

# DEVELOPMENTS IN THE PRACTICE OF PHYSICIAN-ASSISTED DEATH SINCE ITS LEGALIZATION IN THE NETHERLANDS

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Public prostitution, freely available marijuana, conventional same-sex marriage—yet the Netherlands is, perhaps, best known around the world for pioneering physician-assisted death. Outside of the country, its reputation is easily misconceived and sometimes blown out of proportion. For example, in 2012 the Dutch were astonished to hear this assertion of former U.S. Senator and presidential candidate Rick Santorum:

In the Netherlands, people wear different bracelets if they are elderly. And the bracelet is: “Do not euthanize me.” Because they have voluntary euthanasia in the Netherlands. But half of the people who are euthanized—ten percent of all deaths in the Netherlands—half of those people are euthanized involuntarily at hospitals because they are older and sick. And so, elderly people in the Netherlands don’t go to the hospital. They go to another country, because they are afraid, because of budget purposes, they will not come out of that hospital if they go in there with sickness.<sup>1</sup>

His assertions were soon refuted by American journalists.<sup>2</sup>

A realistic bioethical evaluation of the practice of physician-assisted death in the Netherlands requires deeper analysis of the facts. Such analysis is, unfortunately, not easily accessible, since much

of the data has been published only in Dutch. Therefore, a factual overview of the developments of this practice since its legalization in 2002 is given here.

## The History of the Regulation

After a long process of debates and legal cases, the way was opened for legalization of physician-assisted death in the 1980s. In these years, the Royal Dutch Medical Association (hereafter KNMG, the acronym for the association in Dutch *Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst*) negotiated with the Public Prosecutor that physicians would, under certain conditions, not be prosecuted for assisting in death. The Supreme Court also ruled that, despite the prohibition in criminal law, physicians should not be prosecuted under these agreed-upon conditions. The government acknowledged this tolerance in 1994 by establishing a procedure for reporting and reviewing cases of assisted death. It was not until 2002 that the prohibition was legally waived under these conditions. Since then, a physician assisting in death is not punishable if the physician: 1) is convinced that the patient has made a voluntary and well-considered request and that patient’s suffering is unbearable without a prospect of improvement; 2) has informed the patient about his situation and prospects;

3) has come to the conclusion, together with the patient, that no reasonable alternatives exist; 4) has consulted at least one independent physician—who need not necessarily agree with his decision; and 5) terminates the patient’s life with due medical care. Contrary to American states, Dutch law permits not only assisted suicide but also euthanasia—whereby a physician administers a lethal drug to the patient, is not restricted to terminally ill patients, and does not exclude incompetent patients with advance directives.<sup>3</sup>

Physicians are obligated to report each case of assisted death to a Regional Review Committee (hereafter RTE, the acronym for the Dutch *Regionale Toetsingscommissies Euthanasie*, translated “Regional Review Committee”) consisting of a physician, a legal expert, and an ethicist. Formerly a Public Prosecutor inspected each case. Now such oversight is offered only to those cases that have been judged by the RTEs as not meeting the legal conditions. The RTEs have a leading role in the regulation, because their judgments are confidentially decided, final, and cannot be appealed.<sup>4</sup> Since 2012, an experienced secretary to each RTE classifies the reported cases because of the sheer volume of cases. Those cases classified as “raising questions” are judged at the RTEs’ plenary convocations. Other cases classified as “not raising questions” are judged by their members individually. If a member still questions such a case,

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it is referred to the plenary convocation judgment. The RTEs have set out their procedures in a Code of Practice, which is available in English.<sup>5</sup>

The procedure of the RTEs was challenged only once in 2014. A physician, having fruitlessly advised as a consultant against the assisted death of a patient with a psychiatric disorder, was subsequently interrogated by an RTE; after which, he reported feeling humiliated and denigrated by its members. This critique has led to the installation of an independent committee to handle complaints—except that it is not possible to request review of an RTE’s decision.<sup>6</sup>

### The Numbers and Characteristics

The number of reported cases of physician-assisted death has risen steadily from 1,882 in 2002 to 5,516 in 2015, corresponding to 1.3% and 3.7% of all deaths in the Netherlands, respectively (Figure 1). Over the last year, this number has continued to rise with 210 cases, but due to an increase in the total number of deaths, the percentage of cases of physician-assisted death decreased slightly

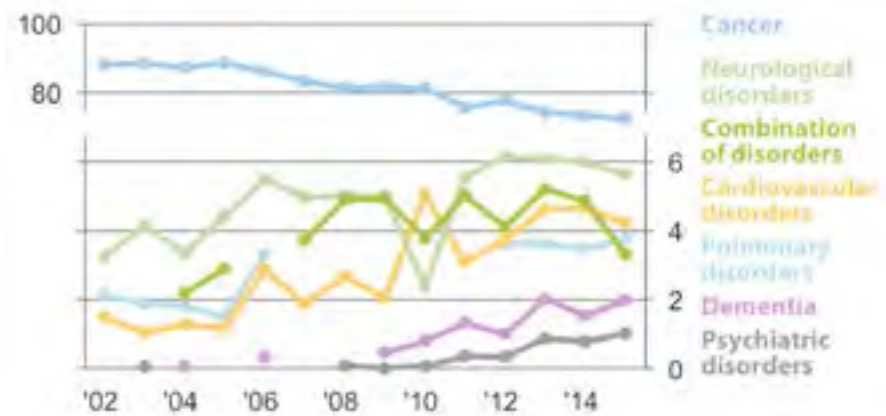


Figure 2. The percentages of cases of physician-assisted death because of cancer (—, on the left scale) and those because of other disorders (—, —, —, —, —, —, on the right scale) relative to all cases of physician-assisted death in each year.

from 3.8% to 3.7% relative to all deaths. Around 80% of the cases are classified by the RTEs as “not raising questions.”<sup>7</sup>

Of the 43,196 cases reported from 2002 through 2015, the RTEs have disapproved 79 (0.2%, Figure 1), with a maximum of 10 per year, mostly because of inadequate consultation of an independent physician or a medically faulty execution. In none of these cases has a physician been prosecuted.<sup>8</sup>

become more common, accounting for 109 (2.0%) and 56 (1.0%) cases, respectively, in 2015. Cases executed because of a combination of mostly age-related disorders have hovered around 4.5% in recent years (Figure 2). The numbers of cases executed by a general practitioner and at the patient’s home have remained stable, and while fewer cases are executed by a hospital specialist (from 11.0% to 3.3%) in a hospital (from 11.1% to 3.5%), more cases are performed by other physicians (from 2.2% to 11.0%) in healthcare facilities like nursing homes and hospices (from 4.9% to 14.8%).<sup>9</sup>

The numbers and characteristics of reported cases of physician-assisted death vary between regions. The numbers relative to all deaths have increased from 1.0% to 3.5% in the southern provinces, from 1.3% to 3.0% in the northern provinces, and from 2.4% to 5.9% in North Holland, which includes the national capital Amsterdam. In North Holland, assisted death is less often executed in the form of euthanasia, by a general practitioner, at home, and/or because of cancer as compared with the other regions. This variation cannot be explained by demographic, socioeconomic, or health-related differences between the regions.<sup>10</sup>

Since the aforementioned data comprise only reported cases of physician-assisted death, it is essential to know whether physicians report all cases. When interviewing physicians, 98% declare to report all cases. However, when evaluating cases of

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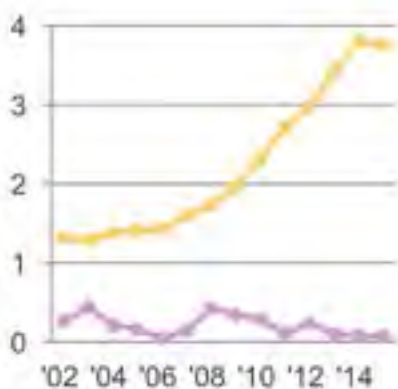


Figure 1. The percentage of cases of physician-assisted death reported to the RRCs relative to all deaths in each year (—) and the percentage of cases disapproved by the RRCs relative to all reported cases in each year (—).

Most cases of physician-assisted death were executed in the form of euthanasia instead of assisted suicide (≥89% of all reported cases in each year), because of cancer (≥88%), by a general practitioner (≥86%), and at the patient’s home (≥79%). However, these characteristics have shifted. The number of cases of euthanasia, as opposed to assisted suicide, has increased from 89% to 96% of all cases. The number of cases executed because of cancer has decreased from 88% to 73% (Figure 2). While physicians have long been reluctant to assist in the death of patients with dementia or psychiatric disorders—reflected by only incidentally reported cases in the early years, such cases have

death, physicians appear to have reported 80% of cases in 2005 and 77% in 2010. Of the non-reported cases, 79% in 2005 and 98% in 2010 is regarded by the physicians to concern “control of symptoms” or “palliative sedation” rather than “termination of life.” In these non-reported cases, morphine and benzodiazepines are used rather than muscle relaxants and barbiturates—as is prescribed for assisted death—and life is shortened by less than a week in 90% of the cases.<sup>11</sup> The non-reporting undermines the controllability and reviewability that are pursued by the reporting procedure which form the foundation of the Dutch legislation of physician-assisted death.<sup>12</sup>

### The Justification

In the initial debates and legal cases, assistance in death was justified as an act of mercy by a physician who found himself in a situation beyond medical control or a state of emergency, in which he experienced a conflict between his duties of preserving life and alleviating suffering.<sup>13</sup> Such a situation had become more common with the expansion of medical technologies to sustain life. Public awareness of such situations was raised by a physician, who pled in a controversial publication from 1969,

Human life may be ended by a physician. . . . He kills the patient. It reads so cruelly: that the physician kills the patient. It seems inappropriate. However, it is inappropriate to make the fully incompetent, long defeated, dying and already dead to vegetate further. That should be unusual. That is in any case cruel.<sup>14</sup>

Appeals to the patient’s autonomy as a justification of assisted death were less dominant. A year before its legislation, the Minister of Justice and Minister of Health declared,

This possibility for a physician can, however, never be explained as a patient’s right to an end of life. . . . We emphatically do not go so far as to mean that anyone who has no will to live anymore, also must have the possibility to end his life or to have his life ended.<sup>15</sup>

Such appeals nonetheless have a long history. Already in 1973, a group of around

1300 people founded the Dutch Society for Voluntary Euthanasia, later renamed into the Dutch Society for a Voluntary End of Life (NVVE).<sup>16</sup> This sentiment was stimulated in 1991 by the widely discussed plea of a former justice of the Supreme Court, writing,

My ideal is that old people who are left to themselves can go to a physician . . . to obtain the means with which they can, at the moment that it appears designated to them, terminate their lives in a manner that is acceptable for themselves and for their neighbors.<sup>17</sup>

The NVVE has become a large and influential organization with an increasing number of members (Figure 3).<sup>18</sup> Its goals encompass,

Advancement of use and social acceptance of existing legal possibilities towards free choice for the ending of life. Advancement of social acceptance and legal regulation of free choice for the ending of life in situations which are not within the scope of existing legal possibilities. Recognition of free choice for the ending of life (and assistance thereby) as a human right.<sup>19</sup>

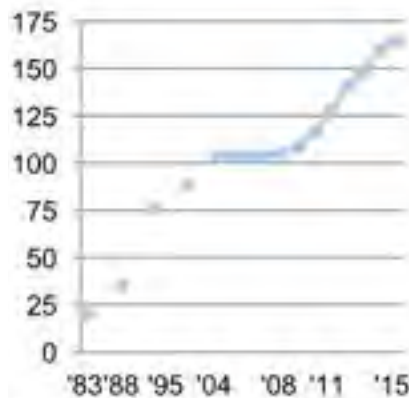


Figure 3. The number of members of the NVVE throughout the years in thousands.

To reach its goals, the NVVE advises its members about, campaigns and lobbies for, teaches at high schools on, and organizes conferences and other events with regards to assistance in death.<sup>20</sup>

The NVVE and at least five other organizations have striven after the recognition of the autonomy of the elderly to freely

choose for assistance in death. A petition in 2010—named *Uit Vrije Wil* (hereafter referred to by my translation By Free Will) and supported by almost 117,000 civilians—compelled Parliament to take into consideration that,

At any moment, we can come to the conclusion that the value and the meaning of our lives have decreased to such an extent that we prefer death over life. . . . Then we wish to die, worthily and peacefully, preferably in the presence of dear family and friends. . . . By Free Will is of the opinion that assisted death of elderly who request for it, should no longer be punishable.<sup>21</sup>

The government has, in response, asked a committee of experts for advice. Although this committee concluded that, “it is not desirable to widen the present legal possibilities concerning assisted death,”<sup>22</sup> a parliamentary party is currently preparing to introduce a bill that would extend these legal possibilities to elderly who are “ready to give up on life.”

A striking paradox in the appeals to patient autonomy is the emphasis on the physician’s assistance, reflected in numbers as the great and increasing preference of euthanasia over assisted suicide. If assistance of a physician is unavailable, it may be expected from family and friends, as revealed by a law case in 2015. A son of a 99-year-old woman, who was ready to give up on life and suffered from multiple mostly age-related disorders, was convicted for assisting in her suicide. He was not punished, though, because he had faced a conflict of duties and had met the legal conditions, precisely as prescribed for physicians.<sup>23</sup>

### The Role of Physicians

Physicians represented by the KNMG have had a leading role in legalization and regulation of physician-assisted death.<sup>24</sup> The “medical-professional norms” encapsulated in their guidelines, in tandem with prior court cases, specify the interpretations of the legal conditions, as has been acknowledged by the government.<sup>25</sup> These interpretations can, consequently, be changed. For example, when delineating the condition that a patient should

suffer unbearably, the KNMG guideline from 2003 holds that, “In the assessment of the suffering of a patient, some extent of subjectivity is inevitable, but there surely are professional and objectifiable elements to be recognized. . . . At least it

accordance with the medical-professional norm and acts not in accordance with the medical-professional norm can fall within the legal scope and be approved [by the RTEs].”<sup>30</sup>

are insufficiently informed about the limits to assistance in death, 24% find it difficult to reject a request, 70% encounter occasional pressure to grant a request, and 64% have experienced an increase in this pressure over the last years.<sup>32</sup>

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should be ‘inter-subjectively’ unbearable, which means that different physicians can empathize with it.”<sup>26</sup> By contrast, the renewed guideline from 2011 states that, “It is the patient who determines whether his suffering is unbearable. . . . The current legal scope and the interpretation of the concept of suffering are wider than many physicians hitherto assume and apply.”<sup>27</sup>

Changes in the guidelines go hand in hand with changes in physicians’ opinions. Although a constant proportion of physicians—around 85%—are willing to assist in death, they granted 37% of all requests in 2005 as opposed to 45% in 2010. The proposition that “everyone has the right to self-determine his life and death” was supported by 47% of physicians in 2005 and by 56% in 2011 (Figure 4).<sup>31</sup>

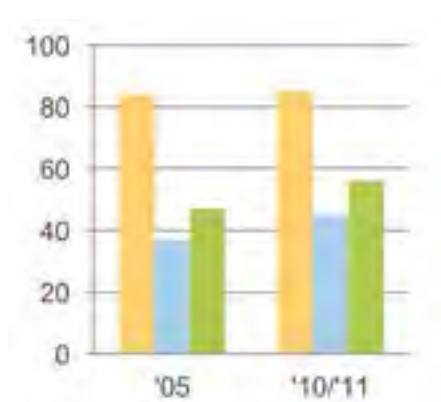


Figure 4. The percentage of physicians willing to assist in death (◀), the percentage of requests for assistance in death granted by physicians (◻), and the percentage of physicians supporting the proposition that “everyone has the right to self-determine his life and death” (◻).

Likewise, the KNMG’s guidelines have changed the delineation of disorders that qualify for assistance in death. The guideline from 2003 explains “that in cases in which the suffering does not predominantly result from a somatic disease or disorder . . . exceptional caution is required . . . and in cases in which the suffering cannot predominantly be attributed to a classifiable disorder . . . physician-assisted death is not legitimized.”<sup>28</sup> By contrast, the guideline from 2011 explains that, “It is completely defensible that vulnerability including aspects like loss of function, loneliness, and loss of autonomy are taken into account by physicians in the assessment of a request of assisted dying.”<sup>29</sup>

In 2014 the KNMG polled physicians for their experience regarding the current possibility to assist in death. Of the 455 responders, 75% believe that the assessment and execution of requests are part of their profession, 88% feel that society should be more aware of the burden this places upon them, 60% hold that patients

**Children**

The Dutch legislation of physician-assisted death applies to patients 12 years and older. Since the 1990s, assisted death of newborns with severe disorders has been tolerated, discussed, and, in two legal cases, approved. To formalize and delimit its practice, pediatricians in the city of Groningen devised the Groningen Protocol in 2002, in cooperation with the Public Prosecutor. The Protocol has been adopted by the Dutch Society for Pediatrics in a national guideline, endorsed by the KNMG, and later referenced in a Ministerial Decree, but has never been implemented in law. The Protocol requires a physician to conform to the same conditions as when assisting in the death of an adult and, additionally, to exclude any doubt about the diagnosis and prognosis and to assure the consent of both parents.<sup>33</sup> The government established a Review Committee in 2007 to judge whether cases meet the conditions. The Public Prosecutor decides, in consideration of the Committee’s judgment, whether the physician should be legally prosecuted. However, the Committee has received only one case report to date, which was approved and suspended from prosecution.<sup>34</sup>

Meanwhile, it is estimated that approximately 1% of all neonatal deaths per year are assisted in death. Of pediatricians who were interviewed, 64% deem it necessary to have this possibility, despite quality palliative care. The number of assisted deaths of newborns has decreased, however, probably because of expanded prenatal diagnostic possibilities and fear of legal uncertainties about risk of prosecution and compliance with medical practice.<sup>35</sup>

Earlier this year, at the request of the Dutch Society for Pediatrics, the Minister of Health commissioned a study on

deficiencies in medical practice at the end of children's lives and established a multi-disciplinary center of expertise to advise physicians about end-of-life care for children. At the same time, contradicting the Society,<sup>36</sup> the Minister dispelled

a misconception that currently no legal possibilities exist for a physician to proceed, as an ultimate act of his duty to care, to actively terminate the life of children between the ages of one and twelve years. A physician can in such a case appeal to a situation beyond control in the sense of a state of emergency.<sup>37</sup>

### The End-of-Life Clinic

The NVVE founded the End-of-Life Clinic in 2012 to help patients with a request for assisted death who are “left in a lurch” by their own physicians. It employs teams of physicians and nurses that travel throughout the country to assess their requests and to provide such assistance.<sup>38</sup> With the founding of the Clinic, assistance in death has been divorced from its role in the long-lasting relationship between a physician and his patient.<sup>39</sup>

In one unique case, the End-of-Life Clinic assisted in the death of a patient at her request, but against the wish of the staff in her nursing home, who asserted that she was incompetent. The Clinic euthanized her only after a court order forced the nursing home staff to comply.<sup>40</sup>

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The number of requests submitted to the End-of-Life Clinic have increased from 714 in its first year to 1234 in 2015 (Figure 5). Over the span of these years an average of 59% of the requests are made because of physical disorders, 36% because of psychiatric disorders, 9% because of a combination of mostly age-related disorders, and 7% because of dementia. Some requests “require urgent commitment,” as was ascribed to 277 requests in 2015, of which 72% were because of terminal

cancer and 17% because of progressing dementia. On average, over these years 24% of the requests are rejected, 21% are granted, 14% are annulled because of the requestor's death, and the remainder are under investigation or still granted by the own physician. The number of rejected requests has decreased from 28% to 23%. The most important reason for rejecting requests of psychiatric patients is an impulsive wish to die; and for those who are “ready to give up on life,” the most important reason for rejecting such request is the lack of a medical disorder.<sup>41</sup>

Why does a patient's own physician not grant the requests of their patients? The End-of-Life Clinic offers the following statistics: 43% of physicians doubt whether the request meets the legal conditions, 33% have conscientious objections as grounds for refusal, 14% lack experience with assisted death, 8% refuse because of their relationship with the patient, and 2% have other reasons.<sup>42</sup>

Since its founding in 2012, the number of requests granted by the End-of-Life Clinic has increased from 15% to 30% in 2015. Consequently, the number of executed cases of physician-assisted death has risen from 51 to 365 (Figure 5), and the number of teams has been expanded from 6 to 43. Of these cases, 64% were granted because of physical disorders, 16% because of a combination of most-

ly age-related disorders, 13% because of dementia, and 7% because of psychiatric disorders. The RTEs have disapproved 4 of the 762 hitherto executed cases (0.5%).<sup>43</sup>

“The ultimate goal,” of the End-of-Life Clinic, “is that in all cases the [patient's] own physician will assist in death and the End-of-Life Clinic will become redundant.” The Clinic strives to be a center of expertise in assisted death, for

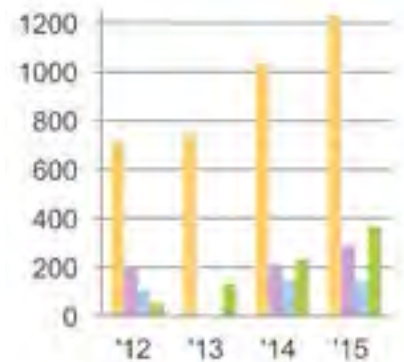


Figure 5. The numbers of received requests (x), annulled requests due to the requestor's death (y), rejected requests (z), and executed requests (w) of physician-assisted death at the End-of-Life Clinic in each year.

which it conducts research, informs the public, develops teaching material for the training of physicians, and provides guest lectures. It additionally established a consultative service in 2014, run by specialized nurses, which supports physicians who lack experience, have questions, encounter complications, or are emotionally burdened in the practice of assisted death. The support ranges from telephone advice to ongoing consultations.<sup>44</sup>

### Conclusion

The Netherlands has a long history of debating, tolerating, and regulating physician-assisted death that has been guided by the practice of physicians and the authoritative jurisprudence of the RTEs. Since its legalization, physician-assisted death has become more common without much public, legal, or juridical disapproval; it is increasingly applied because of less physical and less terminal disorders; it has become a choice for incompetent patients; it is no longer justified as a physician's act of mercy, but rather with an appeal to the patient's autonomy; it has become a possibility for unbearable suffering as experienced subjectively instead of assessed objectively; and it is not only performed in long-standing relationships between physicians and patients, but also by the quick-acting End-of-Life Clinic. Despite their disapproval, Mr. Santorum may be closer to the truth than the Dutch would like to admit.<sup>45</sup>

- 1 Glenn Kessler has provided this quotation in “Euthanasia in the Netherlands: Rick Santorum’s Bogus Statistics,” *The Washington Post Fact Checker*, February 22, 2012, [https://www.washingtonpost.com/blogs/fact-checker/post/euthanasia-in-the-netherlands-rick-santorum-s-bogus-statistics/2012/02/21/gIQAJaRbSR\\_blog.html](https://www.washingtonpost.com/blogs/fact-checker/post/euthanasia-in-the-netherlands-rick-santorum-s-bogus-statistics/2012/02/21/gIQAJaRbSR_blog.html) (accessed July 12, 2016). For a video of the statement, see Michael Morse and Eugene Kiely, “Santorum’s Bogus Euthanasia Claims,” *FactCheck.org*, February 22, 2012, <http://www.factcheck.org/2012/02/santorum-s-bogus-euthanasia-claims> (accessed July 12, 2016).
- 2 See both Kessler, “Euthanasia in the Netherlands,” and Morse and Kiely, “Santorum’s Bogus Euthanasia Claims.”
- 3 Heleen Weyers, *Euthanasie: het proces van rechtsverandering* (Amsterdam: Amsterdam University Press, 2004), 390–391. See also Jacob J.E. Koopman and Theo A. Boer, “Turning Points in the Conception and Regulation of Physician-Assisted Dying in the Netherlands,” *The American Journal of Medicine* 129, no. 8 (2016): 773.
- 4 See Weyers, *Euthanasie*, 392, as well as Koopman and Boer.
- 5 Regional Euthanasia Review Committees, *Code of Practice* (The Hague: 2015), <http://www.euthanasiacommissie.nl/uitspraken/brochures/code-of-practice/1/code-of-practice> (accessed July 12, 2016).
- 6 Alwin Kuiken, “Ruzie om euthanasie, verricht bij jonge geesteszieke vrouw,” *Trouw* January 11, 2014; *Klachtenregeling* (The Hague: Regional Euthanasia Review Committees, without date).
- 7 The RTEs provide data on the reported cases in their annual reports published online in Dutch, <http://www.euthanasiacommissie.nl/uitspraken>. Annual data on all deaths are freely available from the Central Bureau of Statistics, <http://statline.cbs.nl/statweb>.
- 8 *Ibid.*
- 9 *Ibid.*
- 10 *Ibid.* A more detailed description is expected to be published soon in a scientific journal in English as Jacob J.E. Koopman and Hein Putter, “Regional Variation in the Practice of Euthanasia and Physician-Assisted Suicide in the Netherlands.”
- 11 Agnes van der Heide et al., *Euthanasie en andere medische beslissingen rond het levenseinde: Sterfgevallenonderzoek 2010* (The Hague: ZonMw, 2012), 41–45; Agnes van der Heide et al., *Tweede evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding* (The Hague: ZonMw, 2012), 98–101.
- 12 Weyers, *Euthanasie*, e.g. 321–325.
- 13 Weyers, *Euthanasie*, e.g. 77–78, 121, 408, 416.
- 14 Jan Hendrik van den Berg, *Medische macht en medische ethiek* (Nijkerk: Callenbach, 1969), 48, (author’s translation, hereafter indicated by AT).
- 15 *Kamerstukken II* 1999/00, 26691, no. 6, 30, (AT). See also Weyers, *Euthanasie*, 399.
- 16 Weyers, *Euthanasie*, 101.
- 17 Huib Drion, “Het zelfgewilde einde van oudere mensen,” *NRC Handelsblad* October 19, 1991, (AT).
- 18 See Weyers, *Euthanasie*, 101, 177, 304. See also the information about the NVVE which is provided in its statute and annual reports published online in Dutch, <https://www.nvve.nl/over-nvve/organisatie>.
- 19 See NVVE’s annual reports, (AT).
- 20 See NVVE’s annual reports.
- 21 Information about By Free Will has been published online in Dutch, <http://uitvrijwil.nl> (accessed July 12, 2016), (AT).
- 22 Paul Schnabel et al., *Voltooid leven: over hulp bij zelfdoding aan mensen die hun leven voltooid achten* (The Hague: Adviescommissie Voltooid Leven, 2016), 16, (AT).
- 23 ECLI:NL:GHARL:2015:3444.
- 24 Weyers, *Euthanasie*, 412–414.
- 25 *Handelingen II* no. 27 (2000/01) 2250.
- 26 *Standpunt Federatiebestuur KNMG inzake euthanasie 2003*, VI.07, version 3.0 (Utrecht: Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst, 2003), 13. This can be accessed at <http://www.knmg.nl/web/file?uuid=8c5806df-66ba-4c8a-9e68-95052c69a20f&owner=a8a9ce0e-f42b-47a5-960e-be08025b7b04&contentid=41999> (accessed July 12, 2016), (AT).
- 27 *De rol van de arts bij het zelfgekozen levenseinde* (Utrecht: Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst, 2011), 20–21, 24, (AT).
- 28 *Standpunt Federatiebestuur KNMG inzake euthanasie 2003*, 14, (AT).
- 29 *De rol van de arts bij het zelfgekozen levenseinde*, 22, (AT).
- 30 *Kamerstukken II* 2013/14, 32647, no. 30, 5, (AT).
- 31 van der Heide et al., *Euthanasie*, 11–12; van der Heide et al., *Tweede evaluatie*, 85–87, (AT).
- 32 Eric van Wijlick and Gert van Dijk, “Dokters hikken soms tegen euthanasie aan,” *Medisch Contact* no. 1/2 (2015): 16–19.
- 33 *Zorgvuldigheidseisen rond actieve levensbeëindiging bij pasgeborenen met een ernstige aandoening* (Utrecht: Nederlandse Vereniging voor Kindergeneeskunde, 2005, geactualiseerde versie 2014), 6–10; *Medische beslissingen rond het levenseinde bij pasgeborenen met zeer ernstige afwijkingen* (Utrecht: Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst, 2013), 67–69; “Regeling beoordelingscommissie late zwangerschapsafbreking en levensbeëindiging bij pasgeborenen,” *Staatscourant* no. 3145 (2016).
- 34 The Review Committee provides data on the reported cases in their (bi)annual reports published online in Dutch, <http://www.lzalp.nl/procedure/jaarverslagen>.
- 35 See *Zorgvuldigheidseisen rond actieve levensbeëindiging bij pasgeborenen met een ernstige aandoening*, 5, and *Medische beslissingen rond het levenseinde bij pasgeborenen met zeer ernstige afwijkingen*, 28–35. See also Suzanne van de Vathorst et al., *Evaluatie Regeling centrale deskundigencommissie late zwangerschapsafbreking in een categorie-2 geval en levensbeëindiging bij pasgeborenen* (The Hague: ZonMw, 2013), 77–78, 86–88, 95–97.
- 36 *Zorgvuldigheidseisen rond actieve levensbeëindiging bij pasgeborenen met een ernstige aandoening*, 5.
- 37 *Kamerstukken II* 2015/16, 32647, no. 52, 2, (AT).
- 38 The End-of-Life Clinic provides data on the requested and executed cases in their annual reports published online in Dutch, <http://www.levenseindekliniek.nl/informatie>. The citation is from its annual reports *Jaarverslag 2013*, 7; *Jaarverslag 2014*, 7; *Jaarverslag 2015*, 7, (AT).
- 39 Koopman and Boer, “Turning Points,” 774.
- 40 ECLI:NL:RBZWB:2015:2681. See also the Clinic’s annual report *Jaarverslag 2015*, 30.
- 41 See the annual data of the End-of-Life Clinic, <http://www.levenseindekliniek.nl/informatie>. The data on urgent cases are from the Clinic’s annual report *Jaarverslag 2015*, 22; the data on the most important reasons for rejecting cases are from *Jaarverslag 2013*, 21.
- 42 See the Clinic’s annual report *Jaarverslag 2015*, 23.
- 43 See the Clinic’s annual reports.
- 44 The Clinic’s mission is described in its annual reports *Jaarverslag 2014*, 7 and *Jaarverslag 2015*, 7, (AT). Its activities are described in *Jaarverslag 2013*, 22–23, 48–50, *Jaarverslag 2014*, 26–31, 54–58, *Jaarverslag 2015*, 26–33, 44–45.
- 45 See a similar conclusion by John Keown, “Santorum and Dutch Euthanasia: Fact-Checking the ‘Fact-Checkers,’” *National Review: The Corner*, March 19, 2012, <https://www.nationalreview.com/corner/293857/santorum-and-dutch-euthanasia-fact-checking-fact-checkers-john-keown>.