



PERGAMON

Social Science & Medicine 51 (2000) 429–438

SOCIAL  
SCIENCE  
—&—  
MEDICINE

www.elsevier.com/locate/socscimed

## Consultation with another physician on euthanasia and assisted suicide in the Netherlands

Bregje D. Onwuteaka-Philipsen<sup>a,\*</sup>, Gerrit van der Wal<sup>a</sup>, Piet J. Kostense<sup>b</sup>,  
Paul J. van der Maas<sup>c</sup>

<sup>a</sup>*Institute for Research in Extramural Medicine, Department of Social Medicine, Vrije Universiteit Amsterdam, Van der Boechorststraat 7, 1081 BT Amsterdam, The Netherlands*

<sup>b</sup>*Institute for Research in Extramural Medicine, Department of Epidemiology and Biostatistics, Vrije Universiteit Amsterdam, Vrije, The Netherlands*

<sup>c</sup>*Department of Public Health, Erasmus University Rotterdam, Rotterdam, The Netherlands*

---

### Abstract

Consultation with another physician is considered to be an important safeguard of the practice of euthanasia and physician-assisted suicide. The objective is to describe the frequency and characteristics of consultation in cases of euthanasia or physician-assisted suicide (EAS) in the Netherlands. Data from two cross-sectional descriptive nationwide surveys, carried out in 1995, were used. Questionnaires were mailed to physicians attending 6060 deaths, identified from death certificates, and a stratified sample of 405 physicians were interviewed. In 1990, a cross-sectional descriptive postal survey of a random sample of 1042 general practitioners took place. Consultation took place in 63% of cases of EAS in the Netherlands, in 99% of the cases reported to the public prosecutor and in approximately 37% of unreported cases. In almost half of the unreported cases the decision had been discussed less formally with at least one colleague. In 1990, 7% of general practitioners met all 8 criteria for good consultation; this increased to 64% in 1995. Of the respondents, 26% had at some time advised against performing euthanasia or assisted suicide when acting as a consultant. This study shows that approximately two thirds of all cases of EAS are safeguarded by consultation. Although in the majority of these cases the consultation is of good quality, there is certainly still room for improvement. The quality of consultation could be improved, for instance, by appointing independent and specifically trained consultants. © 2000 Elsevier Science Ltd. All rights reserved.

*Keywords:* Euthanasia; Assisted suicide; Consultation

---

### Introduction

In 1995, 2.7% of all deaths in the Netherlands involved euthanasia or assisted suicide (EAS) (van der Maas et al., 1996). Because of its irreversibility and the risk of abusing vulnerable patients, EAS should be strictly regulated. This is not only important in order to obtain insight into the practice of EAS, but also to

---

\* Corresponding author. Tel.: +31-20-4448385; fax: +31-20-4448387.

*E-mail address:* b.philipsen.emgo@med.vu.nl (B.D. Onwuteaka-Philipsen).

control it and to promote quality assurance and improvement.

In the Netherlands, EAS is subject to the penal code, but during the past two decades various compromises have developed in recognition of the fact that it does occur in daily practice, and is supported by the majority of the public and the medical profession. There are two important methods of safeguarding the practice of EAS in the Netherlands, one of which takes place before, and the other after EAS is performed. Before performing EAS, a physician should consult another physician and after EAS has been performed the physician must report it to the Public Prosecutor. This notification procedure has been evaluated (van der Wal et al., 1996). The advantage of consultation over notification is that it can reveal sub-optimal care or decision-making, and, therefore, can be especially beneficial for quality assurance and improvement.

The purpose of consultation is that the consultant checks whether the requirements for prudent practice (a.o. unbearable and hopeless suffering, absence of alternatives for treatment and a voluntary, persistent and well-considered request) have been met in a specific case. Consultation must be distinguished from discussions with colleagues, which an attending physician might have when confronted with a request for EAS. In a discussion, an important function of the colleague is to act as a sounding board, whereas in a consultation the colleague checks the decision made by the attending physician (Board of the Royal Dutch Medical Association, 1996).

Ever since consultation on EAS was first considered to be important, there has been a lack of clarity about who should act as consultant and what good consultation should consist of. However, over the years a general concept of consultation has gradually emerged, as a result of discussions in the medical profession, jurisprudence and the notification procedure.

As early as 1984, before the establishment of an official procedure, the Board of the Royal Dutch Medical Association (RDMA) stressed the importance of consultation (Board of the Royal Dutch Medical Association, 1984). The Board did not comment on the acceptability of EAS, but in view of the fact that it did occur, even though it was illegal, explicit safeguards were considered to be extremely important. Consultation with another physician was thought to be an important method of checking whether a physician had considered his decision carefully. Important characteristics of consultants, mentioned by the RDMA, were (a) independence (important because the attending physician is usually heavily involved in the often complex, and always radical situation), (b) expertise and (c) experience, but these characteristics were not further defined. In 1995, the RDMA renewed its vision

on euthanasia, and gave a more precise description of what could be considered as good consultation. With regard to the independence of the consultant, it was stressed that the consultant should not work (a) in the same practice, (b) be a relative or trainee, (c) have any other subordinate relationship with the attending physician, and (d) be or have been a co-attending physician of the patient. With regard to expertise, it was stated that a consultant can be practicing in the same specialism as the attending physician, but that in some cases, due to specific problems, consultation with a physician from another specialism might be necessary. Therefore, consulting more than one other physician could be advisable. The tasks of the consultant were also described: the consultant should visit the patient, in order to be able to assess the situation correctly, and should make a written report (Board of the Dutch Royal Medical Association, 1996).

Jurisprudence stipulated that if the patient's suffering was not primarily physical, at least one psychiatrist should be consulted. Furthermore, from this judicial point of view, only in these cases is it necessary to talk to and/or examine the patient (Gevers, 1996).

The following criteria for good consultation are stated in the notification procedure: the consultant should not work in the same practice or be a co-attending physician (independence), should see the patient, and should (also) consult a psychiatrist if the patient has a psychiatric illness. The consultant should draw conclusions concerning the patient's condition and estimated life-expectancy, the possibility of alternative methods of treatment, and whether the patient's request is voluntary, well-considered and persistent (Anonymous, 1994).

We conducted a nationwide study on euthanasia, physician-assisted suicide and other medical practices involving the end of life in the Netherlands (van der Maas et al., 1996; van der Wal et al., 1996; Groenewoud et al., 1997; van der Heide et al., 1997). The results presented here concern consultation. The following research questions were addressed: how often does consultation take place and if it does take place, what is the quality of the consultation, what effect does it have on the physician's decision-making, and have there been changes in the practice of consultation over time?

## Methods

### *Study design*

For the 1995 study, data were collected in two sub-studies. In the 'death certificate study' questionnaires were sent to a stratified random sample of physicians attending 6060 deaths, identified from death certifi-

متن کامل مقاله

دریافت فوری ←

**ISI**Articles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات