Turning Points in the Conception and Regulation of Physician-Assisted Dying in the Netherlands

The United States and Canada stand at a turning point, which manifests as spreading support and legalization of physician-assisted dying.\(^1\)\(^2\) The Netherlands, with its pioneeing experiences of physician-assisted dying to which reference is often made, has gone through developments with more than one turning point. Here, we describe and clarify the origins as well as the current trends of these turning points and developments.

A first turning point occurred after physicians, jurists, and ethicists had deliberated during the decades after the Second World War about the definition and permissibility of physician-assisted dying, encompassing euthanasia and physician-assisted suicide. This deliberation gained public attention in 1973, when a physician was sentenced for administering lethal medication to her terminally ill mother. Two days later, the Dutch Society for Voluntary Euthanasia (NVVE, later changed to Dutch Society for a Voluntary Death) was founded, aiming at “social acceptance and legalization of voluntary euthanasia.”\(^5\)\(^6\) Subsequent lawsuits against physicians who had assisted others in dying, various committees, and publications gradually outlined a compromise on the definition of physician-assisted dying and the conditions for its permission.

As a second turning point, physician-assisted dying became defined, its legislation initiated, and its practice tolerated around 1985. The Royal Dutch Medical Association (RDMA) and a State Committee on Euthanasia defined physician-assisted dying as the intentional life-terminating act at the request of the patient performed by another, in case of euthanasia, or by the patient himself with the assistance of another, in case of physician-assisted suicide. A first bill was introduced in parliament and a report was published by the State Committee, both proposing conditions, built on those previously formulated, under which physician-assisted dying could be permitted. In the same year, RDMA and the Public Prosecutor agreed that physicians would not be prosecuted if these conditions were met.

Intensified political and public debates on physician-assisted dying continued, questioning, for example, whether it should be restricted to terminal illnesses and whether it should be regulated by criminal law, while jurisprudence progressively provided answers to these questions. After the tolerated practice of physician-assisted dying was provisionally formalized in 1994, the Netherlands was the first country to legalize it in 2001. A physician assisting in dying is not punishable on several legal conditions.\(^9\)\(^10\) The physician should be convinced that the patient has made a voluntary and well-considered request and that his suffering is unbearable without a prospect of improvement. He should, additionally, inform the patient about his situation and prospects, conclude with the patient that no reasonable alternatives exist, consult at least one independent physician, and terminate the patient’s life with due medical care. Contrary to the US and Canada, physician-assisted dying is not restricted to terminally ill patients and is not precluded for incompetent patients with advance directives.\(^1\)\(^3\) Physicians are obliged to report each case of assisted dying to a Regional Review Committee (RRC) consisting of a physician, a jurist, and an ethicist. The RRCs have largely taken over the role of the Public Prosecutor, who previously inspected each case, but now attends only to cases that have been judged by the RRCs as not meeting the conditions.

From its inception, the Dutch regulation of physician-assisted dying is guided by common practice. From 2002 through 2014, the number of reported cases has increased from 1882 to 5306,\(^9\) corresponding with 1.3% to 3.8% of all deaths. Crucially, the RRCs have a leading role in jurisprudence on physician-assisted dying, because their judgment that a case meets the conditions is confidentially decided, final, and cannot be appealed. Of the almost 38,000 hitherto-reported cases, 75 (0.2%) have been disapproved and referred to the Public Prosecutor, mostly because the consultation of an independent physician or the medical execution was inadequate. In none of these cases have physicians been prosecuted.\(^7\) The RRCs judge cases in the light of current medical, legal, and bioethical norms. RDMA is influential by delineating the medical norms in its guidelines. The Government has confirmed that the law utilizes open norms that “provide scope for developing views within society.”\(^7\) As a result, other more protracted turning points or developments have followed gradual turns in the law’s interpretation and public opinion.

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Of significance, the justification of physician-assisted dying in previous jurisdiction and legislation based on a physician’s conflict of duties—between the protection of life and beneficence—shifts toward an emphasis on a patient’s autonomy. This shift was publicly primed in 1991 by an ex-councillor of the Supreme Court, who advocated assisted suicide for all elderly who wish to die. In the same year, NVVE extended its aim to societal acceptance and legalization of physician-assisted suicide for anyone who wishes to die. Its membership has since then steadily grown to circa 160,000, making it the largest of its kind in the world. Several societies with similar aims have been established and provide instructions on suicidal methods or “self-euthanasia.”

In 2013, parliamentarians proposed that objecting physicians should be obliged to refer a patient who requests assisted dying to a willing colleague. As an indication of a growing demand from patients, RDMA has polled that 70% of physicians experience pressure to assist in dying and 64% observe an increase in this pressure.

In line with the increasingly valued autonomy of patients, it is discussed to what extent patients with a cognitive or psychiatric disorder are eligible for physician-assisted dying. Whereas such cases have earlier been treated with restraint, an increasing number is reported and approved, up to 257 in 2014. Occasional cases have been approved, up to 257 in 2014. For newborns, physician-assisted dying has been regulated by the Groningen Protocol; for children aged 1-11 its permissibility is currently discussed. Children of 12 years and older are already included in the present Act.

Another development stems from the legal open norm, but practically ambiguous condition that a patient should suffer unbearably and without a prospect of improvement. In 2002, the Supreme Court ruled that physician-assisted dying is permitted only if the patient’s suffering is mainly due to a medical disorder. Public debate has meanwhile—stimulated by the aforementioned societies—strived for permission for physician-assisted dying for those “weary of life” or “tired of life.” In 2011, RDMA acknowledged that suffering due to “existential distress,” “meaninglessness,” or “loss of dignity” may be part of the medical domain, and concluded that “the current legal frame and the interpretation of the condition of suffering are wider than many physicians think and apply until now.” The RRCs approve physician-assisted dying only if the suffering is caused by a medical disorder, but in practice, most of those requesting it out of “tiredness of life” also suffer from one or more medical disorders. An increasing number of cases with multiple minor medical age-related disorders have been approved, up to 257 in 2014. Occasional cases have been reported whereby suffering is caused by, for example, blindness, tinnitus, mysophobia, the expected death of a partner, or the prospect of retirement.

A last crucial development is the establishment of the End-of-Life Clinic by NVVE in 2012. Whereas physician-assisted dying was traditionally considered and practiced as an intimate act in a longstanding relationship between a physician and a patient, the Clinic operates teams of traveling physicians who provide physician-assisted dying when a patient’s attending physician refuses to do so. In 2014, about 40 nationally operative teams received 1035 requests and assisted 232 patients in dying, of whom 14 suffered from dementia, 17 from a psychiatric disorder, and 47 from multiple disorders of old age. These have no means of palliative care. Of a total of circa 400 cases, the RRCs judged four of the Clinic’s cases as not meeting the legal conditions.

In conclusion, the Netherlands has a long history of tolerating, legislating, and regulating physician-assisted dying. It is safe to say that legalization has contributed to a normalization of physician-assisted dying and has led, due to its unavoidably flexible and ambiguous nature, to an expansion of its practice. This history may be informative for countries that are currently making decisions at an earlier turning point.

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