



Euthanasia

A guide to the Dutch

Termination of Life on Request

and Assisted Suicide

(Review Procedures) Act

Netherlands Ministry of Foreign Affairs
International Information and Communication Department
in cooperation with
the Ministry of Health, Welfare and Sport
and the Ministry of Justice



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- II. Statistics from:
 - the 1996 evaluation of the euthanasia notification procedure, and
 - the 2000 annual report of the regional euthanasia review committees
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1 Why legislate on euthanasia?

In the Netherlands, euthanasia is understood to mean termination of life by a doctor at the request of a patient. The Dutch government does not turn a blind eye to the fact that euthanasia happens. The question of whether – and how – criminal liability for euthanasia should be restricted has been the subject of broad political and public debate for the past thirty years.


The inclusion in the Criminal Code of a special ground for exemption from criminal liability means that doctors who terminate life on request or assist in a patient's suicide can no longer be prosecuted, provided they satisfy the statutory due care criteria (see Q3) and notify death by non-natural causes to the appropriate regional euthanasia review committee (see Q9).

The main aim of the policy is to bring matters into the open, to apply uniform criteria in assessing every case in which a doctor terminates life, and hence to ensure that maximum care is exercised in such cases.

 Pain, degradation and the longing to die with dignity are the main reasons why patients request euthanasia. Doctors in the Netherlands and in many other countries are increasingly faced with decisions about end-of-life issues. The population is ageing, considerable advances have been made with life-prolonging treatments, and cancer is claiming a rising proportion of victims. Euthanasia does not mean simply desisting from treatment when further intervention is pointless and allowing nature to take its course. This is accepted medical practice, as is the administration of drugs necessary to relieve pain even in the knowledge that they will have the side effect of hastening death. People in the Netherlands do not request euthanasia out of concern at the cost of treatment, since everyone is fully insured under the social security system.

2 Are doctors now no longer punished for performing euthanasia?

Euthanasia (termination of life on request and assisted suicide) is still a criminal offence, but the Criminal Code has been amended to exempt doctors from criminal liability if they report their actions and show that they have satisfied the due care criteria formulated in the Act. The actions of doctors in such cases are assessed by review committees (appointed by the Minister of Justice and the Minister of Health, Welfare and Sport), which focus in particular on the medical and decision-making procedures followed by the doctor. Where a doctor has reported a case and a review committee has decided on the basis of his report that he has acted with due care, the Public Prosecution Service will not be informed and no further action will be taken. But where a review committee finds that a doctor has failed to satisfy the statutory due care criteria, the case will be notified to the Public Prosecution Service and the Health Inspectorate. These two bodies will then consider whether the doctor should be prosecuted (see Q7).

 The aim of exempting doctors from prosecution is to ensure that they no longer feel like criminals and can act openly and honestly in relation to requests for euthanasia, provided that their decision-making and medical procedures satisfy the statutory due care criteria. The requirement of prior consultation with a physician who is not otherwise involved in the case and the review procedures constitute important safeguards for patients voluntarily requesting euthanasia in circumstances where they face unbearable suffering with no prospect of improvement.

3 What are the criteria for assessing whether a doctor has acted with due care?

When dealing with a patient's request for euthanasia, doctors must observe the following due care criteria.

They must:

- a. be satisfied that the patient's request is voluntary and well-considered;
- b. be satisfied that the patient's suffering is unbearable and that there is no prospect of improvement;
- c. inform the patient of his or her situation and further prognosis;
- d. discuss the situation with the patient and come to the joint conclusion that there is no other reasonable solution;
- 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 the four points above;
- f. exercise due medical care and attention in terminating the patient's life or assisting in his/her suicide.

Since 1 November 1998, regional review committees have been assessing whether doctors' actions satisfy the criteria which are now stated in section 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act (see appendix I).

Another important, basic principle established in case law is the existence of a close doctor-patient relationship. A doctor may only perform euthanasia on a patient in his care. He must know the patient well enough to be able to assess whether the request for euthanasia is both voluntary and well-considered, and whether his suffering is unbearable and without prospect of improvement.


4 Do doctors in the Netherlands always comply with requests for euthanasia?

No. Two thirds of the requests for euthanasia that are put to doctors are refused. Treatment frequently provides relief, while some patients enter the terminal stage of their illness before a decision has been reached.

Doctors are not obliged to comply with requests for euthanasia. Experience shows that many patients find sufficient peace of mind in the knowledge that the doctor is prepared to perform euthanasia and that they ultimately die a natural death.


5 Are doctors obliged to comply with requests for euthanasia?

No. Doctors can refuse to perform procedures to terminate life and nurses can refuse to be involved in preparations for euthanasia. Neither doctors nor nurses can ever be censured for failing to comply with requests for euthanasia.

 The ability to refuse a request for euthanasia or assisted suicide guarantees doctors' freedom of conscience. The basic principle underlying the legislation is that patients have no absolute right to euthanasia and doctors no absolute duty to perform it.

6 Why do patients request euthanasia if good palliative and terminal care is available?

The Dutch health care system is accessible to all and guarantees full insurance cover for terminal and palliative care. Unfortunately, even where patients are receiving care of the highest quality, they may still regard their suffering as unbearable and plead with their doctors to terminate their lives. In such cases, euthanasia could represent a dignified conclusion to good palliative care.

 Palliative care is provided in a variety of settings. First of all, the incurably ill can be cared for in their own homes by general practitioners, district nurses, home health aides and other care providers. If this is not appropriate, they must be admitted to some form of residential accommodation. Traditionally, such residential terminal care has been provided in hospitals and nursing or old people's homes. Palliative units have existed for many years in Dutch hospitals and there are several dozen nursing homes and terminal wards within old people's homes. A more recent development is hospices and "home-from-home" units specially designed to cater for incurably ill patients who are unable to spend the remainder of their lives at home.

7

What is the notification procedure?

- The doctor is obliged to notify the municipal pathologist of every instance of death from non-natural causes. In the case of euthanasia or assisted suicide, he compiles a report based on a special model (see Appendix III).
- The pathologist also compiles a report establishing that the patient's death was due to non-natural causes. He sends this to the Public Prosecutor, who must give consent for burial.
- The regional euthanasia review committee receives these two reports, plus a statement by the independent physician consulted by the doctor and any written directive by the deceased (see Q 10).
- The committee assesses whether the doctor has acted in accordance with the due care criteria (see Q 3). If it concludes that he has, no further action is taken against him.
- If the committee finds that the doctor has not acted in accordance with the due care criteria, it reports its findings to the Public Prosecution Service and the regional health inspector. These two agencies will then consider what action, if any, should be taken against the doctor.



An important feature of the legislation is that the regional review committees (each of which includes a doctor) have discretion to decide whether or not a doctor has satisfied the due care criteria. The reason for this is that research has shown that doctors are more likely to report cases of euthanasia if their own peers have a hand in the initial review of them. Otherwise, they feel that they face the threat of immediate condemnation by the Public Prosecution Service (see Q 9).

8

What is the procedure for consulting an independent physician?


Before the attending physician complies with a request for euthanasia, he must first consult a colleague who is neither connected with him nor involved in treating the patient. The independent physician must see the patient for himself, review the progression of the illness, establish whether the request for euthanasia is both voluntary and well-considered, and communicate his findings to the attending physician in writing.



A network has been set up in the Netherlands of general practitioners and other physicians trained to assist doctors facing decisions relating to the terminal stages of life (the SCEN project). Attending physicians dealing with requests for euthanasia should preferably consult one of these doctors.

9 Who sits on the regional review committees and how do they operate?

There are five regional review committees¹ dealing with reported cases of euthanasia or assisted suicide. Each has an odd number of members, including in any event one legal expert (who also chairs the committee), one physician and one expert on ethical issues (see section 3 of the Act). This ensures that proper consideration is given to the legal, procedural, medical and moral aspects of cases. The committees reach their decisions by majority vote. The chairs and the ordinary members are all appointed by the Minister of Justice and the Minister of Health, Welfare and Sport for a period of six years.


 The five regional review committees have been in operation since 1 November 1998. Under the new Act, they are no longer obliged to report cases to the Public Prosecution Service if they feel that the statutory due care criteria have been met. The committees are also responsible for the registration of cases of termination of life on request or assisted suicide notified to them. This does not mean, however, that they have taken over the role of the Public Prosecution Service, since their remit goes no further than assessing whether the due care criteria have been met. The Public Prosecution Service is still free to institute an investigation in any case where there is reason to suspect that a crime has been committed.

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¹ The five regions are: Groningen, Friesland and Drenthe; Overijssel, Gelderland, Utrecht and Flevoland; North Holland; South Holland and Zeeland; North Brabant and Limburg.

10 Does a written directive have the same status as an oral request?

The Act recognises written directives (living wills) as well as oral requests as legitimate forms of request for euthanasia. The recognition of written directives is especially important where a doctor decides to comply with a request for euthanasia in circumstances where the patient is no longer able to express his wishes orally. In such circumstances, a written directive counts as a well-considered request for euthanasia, but its existence can never discharge the doctor from his duty to reach his own decision on the request in the light of the statutory due care criteria.


 The doctor must normally give serious consideration to any written directive. The only exception is where he has reason to believe that the patient was not competent to make a reasonable appraisal of his own interests at the time when he signed it. In that case, the directive will not constitute a request for euthanasia within the meaning of the Act. It is important that the doctor and patient discuss the terms of the directive, if at all possible.

The statutory provision for written directives makes it possible for patients to indicate in advance that they wish their lives to be terminated if they eventually find themselves experiencing unbearable suffering with no prospect of improvement, in circumstances which render them incapable of expressing their wishes personally. Since the Act applies only to termination of life on request, it follows that it is not applicable to patients who have made no advance directive and are unable to decide or express their wishes. The government will make additional statutory provision for this category of patients.

13


11 What is the definition of “unbearable suffering with no prospect of improvement”?

- Suffering is without prospect of improvement if this is the prevailing medical opinion. In other words, if doctors agree that the patient’s condition will not improve.
- It is difficult to establish objectively whether suffering is unbearable. The review committee examines each individual case to establish whether the doctor could reasonably conclude that the patient was suffering unbearably.

 The doctor and patient must discuss every possible alternative treatment. As long as a feasible alternative is available, there is, in a medical sense, a prospect of improvement. This can be assessed objectively. By contrast, the extent to which suffering is unbearable is a highly subjective matter. Nevertheless, where suffering is not obvious either to himself or to the patient’s relatives or carers, the doctor will have to try to imagine what the patient is feeling and – based on his medical experience – attempt to assess his suffering objectively.


12 Does “unbearable suffering” include psychological suffering?

If a patient has a psychological illness and his suffering is not primarily caused by a physical complaint, it is difficult to assess objectively whether a request for euthanasia is voluntary and well-considered. In such cases, the attending physician should consult not one but two independent specialists, at least one of whom must be a psychiatrist, and they must personally examine and interview the patient. The doctor may plead force majeure, but such a plea will be treated with great reserve. In most cases, the Public Prosecution Service will institute proceedings, and it will be left to the court to decide whether a plea of force majeure is justified.

 In 1994, a psychiatrist was convicted of assisting a suicide at the request of a patient whose suffering was psychological (the Chabot judgment), though no penalty was imposed. In upholding the conviction, the Supreme Court held that, if the cause of suffering was psychological, the court must exercise the utmost caution in establishing whether the circumstances constituted force majeure. In April 1995, the Medical Disciplinary Tribunal came to the same conclusion as the Supreme Court and the psychiatrist was reprimanded.


13 Can euthanasia be performed in cases of dementia?

The commonest form of dementia is Alzheimer's disease, a key symptom of which is forgetfulness. The presence of dementia or some other such condition is not in itself a reason to comply with a request for termination of life or assisted suicide. For some people, however, the very prospect of one day suffering from dementia and the eventual associated loss of personality and dignity is sufficient reason to make an advance directive covering this possibility. Each case will have to be individually assessed to decide whether, in the light of prevailing medical opinion, it can be viewed as entailing unbearable suffering for the patient with no prospect of improvement.

 In response to questions on this subject in the House, the Minister of Health, Welfare and Sport stated that dementia can make the patient's quality of life unacceptable if he himself regards his condition in this way, but that even then the doctor must decide whether the patient's suffering is unbearable and without prospect of improvement in the light of prevailing medical opinion.


14 But is it not the duty of the doctor to preserve life?

Yes. A doctor's main duty is indeed to preserve life. Euthanasia is not part of the medical duty of care. However, doctors are obliged to do everything they can to enable their patients to die with dignity. They may not administer pointless medical treatments. When all treatment options have been exhausted, the doctor is responsible for relieving suffering.

 The 1996 study (see Q 18) showed that doctors in the Netherlands exercise the utmost caution in dealing with end-of-life decisions.


15 Can people come from other countries to seek euthanasia in the Netherlands?

This is impossible, given the need for a close doctor-patient relationship. The legal procedure for the notification and assessment of each individual case of euthanasia requires the patient to have made a voluntary, well-considered request and to be suffering unbearably without any prospect of improvement. In order to be able to assess whether this is indeed the case, the doctor must know the patient well. This implies that the doctor has treated the patient for some time (see Q3).

 Granting a request for euthanasia places a considerable emotional burden on the doctor. Doctors do not approach the matter lightly. From this point of view too, longstanding personal contact between the doctor and the patient plays an important role.

16 Can a minor request euthanasia?

The Act contains special provisions dealing with requests from minors for termination of life and assisted suicide. The age groups to which it applies mirror the existing statutory provisions regarding consent for medical treatment. The Act allows twelve to fifteen-year-olds to request euthanasia, but requires parental consent for euthanasia to be performed in these cases. By contrast, it permits sixteen and seventeen-year-olds to make such decisions for themselves, although it prescribes that their parents must always be involved in discussions on them. Before complying with requests from minors, doctors must of course always satisfy themselves that the patient's suffering is unbearable and without prospect of improvement, and that the usual due care criteria have been met.

 Experience shows that in practice the vast majority of cases of euthanasia (90 per cent) relate to patients with terminal cancer. This is equally true of young people's requests for euthanasia. In these extremely rare cases, the parents or guardian should normally be able to reconcile themselves with the wishes of the child. The attending physician, the patient and his parent or guardian usually discuss the question at length, and failure to reach agreement is almost unknown.

17

Is Dutch law on euthanasia compatible with international conventions guaranteeing the right to life?

The Dutch government does not believe that the new Act conflicts with its duty under international law to defend its citizens' right to life against violation by government or by individuals. That duty is laid down, for example, in article 6 of the UN's International Covenant on Civil and Political Rights (ICCPR) and article 2 of the European Convention on Human Rights (ECHR). What underlies both provisions is respect for life. The conventions deprive government and others of the right to take an individual's life against his will (except in specified circumstances).

These provisions are not intended to perpetuate unbearable suffering where there is no prospect of improvement, but rather to offer the individual protection against the violation of his right to life. Neither the wording nor the drafting procedure clarifies what constitutes such unlawful violation. It is generally believed that signatories to the conventions have considerable freedom to interpret their broadly worded provisions within their own national legal systems. However, even if the conventions cannot be interpreted as imposing a general prohibition on the termination of life on request or assisted suicide, the national provisions of signatory states must certainly provide sufficient protection to meet the criterion of "respect for life". This is the basis of Dutch legislation on euthanasia. Performing euthanasia in response to a voluntary request from a patient does not constitute intentional deprivation of life within the meaning of the articles of the conventions cited above.

20



Article 2 of the ECHR reads as follows:

- (1) Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
- (2) Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:


- (a) in defence of any person from unlawful violence;
- (b) in order to effect a lawful arrest (...).

The new Act is therefore not incompatible with international conventions and the most fundamental human rights laid down in them. The Dutch government vigorously endorses these rights, but does not go so far as to forbid individuals to decide for themselves whether or not their lives are worth living. For that reason, suicide is not an offence in the Netherlands, as it is in some other countries.

21

18 How willing were doctors to notify cases of euthanasia in 1990-1999?

Statistical material obtained by independent research (commissioned by the Dutch government) in 1991 and 1996 into medical action to terminate life showed that there was no question of a “slippery slope”, but that greater openness had on the contrary led to increasing care in the performing of euthanasia (see appendix II). Statistics included in the annual reports of the regional review committees for 1998/1999 and 2000 support this conclusion by showing an increase in the number of notifications by doctors. The Netherlands is the only country in which such research has so far been conducted. A new study is to be launched in 2001. This will evaluate the operation and procedures of the regional review committees, examine factors influencing the willingness of doctors to report euthanasia and assess the latest state of affairs surrounding medical action to terminate life. The last of these will permit comparison with the data from the 1991 and 1996 studies.

22  The 1996 study included interviews and an anonymised survey of doctors. The results showed no increase in the number of euthanasia cases among vulnerable categories of patients or the less seriously ill. In fact, it showed that the number of cases in which life was terminated without the patient's request had actually decreased over the 1990-1995 period. At the same time, the number of cases of termination of life on request over that period had not risen disproportionately, although the number of notifications of termination of life on request and assisted suicide had tripled. The existence of the notification procedure had led doctors to consult more frequently with colleagues and to record in writing how they had reached their decisions.

23

Q & A

Appendices

I

Provisions quoted from:

The Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act (Senate, session 2000-2001, 26 691, no. 137) (debated in the Senate of the States General on 10 April 2001; due to enter into force on a date yet to be decided)

II

Statistics from:

- the 1996 evaluation of the euthanasia notification procedure, and
- the 2000 annual report of the regional euthanasia review committees

III

Model report for use by doctor following euthanasia or assisted suicide

I

Chapter 2. Due care criteria

Section 2

1. In order to comply with the due care criteria referred to in article 293, paragraph 2, of the Criminal Code, the attending physician must:
 - a. be satisfied that the patient has made a voluntary and carefully considered request;
 - b. be satisfied that the patient's suffering was unbearable, and that there was no prospect of improvement;
 - c. have informed the patient about his situation and his prospects;
 - d. have come to the conclusion, together with the patient, that there is no reasonable alternative in the light of the patient's situation;
 - e. have consulted at least one other, independent physician, who must have seen the patient and given a written opinion on the due care criteria referred to in a. to d. above; and
 - f. have terminated the patient's life or provided assistance with suicide with due medical care and attention.
2. If a patient aged sixteen or over who is no longer capable of expressing his will, but before reaching this state was deemed capable of making a reasonable appraisal of his own interests, has made a written declaration requesting that his life be terminated, the attending physician may comply with this request. The due care criteria referred to in subsection 1 shall apply mutatis mutandis.
3. If the patient is a minor aged between sixteen and eighteen and is deemed to be capable of making a reasonable appraisal of his own interests, the attending physician may comply with a request made by the patient to terminate his life or provide assistance with suicide, after the parent or parents who has/have responsibility for him, or else his guardian, has or have been consulted.
4. If the patient is a minor aged between twelve and sixteen and is deemed to be capable of making a reasonable appraisal of his own interests, the attending physician may comply with the patient's request if the parent or parents who has/have responsibility for him, or else his guardian, is/are able to agree to the termination of life or to assisted suicide. Subsection 2 shall apply mutatis mutandis.

Chapter 3. Regional review committees for the termination of life on request and assisted suicide

Division 1: Establishment, composition and appointment

Section 3

1. There shall be regional committees to review reported cases of the termination of life on request or assisted suicide as referred to in article 293, paragraph 2, and article 294, paragraph 2, second sentence, of the Criminal Code.
2. A committee shall consist of an odd number of members, including in any event one legal expert who shall also chair the committee, one physician and one expert on ethical or moral issues.
A committee shall also comprise alternate members from each of the categories mentioned in the first sentence.

Chapter 4. Amendments to other legislation

Section 20

The Criminal Code shall be amended as follows.

A

Article 293 shall read as follows:

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 fifth- category fine.
2. The act referred to in the first paragraph shall not be an offence if it is committed by a physician who fulfils the due care criteria set out in section 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 section 7, subsection 2 of the Burial and Cremation Act.

B

Article 294 shall read as follows:

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 to a fourth-category fine.
2. Any person who intentionally assists another to commit suicide or provides him with the means to do so 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.

Statistics from:

the 1996 evaluation of the euthanasia notification procedure, and the 2000 annual report of the regional euthanasia review committees.

II

Mortality in the Netherlands (population 16 million)

Year	1990	1995	2000**
Total mortality	128,824	135,675	
- termination of life on request*	1.8%	2.4%	
- assisted suicide*	0.3%	0.3%	
- termination of life without express request *	0.8%	0.7%	

(*estimate)

(**not available)

Notification behaviour in cases of euthanasia

Year	1990	1995	2000**
Estimated number of requests	8,900	9,700	
Estimated number of cases per year:			
- termination of life on request	2,300	3,600	
- assisted suicide	242	238	
- termination of life without express request	976	913	
Number of notifications	486	1,466	2,123
Percentage of cases notified	18%	41%	

(**not available)

Model report for use by doctor following euthanasia or assisted suicide

III

Model report

For the use of the attending physician in notifying the municipal pathologist of a death resulting from euthanasia or assisted suicide as referred to in section 2.

In notifying the municipal pathologist of a death from non-natural causes, i.e. euthanasia or assisted suicide, the attending physician is required to submit a report compiled on the basis of the following model.

NB: Please give reasons for your answers to the questions. You are free to include additional information in appendices to your report. If you need more space to answer a question in full, please attach an appendix.

Please remember to indicate clearly to which question or questions the information contained in each appendix refers.

PERSONAL PARTICULARS OF THE PHYSICIAN

Surname:
Initials: sex: M/F
Position: general practitioner
 attending physician in nursing home
 specialist (give specialism)
Name of hospital/institution (where applicable):
Work address:
Postcode:

PERSONAL PARTICULARS OF THE DECEASED

Surname:
Initials: sex: M/F
Date of death:
Age:
Municipality in which death took place:

I. THE CASE HISTORY

- 1 From what disorder(s) was the patient¹ suffering, and since when?
- 2 What medical treatments were attempted?
- 3 Could the patient be cured?
- 4 What was the nature of the patient's suffering?
 - 5a Could his/her suffering be relieved?
 - 5b If so, what was the patient's view of these options?
- 6 How long do you estimate the patient would have lived had his/her request for euthanasia or assisted suicide not been granted?

II. REQUEST FOR EUTHANASIA OR ASSISTED SUICIDE

- 7a When did the patient request euthanasia or assistance with suicide?
- 7b When did he/she repeat this request?
- 8 In whose presence did the patient make this request?
 - 9a Did the patient leave a living will?
 - 9b If so, on what date? (please enclose the living will with the report)

¹In this model report, the term "patient" can refer to either sex

9c If not, why not?

10 Are there any indications that the patient made the request under pressure from or under the influence of others?

11 Was there any reason to doubt that the patient was fully aware of the implications of his/her request and of his/her physical condition at the time he/she made the request?

NB: The termination of the life of a patient whose suffering was primarily psychological or whose ability to express a well-considered request might have been impaired by, for example, depression or the onset of dementia should be notified in accordance with the procedure for termination of life without the explicit request of the patient. This also applies if the patient was a minor.

12a Did you consult the nursing staff/the patient's carers about terminating the patient's life?

12b If so, whom did you consult and what was their view?

12c If not, why not?

13a Did you consult the patient's family about terminating his/her life?

13b If so, whom did you consult, and what was their view?

13c If not, why not?

III. CONSULTATION

14 Which physician(s) was/were consulted?

15a In what capacity?
(general practitioner, specialist, psychiatrist, other, i.e.)

15b Was/were the physician(s) attending the patient?

15c What is their relationship to you?

16a When did the physician(s) examine the patient?

16b If the physician(s) did not examine the patient, why not?

17 **NB:** Please enclose the written report compiled by the consultant physician(s) confirming that the patient had no prospect of improvement, that his/her suffering was unbearable, and that his/her request was both explicit and well-considered.

If the physician(s) did not compile a written report: what were their findings in respect of the points referred to above?

IV. PERFORMANCE OF EUTHANASIA OR ASSISTANCE WITH SUICIDE

18a Was this a case of:
 euthanasia (proceed to question 18b)
 assistance with suicide?

18b Who actually performed euthanasia?

19 What substances were used, and how were these administered?

20 Did you seek information on the method to be applied, and if so, from whom?

21 Who else was present when the patient died?

V. OTHER COMMENTS

22 Do you have any other comments you wish to make to the regional review committee?

Date:

Name:

Signature: