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Advance directives requesting euthanasia in the Netherlands: do they enable euthanasia for patients who lack mental capacity?

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Abstract

With the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, which came into force in 2002 in the Netherlands, euthanasia, although a criminal act, is justified if performed by a physician complying with specified due care requirements. These requirements are largely based on jurisprudence. New in the Act is article 2.2, which allows physicians to carry out euthanasia on patients lacking mental capacity based on i) a written advance directive requesting euthanasia, and ii) fulfilment of the due care requirements 'to the extent allowed for by the actual situation'. Uncertainty exists about the interpretation of the wording. In addition, the professional code prescribed by the Royal Dutch Medical Association is stricter than the law, resulting in further ambiguity regarding the significance of advance directives.

Here, we will discuss the current debate in the Netherlands, and examine whether there is a conventional approach in applying the due care requirements based, among other things, on our case law study requested by the Ministry of Security and Justice and the Annual Reports of the Regional Euthanasia Review Committees.

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1. Introduction

Although legislation on euthanasia came into force in 2002 in the Netherlands, many legal and practical challenges still exist. It is thus not surprising that the debate on euthanasia and physician-assisted suicide has recently been rekindled. Currently, one of the issues is the significance of a written advance directive requesting the euthanasia of a patient who was competent when drawing up the directive but now lacks, or has impaired, mental capacity. In practice, this usually concerns patients with (an advanced stage of) dementia. Under Dutch law, the legal position of a written advance directive in such a situation is complex. Sections 293 and 294 of the Dutch Penal Code form the basis for the legislation on euthanasia.[1]

With the Termination of Life on Request and Assisted Suicide (Review Procedures) Act (hereafter 'law on euthanasia'), which came into force in 2002, physician-assisted dying became, although a criminal act, justified if performed under certain conditions/requirements.[2]

Besides the patient's *voluntary and well-consideredrequest* the statutory due care requirements are:

Physicians must:

a. be satisfied that the patient has made a voluntary and well-considered request;
b. be satisfied that the patient's suffering is unbearable and that there is no prospect of improvement;
c. have informed the patient of his or her situation and further prognosis;
d. have come to the conclusion, together with the patient, that there is no other reasonable alternative;
e. consult at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled;
f. have exercised due medical care and attention in terminating the patient's life or assisting in his or her suicide.[3]

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1 For reasons of clarity, we use the word 'euthanasia' in the following, pertaining to both crimes referred to in Sections 293 and 294 of the (Dutch) Penal Code.

2 In full, the 'Termination of Life on Request and Assisted Suicide (Review Procedures) Act', *Bulletin of Acts and Decrees* 2001, 194 (entry into force *Bulletin of Acts and Decrees* 2002, 165).

3 Section 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act. In the vast majority of the reports, the committees judged that the physician had acted with due care. In 2012, the review committees received 4188 reports, 10 of which were deemed to be negligent. In 2013, the committees received 4829 reports, in 2014 5306 and in 2015 5516. From these reports the committees came to the conclusion in 5 (2013), 4 (2014) and 4 (2015) that the physician had not acted in accordance with the due care requirements. The Public Prosecution Service did not see cause to institute criminal proceedings in any of these cases. See the Regional euthanasia review committees, 2012 Annual Report, p. 32, the 2013 Annual Report, p. 58, the 2014 Annual Report, p. 9 and the 2015 Annual Report, pp. 7 and 17.

A Regional Euthanasia Review Committee (hereafter 'review committee') assesses in every specific case whether physician-assisted dying has been carried out in accordance with these statutory due care requirements. If there is reason for doubt, the case is handed over to the Public Prosecutor who in turn judges whether there are grounds for prosecution.

Fulfilling the due care requirements for justified euthanasia is more or less unproblematic when it concerns competent patients with a somatic, medically classifiable illness, whose suffering is unbearable and without prospect of improvement. The Dutch law on euthanasia also allows for physician-assisted dying of patients lacking mental capacity based on an advance directive requesting euthanasia:

'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 apply mutatis mutandis.'[4]

However, physicians struggle with the question of whether an advance directive in writing can replace an oral request,[5] because according to the law, the due care requirements apply 'mutatis mutandis' to such a situation (which was meant to be interpreted as 'the due care criteria apply to the greatest extent possible in the given situation'[6] according to the regulator). Uncertainty exists about the interpretation of this wording.

Upon request from the Ministry of Security and Justice, we carried out a case law study to address this problem,[7] the general outline of which is discussed in this article, complemented with information from the 2013, 2014 and 2015 review committees' Annual Reports.[8]

In this paper, we will first clarify the Dutch law on euthanasia, provide a legislative history, and discuss the current debate on advance directives requesting euthanasia in the Netherlands. Subsequently, we will discuss the results of the literature study. Last, we will examine our findings of the case law study,

4 Section 2, subsection 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.

5 T.D. Ypma and H.L. Hoekstra, 'Beoordeling van euthanasieverzoek door SCEN-artsen', NTvG 2015; 159:A8135 and T.A. de Boer, 'De rafelranden van de euthanasiewet', NTvG 2015; 159:A8809.

6 Regional Euthanasia Review Committees, Code of Practice 2015, p. 23. The Code of Practice can be accessed on www.euthanasiecommissie.nl/uitspraken/brochures/brochures/code-of-practice/1/code-of-practice.

7 P.A.M. Mevis, S.R. Bakker, L. Postma and J.H.J.Verbaan, *Schriftelijke wilsverklaring euthanasie bij wilsonbekwame patiënten: een jurisprudentie onderzoek*, Erasmus School of Law/WODC 2014.

8 Regional Euthanasia Review Committees, 2013 Annual Report, 2014 Annual Report and 2015 Annual report, on: www.euthanasiecommissie.nl/uitspraken.

focussing on whether a conventional approach exists as to how to apply the due care requirements in the case of an advance directive requesting euthanasia.

2. The Law and Legislative History

The Dutch law on euthanasia allows doctors to honour a request for euthanasia from patients lacking capacity (aged sixteen years or older) based on a written advance directive, drawn up at a time when the patient was competent (section 2(2)). Advance care planning in the Netherlands thus not only exists in DNAR (do not attempt resuscitation) orders and advance refusals of treatments, but also of written advance directives requesting euthanasia. However, since there is no right to euthanasia under Dutch law, a physician is not obliged to comply with a request to end a patient's life, even in the presence of a written advance directive. In contrast, advance refusals of treatments are legally binding.[9]

According to the Parliamentary papers, a written advance directive requesting euthanasia has the same legal force as an oral request of a competent patient.[10] No additional requirements are prescribed by the law on euthanasia for advance directives requesting euthanasia, except that it should be documented in writing. Thus, the due care requirements necessary for euthanasia to be lawful for a competent patient apply 'mutatis mutandis' to a patient lacking mental capacity with a written advance directive. The Parliamentary documents show that the legislator used the words 'mutatis mutandis' to indicate that the due care requirements 'apply as much as possible to the given situation'. 'Mutatis mutandis' was therefore interpreted as 'to the extent allowed for by the actual situation'.[11] For euthanasia to be labelled as justified, or 'performed with care' by the review committee, the physician has to be convinced that the due care requirements are met, based on: 1) his own assessment of the patient's specific situation and medical record, 2) consultation with other care providers who are treating, or have previously treated, the patient, and 3) consultation with close relatives, caretakers, or friends.[12] Unless the physician has reason to believe otherwise, he can assume the patient's request was voluntary and well considered.[13] However, this does not provide a definitive answer to the question of how to apply the other due care requirements in a case of a written advance directive

9 *Parliamentary Papers II* 2013/14, 32647, No. 30, p. 2; since treatment requires the patient's consent. See inter alia Leenen, Gevers and Dute (eds), *Handboek gezondheidsrecht*, The Hague: Boom Juridische Uitgevers 2014, p. 375.

10 *Parliamentary Papers II* 2000/01, 26 691, No. 22, p. 60.

11 *Parliamentary Papers I* 2000/01, 26 691, No. 137b, pp. 16 and 54.

12 *Parliamentary Papers I* 2000/01, 26 691, No. 137b, pp. 16 and 51.

13 *Parliamentary Papers I* 2000/01, 26 691, No. 137b, pp. 16 and 51.

requesting euthanasia: do they apply in full, or can they be altered to apply to the specific situation?[14] For example, how should practitioners apply the requirement of unbearable suffering if the patient (e.g. in an advanced stage of dementia) does not seem to be suffering? Although the patient may have indicated in the advance directive that he would suffer unbearably when for example he would not recognize his children anymore, he may not experience any suffering if this envisaged situation arises.

The public debate was rekindled in 2013 following a television programme on euthanasia for patients with dementia. The Royal Dutch Medical Association (RDMA) (in Dutch: Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst) argued that it is essential to *communicate* with a patient in order to meet the due care requirements.[15] The RDMA argued that if communication is not possible, professional standards stand in the way of (a decision by the physician to provide) euthanasia, even if a previous advance directive was drawn up regarding this very situation. The former Minister of Health, Dr. E. Borst, counter-argued that the RDMA's interpretation of the regulations regarding written advance directives was too narrow. Following this discussion, the current Minister of Health, Welfare and Sport set up a working group in order to develop guidelines for physicians and (separate) guidelines for the public to clarify the significance of written advance directives requesting euthanasia of patients who lack mental capacity.[16] The literature and case law studies we carried out contributed to the development of these guidelines.[17]

3. Literature Study: The Advance Euthanasia Directive in Practice

We reviewed the literature to examine the role and the challenges of advance directives requesting euthanasia in clinical practice.[18] The studies we examined demonstrate that most members of the Dutch public consider physician-assisted dying acceptable for patients lacking capacity based

14 See also P.A.M. Mevis, S.R. Bakker, L. Postma and J.H.J. Verbaan, *Schriftelijke wilsverklaring euthanasie bij wilsonbekwame patiënten: een jurisprudentie onderzoek*, Erasmus School of Law/WODC 2014, p. 16.

15 Position of the Board of the (KNMG) Federation on euthanasia 2003 and the further explanation of this position, Utrecht 6 February 2012.

16 *Parliamentary Papers II* 2012/13, 32647, No. 19, pp. 2-3.

17 P.A.M. Mevis, S.R. Bakker, L. Postma and J.H.J.Verbaan, *Schriftelijke wilsverklaring euthanasie bij wilsonbekwame patiënten: een jurisprudentie onderzoek*, Erasmus School of Law/WODC 2014, pp. 6-7.

18 A. van der Heide, E. Geijteman and J. Rietjens, *Schriftelijk vastgelegde euthanasiewensen van wilsonbekwame patiënten. Een literatuuroverzicht van opvattingen, praktische ervaringen en knelpunten*. Erasmus Medical Center, Rotterdam, 2014.

on an advance directive, although few would choose to draw up such an advance directive themselves. Several studies showed that fewer than 5% of adults have signed an advance directive. Individuals more likely to have signed an advance directive are, among others, elderly, women, more highly educated, non-religious people who have little faith in adequate medical care in the final stages of life, individuals with experience of euthanasia in their immediate environment, and those who are in poorer health. Reasons to sign an advance directive are the desire to be in control in the final stages of life and to ensure that life ends with dignity. Many people fear the advanced stages of dementia, with the corresponding loss of control over their thoughts and actions. Although many citizens understand the complexities of carrying out euthanasia for patients lacking capacity, they nevertheless have the expectation, that when necessary, an advance directive is acted upon.

The literature study revealed that most physicians have dealt with patients who have signed an advance directive in case they lose mental capacity because of dementia or other reasons. However, handing over such an advance directive to a general practitioner does not always lead to a conversation about end of life decisions, even when the situation covered in the written advance directive becomes imminent. Geriatricians are more likely to see a patient at a time when the situation described in the advance directive has occurred. In such situations, the written advance directive is often discussed with family members, but the impact it has on medical care seems limited. Although physicians empathize with a patient's wish to end his life in the late stages of dementia, and most doctors view late-stage dementia as having the potential to cause unbearable suffering (a prerequisite for lawful euthanasia), they rarely carry out euthanasia on the basis of an advance directive. This is in part because many patients in an advanced stage of dementia *do not show clear signs* of unbearable suffering at the moment when the doctor would perform euthanasia. Additionally, the patient's family is often opposed to physician-assisted dying. If a patient does seem to be suffering unbearably, a restrictive treatment policy is usually pursued, as a result of which the patient typically dies of 'natural' causes (e.g. pneumonia) usually within a short time. In a minority of cases, medication (e.g. morphine) is administered which may hasten the patient's death, but is primarily intended to alleviate physical symptoms.

The main argument of physicians not to terminate the life of a patient with dementia based on an advance directive is that in the absence of communication with the patient, the patient is not able to confirm his wish to end his life, nor able to express that his suffering is unbearable. How can a physician end the life of a patient that is not aware of this anymore? Indeed, most physicians will

feel unable to end the patient's life on the sole basis of a previously drawn up advance directive, especially if the directive was not regularly updated.[19]

4. Case Law

Jurisprudence of the Regional Euthanasia Review Committees provides information on how article 2 of the law on euthanasia is interpreted. The decisions of the review committees are collated in annual reports. In April 2015, the review committees drew up a Code of Practice in order to provide better access to their assessments.[20] The Code is primarily intended for physicians performing euthanasia and the independent consultants, and outlines how the committees interpret the statutory due care requirements.

It further contains a short and general section on the application of the law on written advance directives requesting euthanasia. The following is based on the more detailed annual reports that contain specific cases of the review committees.

Based on these reports, it appears that advance directives firstly play a role when patients are in a reduced state of consciousness but are still able to experience (unbearable) suffering, e.g. patients who are in what is referred to as a 'reversible' coma. Unlike in Belgium, physician-assisted dying is not permitted in the Netherlands when patients are in an *irreversible* coma, because in this situation the patient can no longer experience suffering.[21] By contrast, performing euthanasia on individuals who are in a *reversible* coma, for example as a result of (palliative) sedation, is permissible. Even though communication is not possible with the patient, it is seen as inhumane to force the patient to come out of a reversible coma to confirm that his suffering is unbearable. This is shown in a case from 2012 (case 15) about a patient who was drowsy and unresponsive due to the administration of morphine:

'administering medication to relieve pain or other symptoms can result in reduced consciousness or coma. The committee considers it inhumane to wake a patient in

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19 A. van der Heide, E. Geijteman and J. Rietjens, *Schriftelijk vastgelegde euthanasiewensen van wilsonbekwame patiënten. Een literatuuroverzicht van opvattingen, praktische ervaringen en knelpunten*. Erasmus Medical Center, Rotterdam, 2014.

20 The Code of Practice can be accessed on www.euthanasiecommissie.nl/uitspraken/brochures/brochures/code-of-practice/1/code-of-practice.

21 Regional Euthanasia Review Committees, 2013 Annual Report, p. 35. In Belgium, euthanasia on the basis of an advance directive in writing is reserved for the very patients who are in an irreversible state of unconsciousness (irreversible coma or persistent vegetative state), i.e. demented patients fall outside the scope of the law. See: C. Lemmens, *Voorafgaande wilsverklaringen met betrekking tot het levenseinde*, Antwerp: Intersentia 2013, pp. 243 and 714-716.

this state only so that he can confirm that he is again, or still, suffering unbearably. In this case the physician reached the conclusion that the patient was suffering unbearably without waking him from his state of reduced consciousness.'[22]

One may also conclude from this case that even when it is no longer possible to communicate with the patient, a previously written request for euthanasia can be granted. However, although the advance directive is a *conditio sine qua non* for patients lacking capacity, it is not the only, or the decisive factor:

'The patient was no longer conscious on the day the procedure was carried out. He had been administered a high dose of morphine, so that it was impossible to ask him to confirm his request and the unbearable nature of his suffering. Based on the patient's previous repeated, specific requests and his advance directive, the physician carried out the termination of life on request. (...) In this case the patient – when he was decisionally competent – had drawn up both an advance euthanasia directive and a refusal of treatment directive some years before, and discussed these with his GP and with his family. He clearly described the circumstances in which he would want his life to be terminated. (...) With regard to the requirement to consult at least one other, independent physician, the committee considers that it is generally preferable if the independent physician can speak with the patient privately in order to reach a conclusion on whether the due care criteria have been fulfilled. If the independent physician is unable to speak with the patient, for instance because the patient is in a state of reduced consciousness, he should still see the patient and reach a conclusion based on the patient's circumstances and information obtained from other sources.'[23]

Secondly, advance directives can play a role when patients lack capacity as a result of (late-stage) dementia.[24] If there are reasonable doubts about a patient's competence, a psychiatrist must be consulted.[25] According to the annual reports of the Regional Euthanasia Review Committees, 'being able to express one's will' means that a patient is able to understand the relevant information on his situation and prognosis, to consider the alternatives (if any), and to appreciate the consequences of his decision.[26] This is often no longer the case in late-stage

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22 Regional Euthanasia Review Committees, 2012 Annual Report, case 15, p. 26 (original English translation). A similar decision can be found in the Regional Euthanasia Review Committees, 2014 Annual Report, case 2014-25 and 2015 Annual Report, case 2015-26.

23 Regional Euthanasia Review Committees, 2012 Annual Report, case 15, pp. 26-27 (original English translation). A similar decision can be found in the Regional Euthanasia Review Committees, 2015 Annual Report, case 2015-26 and case 2015-52.

24 Regional Euthanasia Review Committees, 2012 Annual Report, p. 12 and P.A.M. Mevis, S.R. Bakker, L. Postma and J.H.J.Verbaan, *Schriftelijke wilsverklaring euthanasie bij wilsonbekwame patiënten: een jurisprudentie onderzoek*, Erasmus School of Law/WODC 2014, p. 20.

25 Regional Euthanasia Review Committees, 2013 Annual Report, p. 11.

26 Regional Euthanasia Review Committees, 2013 Annual Report, p. 16.

dementia. Demented patients who no longer have mental capacity may be able to communicate to some extent, verbally or non-verbally.[27] According to case law, deciding whether a request for voluntary euthanasia is sufficiently voluntary and well considered in such a case, comes down to interpreting the patient's behaviour.[28] Minor indications which may lead one to conclude that a patient is confirming his previously written advance directive are taken into account. Indications that the patient still wishes his life to be terminated can also be found in the acquiescent behaviour which a patient displays just before his life is terminated:

'In the weeks before her death (...) the patient was no longer able to put her wish into words as such, but she did make clear that she wanted to die. According to the doctor she had said she "didn't want to live this way any longer" and "couldn't take it any more". She also refused to take her medication because she "wanted to die anyway". In the weeks before her death she had thanked the physician profusely and said goodbye to her loved ones. On the evening the procedure was carried out the patient had been unusually calm. When the physician said she was going to give her a small injection, the patient had expressed her acquiescence.'[29]

Such minor indications, in combination with the content of a written advance directive, seem to be sufficient to conclude that the requirement of a voluntary and well-considered request has been met, even after the patient has lost the capacity to express her will:

'On the question of whether the patient's request was voluntary and well-considered, the committee noted that, although the patient could not request euthanasia in so many words, her behaviour and things she said until just before her death made it clear that she wanted to die because of her pain, her forgetfulness and because she did not want to be put in a nursing home. The physician established satisfactorily that she had become convinced that the patient's wish to die was in complete accordance with the patient's wish for euthanasia, as previously expressed both orally and in writing.'[30]

It should be noted that, apart from the voluntary request, physicians must be convinced that the patient is suffering unbearably and without prospect of relief. Although a patient may have described situations in the advance directive that, according to him, would entail unbearable suffering (e.g. ending up in a nursing home or no longer recognizing his family), it is the physician who has to be convinced that the patient suffers unbearably at the moment the euthanasia

27 Regional Euthanasia Review Committees, 2013 Annual Report, p. 21.
28 Regional Euthanasia Review Committees, 2013 Annual Report, p. 21.
29 Regional Euthanasia Review Committees, 2012 Annual Report, case 4, pp. 15-16 (original English translation).
30 Regional Euthanasia Review Committees, 2012 Annual Report, case 4, p. 16 (original English translation).

is carried out. Moreover, this diagnosis has to be accepted by the review committee afterwards. The patient's advance directive cannot simply be followed.[31]

4.1. The relevance of the content of an advance directive

The Dutch law on euthanasia does not set out requirements regarding the written advance directive requesting euthanasia itself. By contrast, jurisprudence demonstrates that there is a high threshold for allowing advance directives to replace an oral request for euthanasia: an advance directive has greater weight if it is more precise, specific, detailed and personal:
'A handwritten directive drawn up by the patient in which he describes, in his own words, the circumstances in which he would want euthanasia to be carried out often provides additional personal confirmation, and is therefore more significant than a standard form, particularly one that is conditionally worded (...) The clearer and more specific the advance directive and the better the records kept, the firmer the basis they provide for everyone involved.'[32]

Case law of the review committees also shows that it is important for a patient to regularly update his written advance directive as well as to repeatedly discuss it with his physician while he is still competent:

'In the many conversations he had had with his physician about his desire for euthanasia, the patient had discussed in detail what he considered to be unbearable suffering. His greatest fear was to become completely dependent, a position which he regarded as degrading. Since the patient was now in precisely the situation he feared and, as indicated in his advance directive, he expressly did not wish for any such situation to persist, the physician was convinced that the patient was suffering unbearably, an impression reinforced by the patient's desperation in the face of his inability to communicate (...) The committee noted the following with regard to the criterion that a voluntary and well-considered request be made. Under section 2, subsection 2 of the Termination of Life and Assisted Suicide (Review Procedures) Act, a signed written directive constituting a request for termination of life may replace a verbal request in the case of patients who were previously decisionally competent but are no longer able to express their wishes when the time comes for their life to be terminated. In the present case, during the nine years prior to his death the patient had discussed termination of life with his family and his physician on many occasions, in response to several successive periods of illness. Each time, the patient had indicated the circumstances in which he would regard his suffering as unbearable and would want his life

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31 Regional Euthanasia Review Committees, 2014, Annual Report, case 2014-02 and case 2014-35.
32 Regional Euthanasia Review Committees, 2012 Annual Report, p. 13 (original English translation).

to be terminated. The patient had recorded his views in a request for euthanasia in the form of an advance directive which he had signed and regularly updated while he was decisionally competent. In the opinion of the committee, the physician had convincingly argued that the request made by the patient in the advance directive was voluntary and well-considered."[33]

An updated and regularly discussed advance directive can thus reinforce a physicians' conviction that the request is voluntary and well-considered. This is also relevant for the assessment by the review committees as to whether the termination of life was carried out with due care and (therefore) with justification under criminal law.[34]

4.2. Contra-indications

If, at the moment prior to carrying out euthanasia, a patient's 'behaviour' indicates that he no longer wishes the physician to assist him in dying, the physician is not allowed to proceed. Based on a case dating from 2012, euthanasia cannot be carried out if there is any indication of resistance.[35] A patient suffering from Huntington's disease had drawn up an advance directive more than six years before her death and had made it known in conversations with her physician and husband that she wanted her life to be terminated when she had to be admitted to a nursing home on a permanent basis. When, a few years later, the physician raised the subject of euthanasia, the patient indicated that she did not want to be given an 'injection' at that point in time. She became restless when the physician raised the subject of euthanasia, which led the physician to conclude that she clearly did not yet want it and he decided to let the matter rest. A few years later, when the patient lost her mental capacity and admission to a nursing home on a permanent basis seemed unavoidable, the patient's husband submitted a request on her behalf to have her life terminated. The patient did not react when her physician or husband raised the subject, but did become restless whenever her husband moved away. The physician regarded this as indirect permission for euthanasia, and considered the advance directive to be a valid proxy consent. However, in its judgment, the review committee considered the case not to fulfil the due care requirements partly because the patient's advance directive had not been updated and had been insufficiently discussed with the physician. Because of the lack of 'updates',

33 Regional Euthanasia Review Committees, 2009 Annual Report, case 3, pp. 11-12 (original English translation).

34 *Parliamentary Papers II* 2013/14, 32647, No. 30, p. 3.

35 Regional Euthanasia Review Committees, 2012 Annual Report, case 3 (negligent) and P.A.M. Mevis, S.R. Bakker, L. Postma and J.H.J. Verbaan, *Schriftelijke wilsverklaring euthanasie bij wilsonbekwame patiënten: een jurisprudentie onderzoek*, Erasmus School of Law/WODC 2014, p. 34.

there was no clear-cut and consistent indication that the patient had a persistent wish for euthanasia. According to the committee, the physician could therefore not have come to the conclusion that the request was 'voluntary and well-considered'.[36]

4.3. Not a document to be kept in a safe

An advance directive is not a document to be kept in a safe, such as a will or testament, which only has to be carefully drawn up and filed once to be legally valid. On the contrary, a written advance directive requesting euthanasia has no legal force, independent of whether or not it was notarized.[37] The review committees have also made a point of not standardizing time limits for discussing and updating advance directives (e.g. in terms of intervals) in its judgments and annual reports, because any period of validity would be arbitrary. The Dutch legislator was vehemently opposed to introducing an expiration date for advance directives, as is the case in Belgium (where an advance directive is valid for a period of five years).[38] It seems to be the case that the review committees regard an advance directive as the *starting point* of a process: an advance directive is a *conditio sine qua non* for a patient who lacks mental capacity and is an important factor in the process of assessing whether the due care requirements have been met. The case law of the review committees demonstrates further that physicians are given certain leeway in seeking confirmation of a written advance directive; minor indications such as a patient remaining calm whilst preparations for terminating his life are being made can be seen as confirming the patients advance directive.[39] However, if an advance directive has not been updated for a long period of time after it was drawn up,[40] its value seems to decrease. We can conclude that an inability to communicate with the patient does not prevent a doctor from carrying out lawful euthanasia on the basis of an advance directive; however, it simultaneously does not automatically lead the review committee to judge the physician to have acted in agreement with the necessary due care requirements. In our review of judgments by the review committees, we found that specific facts and circumstances are taken into consideration; therefore, it is difficult to infer general criteria as to how to fulfil the due care requirements in the case of a written advance directive.

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36 Regional Euthanasia Review Committees, 2012 Annual Report, case 3.

37 P.A.M. Mevis, S.R. Bakker, L. Postma and J.H.J. Verbaan, *Schriftelijke wilsverklaring euthanasie bij wilsonbekwame patiënten: een jurisprudentie onderzoek*, Erasmus School of Law/WODC 2014, p. 51.

38 *Parliamentary Papers II* 1999/00, 26 691, No. 6, p. 83 and C. Lemmens, *Voorafgaande wilsverklaringen met betrekking tot het levenseinde*, Antwerp: Intersentia 2013, p. 353.

39 Regional Euthanasia Review Committees, 2012 Annual Report, case 4.

40 It is not necessary that the physician who carried out the euthanasia actually knew the patient at the moment he or she provides an advance directive.

5. Conclusion

The Dutch legislator has explicitly left open the possibility of honouring a request for euthanasia from patients lacking mental capacity on the basis of a written advance directive. In this sense, the directive does have a certain legal force, but there is no such thing as a right to euthanasia. The decision as to whether the request made in an advance directive will actually be complied with is the prerogative of the physician. He is liable in law for this decision, and liable under criminal law if the legal due care requirements have not been met. An advance directive is only one of the requirements when patients lack mental capacity.

Although the public expects physicians to comply with advance directives requesting euthanasia, in practice, physicians are very reluctant to actually carry out euthanasia on patients lacking capacity on the basis of an advance directive. For them it is of utmost importance that patients confirm until the very last moment that they are suffering unbearably and choose to end their life.

For euthanasia based on an advance directive, certain conditions need to be met. Most importantly, the directive must be updated and discussed with the physician regularly in order to demonstrate the voluntary and well-considered nature of the patient's request in the event that he no longer has mental capacity. Indications that support the content of an advance directive and conversations with other practitioners and family members can also reinforce the physician in his assessment and conviction that the request is voluntary and well-considered and that the patient is suffering unbearably. This demonstrates that a written advance directive is a *conditio sine qua non* for euthanasia concerning patients lacking mental capacity, but, at the same time, just one factor of importance in the process to determine if the due care requirements have been met. However, the question of whether the due care requirements apply in full or 'in so far as actually possible' cannot be answered unequivocally on the basis of the case law.

Dutch law on euthanasia based on advance directives requesting euthanasia is imprecise and ambiguous. Case law of Regional Euthanasia Review Committees does not provide much clarity either, nor does the recently published Code of Practice of the review committees, which is necessarily too general and relatively short. We therefore recommend that the review committees increasingly clarify their judgments, as well as their interpretation and application of the due care requirements. The judgments and annual reports of the review committees could then play an informative role and would provide further guidance for practitioners.[41]

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41 P.A.M. Mevis, S.R. Bakker, L. Postma and J.H.J. Verbaan, *Schriftelijke wilsverklaring euthanasie bij wilsonbekwame patiënten: een jurisprudentie onderzoek*, Erasmus School of Law/WODC 2014, p. 61.

The current Minister of Health, Welfare and Sport is well aware of the fact that, at present, the legislative history and case law do not seem to provide enough guidance for a careful and practical application of an advance directive for patients lacking capacity.[42] Therefore, a detailed 'guide' for patients, and one for physicians, was published in December last year to provide further clarity. This, however, is only a 'clarifying paper' which is not binding. Unfortunately, misconceptions are still present among the public as well as physicians.[43] We therefore urge the review committees to clearly communicate how they interpret and apply the due care requirements in the case of euthanasia on patients lacking capacity with an advance directive requesting euthanasia, on the basis of the legal principle of 'mutatis mutandis'.

42 *Parliamentary Papers II* 2013/14, 32647, No. 30, p. 7.
43 B. Knoop, 'Laat wilsverklaring euthanasie niet verstoffen', *Medisch Contact* 2016, 2.