How to handle a patient request for euthanasia in psychiatry under current law?

Advice from the Flemish Psychiatric Association (VVP) on the requirements of due care

2017

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Table of contents:

A. Summary
B. Introduction
C. Structure of the advice
1. A careful evaluation process combined with ongoing care
   1.1 Parties involved, terminology and due care requirements
   1.2 Focus on the wish to die *and* life
   1.3 Duties of the psychiatrists concerned
2. Evaluation of medically futile situation
3. Evaluation of the persistent and unbearable nature of the physical and mental suffering.
4. Evaluation of the repeated, voluntary and well-considered nature of a request for euthanasia
5. Informing the patient
6. Involvement of family or important others
7. Involvement of other care and healthcare providers
8. Values, emotions and potential counter-transference
9. The final decision-making
10. Euthanasia and physician-assisted suicide
11. Due medical care in the performance of euthanasia (Appendix A)
12. Report (Appendix B and C)
13. Support for the bereaved

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A. Summary

This Advice reflects the standpoint of the Flemish Psychiatric Association (VVP) on the due care criteria to be considered when euthanasia is requested due to unbearable psychological suffering caused by a psychiatric disorder, under current law. The advice sets out the VVP's due care recommendations for psychiatrists (and other healthcare professionals). These due care criteria may offer a particular interpretation of the legal conditions, or embody them in the specific context of euthanasia in psychiatry, or they may even reflect a position adopted by the VVP, in the sense that due care, as seen by a group of professionals in a particular situation, should go beyond the legal requirements. The request for euthanasia must come from the patient and must not be at the suggestion of a healthcare professional. We advocate that appropriate caution be exercised, and that there be an ongoing focus on life and recovery. The legal criteria are expressed as reasoned due care requirements, for thorough application as part of an evaluation process of ample duration and scope. There is particular concern for the evaluation of mental capacity and an exploration of the personal and interactive drivers behind a request for euthanasia. In the course of the evaluation every opportunity is taken to make life more bearable. We know from experience that many of the patients who request euthanasia do not proceed in the end. The patient's family and loved ones are involved in the process, with the patient's consent. For the criteria 'medical futility, 'untreatability' and 'unrelievable suffering', the bar is set high. Guidelines specific to the diagnosis are used to check that every reasonable prospect of cure has been exhausted. The evaluation is a medical and psychiatric one, made from the psychiatrist's perspective, whereas unbearable suffering is assessed from the patient perspective.

We endorse the three points on 'reasonable prospect of cure' in the Dutch guidance: prospects of improvement through adequate treatment, within a foreseeable term and in which there is a reasonable relationship between the results to be expected and burden of the treatment on the patient. Every evidence-based treatment for the disorder(s) must have been attempted with proficiency and a view to recovery, and, in the case of non-medical, recovery-oriented interventions, due consideration must have been given to a palliative approach (e.g. social support, change of home environment, (voluntary) work, meaningfulness, etc.). Every patient has the right to refuse a reasonable prospect of cure, but this makes it impossible to show that the criteria of 'medical futility, 'untreatability' and 'unrelievable suffering' have been satisfied, and so euthanasia will not be possible. In other words, euthanasia is only available as the last remaining option, in the case of a well-considered, repeated and persistent request by a patient with capacity, in the absence of any reasonable prospect of cure. Two psychiatrists must be involved at minimum. The physicians concerned, and the multidisciplinary teams, if any, must be satisfied that the patient has no reasonable prospect of cure, is facing unbearable suffering due to a psychiatric illness and is requesting euthanasia of his/her own accord. The two independent physicians make a thorough evaluation of all the legal criteria, not merely those specific to first and second independent physicians. They give a full, in-depth report of their opinions and the reasons for them. Two positive opinions must be given and any negative opinions

must be taken into consideration. Before the euthanasia is performed, all current and previous physicians and healthcare professionals must consult, in the presence of other relevant experts if needs be. Afterwards, great care must be taken to support the bereaved and provide care for the medical staff concerned.

B. Introduction

This advice sets out the VVP's understanding of due care as it applies to euthanasia requests from patients facing unbearable suffering through a psychiatric disorder (hereafter 'euthanasia in psychiatry'). Euthanasia in psychiatry is lawful in Belgium under certain conditions (Euthanasia Act, 2002). The request must be repeated, persistent and well-considered (meaning also that the wish to die must not be symptomatic of the disorder). The psychiatric disorder must be severe and incurable, the suffering persistent and the situation medically hopeless, that is to say there is no reasonable prospect of cure. In the psychiatric setting this means that the patient is in a medically futile situation, facing persistent and unbearable psychological suffering with no prospect of improvement as the result of a severe and incurable psychiatric disorder.

While euthanasia in psychiatry is regulated by law, it remains controversial. Opinions vary greatly and the debate is often heated, in society, the media and the psychiatric profession. Among Flemish psychiatrists there is no consensus at present on whether euthanasia in psychiatry should be allowed. Some psychiatrists are strongly in favour of euthanasia in psychiatry. Others argue that euthanasia in psychiatry should be made unlawful, as it was before. They take the view that it can never be justified, and that the Flemish Psychiatric Association should make a stand against euthanasia in psychiatry, as the American Psychiatric Association has done. Between these poles we find psychiatrists who do not hold a strong opinion, or have their doubts, and a large group who support the option of euthanasia in psychiatry, but urge due care and caution, seeing it only as the very last option when every reasonable prospect of cure has been exhausted.

There is very little research on the distribution of viewpoints among Flemish psychiatrists as a group. The only study we know of is a master's thesis (Shana Wouters, KU Leuven, 2017, promoted by Ludwina Van Bouwel, Joris Vandenberghe and Jan De Lepeleire). The thesis is based on an anonymous survey of 111 psychiatrists and trainee psychiatrists affiliated to the KU Leuven University Psychiatric Centre (45% response). It shows that 64% of respondents were comfortable with euthanasia for a psychiatric illness. However, this figure may not be representative of Flemish psychiatry as a whole, and it calls for broader follow-up research, which is currently in the pipeline.

It is precisely because of the lack of consensus, and the huge disparity in the psychiatrists' views, that this VVP advice says nothing about whether euthanasia in psychiatry should be allowed. That debate – and the arguments for and against – has no place in this advice and is covered at length elsewhere, in the media and academic literature. However, we, as a professional association, wish to say something about the due care criteria to be applied by the psychiatrist who decides, for one reason or another, to handle a request for euthanasia in psychiatry. For some of those who oppose euthanasia in psychiatry this will not be welcome, for in it they see the VVP's legitimisation of euthanasia in psychiatry. That said, the broadly representative board of the VVP reached the unanimous decision on 22 February 2016 that it is appropriate and important for the VVP to issue a statement on due care criteria. That decision led to the creation of a working group[1], which consisted of a diverse range of VVP board members and was given the task of establishing due care

criteria for psychiatrists faced with euthanasia requests.

This advice is the product of the working group's activities, of repeated feedback with the VVP board and of 2 broadly representative feedback groups. The first feedback group[2] focused on-psychiatrists concerned with the issue: lived experience experts, ethicists, non-psychiatric physicians, LEIF doctors (Life's End Information Forum), legal experts, politicians, etc. The second feedback group[3] focused on a broader group of psychiatrists with an interest in the theme (as a critic and/or through involvement in euthanasia requests). After thorough review, based on input from the feedback groups, the advice was approved by the VVP board on 20 November 2017. Therefore, the advice takes in a broad spectrum of input, accepted by the board by way of compromise, and does not necessarily reflect the individual views of the working group members or board members. Nor, obviously, is the advice binding to the members of the feedback group.

The advice focuses on the due care criteria to apply following a request for euthanasia from an adult patient facing unbearable suffering due to a psychiatric disorder. Minors are beyond the scope of this advice as euthanasia is only available to minors conditionally in cases of physical suffering in the terminal phase of an illness. This advice does not cover euthanasia requests for unbearable suffering due to neuropsychiatric disorders such as dementia, as the disparities are too great. A separate analysis and approach is required. Also beyond the scope of this advice are psychiatric patient requests for euthanasia for a physical disorder and psychiatric evaluations for patients requesting euthanasia in a non-terminal phase of a physical disorder.

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1 Composition of the working group: Joris Vandenberghe (co-chairperson of the working group and pen), Koen Titeca (co-chairperson of the working group and pen), Frieda Matthys (chair of the VVP), Kris Van den Broeck (director of the VVP), Thomas Detombe (VVP communications manager), Stephan Claes, Jonas Claeys, Jürgen De Fruyt, Marc Hermans, Gilbert Lemmens, Dirk Peeters en Rob Van Buggenhout, all VVP board members

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Finally, this advice does not extend to euthanasia combined with organ donorship. A subject on which the Belgian Advisory Committee on Bioethics is currently preparing advice.

It should be stressed that this advice is not guidance, given that a decision was made not to apply the strict structure and methodology required by the best practices for guidance. Firstly, we do not believe that the subject lends itself well to this, given the ethical considerations. And secondly, the time needed would render the process unworkable without specific funding. The psychiatrists and external parties involved in this advice gave of their time freely.

This advice rests heavily on the Dutch guidance: 'Request for assisted suicide from patients with a psychiatric disorder' (2009). In the Netherlands euthanasia and assisted suicide are regulated by law in certain circumstances. While our advice was at the preparation stage, the Dutch guidance was already under thorough review. We managed to get in contact with our Dutch colleagues on several occasions and at the final stage obtained a copy of their draft text (Guidance on Assisted Dying at the Request of Patients with a Psychological Disorder). At that time the draft was circulating the Netherlands for commentary by the professional group and other stakeholders. In the Netherlands they had decided to use the structure and procedures required for formal guidance. Given that the final version of the Dutch guidance had not been issued at the time of presenting our advice, we decided, after consultation, to use and cite the 2009 version in the interim. The two main references for our advice are therefore the Euthanasia Act of 28 May 2002 and the Dutch 'Guidance on requests for assisted suicide from patients with a psychiatric disorder' (Dutch Psychiatric Association. De Tijdstroom, Utrecht 2009).

When citing the Dutch 'guidance on requests for assisted suicide from patients with a psychiatric disorder', we consistently substitute the term 'assisted suicide' for 'euthanasia'. This helps tailor the citations to the Belgian context. Indeed, in the reviewed version of their guidance our Dutch colleagues consistently use the term euthanasia instead of assisted suicide. The present advice delves deeper into the status of assisted suicide and physician-assisted suicide in Belgium (see Section 10).

When the publication of the VVP's present advice is due, two other advisory papers will appear: ethical advice from Zorgnet-Icuro and advice on euthanasia and psychological suffering from the Belgian Advisory Committee on Bioethics. Each has its approach and accents, but there are overlaps, and consultations were had between all concerned.

Below, we show the **VVP's specific due care requirements in bold**. Due care criteria may offer a particular interpretation of the legal conditions, or embody them in the specific context of euthanasia in psychiatry, or they may even reflect a position adopted by the VVP, in the sense that due care, as seen by a group of professionals in a particular situation, should go beyond the legal requirements.

Finally, an evaluation of a patient request for euthanasia alongside ongoing patient care makes heavy demands of the patient, the family, the physicians and the healthcare professionals. It is impossible to capture what are, perhaps, the most important things of all through recommendations and due care requirements. These are treatment, empathy, care, trust, engagement, timing, respect (and mutual respect of boundaries), the manner in which conversations are held and messages conveyed. For example, "I am *not yet* ready to advise in favour of this" or "the legal criteria and due care requirements are not yet satisfied" give a completely different message to "I advise against this."

C. Structure of this advice

This advice comprises a list of contents, the introduction above, and, in the pages to follow, 13 points which are essential to handling a request for euthanasia with due care. In 1 we focus on what is meant by a careful evaluation process combined with ongoing care. Section 2 explains the criterion of the medically futile situation. Here, the VVP makes reference to the Dutch guidance, in which the criterion is covered in considerable depth and breadth. 3 gives a description of the criterion 'persistent and unbearable nature of the physical or mental suffering'. In 4 we set out the due care criteria relative to the root and repeated nature of a request for euthanasia, in the absence of external pressure. 5 deals with transparency between physician and patient. 6 stresses the importance of involving family and friends. 7 focuses on the need to involve other carers and healthcare professionals. 8 centres on the relevance of the physicians' values and emotions, as well as the potential for counter-transference. 9 concerns the final decision. 10 explains the difference between euthanasia and physician-assisted suicide. 11 focuses on what is meant by due medical care in the performance of euthanasia. 12 gives extra details on the reporting requirements, and, finally, 13 deals with support for the bereaved.

1. A careful evaluation process combined with ongoing care

1.1. Parties concerned, terminology and due care requirements

Clearly, the patient requesting euthanasia takes centre stage. Then come the patient's loved ones (family, friends, fellow patients, and so on) and healthcare professionals (multidisciplinary teams, GP, visiting psychiatrist, psychologist, psychotherapist, etc.). Given that in the case of a request for euthanasia in psychiatry the patient is generally not in a terminal phase ('the physician is of the opinion that the patient will not die in a foreseeable term'; Article 3.§3), the law has it that three physicians should be involved: the physician who will eventually perform the euthanasia (this is also the physician who receives the written request for euthanasia and reports it to the Federal Control and Evaluation Committee (FCEC), and two independent physicians, consulted by the executive physician, who report to him or her on the subject of the euthanasia request. Below we talk about the 'executive physician', the 'first independent physician' and the 'second independent physician'. The term 'executive physician' does not even remotely suggest the

execution of the euthanasia. The term is intended only as an abridgement of 'the physician who is prepared to perform the euthanasia provided that all the legal conditions appear to have been satisfied and two positive opinions have been received from the independently consulted physicians, and provided that the patient wishes to confirm his or her request after the evaluation process.'

Where the law is concerned, the executive physician may be one of the attending physicians, for example the GP or the attending psychiatrist. If the attending psychiatrist is willing to accept the task he or she may call on the assistance (e.g. technical support) of a colleague (a LEIF doctor (LevensEinde InformatieForum; specific training and accreditation), palliative doctor, GP, etc.). **If none of the attending physicians are prepared to serve as executive physician, it will be necessary to find another physician for the role. The VVP endorses the LEIF rules, which state that this must happen early enough in the process to give the new physician the opportunity to develop a relationship of trust with the patient and make his or her own assessment of the legal criteria. It is not within the bounds of due care to bring in a doctor to perform the euthanasia at the end of the evaluation process.**

The two physicians consulted must be independent: that is independent of the patient, of each other and of the executive physician. We take a closer look at this independence below. **In any case it is clear that the attending physician may not occupy the position of independent physician. To ensure an independent and unbiased assessment it is also important that these independent physicians do not attend the patient during the evaluation process. A relationship of trust may however be developed in the course of the evaluation process. They are also permitted to share treatment recommendations with the attending physicians.** This can put the attending physician in the difficult position of finding that a patient is prepared to follow further treatment, but that his or her motivation is very low, possibly inappropriate, as his or her main reason for following the treatment is to advance the evaluation of the euthanasia request. While the doctors and healthcare professionals feel that improvement and recovery are still possible, this hope is not shared by the patient, who merely wishes to satisfy the criterion that every meaningful treatment option be exhausted. This matter should be discussed in a fully transparent manner with the patient and all concerned. On the other hand, this external, possibly inappropriate motivation may be a new starting point that helps the patient forward, against all expectations, and brings relief to the suffering, or even recovery. In psychiatry we often see that the treatment welcomed with a certain ambivalence, and that the reasons for starting are motivated by external factors, but then change comes as the treatment progresses (e.g. the treatment for substance abuse).

1.2. Focus on the wish to die *and* on life

To begin with, a patient's wish to die is explored in the therapeutic relationship. That wish to die often contains a request for help. The wish to die is also of significance in the relationship, and it is processed in therapy, through exploration, expressing empathy, challenging and questioning ideas. Psychiatrists handle suicidal patients every day. In an acute suicidal crisis (when a person is a serious danger to him or herself) due to a severe psychiatric disorder it is possible, in exceptional cases, to take protective measures such as involuntary admission when there are no alternatives and the patient can no longer be reached and kept safe through

voluntary care and help. But the vast majority of suicidal patients either work on or through these suicidal tendencies in a trusting relationship with a therapist. This advice does not cover that process, but the response with which a formal request for euthanasia is met and the procedure followed thereafter. This therapeutic process continues while the request for euthanasia is processed and evaluated.

A request for euthanasia is not a wish to die in the narrow sense. But a wish not to (have to) live any longer. Death is just one of the options. In the first place we should understand the request as a person's desire for a change in their present life circumstances and/or life prospects.

For that reason the evaluation of a person's request for euthanasia involves more than merely checking the request against the legal conditions and due care requirements. It carries with it an opportunity to explore and realise new opportunities. These may be medical or psychotherapeutic procedures, changes of psychosocial context (training, work, voluntary work, housing type, network, etc.), contact with lived-experience experts, palliative or crustative care, etc. The support offered by lived-experience experts who manage their own recoveries from serious mental illness day after day can be a great asset. Contact with fellow sufferers can make patients more aware of their own strengths, despite their suffering.

Contacts in the framework of a request for euthanasia should always focus on death (exploration and evaluation of the request for euthanasia) and life (recovery, building a meaningful life despite the suffering and disabilities). This 'twin-track' policy implies that an attending psychiatrist and other clinicians will remain involved while a request for euthanasia is processed. The physicians involved in the request for euthanasia will insist that the patient continues or resumes his or her healthcare while the request for euthanasia is under evaluation. Consideration can also be given to finding pathways to lived-experience experts in recovery. It is important that care continues while a request for euthanasia is processed, to prevent the independent physicians from feeling too much pressure during their evaluation, as a result of the patient's suicidal tendencies or crises, for example. It also prevents independent physicians from feeling pressed into the role of attending physician, by having to respond in a crisis, for example. The independent physicians must have faith that care is being provided by healthcare professionals in an ongoing care plan. Crises experienced by a patient whose request for euthanasia is under evaluation get in the way of an evaluation with due care if the independent physician cannot rely on the active involvement of healthcare professionals. **Due care is only possible if there is an attending psychiatrist, and, ideally, other active healthcare professionals, in addition to the independent physicians.**

The term 'twin-track policy' does not imply strict separation, uncoupling or division: and the physicians and all other healthcare professionals concerned will take the treatment, recovery, wish to die and request for euthanasia into consideration. However, the emphasis will be different for all concerned. More than a specific methodology,

the twin-track policy is a fundamental attitude, through which all requests for euthanasia focus on the death and life of the patient.

At least three physicians are involved in processing a request for euthanasia. As the law sees it, a patient will generally take his/her request for euthanasia to his/her attending physician. This physician checks whether the legal criteria and due care requirements are satisfied. The attending physician (GP or consultant) contacts two independent doctors (the independent physicians) and asks for their opinions. Where psychiatric illness is involved a minimum of two independent physicians must give opinions, one of whom, by law and where psychiatric illness is concerned, must be a psychiatrist (Euthanasia Act, Article 3 §3). The attending physician, if willing, performs the euthanasia. In which case the attending physician becomes the executive physician.

In the eyes of the law, therefore, the attending physician is the executive physician. This regularly turns out differently in practice, if the attending physician(s) is (are) not willing to act as executive physician, a choice which they are of course free to make. Article 14 of the Euthanasia Act states that no physician may be forced to perform euthanasia and that no other person may be forced to participate. The following alternative scenario often comes into play.
The patient reaches out or is referred to a psychiatrist to explore and evaluate his or her request for euthanasia. This psychiatrist fills the role of first independent physician. After an exploration and evaluation, the patient is referred to another psychiatrist, who fills the role of second independent physician. If both ultimately gave a positive opinion, there would be one attending physician (who may or may not have asked for an opinion), but no executive physician. Only at that point would they seek another physician who was willing to perform the euthanasia. Obviously, this physician would have several consultations with the patient, make his or her own assessment of the legal criteria and take 2 opinions into consideration.

The VVP views this method, in which the executive physician is brought in late in the process, as an inadequate consideration of due care. It goes without saying that the physician who asks for an opinion must notify the independent physician(s) of the consultation (Euthanasia Act, Article 3 §2.3 and §3.1). The VVP also insists that there be consultation between the physicians to establish the viewpoint, relationship, expectations and roles of all concerned. In principle, an opinion is given to a physician whose role is clear to the patient and the independent physician. Clarity over the division of the roles can prevent additional suffering on the part of the patient and confusion of the roles by the physician. We must also prevent a situation in which a patient has been given opinions, but does not have an attending physician and/or executive physician. For that reason the VVP insists on the correct legal sequence, in which the executive physician is brought in early in the process and the independent physicians are asked to give their opinions in a report to the executive physician.

Unwillingness on the part of psychiatrists to perform euthanasia is sometimes met by a lack of understanding from their colleagues, who are then asked to perform it themselves. One possible alternative is having a psychiatrist in the position of executive physician,

with technical assistance from an experienced colleague (e.g. a LEIF doctor or palliative care doctor).

Whatever the scenario, the following legal principles apply. The exploration, evaluation and performance of euthanasia (requests) in psychiatry involves at least three physicians and, preferably, other attending or healthcare professionals. The two independent physicians consulted must be independent of the patient, the executive physician (Article 3 §1.3) and each other. They perform their evaluations independently of each other. Independence is also taken to mean that they are not related, related by blood, or in a personal relationship. **The VVP also insists that the independent physicians must not have (had) a long-term treatment relationship with the patient, and that the relationship between the physicians concerned is not hierarchical.**

Given the complexity of euthanasia-request assessments in psychiatry **the VVP insists on the due care requirement that at least two of the three doctors concerned be psychiatrists.** This is because the evaluation of euthanasia requests in psychiatry draws on the following expertise: evaluation of mental or decision-making capacity, diagnostic and therapeutic expertise in the psychiatric illness for the purpose of assessing medical futility, psychotherapeutic expertise with regard to the subtlety, implicit meanings and dynamics (transference and counter-transference) involved in the wish to die and the euthanasia request.

Due to the complexity of euthanasia-request evaluations in psychiatry this is never a snapshot, but **a process in which adequate time and multiple meetings are required**. The minimum legal term between the euthanasia request and performance of euthanasia is one month in a non-terminal phase of the illness. **In the context of requests for euthanasia due to psychiatric illnesses this term is much longer,** as we shall see from the due care requirements discussed later in this advice.

The VVP also insists that the fact that a patient has requested euthanasia must never be a reason to deny him or her a particular course of care or treatment, or to refuse him or her access to certain therapies. It is sometimes reported that patients who have requested euthanasia are not permitted to take part in certain therapies because they have not chosen life, or because of the detrimental effect it would have on fellow patients. It seems to us that this underestimates the complexity, subtlety and often also the ambivalence of euthanasia requests. Analogous with suicidal patients, patients can of course be expected to show a clear commitment to therapy.

If a physician refuses to grant a request for euthanasia he or she must notify the patient or the patient's confidential advisor in good time and give the reasons for refusal (Article 14 of the Euthanasia Act). If the refusal is on medical grounds it must be noted in the patient’s medical records. The physician who refuses to grant a request for euthanasia must, at the request of the patient or the patient's confidential advisor, share the patient's medical records with the physician assigned to the patient or confidential advisor.

1.3. Task of the psychiatrists concerned

A physician who performs euthanasia (executive physician), must follow a number of legally prescribed steps (Article 3). We give an overview of these steps below.

- "Be certain that the request is voluntary, well-considered and repeated, and has not come about as the result of external pressure."
- "Be certain that the patient is in a medically futile situation involving persistent and unbearable physical or psychological suffering that cannot be alleviated, and that it is the result of a severe and incurable disorder caused by accident or illness."
- "Notify the patient of his state of health and life expectancy and consult the patient about his request for euthanasia and discuss with him the therapeutic options still open to him, including palliative care, and the consequences involved."
- "If a (multidisciplinary) nursing team is involved, and it is in regular contact with the patient, discuss the patient's request with the team or the team members."
- "If the patient is willing, discuss the patient's request with any loved ones he identifies."
- "Be certain that the patient has had the opportunity to talk to the people he wished to meet."
- "Check for a written request: the patient must make his or her request in writing."
- The request must at a minimum contain the advisory text 'I want euthanasia', the date of the request, the name and signature of the person making the request, and, if possible, the reason for the request.
- "If the patient is unable to write, the request may be written by a third party who is not a beneficiary. In which case it must be written in a doctor's presence. A note must also be made of the reason for the patient not being able to write it, the name of the writer and the name of the doctor present when it was written."
- Since these are non-terminal situations: "Allow at least one month to pass between the patient's written request and the performance of the euthanasia."
- "Make regular notes in the patient's medical records of all requests made by the patient, as well as the interventions of the attending physician and their results, including the report(s) by the independent physician(s)."

The law describes the task of the first independent physician as follows: (literally from article 3)

- "Evaluate the severity and incurability of the disorder."
- "Be certain that there is persistent and unbearable physical or psychological suffering that cannot be alleviated."

The law describes the task of the second independent physician as follows: (literally from article 3)

- "Be certain that there is persistent and unbearable physical or psychological suffering that cannot be alleviated."
- "Be certain that the request is voluntary, well-considered and repeated."

The VVP insists on the due care requirement that the three physicians concerned each give detailed commentary on all of the legal criteria and due care requirements (and not merely the legally required tasks for each physician as set out above), following several consultations spread over a reasonable period of time:

- Evaluate the severity and incurability of the disorder.
- Evaluate whether the situation is medically futile (no reasonable prospect of cure).
- Evaluate whether the suffering is persistent and unbearable and cannot be alleviated.
- Evaluate the mental or decision-making capacity.
- Evaluate whether the request is voluntary, well-considered and repeated.
- Evaluate whether the request came about as the result of external pressure.

One of the two psychiatrists concerned (executive physician or first independent physician) runs through an evaluation process with the patient that requires multiple meetings, spread over a period of adequate length. In the process not only does this psychiatrist evaluate the legal criteria and due care requirements, but he/she explores the euthanasia request in depth: the layers of meaning, the face value of the request and the reasons behind it, the implicit messages or meanings, the underlying dynamics (e.g. transference and counter-transference), etc. He or she involves the family and important others in the process.

A process of this kind generates a relationship of trust between the patient and the psychiatrist. Biases and (counter) transference could complicate the independent, more objective evaluative stance of this psychiatrist. **For that reason it is essential to involve at least a second psychiatrist, who can then assume the role of one of the independent physicians. This second psychiatrist then occupies a stricter evaluative position and sees the patient only a few times, which offers the most concise and objective check of whether the euthanasia request satisfies the legal criteria and due care requirements, and whether there are any prospects of recovery (in order words, if the suffering can be alleviated). If necessary, another opinion can of course always be invited** (e.g. a second opinion from a specialist in that disorder, to help assess medical futility; or from a specialist in mental capacity; in psychodiagnostics; psychotherapeutic advice; etc…).

Both independent physicians consult the medical records, examine the patient and report their findings. They provide a detailed and careful report for the executive physician, and give justification of their opinion. They have one or more conversations with the (previous and/or current) attending physician(s) and other healthcare professionals and see the patient alone (private conversation) or in the presence of family.

These elements call for an accurate reconstruction of the history, disease progression and treatment to date. Finding and collecting this information is a significant task. Drawing on the cooperation of colleagues (current and previous clinicians) to provide clear and complete information is essential in performing the evaluation with due care. The medical information can be called up by the physician or patient, in reference to Article 9 of the Act concerning the Rights of Patients of 22 August 2002. This article states that every patient has a right to carefully maintained patient records and the option to view or make a copy of them.
When a physician calls up information, a signed consent form is required. The other physicians and healthcare professionals contribute to a careful evaluation of the euthanasia request by providing complete information, not by participating in the euthanasia.
An evaluation made with due care rests on extensive and detailed information: e.g. nature, duration and frequency of outpatient and residential psychotherapeutic treatment, admissions, type, doses, duration, effects and side effects of medication, technical treatments, employment care, adapted housing, community care, etc.

Besides gathering this information it is essential to consult current and previous clinicians with regard to the euthanasia request and due care criteria. Consultation often provides more context than reports, and it gives an opportunity for joint reflection. Clinicians are contacted with the patient's consent. But if the patient does not consent to the gathering of information or to contact, the executive or independent physician may decide that he or she is unable to do the work satisfactorily or to carry out the evaluation.

All physicians concerned, especially the clinicians, must consider the following:

- stimulate and support the process, to get the patient to consider options other than death – embrace every opportunity for recovery and change - exploration of interventions that could possibly alleviate the suffering in a recovery-oriented approach. The involvement of family and important others may be an important factor here.
- Support the patient and his or her loved ones (even if it comes down to euthanasia): preparation, final goodbyes, etc.

In strict legal terms, euthanasia can proceed without positive opinions from the independent physicians. **The VVP proposes the due care requirement that two positive opinions must be obtained, and that any negative opinions must be taken into consideration.**

In summary, the VVP insists on the due care requirement that the processing of a request for euthanasia in psychiatry must involve an attending physician (and if necessary two other clinicians), an executive physician (who may also be the attending physician) and two independent physicians. Of the three physicians involved in the euthanasia request (the executive physician and the two independent physicians) at least two must be psychiatrists. At least one of these psychiatrists will run through a lengthy and thorough evaluation process with the patient, involving contact at various points and a broad exploration of the case. The other psychiatrist (one of the independent physicians) may have fewer points of contact, allowing a stricter evaluative position from which to check the legal criteria. This sets up a complementarity between a thorough evaluation and exploration, which creates a bond of trust (but not a clinical position) which could lessen the objectivity of the assessment (e.g. counter-transference), and a stricter evaluation of the legal criteria, which reduces the space for trust to develop and therefore the depth of understanding (exploration of the subtleties, ambivalence, etc.).

Under the terms of the law, the independent physicians are consulted by the executive physician and report to the latter. This means that an independent physician cannot commence his evaluation until he or she is consulted by an executive physician. An independent physician who acts on the strength of patient self-referrals is not exercising due care, as this carries the risk of 'opinion shopping'. Furthermore, the VVP insists on the due care requirement that each of the physicians concerned (the executive and two independent physicians) carry out a complete evaluation of all the legal criteria, and not just those set out for the first and second independent physicians. The two independent physicians present their findings in a detailed, carefully substantiated and justified report addressed to the executive physician and, if necessary, the other healthcare professionals concerned. Under the Act on the Patients' Rights the patient does of course have the right to see a copy of the report or opinion addressed to the executive physician. There must be two positive opinions and any negative opinions must be taken into consideration.

2. Evaluation of the medically futile situation

The Euthanasia Act states that "the patient is in a medically futile situation of persistent and unbearable physical or psychological suffering that cannot be alleviated, and this is the result of a severe and incurable disorder caused by accident or illness" (the Euthanasia Act. Article 3, § 1).

Medically futile carries the meaning that the disorder is severe and incurable, and that the persistent and unbearable suffering cannot be alleviated. **Medical futility, then, implies not the patient's subjective experience of futility, but the lack of treatment options and**

means of alleviating the suffering from a more objective, medical and psychiatric perspective.

We cite the guidance of the Dutch Society for Psychiatry (NVvP) as regards medically futile situation:

> *Suffering is futile when there are no prospects of relieving, alleviating or eliminating it. In other words: when there are no longer any prospects for treatment. In some types of somatic suffering, such as an irreversible spinal cord lesion, there is no doubt that the disorder is untreatable. In many, if not all psychiatric disorders, it is impossible to predict the further course with absolute certainty. It is, theoretically at least, always possible for a patient to recover spontaneously after a number of years. Moreover, when the most obvious treatments have been exhausted, there are often in theory a variety of other potential, alternative treatments. Therefore absolute untreatability is as good as non-existent in psychiatry, unless the psychiatric disorder can be attributed to irreversible brain damage. For this reason the committee considers it important to speak of untreatability if there is no longer any reasonable prospect of cure [see reasonable prospect of cure].*
> *In an assessment of the life prospects of a patient who sees his situation as futile, there are more than medical considerations at play. This is because life prospects are closely associated with things that the patient considers valuable, meaningful and worth pursuing. In this sense the experience of futility is highly personal and individual. The healthcare professional will have to take all of the patient's values, standards and life goals into consideration when assessing whether his life is futile.*

This excerpt shows that the NVvP takes medical futility as the due care requirement that a reasonable prospect of cure no longer exists (or no other reasonable alternative exists) This is essentially a medical assessment, which also, of course, takes the patient's values and experiences into consideration. But the emphasis is on a medical and psychiatric evaluation, whereas for an assessment of the unbearable and persistent nature of the suffering, the patient is the focal point, alongside the physician's assessment (perceptible suffering, mental assessment, etc.). **The VVP follows the NVvP in that from a medical and psychiatric perspective it must be demonstrated that reasonable treatment options or reasonable prospects of cure no longer exist. The VVP follows the manner in which the NVvP describes this reasonable prospect of cure.**

> *The committee places three requirements on a reasonable prospect of cure. In line with current medical understanding there is:*
>
> *a. a prospect of improvement with adequate treatment;*
> *b. within a foreseeable term;*
> *c. and with a reasonable relationship between the expected results and the burden of the treatment on the patient.*

a. A prospect of improvement with adequate treatment:

(…) What the healthcare provider sees as improvement, need not necessarily be improvement to the recipient. When can a psychiatrist say that the treatment options have been exhausted? ***The basic principle is that all treatment options known to medicine and psychiatry and available to this patient have been attempted and found to be ineffective.*** *It is beyond the scope of this document to list the common treatments for all disorders. A few general guidelines are given below which the psychiatrist can follow in his assessment.* ***In the committee's view a patient can only be considered untreatable after the following interventions have been attempted:***

- ***all indicated standard biological treatments;***
- ***all indicated psychotherapeutic treatments;***
- ***social interventions that may alleviate the suffering.***

In all cases the practitioner must follow the guidance and consensus documents established by the professional association. The treatments must be state of the art. *In a patient with a depressive disorder, for example, the biological treatment must necessarily have involved: a modern antidepressant, a tricyclic antidepressant with blood level checks, a strategy such as lithium augmentation, a classic monoamine oxidase inhibitor and electroconvulsive therapy. The psychiatrist will also need to check whether there is reason to try some of the other, less standard treatments listed in the guidance, such as other augmentation strategies. Furthermore, in the case of a patient with depression, he will need to check whether standard forms of psychotherapy, such as interpersonal therapy, cognitive (behavioural) therapy or, where indicated, other therapies, have been given by a qualified therapist.*

This guidance gives the state of the art treatments at the time of writing. In all of these disorders consideration must be given to placebo effects. These include aspecific factors, such as the quality of the therapeutic relationship, influences from the patient's environment and the setting in which he lives. Relocation to another setting could influence the treatment relationship, the patient's motivation, the disorder and its effects, and therefore the wish to die. Finally, there should always be some consideration of the reasonable chances of spontaneous recovery from the disorder.
There is always a reasonable prospect of cure if it can be reasonably assumed that the patient's situation may improve as a result of focused interventions or spontaneously of itself. The psychiatrist need not consider the purely theoretical possibility of an effective therapy coming available in the future. He may conclude that there is no prospect of improvement if promising treatments that could have been beneficial have been exhausted at the point when it falls upon him to decide whether or not to grant euthanasia.

To establish whether a prospect of cure still exists, there must be detailed examination of the healthcare history and the current situation. The following questions are an important part of that examination.

- *What biological and psychological treatments and social interventions have been applied?*
- *Have these treatments reached an end or might they be prematurely abandoned?*
- *Are they state of the art treatments?*
- *What were the treatment results?*
- *Were there circumstances that contributed to the ineffectiveness of the treatments?*

b: Foreseeable term

If, according to latest medical opinion, there is a prospect of improvement, but not within a foreseeable term, there is no reasonable prospect of cure. It is not possible to determine a foreseeable term independently of the individual situation and previous medical history of the patient. The committee finds that it is not possible in a quantitative sense to state what a 'foreseeable term' might be, but believes that the following pointers are important to its determination:

- *The duration and scope of the preceding healthcare;*
- *the duration of the proposed treatment (in any case the committee finds unforeseeable a term in which a full psychopharmacological protocol and complaint-centred psychotherapeutic treatment can be performed);*
- *the age of the patient;*
- *the ratio of the chances of improvement to the burden on the patient.*

c: Ratio of results to burden on the patient

For a reasonable prospect of cure the burden of the available treatment that gives a prospect of improvement within a foreseeable term is in reasonable proportion to the results expected. What constitutes reasonable proportion is difficult to quantify. It must be assessed in each individual situation. The committee is of the opinion that several pointers may be used to improve that quantification, being:

- *the nature and amount of improvement and chances of the improvement taking place;*
- *the nature and severity of the risks and side effects of the treatment and the chances that they will occur;*
- *the burden on the patient."*

What if a patient rejects a reasonable prospect of cure? Does medical futility apply if the patient rejects a reasonable prospect of cure (e.g. ECT in the case of treatment-resistant depression)? **In line with the Dutch guidance the VVP insists that each patient has the right to reject a reasonable prospect of cure. As a consequence it cannot in theory**

be demonstrated that the criteria of 'medical futility, 'untreatability' and 'unrelievability of suffering' are satisfied, in which case euthanasia is not possible:

> *"Consent to treatment"*
>
> *If a treatment is to be effective, it will of course be necessary for the patient to give consent: he must be prepared to take the medication, take part in the psychotherapy and cooperate with any other interventions. When a patient refuses a proposed treatment this can lead to dilemmas. In the view of the High Court in 1994 (…), there can in theory be no talk of futility if a reasonable alternative to alleviate the suffering is freely refused by the patient. However, this ruling needs further clarification. In the committee's opinion some treatments can never be refused. This is true of biological-psychiatric treatments in all indicated cases, due to their relatively rapid effect and the rarity of any serious side effects. However the psychiatrist will need to consider how any other, more intrusive treatments he proposes might affect the patient's suffering.*
>
> *Obviously, this involves judgement of the chances, possibilities and probabilities, and not certainties. And so the next question is: will the patient feel the value of any improvements? Here, his values, standards and life goals come into play [see the paragraph on futile suffering]. If the psychiatrist can reasonably assume that the patient will continue to experience his suffering as unbearable, the refusal of the treatment is acceptable. In which case the refusal need not exclude the possibility of euthanasia. If the psychiatrist expects the patient to see the value of the treatment results, it would however be unacceptable to grant euthanasia.*
>
> *When assessing a refusal of treatment the pointers for futile suffering and reasonable prospect of cure [paragraphs on futile suffering and reasonable prospect of cure] should be taken into consideration. In individual cases the psychiatrist may conclude that the relationship between the burden on the patient and results to be expected through the proposed treatment is not reasonable.*
> *By way of example, a severely traumatised, rapidly disintegrating patient who has already been admitted several times has become psychopharmacologically resistant and has received psychotherapy several times, and is now refusing long-term clinical treatment at a top reference clinic. If the treatments already given were state of the art, the refusal of treatment need not stand in the way of euthanasia."*

In summary, the VVP follows the Dutch guidance. To judge medical futility there should be a check to see if a reasonable prospect of cure or a recovery-oriented care plan or intervention can be offered. This can be confirmed by checking the treatments already given against the specific evidence-based treatment guidelines for this disorder. There can be no talk of medical futility if a patient refuses a reasonable prospect of cure. We note, however, that this approach to medical

futility is heavily based on the traditional medical perspective. The law does tend to enshrine the medical model, which is certainly biopsychosocial. But suffering is also related to meaningfulness. The medical model is evolving, and the emphasis is constantly shifting towards the recovery vision, which guides many of the reforms in mental healthcare. In the recovery vision the emphasis is on personal recovery as opposed to clinical recovery: pursuit of a life of meaning and quality, despite disabilities or severe suffering through illness. The patient is encouraged to self-manage and to consider what he or she needs in order to do so. This type of recovery-based approach can also motivate patients with bad experiences of mental healthcare – which in themselves sometimes contribute to the suffering - to follow new, recovery-based treatments and interventions or to introduce changes in their lives.

Sometimes a new diagnosis (such as autism spectrum disorder, personality disorder, etc.) made in the course of an evaluation can be seen as an extra argument for the severity of a condition and for medical futility. **The VVP does not follow this and insists on the due care requirement that a new diagnosis is a new starting point for potential treatment and reduced suffering. It is only logical that a newly diagnosed comorbidity be treated with the appropriate expertise, in conformance with the existing guidelines for the pathology. There can be no talk of medical futility until the patient has had time to process and the new diagnosis and until every treatment, including psychoeducation, skills training, and so on, has been exhausted.**

3. Evaluation of the interminable and unbearable nature of the physical or psychological suffering

The Dutch guidance puts the due care requirement for unbearable and futile suffering as follows:

> *"Futility and the unbearable nature of the suffering are often strongly linked. The psychiatrist will need to assess and weigh both aspects separately and as a whole. The psychiatrist's professional opinion on the prospects of cure and care still available to the patient plays an important role in his assessment of the futility of the suffering. In the assessment of the unbearable nature of the suffering the subjective experience of the patient comes to the foreground.*
>
> *Unbearable suffering*
>
> *Suffering is always subjective and can never be fully understood by another. A certain degree of subjectivity cannot therefore be avoided when assessing a patient's suffering. Thresholds of pain and emotional resilience vary from patient to patient. Nonetheless, the unbearability of the suffering must be at least apparent to the psychiatrist. He may take his knowledge of the patient's personality, biography and psychiatric history into account. The assessment of*

the patient's suffering therefore rests on important professional and quantifiable elements. The degree to which the psychiatrist can sense the patient's suffering is partly dependent on the nature of the suffering and the length and nature of the therapeutic relationship.
In any case the psychiatrist will have to take note of the various aspects of the suffering and the factors that make it bearable or unbearable. Subjective experience of the patient aside, it is about the relationship between the burden and the ability to bear it. Against the patient's carrying capacity and his social environment must be set the burden resulting from the symptoms, limitations, disabilities and additional setbacks. The origin and progression of the suffering must also be examined, alongside the somatic, psychological or social factors that initiated or maintain the disorder.

Although the patient's experience of unbearable suffering is personal and subjective, the psychiatrist will need to be ready and willing to form his own opinion of it. This opinion can be supported, with the patient's consent, by asking others for their impressions of the patient's suffering.
The unbearability of the suffering can to a large extent be determined by its longevity. This makes it necessary to carry out repeat evaluations. Longevity need not necessarily mean that the illness is constant. The degree to which the patient experiences the suffering as unbearable may fluctuate. Many chronic psychiatric disorders have a varying intensity. Suffering may be experienced as unbearable due to the umpteenth recurrence of a severe psychotic episode or depression. A request for euthanasia must therefore be discussed with the patient, and assessed, at a time when the patient is doing better."

The VVP endorses the Dutch guidance and adds that the intersubjective nature of the unbearable suffering can be evaluated through repeated consultations, thorough observation and an examination of the patient. When compiling the medical and psychological file special consideration must be given to the history and life context.

4. Evaluation of the repeated, voluntary and well-considered nature of a request for euthanasia

This due care requirement can be found in Article 3, § 1 of the Euthanasia Act. The Dutch guidance puts the due care requirement on the voluntary and well-considered request as follows:

Voluntary request

The requirement of voluntariness means that the psychiatrist must be certain that the request came about independently of any undue influence from others. Due to their psychological vulnerability and social limitations psychiatric patients are often dependent on others. They may, for example, in response to more or less covert signals from their environment or through a sense of guilt or feelings of being a burden, find themselves compelled to respond to their environment or to ease it

by bringing an end to their life. The exploration of these subjectively experienced or even real-life pressures in the environment must be a part of any evaluation of whether a request for euthanasia is voluntary.
The psychiatrist must be able to find answers to questions such as: does the patient see himself as a burden to his environment, if so, why, and what signals is he picking up on? Are alternative living or support arrangements available to allow him to escape these undue influences? A change of situation can also affect the degree to which suffering is experienced as unbearable and futile. The requirement of voluntariness does not mean that the patient should reach his decision entirely free of undue influence in all cases. Situations can be envisaged in which a patient presents with such severe, unalterable behavioural disorders, that it is impossible to prevent his environment from seeing him as a burden. If the patient is aware of this, the realisation can be a major contributor to the unbearability of the suffering. This type of diminished voluntariness need not be a reason to refuse his request for euthanasia from the outset.

Well-considered request

Euthanasia can only be an option if the psychiatrist is entirely convinced that the patient genuinely wishes to die. This evaluation process demands the utmost of the psychiatrist. He must assess whether the request is well-considered. The patient's ability to reach a well-considered decision, in other words his mental capacity, plays a major role. The bar must be set high for mental capacity. Aside from undue external influences [paragraph above] there are undue influences, of a pathological nature, which originate on the inside. In principle, there can only be talk of self-determination if the patient is free of both. 'In principle': in reality it is possible to envisage situations in which the patient does not have optimal capacity, but the psychiatrist is nonetheless convinced of the seriousness of the wish to die […]. The guideline is always whether the patient has given enough consideration to the relevant facts and circumstances over a length of time.

What criteria can the psychiatrist use to establish the well-considered nature of a wish to die? In any case, he will need to establish the following.

a. *The patient is making a clear choice to die.*
b. *He has weighed the choice to continue life, possibly with ongoing disabilities as the result of his psychiatric disorder, against the choice of euthanasia, and he must be able to argue the choice to die within the bounds of his intellectual capabilities.*
c. *There is talk of a persistent desire to die.*

Only when these three criteria are satisfied can the psychiatrist conclude that the patient has made a well-considered request for euthanasia.

a: A clear choice to die

In a well-considered choice to die the patient will always have weighed his suffering against those aspects of his life which still hold value for him. Even when he makes a clear choice to die, he will often, if not always, show a measure of ambivalence in his thoughts and feelings. In principle, this does not imply an incapacity for decision-making. It may mean that the patient is capable of experiencing and taking into consideration other aspects of his life and life prospects. Furthermore, in a well-considered decision to die he will need to overcome a fear of death, often to the very end.
(…)

b: The process of consideration
A precondition for careful consideration is that the patient be well-informed about his situation and prospects [see also c] and that he understands that information. For an adequate consideration of the choice between death and life it is also necessary for the patient to have an adequate awareness of the illness and knowledge of himself. Awareness of the illness can be defined as: awareness of the symptoms and consequences of the illness. Does the patient know which functional disorders affect him, and does he understand how they affect his behaviour and situation? Does he understand the information he has received from the clinician, and does he apply it properly to his own situation?
In depressive disorders a patient may argue his choice through a sombre, nihilistic view of himself, his past and his future, and facts that cast a sunnier light on the future may not make it through to the process of consideration In which case the patient's view of life and the future is sick, and he is unaware of the consequences of his own illness. In psychoses too there is often a distorted awareness of the illness, because the patient lacks the ability to weigh his own beliefs against reality and so recognise his illness. Therefore a request for euthanasia can be made on the basis of beliefs which are not grounded in reality.

A patient with severe, recurring psychosis or depression can be considered to have made a well-considered choice for euthanasia with full awareness of the illness during the good periods between episodes. Some patients are also able to reach a well-considered decision during psychopathological episodes. For example, a psychotic patient who has isolated hallucinations but no other obvious delusions. Or a patient with chronic depression, whose illness, besides a sombre mood, is marked by psychomotor retardation and sleep disorder, but has no thoughts of guilt or nihilism.
Self-knowledge can be defined as: knowledge of personal attributes that are of material influence on the quality of life, such as a tendency to avoid social situations or become dependent on others. Self-knowledge implies an understanding of how certain character traits affect the perception of the environment and interactions with others. In personality disorders the interaction with the healthcare provider can be heavily influenced by pathological personality traits of which the patient is not aware. At times these characteristics may not only influence the patient's suffering, but

may also exert a relationship-centred influence on the euthanasia request, through a desire to disempower the health professional, for example, based on delusions of grandeur, and to undermine the treatment and life assistance. Sometimes these personality disorders can be so pronounced that there is talk of diminished capacity.

At times awareness of the illness and self-knowledge demand much of the patient in terms of intellectual and psychological insight. Patient and psychiatrist must both make every effort to come to the best understanding that can be reasonably expected on the grounds of the patient's psychosocial and intellectual background. There are times when an optimal awareness of the illness and a certain degree of self-knowledge are essential to the success of a treatment plan. In the committee's opinion a lack of awareness of the illness or knowledge of the self should lead to a longer period of information provision and psychoeducation.
It is possible that the psychiatrist may not be able to relate to the patient's choice to die. However, this should not come into play in his evaluation of the well-considered nature of the choice. The concepts of proper consideration and capacity refer to the process by which all the relevant information is considered, not to the psychiatrist's judgement of what constitutes the right or wrong choice. People simply differ in the choices they make. It is about the way in which the patient has processed the relevant information, and not about whether he has made the 'right' choice.
(…)

c: Persistent wish to die

It is necessary to prevent a psychiatrist from granting a request for euthanasia that was made on impulse. The development of the wish to die must be considered as a process in which certain stages are passed until death becomes the only option remaining. In the opening stage the experience is heavy with the realisation that the situation is unbearable. This slowly or rapidly develops until there is a feeling that something must be done about it, and it ends with the realisation that death is the only option. In this process several events and circumstances affect the transition to the next stage. By paying close attention on how the wish to die evolved over time, the psychiatrist can gain a picture of its persistence. He can also ask the patient's family and relatives for more information [see also consultation with loved ones].

There is no specific answer as to how long a wish to die should exist before it is considered persistent. In any case, a clinician should allow plenty of time after a patient makes his first request for euthanasia. In the committee's opinion a persistent wish to die will only exist if the patient has unequivocally expressed his wish over a period of several months, in a well-considered manner, on several occasions and to third parties."

The VVP follows the recommendations of the Dutch guidance but adds that it is also desirable to involve the patient's loved ones to ascertain,

by means heteroanamnesis and observation of the interactions, whether or not the patient is being pressurised.

The VVP also insists that the three physicians concerned make a careful and thorough assessment of capacity, and that this be included in the report. They must take a broad view of the concept of mental or decision-making capacity in the context of the well-considered nature of the request. The term mental or decision-making capacity refers to the actual capacity of the patient, which is a clinical judgement and distinct from the concept of legal capacity. Is the patient capable of a reasonable valuation and assessment of his interests? Is he or she capable of making a well-considered choice, based on an understanding and comprehension of his or her situation?

The psychiatric illness may diminish a person's capacity to make certain decisions. For example, the wish to die may be symptomatic of the illness, not a well-considered choice. But psychiatric illness does not automatically imply that the patient lacks decision-making capacity. In every request for euthanasia there must be an examination of the degree to which the existing psychiatric illness affects the patient's capacity to make that request in a well-considered manner.

Mental or decision-making capacity is therefore a clinical judgement on a specific decision, choice or request. Due consideration must be given to the capacities of the person concerned. Firstly, an evaluation must be made of the patient's cognitive, emotional and social capacities. Secondly, checks must be made to ensure that the patient has adequate self-knowledge and awareness of the illness. Thirdly, a review should be made of the patient's life history.
The complexity of the decision, and its potential ramifications, must also be taken into account. A request for euthanasia involves life and death decisions. The judgement of a person's specific mental and decision-making capacity is not a snapshot in time, but a process.

The draft of the new Dutch guidance (Guidance on Assisted Dying at the Request of Patients with a Psychological Disorder) is illuminating as regards the evaluation of capacity from four separate perspectives, all of which highlight certain aspects. We adopt the draft without references:

> *Capacity is independent of the nature of the decision: further-reaching choices require higher levels of capacity.*
> *The literature identifies a variety of approaches to capacity, with differing criteria:*
>
> - *In the cognitive approach capacity depends on the patient having sufficient cognitive capacity. Four criteria are identified: the capacity to make and express a choice, the capacity to understand information, the capacity to apply information to one's personal situation, and the capacity to reason.*

In this approach, if a person is lacking or lacks adequate command of one of these capacities, there is talk of incapacity.

- *The second approach refers to the importance of a heartfelt choice, accompanied by the appropriate emotions. From this perspective questions are raised over the capacity of a person who is able to make a reasoned choice without identification in an emotional sense.*
- *The third approach suggests that capacity can be diminished if a choice is based on a pathological value, for example, an anorexia patient who places more importance on being slim than on being alive.*
- *The fourth approach is based practical rationality, that is the capacity to make something of the major values in life.*

In the case of a request for active assisted dying the first step, in keeping with the cognitive approach, is to look at the patient's cognitive capacities. Is the patient capable of understanding information on his prospects and basing his decision on these? The patient's emotions are also relevant: is the patient capable of a heartfelt consideration of the alternatives? Thirdly, the patient must not be driven by pathological values, arising from depression, for example, (this means that the illness has no influence on the request, as described under voluntariness above). Fourthly, the patient must be able to place the request in the context of values that are important in his life. This need not imply that the patient's personality is fully balanced.

The VVP endorses this approach.
Finally, the VVP adds that a persistent request does not imply that the wish to die or the request for euthanasia no longer contains an element of ambivalence. A feeling of ambivalence is normal in this complex and multi-layered decision-making process. Ambivalence and doubt can be levers that redirect the patient to life and recovery. When the wish to die and the request for euthanasia appear to strengthen and clarify, and ambivalence declines, the criterion of 'persistent request' is satisfied.

5. Informing the patient

This corresponds to Article 3, § 2 of the Belgian Euthanasia Act. The Dutch guidance gives the following due care requirement on information, situation and prospects (p. 36):

"To reach a well-considered decision the patient must have all the relevant information on his illness. The psychiatrist will need to provide him with full information, in a way that he understands, about his situation and prospects:

- *explanation of the pathology causing his suffering;*
- *possibilities of alleviating or reducing his suffering;*

- *the positive and negative effects to be expected;*
- *the prognosis if further treatment is stopped.*

The psychiatrist must not only consider the patient's psychological and cognitive impairments. The social and cultural differences between the psychiatrist and patient can also impair the communication.

The demand for information implies that the patient is willing to take information on board and weigh up all the angles. He has a duty to make every effort to receive the information and allow it to sink in. In the process, space must be set aside to discuss the emotional significance of the request and the possible run-up to the euthanasia, for himself and others. For his part the psychiatrist has a duty to assist the patient with his intellectual and emotional processing of the information and to assess whether or not he is capable. If he notes that the patient is unable to reproduce the information offered, he must attempt other ways to help inform him. The family may be brought into this process."

The VVP endorses this and adds that from the outset the patient must also be informed in a transparent manner of how his euthanasia request will be handled, of his own position and of the fact that the procedure following a request for euthanasia takes a long time and involves a variety of consultations, as well as information gathering, the involvement of several physicians, loved ones, etc.

6. Involvement of family and other important others

The law provides that the physician will discuss the patient's euthanasia request with the loved ones of his choosing "if the patient so chooses" (Article 3 §2.5). On the other hand, the law also allows the physician to set extra conditions (Article 3 §2), such as, for example, that the family or others be involved. The involvement of others is important, not just to allow them the chance to say goodbye, but because their involvement may offer up opportunities for recovery or initiate or facilitate the restoration of bonds. **The VVP insists that the patient's family and important others be involved, unless there are well-founded reasons for not doing so. In which case at least one person from the patient's immediate environment and named by the patient must be involved. Family or other important others will be involved with the patient's consent. However, a patient's refusal to allow others to be involved may lead to a situation in which the physicians are unable to perform their duties properly. For that reason the VVP insists on the due care requirement that the physicians concerned set the extra condition that important others be involved in keeping with the logic and principles above.** There is clearly no need for the family to consent to euthanasia; nor is it desirable to seek their consent. But note will be taken of the reactions, thoughts and feelings of family and loved ones, of how much understanding they show for the request, and so on. Any situation in which the family feel obliged to give their consent is to be avoided.

It is not their responsibility, and it is not something with which they should be 'saddled'. It could also complicate the last goodbyes and the grieving process.

7. Involvement of other care and healthcare providers

The cause of the suffering, a psychiatric illness, falls within the biopsychosocial model and is part of the medical domain. The psychiatrist is often not the only healthcare professional involved.

The law states that where a nursing team is present and in regular contact with the patient, the patient's request must be discussed with the team or the team members (Article 3 §2.4). The law allows the physician to set extra conditions (Article 3 §2), such as discussion of the request with current or previous care providers. **The VVP insists that other important care and healthcare professionals who were or are involved with the patient be contacted in all transparency, unless there are well-founded reasons for not doing so. There is no need to confine this contact to the nursing team referred to in the law.**

8. Values, emotions and potential counter-transference

The VVP emphasises the point that the physician or team must also look to themselves to uncover all of the factors involved in deciding a patient's capacity to make this decision, in their evaluation of the other legal criteria and due care requirements, and, beyond that, in deciding whether to grant or deny the request. This is because their own values, standards and emotions always have a background effect in the euthanasia request and the matter of assessing another's capacity This applies to the attending physician, the independent physicians and the executive physician.

Help with this self-reflection can be found in the Dutch guidance (2009, p. 40-41) on transference and counter-transference. This concerns the significance of a request for euthanasia in the relationship with the physician and other healthcare professionals, and the emotions evoked by the patient and healthcare professionals, as well, for example, as the degree to which healthcare professionals are 'contaminated' by the patient's futility, or unable to bear or 'tolerate' the patient's despair.

> *"The decision to grant euthanasia may arise through the fact that the clinician finds it so easy to put himself in the situation. This is a dangerous argument, as it may be associated with his own fear of decline, isolation and illness.*
> *A fear of one's own death may stand in the way of an open conversation about the wish to die.*
> *The patient's wish to die may become a bone of contention in the treatment relationship.*

A psychiatrist may decide to grant euthanasia to free himself of feelings of powerlessness and helplessness, resulting in the feeling that at least he has been able to take action against the suffering.
Irrational life-saving fantasies on the healthcare professional's part, on the other hand, can lead to a denial of euthanasia. Many healthcare providers see suicide as a personal failure.
(…)

Unbearable suffering and a request for euthanasia will evoke all manner of conscious and unconscious feelings in the independent psychiatrist, not least because euthanasia by a psychiatrist is still a matter of criminal law. He may think, for example, that he is respecting the patient's choice to die, but he may keep returning to the conclusion that the due care requirements have not been satisfied, his hidden agenda being his personal opinion that only one choice is possible, the choice of life.
When evaluating the patient's suffering, transference and counter-transference can also come into play. The psychiatrist must always be alert to this and confer with others for their reactions to the patient. The report for the consultant must include his own observations and any questions he has in relation to them. Many of the motives and feelings that the patient evokes in the psychiatrist can come into play when deciding whether or not euthanasia should be granted.
(…)
These counter-transference issues can soon arise. It is therefore important that the attending physician describes his own response to the help request, or discusses it with the consultant. If these feelings have interfered with the professional working relationship, supervision, referral or possibly admission elsewhere may create a situation that permits a more neutral assessment of the help request.

Unconscious motives always come into play in psychiatrist-patient relationships. When a patient requests euthanasia this is reason enough to stay alert to the possibility of transference and counter-transference. The committee takes the view that a psychiatrist acting with due care is capable of recognising, treating or at least taking account of transference and counter-transference between the patient and himself. He should, if needs be, ask for peer review on this matter. A procedure carried out with due care, especially the requirement that a second psychiatrist speaks to the patient, does offer in the committee's opinion a sufficient guarantee on this point."

These processes of transference and counter-transference can colour the evaluative process and call for therapeutic expertise (e.g. personal therapeutic expertise and/or opinions from or cooperation with psychotherapists), reflection, transparency and above all teamwork and constructive cooperation in an open atmosphere of peer support.

9. The final decision-making

Although the final decision rests with the patient and the executive physician, the VVP also insists that all physicians and healthcare professionals concerned should, ideally, gather around the table to discuss the matter openly and consider the points together. A round table meeting of this kind could take the shape of an ad hoc ethical consultation, involving representatives from the ethics committee, joined by the healthcare professionals and clinicians concerned (and of course the GP and psychotherapists, social workers, CAW, street workers, etc.), independent psychiatrists and executive physician, and other experts if needs be (e.g. specific expertise in the area of capacity, or on the illness in question, or psychotherapeutic expertise, etc.). **A round table meeting, alongside an evaluation and exchange of views and understandings over the euthanasia request, widens the assessment base and so heightens the level of due care. Wide-ranging consultation or a round table meeting might also prove extremely useful earlier in the evaluation process.**

When the executive physician receives positive opinions from two colleagues, after consultation, the ultimate decision to perform euthanasia lies with the patient and the executive physician. We know from experience that at this point – or sometimes earlier in the evaluation process - patients find a kind of serenity or reassurance: their request has been heard and is being taken seriously, and there is a prospect of the euthanasia taking place. **The VVP states first and foremost that this situation must be fully exploited in order to explore whether this serenity and reassurance can be a sufficient basis for focusing again - temporarily or otherwise - on life and on recovery, and not to make the implementation of euthanasia immediately concrete or to postpone it. This includes explicitly stating that the procedure can be put 'on hold' or aborted at any time, and that it can be stopped until the last moment. In this way, every effort is made to avoid creating implicit or explicit pressure to take further steps 'now that they have come this far in the evaluation procedure'. Here, too, the involvement of the family and/or next of kin, for whom this whole process can also be extremely difficult, is important.**

If the patient decides not to proceed with euthanasia (immediately), the question arises as to how long the positive opinions of the independent physicians are valid. As the law sees it the matter involves a 'current euthanasia request' and not a request for euthanasia in the future. Euthanasia on the basis of a prior written statement of intent is possible only in the case of irreversible coma. **For that reason the VVP insists that, if more than one year passes between the offer of the two opinions and the performance of euthanasia, the consultations with the independent physicians should take place again. They must satisfy themselves that the legal conditions and due care requirements are still met and update their report. If the overall situation remains unchanged, this may be a brief re-evaluation compared to the original evaluation. They will look into the reasons for the postponement and see whether they involve any chances of further deferral.**

10. Euthanasia and physician-assisted suicide

By physician-assisted suicide we mean help with suicide in the presence and under the guidance of a doctor, following a thorough evaluation process and under the same criteria and due care requirements as euthanasia. The current Belgian law on euthanasia does not regulate physician-assisted suicide. Article 2 of the Act describes Euthanasia as "deliberate, life-ending action taken by someone other than the person concerned, at their request". Article 3 goes on to specify that only doctors may perform euthanasia. However in Belgium, when it comes to the practicalities of life termination, some doctors prefer physician-assisted suicide if the patient is capable of ingesting a drug or opening an infusion tap. This is usually so for patients with psychiatric illnesses, but also applies to many other patients who request life-ending action. The patient's willingness to take the action can be seen as the ultimate expression of the wish to die. Some doctors find physician-assisted dying more acceptable than euthanasia, for personal reasons. Ethically and emotionally, many doctors feel a genuine difference between administering a lethal dose and assisting a patient to do it themselves.

Although in Belgium physician-assisted dying is not formally regulated by law – unlike the Netherlands - it is equated ethically (Advice of the National Council of the Order of Physicians, 22 March 2003) and by the Federal Commission for Euthanasia Control and Evaluation (sixth report to the legislative chambers, 2012 – 2013) to euthanasia, provided the conditions and legal procedures for euthanasia are respected and the act takes place under the responsibility of the attending doctor, who may intervene if necessary. As the argument goes, the law does not prescribe how euthanasia should be performed. Physician-assisted suicide is therefore considered as a means by which euthanasia can be performed. This position is at odds with the phrasing in the legislation, which says that euthanasia is performed by someone other than the person concerned, whereas in physician-assisted suicide it is at least partly through the patient's doing. Legally, therefore, there is some uncertainty over the status of physician-assisted suicide. That said, physician-assisted suicide is currently practised in Belgium by applying the legal conditions and due care requirements for euthanasia. Some euthanasia registrations, as reported and as apparent from the registration documents, are actually cases of physician-assisted suicide. In practice there is little difference: they follow the same procedure, only it is not the doctor, but the patient who performs the act (opens the infusion tap or self-administers the lethal drink). But as we have said above, for some doctors, and patients too, there is huge difference in emotion, principle and/or theory. **The VVP insists that in any case the choice between euthanasia and physically-assisted suicide be discussed**

by a well-informed patient and executive physician, and that the arrangements be made early enough in the process.

11. Due medical care in the performance of euthanasia

The VVP wishes to emphasise due care in the performance of euthanasia. Due care in the performance of euthanasia begins by involving the independent physicians, care providers and loved ones in the consultations with the patient in good time and in a fully transparent manner.

Besides the due care requirements set out by law, the VVP insists on the points in the LEIF document *(Leif guidance for due care in the performance of euthanasia. Wim Distelmans, version 2017).* An overview of the LEIF points is given in ***Appendix A*.**

The VVP would also like to emphasise due care, expertise, serenity and respectful treatment. It is extremely important to be well prepared. If necessary, the executive physician may be assisted by a nurse or experienced colleague. Obviously, the fact that family is present is not to say that they should take active part or assist the act.

Afterwards the executive physician will of course register the euthanasia (see further) by means of the dedicated forms and in accordance with the procedure prescribed by the law.

12. Reports

1. Report of the independent physician

The independent physician's report to the executive physician must follow the due care requirements set out in point 1 of the registration and given in this VVP advice. In view of the huge importance of the outcome of this report, the VVP advises an expert, written report following verbal consultation between the colleagues concerned.

The report is not merely a check that the due care criteria are satisfied, but it is a medical report. This means that it most contain all of the information needed to justify the decision reached. The specimen report in *Appendix B* may serve as an example. It merges the medical report and the due care criteria into a consistent whole. This specimen report may also be of assistance when requesting essential information from the clinicians, so that much of this information can be taken as it stands from the case records.

The VVP is well aware that these reports can be labour intensive and taxing. **However, given the complexity of the request and the due care with which it must be handled, a careful and detailed report is the outcome of careful and detailed work.** It is important that the physicians and healthcare professionals concerned, the patient and his loved ones supply this information, provided the patient gives consent. At the same time, the due care requirement must be reasonable and useful: little is gained if in his report to the executive physician the independent physician reiterates information already received from the executive physician. **Therefore the greatest emphasis is on the quality of the report's content: incorporation of the information with the findings of consultations with and an examination of the patient, a consideration of these findings, checks against the legal criteria and due care requirements and substantiation of the opinion and conclusion.**

2. Registration (by the executive physician)

The Act of 28 May 2002, Article 5, states that the physician who performs the euthanasia must, within four working days, by means of a fully completed registration form (http://overlegorganen.gezondheid.belgie.be/nl/documenten/fcee-registratiedocument-van-een-euthanasie) notify the Federal Control and Evaluation Committee (FCEE). Notification must be by recorded delivery and signed for.

The registration form is in two parts. The first is strictly confidential and contains personal information on the patient, the physicians concerned and the pharmacist. This part is to be completed and sealed by the physician who performed the euthanasia. The FCEE will only open it if it wishes to request additional information from the executive doctor. The second part is also strictly confidential, but must also be anonymous. Here, anonymous means that the form does not state the names of: patient, physicians, healthcare professionals, hospital or other. This part is used to state the conditions (including the diagnosis and a brief summary of the opinion) and the procedure followed. It is evaluated by the FCEE.

Registration form (Chapter V Article 7)
The questions in this registration form are given in ***Appendix C***, along with pointers added by the VVP. These pointers give the minimum conditions to be satisfied by the report for the FCEE. It is important for the psychiatrist who performs the euthanasia to keep careful and chronological records in the case file, including the progress of the request, his activities and the reasons for reaching the decision. This file can be based on the report summary described in point 2.

13. Support for the bereaved

The Dutch guidance (2009, p. 50) says the following on 'support for the bereaved':

> *"When supporting the bereaved the same care should be taken as when dealing with a suicide for which no support was offered. If at all possible, the previous psychiatrist must consult the family and general practitioner about how support can be offered.* ***To assist processing afterwards, it is extremely important that he consults with the loved ones prior to the euthanasia and takes their views and feelings into consideration. The patient must obviously consent to this consultation.***
>
> ***After the euthanasia the attending psychiatrist informs the family and invites them for a consultation. It may sometimes be wise to bring in a general practitioner, healthcare professional or mental healthcare practitioner, for example, or to involve them in the process of informing the relatives in a case where consultation had not taken place before.*** *This too must be accompanied by an invitation from the attending psychiatrist to an aftercare consultation*."

To this the VVP adds that it is therefore crucial that the family and/or important others be involved beforehand, and to work in conjunction with or around the general practitioner. The potential impact of euthanasia on every physician and healthcare professional concerned calls for systematic debriefing and mutual support.

Appendix A *(from Leif guidance for due care in the performance of euthanasia. Author: Wim Distelmans, version 2017)*

Beforehand:

- *Has the patient put his affairs in order? (e.g. a will, mending bridges, last goodbyes, funeral arrangements, who the patient wishes to attend the euthanasia, etc.)*
- *Discussion with relatives (e.g. are they comfortable with the euthanasia; give them the opportunity to express (conflicting) feelings; who would like to be there; what to tell friends, acquaintances, young children in the family, is aftercare needed or in place?)*
- *Discussion of the technicalities with the patient (and relatives) (...)*
- *Order and collect the euthanasia drug IN GOOD TIME*
- *Agree the date and time with the patient (and relatives) (avoid 'special days': such as the wedding anniversary of a family member)*

On the day:

When arriving to perform the euthanasia:
Beforehand (!) prepare the euthanasia drug; a sedative for the relative(s) if needed; arrive a few minutes early (wait in the car or nursing station if necessary); check that the maintenance infusion is in place, or install it (...) switch off the doorbell, mobile phone or land line phone; have the goodbyes been said? Are there enough chairs in the room? Rehearse the 'final' words

At the appointed time:

- *Ask the patient how they feel, and if they are sure they want to proceed with euthanasia (the final words are important, also for grieving relatives)*
- *Ask if everyone is present as agreed*
- *Is the patient comfortable?*
- *Say goodbye (be aware of non-verbal communication: keep to the style of your previous contact!) and show discretion ('self-effacement') to allow relatives to say goodbye in their own way*
- *Concern for family members: calmly inform them that breathing has stopped (e.g. mention the possibility of a 'cough/hiccup'), and that after several minutes the heart stops through a lack of oxygen and the patient's skin changes colour (hypostasis)*
- *After injection, during the coma: check how everyone present is feeling; keep them up to date on the situation*
- *Remain calm and 'professional' until the patient has passed away. Be discreet when checking for death (e.g. carotid pulse; discoloured appearance) and do not use a technical aid (such as a stethoscope)*

After death:

- *Inform those present that the patient has died and offer condolences*
- *Confirm that the patient's wish has been granted*
- *Allow those present to say their goodbyes*
- *Gather all equipment (syringe, etc.), fill in the form, complete the death certificate ('natural causes')*

- *Say goodbye to those present and stress that you are always available 'later' (tomorrow, next week, next year) to talk things over with them 'again'."*

***Appendix B (from** [http://overlegorganen.gezondheid.belgie.be/nl/documenten/fcee-registratiedocument-van-een-euthanasie)](http://overlegorganen.gezondheid.belgie.be/nl/documenten/fcee-registratiedocument-van-een-euthanasie)*

Part I: personal information

1. Surname, first names and address of the patient.
2. Surname, first names, NIDHI registration number, address and email address of the attending physician
3. Surname, first names, address, NIDHI registration number and date of consultation with the first and second independent physicians
4. Surname, first names, capacity and date of consultation with any other people consulted
5. Euthanasia performed on the basis of a declaration of intent: any confidential advisers indicated
6. Surname, first names, NIDHI registration number, address of the pharmacist that supplied the euthanasia drug. The products and quantities supplied. Any remainder returned to the pharmacist.

Part I must be dated, signed and stamped by the executive physician.

Part II: conditions and procedure followed

1. Place of birth, date of birth and sex of the patient
Do not state name (anonymity)
2. Date, time and place of death
Do not state the address or the name of the hospital or institution
3. Nature of the severe and incurable disorder caused by accident or illness from which the patient was suffering
State precise diagnosis
When was the diagnosis given?
Describe the symptoms and disabilities associated with the pathology.
4. Describe the nature of the persistent and unbearable suffering
Symptoms and disabilities associated with the pathology and experienced by the patient as unbearable (describe from the patient's perspective).
5. The reasons why the suffering could not be alleviated
Prognosis for the pathology.
Treatments and results (biological treatments, psychotherapy and social interventions).
Palliative care given.
State reasons why a reasonable prospect of cure/care no longer exists.
6. On the basis of which elements it is certain that the request is voluntary, well-considered and repeated and has not come about as the result of external pressure?
Why does the patient have capacity? Describe the components and give reasons for them. Why not pressurised by others?
Why well-considered and repeated?

7. Expected term of death
Check off
8. Procedure followed by physician
Check off and enter date of written request.
9. Capacity, date of consultation and opinions of the mandatory independent physicians (do not give identities)
Give a summary of the physician's report.
Reasoned opinions of the physician on the persistent and unbearable suffering; the voluntary, well-considered and repeated nature of the request; mental capacity; diagnosis; severity and incurability; medical futility, unrelievability of the suffering and lack of a reasonable prospect of cure;...
10. Capacity and date of consultation with other people or authorities consulted (do not state identity)
11. Means by which euthanasia was performed, and drugs used
Name, quantity and method of administration.
12. Additional information volunteered by the physician
Optional.

Appendix C (VVP-recommended specimen report)

Patient information
Clarifies majority or emancipated minority at the time of the request (HII Art3 §1).

Information on physician requesting an opinion
Surname and first
name
Date of request

Reason for consultation
Own role?
Patient inquiry?
Inquiry of physician requesting consultation?

Independence
In what way are you independent from the physician requesting an opinion, the patient or others? Transparency over possible dependence is required here (avoid appearance of non dependence).

Activities and information
How and when was information gathered?
Private meeting with patient is a requirement.
Consultation with healthcare professionals
recommended(with whom and how?)
How did you compile and review the case file?
Talks with support figures (with whom and how?)

Medical history
Diagnosis (when and by whom?)

Social and family anamnesis
Describe the patient's life.
Consider support figures, losses, trauma and personality traits.

Precise diagnosis/diagnoses why patient seeking euthanasia
Give precise description of diagnosis/diagnoses
Describe symptoms and disabilities of the pathology
Who made the diagnosis?
How was the diagnosis made?
When was the diagnosis made?
Origin and progression of the pathology?
Who informed the patient of his pathology?

Current clinical picture
Status praesens mentalis

Current treatment
Biological, psychotherapeutic and sociotherapeutic.

Nature and description of the unbearable suffering
Symptoms and disabilities as part of the pathology which the patient experiences as unbearable (describe from the patient's perspective).
State whether you sympathise with this suffering.
What environmental factors may affect this suffering?
Why is there no longer a reasonable prospect of cure or care for the patient?

Why the suffering cannot be alleviated
Prognosis for the pathology?
Chronological description of treatments and results (biological, psychotherapeutic and social)
Motivation and therapeutic compliance?
Describe and give reasons why a reasonable prospect of cure or care no longer exists.
Have treatments been refused? Why were these treatments refused? State way in which no reasonable treatment options were refused.
What palliative care was offered?

Request (voluntary, well-considered and persistent)
Why does the patient have capacity? Why do you find this to be the case? Why does the opinion-seeking physician find this to be the case? From what is this deduced?
When was the first request for euthanasia? With whom was the request discussed?
With whom and when did the patient discuss the request?
What are the findings of those who discussed the request with the patient?
Has the patient been informed about the illness, prognosis and treatment options? What has been discussed with the patient and by whom?
From what have you deduced that he considered this information in his request?
From what have you deduced that the request did not come about under pressure from others? From what have you deduced that the patient has considered the consequences of the request?

Interpretation and processing of the meanings and dynamics underpinning the euthanasia request, in relation to the psychiatric illness.

Conclusion
The conclusion must follow logically from the above descriptions.