the case with a doctor from the Expertise Center Euthanasia (hereinafter: EE), in which they also discussed the unbearable nature of the suffering.

In view of the foregoing, the Committee is of the opinion that the physician has carefully examined and substantiated the unbearable nature of the suffering.

No reasonable alternative
In view of the patient's progressed dementia, this due care requirement can no longer relate to her current beliefs, and so the physician cannot come to the conclusion with the patient that there was no reasonable alternative solution for her situation. Therefore, the physician must be convinced that there is no reasonable alternative to the current situation in which the patient finds herself, both according to medical judgment and in the light of the patient's advance directive. The physician will have to base this on her own assessment of the medical file and the concrete situation of the patient, consultation with other care providers who have or had a treatment relationship with the patient and consultation with family and relatives of the patient.

As already considered by the Committee, this was a situation as described in the patient's written living will. The first consultant found that attempts to find a reasonably different solution through a change of environment were given up

very quickly because patients with dementia take longer to get used to. She saw admission to a nursing home as a reasonable alternative and it would only take about six weeks to assess how seriously the patient would suffer in that environment. The doctor explained that during the introductory meeting, when she was still decisively competent, the patient explicitly indicated that she did not want to go to a nursing home. Given the experiences with a close relative, this had become a nightmare for her. The patient could also have confirmed this at later times in response to closed questions. Considering this statement in conjunction with the patient's living will, the physician was convinced that a trial admission to a nursing home, as suggested by the first consultant, was not a reasonable alternative for the patient. The second consultant confirmed this to the doctor. He concluded that the patient's personality would not tolerate the group process in a nursing home and that the patient was no longer able to participate in activities there, such as games and the like. Moreover, such a recording had always been her specter, according to the second consultant. Considering this statement in conjunction with the patient's living will, the physician was convinced that a trial admission to a nursing home, as suggested by the first consultant, was not a reasonable alternative for the patient. The second consultant confirmed this to the doctor. He concluded that the patient's personality would not tolerate the group process in a nursing home and that the patient was no longer able to participate in activities there, such as games and the like. Moreover, such a recording had always been her specter, according to the second consultant. Considering this statement in conjunction with the patient's living will, the physician was convinced that a trial admission to a nursing home, as suggested by the first consultant, was not a reasonable alternative for the patient. The second consultant confirmed this to the doctor. He concluded that the patient's personality would not tolerate the group process in a nursing home and that the patient was no longer able to participate in activities there, such as games and the like. Moreover, such a recording had always been her specter, according to the second consultant. He concluded that the patient's personality would not tolerate the group process in a nursing home and that the patient was no longer able to participate in activities there, such as games and the like. Moreover, such a recording had always been her specter, according to the second consultant. He concluded that the patient's personality would not tolerate the group process in a nursing home and that the patient was no longer able to participate in activities there, such as games and the like.

Moreover, such a recording had always been her specter, according to the second consultant.

In her view, the doctor also felt supported by a specialist in geriatric medicine she had consulted. The doctor had asked this geriatric specialist whether she saw any possibilities to improve the patient's quality of life and reduce her suffering pressure. After studying the patient's medical file, her living will, the available video images and the other documents, the geriatric specialist indicated that everything had been tried in the home situation, including daytime activities, medication and activities at home. These options did not have the intended effect and the patient did not want admission to a nursing home, according to the specialist in geriatric medicine. The doctor stated during the oral explanation that the geriatric specialist had indicated during a telephone contact that she did not consider a trial admission to this patient, who could not thrive on a care farm, useful. This almost felt like bullying, especially now that this was explicitly against the will of the patient, as the geriatric specialist had indicated.

The Committee has established that the physician did not officially consult the geriatric healthcare provider specialist as an expert, but approached it indirectly to obtain more certainty about her own opinion. Although it would have been better if the doctor had approached this geriatric specialist with a specific question regarding the due care requirements, the Committee considers that the geriatric specialist did comment on whether there were reasonable alternatives for the patient and they, the doctor and the specialist geriatric medicine, were independent from each other. In view of the foregoing, in which the doctor has considered both the contents of the patient's living will and her statements about admission to a nursing home, the Committee is of the opinion that the doctor could come to the conclusion that there was no reasonable alternative to these circumstances. (that were the unbearable suffering) to eliminate or substantially reduce it. In doing so, the physician also relied on discussions with the patient's loved ones and professionals.

In view of the foregoing, the Committee is of the opinion that the physician was able to come to the conviction that the patient was suffering unbearably hopeless and that there was no reasonable alternative for the situation in which the patient found herself.

Informed about the situation and the outlook

Considerations

The doctor must have come to the conviction that the patient was sufficiently informed at the time about his situation and prospects and about the meaning and consequences of his advance directive. Within the limitations that are the inevitable consequence of the patient's condition, the doctor must also make an effort to communicate meaningfully with the patient about this, unless it is clear that these limitations imply that this is impossible (Supreme Court 21 April 2020; ECLI: NL: HR: 2020: 712).

The Committee considers that it follows from the documents that the patient had experienced little involvement from her previous GP after the diagnosis of dementia. This had damaged confidence, as a result of which the patient had switched to another GP. During the introductory meeting with the doctor, the patient explained in which situation she did not want to end up and explicitly referred to the living will signed by her. In the Committee's opinion, it follows from this that the patient was aware of her clinical picture and the associated course of it. In addition, it appears, both from the documents and from the oral explanation, that the doctor spoke with the patient about her euthanasia wish. Even after a coherent conversation with the patient was no longer (properly) possible, the patient also made comments such as 'I don't want this' or 'I don't want to anymore' during these conversations. These sentences were often spoken loosely, not as an answer to a question or action, according to the doctor. In view of the foregoing, the Committee is of the opinion that the physician has attempted to achieve meaningful communication with the patient.

In view of the foregoing, the Committee is of the opinion that the patient was sufficiently informed at the time about the situation in which she found herself and about her prospects, as well as about the meaning and consequences of her living will.

Consultation

Considerations

Now that there is advanced dementia in which the patient could no longer be considered to be competent in the matter, it must be examined how the consultant formed an opinion about the due care criteria. The law prescribes that the consultant sees the patient. There will be little or no communication between the consultant and the patient. This means that in addition to his own observation, the consultant will also have to use information from the doctor and additional information from others than the doctor in order to reach a judgment and make his report. This may include the patient file and oral information from the doctor, specialist letters, the content of the advance directive and conversations with family and / or carers (Supreme Court 21 April 2020; ECLI: NL: HR: 2020: 712).

The Committee has established that the doctor has consulted two consultants. Both consultants saw and spoke to the patient. In addition, both consultants conducted their own research by studying the living will, the medical file, the video recordings made and having conversations with the immediate family. Subsequently, both consultants gave their written opinion on the due care criteria. As follows from the foregoing, the Committee is of the opinion that the physician has sufficiently motivated why she decided to consult another consultant and why she set aside the conclusions of the first consultant. The second consultant concluded that the due care criteria had been met.

The circumstance that the patient can no longer express his will will usually give rise to consult a second independent doctor with specific expertise in the matter (such as a geriatrician, a specialist geriatric medicine or an internist-geriatric medicine). This expert must give an opinion - where necessary based on his / her own research - about the patient's competence, the unbearable and hopelessness of the patient's suffering and any reasonable alternatives (Supreme Court 21 April 2020; ECLI: NL: HR: 2020 : 712).

As already considered by the committee, the doctor did not do this. When asked, the physician stated that she assumed that she had fulfilled this requirement by consulting the psychiatrist and approaching the geriatric specialist. She also indicated that she had consulted the dementia case manager and had spoken with a doctor from EE on the advice of the second consultant. With the report of the psychiatrist and the advice of the colleagues she consulted, she thought she had been sufficiently informed and advised, all the more since she had not been

made aware by these colleagues of the fact that consultation of a specific expert with regard to decisive competence, as well as the unbearable and hopelessness of the suffering. The Committee was thus faced with the question whether the doctor had observed the extra caution referred to. In view of the contacts of the doctor with the independent psychiatrist, the specialist in geriatric medicine, the peer consultation with a doctor from EE and the way in which the doctor reflected on her actions after the conclusions of the consulted consultants, all as considered above, the committee decides that the due care criteria have been met. The Committee also takes into account that the formulation of the Supreme Court, with the wording 'usually gives cause', offers some room to weigh up all the circumstances. Nevertheless, the Committee would like to emphasize that, under these specific circumstances, it can be concluded that the due care criteria have been met, but it would certainly have been preferable to consult a relevant expert. During the oral explanation to the committee, the doctor has acted in a verifiable way and reflected on her actions in this report during the interview. She stated that she thought she had complied with the due care criteria, but concluded from the discussion with the committee that according to the rules she should have consulted an independent expert (with questions focused on the special situation), which she will also take to heart for the future. . During the oral explanation to the committee, the doctor has acted in a verifiable way and reflected on her actions in this report during the interview. She stated that she thought she had complied with the due care criteria, but concluded from the discussion with the committee that according to the rules she should have consulted an independent expert (with questions focused on the special situation), which she will also take to heart for the future. . During the oral explanation to the committee, the doctor has acted in a verifiable way and reflected on her actions in this report during the interview. She stated that she thought she had complied with the due care criteria, but concluded from the discussion with the committee that according to the rules she should have consulted an independent expert (with questions focused on the special situation), which she will also take to heart for the future. .

De commissie is gezien het voorgaande van oordeel dat de arts ten minste één andere, onafhankelijke arts heeft geraadpleegd, die de patiënte heeft gezien en schriftelijk zijn oordeel heeft gegeven over de zorgvuldigheidseisen, bedoeld in de onderdelen a tot en met d.

Uitvoering

Overwegingen

Onderdeel van een medisch zorgvuldige uitvoering is een voorbereiding en uitvoering waarbij ook rekening wordt gehouden met mogelijk irrationeel of onvoorspelbaar gedrag van de patiënt. De toepassing van euthanasie moet op een voor de patiënt zo comfortabel mogelijke manier gebeuren. Als er bij een wilsonbekwame patiënt aanwijzingen zijn dat onrust, agitatie of agressie kan ontstaan bij de uitvoering van euthanasie, kunnen de door de arts in acht te nemen medische maatstaven hem tot de conclusie brengen dat premedicatie is aangewezen. Als er geen betekenisvolle communicatie mogelijk is met de patiënt als gevolg van de situatie waarin de patiënt zich bevindt, is het niet noodzakelijk dat de arts met de patiënt overlegt over het moment en de wijze waarop de euthanasie zal worden uitgevoerd. Zo'n gesprek zou niet alleen zinloos zijn omdat bij een dergelijke patiënt het begrip over deze onderwerpen ontbreekt, maar zou mogelijk ook agitatie en onrust kunnen veroorzaken (Hoge Raad 21 april 2020; ECLI:NL:HR:2020:712).

De commissie stelt vast dat de arts de uitvoering nog uitvoerig heeft besproken tijdens het intercollegiaal contact met de arts van EE. Tevens heeft de arts mondeling verklaard met de familie, de arts van EE en de apotheker een draaiboek te hebben besproken. Naar aanleiding van het overleg met EE heeft de arts besloten over te gaan tot het toedienen van premedicatie. De arts gaf tijdens de mondelinge toelichting aan dat het onrustige gedrag van patiënte daartoe aanleiding gaf. Zij wilde graag dat de uitvoering op rustige en respectvolle wijze zou verlopen. Patiënte dronk de premedicatie zonder problemen op en viel vrij snel in een diepe slaap. Hierna heeft de arts de levensbeëindiging uitgevoerd conform de KNMG/KNMP Richtlijn Uitvoering euthanasie en hulp bij zelfdoding van augustus 2012.

De commissie is gezien het voorgaande van oordeel dat de arts de levensbeëindiging op verzoek medisch zorgvuldig heeft uitgevoerd.

Beslissing

De arts heeft gehandeld overeenkomstig de zorgvuldigheidseisen bedoeld in artikel 2, eerste lid, WTL.

Zie ook

- Huisarts
- Dementie
- Uitzichtloos en ondraaglijk lijden
- Geen redelijke andere oplossing
- Vrijwillig en weloverwogen verzoek
- Onafhankelijke arts geraadpleegd
- Medisch zorgvuldige uitvoering
- Voorlichting aan de patiënt
- 70 tot 80 jaar
- Overeenkomstig de zorgvuldigheidseisen
- Vragen oproepende meldingen
- Levensbeëindiging op verzoek