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Opinion Piece

Extending' euthanasia to those 'tired of living' in the Netherlands could jeopardize a well-functioning practice of physicians' assessment of a patient's request for death

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ABSTRACT

The Dutch Euthanasia Act (EA) took effect in 2002 and regulates the ending of one's life by a physician at the request of a patient who is suffering unbearably. According to the Dutch Supreme Court, unbearable suffering is a state for which the presence of a medical condition is a strict prerequisite. As a consequence, the Dutch EA has attributed the assessment of unbearable suffering to physicians who evaluate the presence of a medical classifiable disorder. Currently, a debate within the Netherlands questions whether older people, without a medical condition, who value their life as completed, should be granted euthanasia. To concede the autonomy of such a person, the Dutch government intends to create a separate legal framework that regulates this tired of living euthanasia request. This debate is crucial for policy-makers and an international audience because it discusses if a self-directed death of older people, should be implemented in (the current Dutch) euthanasia practice. However, this article argues that the current legal proposal that regulates the tired of living euthanasia request ignores crucial jurisprudence on physicians' application of the *unbearable suffering* criterion in practice. Furthermore it points out that this proposal neglects physicians role in guaranteeing a euthanasia practice of due care and that its use of an ethic of absolute autonomy could jeopardize this well-established practice.

1. Political and legal background

The Dutch Euthanasia Act (EA) took effect in 2002 and regulates the ending of one's life by a physician at the patient's request [1]. Granting this patient's request depends on physicians' assessment of whether the following requirements have been satisfied: 1) the request is voluntary and well-considered, 2) the patient is suffering unbearably without any prospect of improvement, 3) the patient is informed about his situation and prospects, 4) there are no reasonable alternatives to relieve suffering, 5) an independent physician must be consulted by the treating physician to evaluate criteria 1–4 prior to physicians' granting of the request and 6) euthanasia is performed with due medical care and attention. Upon granting euthanasia, physicians invoke force majeure in the sense of an emergency situation caused by a conflict of duties because physicians' duty to protect life is in conflict with the duty to alleviate the suffering. This assumes that there is in all reasonableness no other solution to alleviate the patient's suffering other than to end the patients' life out of compassion and solidarity.

Even though physicians have to comply with the six criteria for due care in carrying out euthanasia, they often mention that the *unbearable suffering* criterion is the most difficult to judge and most often the reason for refusing euthanasia requests [2]. In their assessment, Dutch physicians put more emphasis on the presence of physical suffering, while their patients rather emphasise their psychosocial suffering [3]. For patients, particularly non-medical aspects such as loss of autonomy and being a burden augment suffering, and when accompanied by psycho-emotional and existential problems, this suffering becomes *unbearable* [4]. Physicians' emphasis on physical suffering in their assesment, was demonstrated in a case vignette-study among 115 Dutch general practitioners (GPs). This study demonstrated a high level of concordance between the classification of a patient's suffering as 'unbearable' (if suffering was rooted in a medical condition and constituted untreatable and actual pain or physical symptoms) and GPs' willingness to grant euthanasia requests [5]. However, when physical symptoms are absent and patients' suffering is rooted in a combination of irreversible functional loss and 'existential' suffering, Dutch GPs seem to be reluctant to classify patient's suffering as 'unbearable' and are therefore sometimes less willing to grant requests [5]. Nonetheless, among the 115 responding GPs in this

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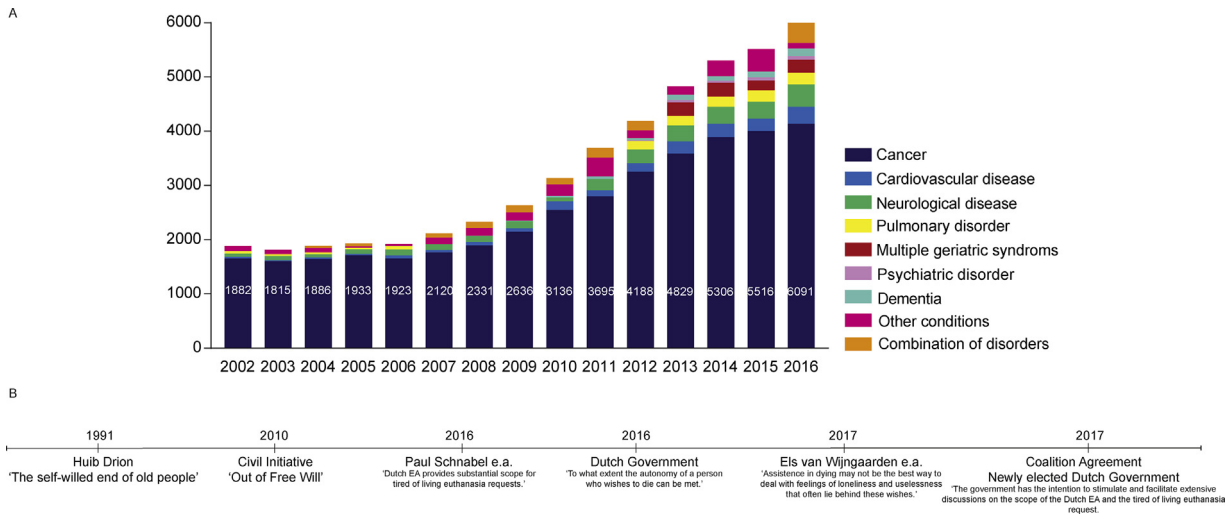

Fig. 1. The current Dutch EA practice and timeline that explains the tired of living policy proposal. (A) An increasing number of euthanasia notifications over the years 2002–2016 demonstrates physicians' willingness to report euthanasia cases and shows the distribution of cases across different illnesses. (B) Timeline which highlights legal court rulings, crucial events and law-drafts that precluded the intention for a new legal framework that should regulate the tired of living euthanasia request. Numerical data was gathered by the Dutch RRVs and is published on and derived from https://english.euthanasiecommissie.nl/.

particular study, 16 GPs still considered patient's suffering in tired of living euthanasia requests as unbearable, and were also willing to grant such requests [5].

How the *unbearable suffering* criterion should be applied in practice by physicians has been clarified in a series of subsequent Dutch Supreme Court (DSC) legal cases. In 1984, the DSC stated in the Schoonheim case that *unbearable suffering* is '*not only due to an actual situation of suffering, but can also exist because of fear of a further loss of dignity, or a prospect of losing control on dignity in death*' [6]. It has often been argued that this notion appeals to autonomy or self-determination. However, the DSC in this particular case did not initially connect the loss of dignity with the patient's wish for self-determination, but regarded this mainly as part of the patient's suffering [7]. Furthermore, the DSC in this case also stated that both a further loss of dignity nor a prospect of losing control on dignity in death are in itself legal titles for granting euthanasia requests. Instead, because both are not legal titles but contribute to the patient's suffering, both should be included within the assessment of physician's invocation of an emergency situation [7]. Therefore, the DSC considered that a physician can only successfully invoke force majeure within the meaning of an emergency situation, when he or she 1.) has carefully weighed the obligations and interests of the case against each other 2.) has acted according to the standard of medical ethics and the medical professional standard and 3.) made a choice that was justified from an objective point of view, given the particular circumstances of the case [7]. Collectively, this implied physicians could only invoke force majeure in the sense of an emergency situation if their assessment and interpretation of the unbearable suffering criterion consists of medical suffering and is confined to a medical professional standard (Fig. 1).

Interestingly, ten years later, the DSC declared in the Chabot case that '*the origin of suffering does not affect the degree of the suffering experience*' [8]. This judicial decision was further specified in 2002 when the DSC stated in the Brongersma case that patients suffering '*should originate from a medically classifiable disease or disorder, which could be either somatic or psychiatric*' [9]. This reasoning led the DSC to conclude that in those cases that the patient's suffering is mainly caused by a lack of life perspective and not by an illness or disorder, the professional competence of the physician is limited to supporting duties and to ease the patient's suffering. Interestingly, earlier in the legal procedure of this particular case, the Amsterdam Court of Appeal (ACA) also ruled that self-determination cannot be regarded as socially accepted to the extent that for that reason alone, euthanasia would no longer be illegal. As a consequence, with the notion that a physician can only invoke an emergency situation when it concerns unbearable suffering, the ACA and DSC considerably limited the patient's right to self-determination because this notion excludes an entire category of suffering that cannot be traced back to a medical classification [7]. Therefore, it has been argued that the implication of the Brongersma case is that being "tired of life" cannot be a basis for physicians to carry out euthanasia [10] because in situations of non-medical suffering, physicians are not able to judge the extent of patients personal suffering [11]. Similarly, the Royal Dutch Medical Association (RDMA) has advocated in 2011 that '*the presence of a medical condition should be a strict prerequisite for euthanasia*'. However, the RDMA also stated that suffering due to '*existential distress, meaninglessness or loss of dignity can also be part of the medical domain*' [12]. According to the RDMA, this has made '*the current legal framework and the interpretation of the suffering criterion wider than many physicians have thought and applied until now*' [12].

Physicians are obliged to report their application of the suffering criteria to a Regional Review Committee (RRC) which is installed to pass judgement on whether the six criteria for euthanasia with due care have been fulfilled [13]. Of the 42.171 reported cases during the years 2002–2015, only 0.2% (76) of cases were not in accordance with the criteria of due care [14,15]. In the majority of cases that were not in accordance with the criteria of due care, this was not related to a violation of the *unbearable suffering* criterion or other material criteria of the law. (During the years 2012–2016 due care was jeopardized in 8 out of 46 cases due to a violation of the *unbearable suffering criterion*, in 7 out of 46 cases due to a violation of the *reasonable alternative to relieve suffering criterion* while in 4 out of 46 cases this was related to the *voluntary request criterion*) [15].

Taken together, this demonstrates that the enactment of the Dutch EA has attributed to physicians an indispensable and guaranteeing role in keeping up the current practice of due care in performing euthanasia for cases in which suffering is rooted in a medical classifiable disorder. It could be argued that this is for good reason because solely physicians are able to assess if their patient is suffering unbearably and if the patient is without other solutions to alleviate the suffering.

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