Article

And What About the Pharmacist?

On the Position of the Provider of Lethal Drugs in Dutch Euthanasia Practice

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Abstract: In the Netherlands, euthanasia has been decriminalized. Termination of life on request and assisted suicide are criminal offences under Dutch law; but if physicians comply with the due care requirements of the Euthanasia Act and report their actions in the manner prescribed by law, they will not be prosecuted. One of the requirements relates to the act of euthanasia itself. If this is to be performed with due medical care, the physician relies on the services of a pharmacist. However, the responsibilities of the pharmacist with respect to euthanasia are not laid down in law. At present, Dutch pharmacists have to make do with professional rules that do not offer adequate solutions for the problems that may arise when euthanasia is performed.

Keywords: euthanasia; termination of life on request; physician-assisted suicide; lethal drugs; pharmacist; professional rules; professional standard

Introduction

Although Dutch law and the rulings of the regional euthanasia review committees suggest otherwise, euthanasia (termination of life on request and assisted suicide) does not just involve patients and their physicians.[1]

In 2016, one of the regional euthanasia review committees judged that a geriatric specialist had not acted in accordance with the due care requirements of the Euthanasia Act, partly because she performed the euthanasia incorrectly.[2] According to the review committee, the physician crossed a line by not halting when the patient—a severely demented and incompetent elderly woman—responded negatively to the administration of the lethal drugs. The doctor had also deemed it necessary to covertly add Dormicum to the patient's coffee in advance. The patient had not been taking any medication and, according to the physician, would have asked questions and refused to take the drugs. The doctor wanted to avoid a struggle during the procedure and preferred not to give her patient an injection. After the doctor subsequently gave the patient a second dose of Dormicum subcutaneously, resulting in a state of reduced consciousness, a paramedic inserted an infusion to administer the lethal drugs. When the geriatric specialist began to inject thiopental, the patient tried to sit up, upon which her family helped hold her down so that the doctor could administer the remainder of the dose.[3]

Of course, this case is not typical of Dutch euthanasia practice. The review committee did not fail to remark that when euthanasia is performed, "force, even the appearance of force, must be avoided at all costs."[4] Although the facts described are exceptional, they do show that it is not just doctors and their patients who are involved in performing euthanasia. However, one of the people involved is never considered. And that is the person who is providing the lethal drugs: the pharmacist. A physician who wishes to comply with the legal requirements must perform

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the euthanasia with due medical care,[5] and therefore relies on the services of this healthcare professional.

The guideline *Performing euthanasia and assisted suicide*, which is a set of professional rules issued in 2012 by the Royal Dutch Medical Association (KNMG) and the Royal Dutch Pharmacists Association (KNMP), supplements and specifies the legal requirement of due medical care.[6] The guideline is aimed at advising doctors and pharmacists about practical, effective and safe ways of performing euthanasia. Death must occur with certainty within moments and without the patient having to consciously experience the process of dying. The guideline applies from the moment the doctor issues a prescription to a pharmacist to provide lethal drugs up to the moment the remainder of the drugs and the emergency kit are returned by the physician.[7] It is a guideline that, like all guidelines, allows deviation if and when deviation is considered desirable and/or necessary under the circumstances. Deviations are permitted, but acting in that manner requires motivation and documentation. The guideline does not include rules concerning the decision-making process that precedes the performance of euthanasia or other ways of avoiding suffering.[8]

According to the guideline, the physician is ultimately responsible for performing euthanasia with due medical care, including the choice and dosage of substances used. Only a doctor may administer the lethal drugs or help the patient to take them. With regard to the other due care requirements physicians must meet, the guideline refers to the Euthanasia Act itself and to other professional guidelines: the *Reflections by the Royal Dutch Medical Association on Euthanasia* and *The role of physicians in the voluntary termination of life*.[9]

The same guideline requires pharmacists to responsibly check the pharmaceutical technical aspects of the euthanasia to ensure that it is performed using the correct substances in the correct dosage. If the pharmacist prepares the syringes, elastomer pump, infusion bag or drink, he is responsible for the preparation and labelling. The due care criteria for the pharmacist, specified in a separate appendix on the KNMP website, refer to the decision to issue lethal drugs; verification that the substances, the dosage and administration method are appropriate for the patient; and the request for provision, preparation and delivery of the lethal drugs.[10]

So what would pharmacists have thought when they heard the review committee's ruling in the case described above? And what would the pharmacist who actually provided the drugs have thought when he learned that this doctor not only did not perform the euthanasia with due medical care but also could not have come to an unambiguous conclusion that the request was voluntary and well considered? The patient never verbally requested euthanasia, nor was there a clear advance directive.[11] It is conceivable that this pharmacist had wondered how his involvement in this unfortunate event would be interpreted legally. Strangely enough, the more general question of the legal purport of pharmacists' involvement in euthanasia has not yet been examined by legal scholars.[12] Worse still, nor has it been looked into by the legislators.

Non-standard Pharmaceutical Practice

According to Dutch criminal law, termination of life on request and assisted suicide are punishable acts.[13] However, the legislators created a special arrangement for physicians in 2002. If a physician complies with a patient's request, he can refer to this exception if he has performed the euthanasia himself, has satisfied the legal due

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care requirements when doing so, and has registered the act with the municipal coroner.[14] If the competent regional euthanasia review committee subsequently rules that the doctor acted with due care, the public prosecutor is not notified.[15] The physician is indemnified from criminal prosecution.

In the case described above, the geriatric specialist cannot successfully appeal to the special arrangement made for doctors. She was judged as having failed to act in compliance with two of the due care criteria of the Euthanasia Act.[16] It is consequently up to the public prosecutor to examine whether it is appropriate to press criminal charges. The specialist is suspected of having committed a criminal act. Not a minor offence, but a serious crime. And the pharmacist provided the substances with which the crime was committed.

In such cases pharmacists appear to have little to fear from the public prosecutor; a claim that can easily be substantiated because doctors themselves have little to fear. Since the Euthanasia Act came into force on 1 April 2002, the public prosecutor has never prosecuted a physician who acted, according to the review committee, without due care.[17] Since then (up to January 1, 2018) physicians were found not to have acted in accordance with the legal due care requirements in 95 instances.[18] It therefore remains to be seen whether the geriatric specialist in the aforementioned case will ever be charged with a crime. The disciplinary court did, however, reprimand the geriatric specialist—a first in Dutch disciplinary case law.[19]

Since criminal law applies, and not the ordinary rules of civil law with respect to healthcare provision, Dutch physicians tend to speak of euthanasia as 'non-standard medical practice':[20] for certain acts, special rules apply. Consequently, there must be something that one could rightfully call 'non-standard pharmaceutical practice,' if only because the prosecution and criminal liability of an accomplice do not depend on the prosecution and liability of the party who actually committed the crime. Dutch pharmacists, on the other hand, are not in the habit of labelling their involvement with euthanasia as 'non-standard pharmaceutical practice.' The fact that they do not probably indicates that the situation is conceptually less clear for pharmacists. And this would explain why certain difficulties arise in practice.

The Euthanasia Act has several purposes, including offering legal certainty to physicians.[21] If the coroner is notified and the review committee rules that the doctor has acted in accordance with the legal due care criteria, the facts are not forwarded to the public prosecution service. If a doctor is considering fulfilling a patient's request for euthanasia, it must be clear to him in advance which conditions he must meet if he wishes to avoid being held liable.

Legal certainty is provided by a now well-developed set of rules, rules that can be found in legislation (mainly the Criminal Code and the Euthanasia Act) but also in a number of professional guidelines, such as the *Reflections of the Royal Dutch Medical Association (KNMG) on Euthanasia*, the KNMG position paper *The role of the physician in the voluntary termination of life* and the above-mentioned KNMG/KNMP guideline *Performing euthanasia and assisted suicide.*

In addition, the regional euthanasia review committees account for their application of these rules in detail every year. A considerable number of the committees' rulings have also been published on their website.[22] The annual reports and published rulings provide a clear picture of how the review committees apply and interpret the legal due care criteria. Since 2015, the committees have also used a *Code of Practice*, a digest that offers a general overview of the aspects and considerations that the committees deem relevant with regard to these criteria.[23] This *Code*,

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revised in 2017 and renamed *EuthanasiaCode 2018*, can also be found on the committees' websites.[24]

In the past few years, the review committees have made their position clear as regards the due care that physicians must exercise when performing euthanasia on patients with dementia and patients with severe psychiatric conditions. That doctors hesitate to act at the request of these patients can hardly be explained by legal uncertainty. After all, the performance of euthanasia on patients with dementia or psychiatric illness is clearly allowed, and no prosecutions have ever been instituted.

Physicians are perfectly aware of the fact that the applicable rules are part of their professional standard in a particular manner. The Dutch Medical Treatment Agreement Act, which is part of the Dutch Civil Code, lays down the applicable legal rules for medical treatment.[25] In the Netherlands, the relationship between providers of healthcare and their counterparts (usually patients or clients) is contractual. The Medical Treatment Agreement Act, which includes rules pertaining to information, consent, confidentiality, quality of care, surrogate decisionmaking, etc., is aimed at safeguarding patients' rights. The rules of the Medical Treatment Agreement Act apply to standard medical practice.

Under Dutch law, parties to an agreement are bound by the limits imposed by law. The Dutch Civil Code states as a general rule that legal acts that conflict with duty-imposing statutory provisions are invalid.[26] Because termination of life on request and assisted suicide are included in the Criminal Code as punishable acts, these acts cannot be part of an agreement between a patient and a provider of healthcare in the context of medical treatment. The patient who asks for euthanasia cannot accuse his doctor of malpractice if he is unwilling to grant it. Complying with such requests is not a requirement of the Medical Treatment Agreement Act, and neither is refusing to comply. Again, the rules that apply to termination of life on request and assisted suicide are rules of criminal law, not rules of civil law. They do not apply to standard medical practice.

The guideline *Performing euthanasia and assisted suicide* has been issued by professional bodies. Therefore, there is little doubt that it contains professional rules. How do these rules relate to the professional standard of physicians? And how do they relate to the professional standard of the pharmacist?

The Professional Standard of Healthcare Providers

Both physicians and pharmacists are healthcare providers as defined in the Medical Treatment Agreement Act.[27] A pharmacist can also be party to medical treatment agreements, personally but also as a legal entity ('the pharmacy'). Once such an agreement has been concluded between a pharmacist and the other party (the patient or a person acting on his behalf), both parties are subject to the agreed rights and obligations, with the obligations of one being the rights of the other. The obligations the pharmacist is subject to therefore correspond to the patient's rights. In the interests of the party that is usually weaker in relationships with healthcare providers—i.e., the patient—the rights have been laid down in the Medical Treatment Agreement Act. This law also prohibits contractual stipulations that conflict with one or more of its provisions and that are to the disadvantage of the patient.[28]

According to the Medical Treatment Agreement Act, the patient is contractually entitled to care in accordance with the healthcare provider's professional

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standard.[29] Also in the Act, 'professional standard' is used as an open concept; it is meant to be supplemented by the professional groups primarily concerned.

Deviation from the professional standard is never allowed. A healthcare provider who does not achieve the standard of his profession is not fulfilling his contractual obligations. However, the professional standard must not be confused with the professional rules developed by professional bodies, which are meant to help define the professional standard. Professional rules (protocols, guidelines, recommendations, rules of conduct, etc.) may be deviated from as long as the deviation is justified, i.e., when deviation from the rule is in the interest of the individual patient. Deviation is even mandatory in such cases and not deviating from the relevant professional rule would be a failure, because the professional standard has not been achieved. Not acting in compliance with an applicable professional rule when it should be followed is also a failure. It should be noted, however, that the space to deviate from professional rules with justification applies only to professional rules that refer to the technical aspects of the profession, to artisan rules. Professional rules that apply to other aspects of the profession, such as the protection of patients' rights or the organization of healthcare (rules referring to medical record-keeping, confidentiality, division of labor, etc.) may never be deviated from.[30]

The professional standard should primarily be defined by bodies representing the various groups of healthcare professionals—primarily, but not exclusively. The legislator has also laid down rules that are part of the standard, for example, the provisions of the Medical Treatment Agreement Act itself. Reference is made to the professional standard in similar ways elsewhere in healthcare legislation. The professional standard referred to in the Medical Treatment Agreement Act is a quality standard, and as such, it is referred to in other Dutch laws as well.[31] The professional standard, supplemented primarily by professional rules, also constitutes the supervisory framework for the Dutch Health and Youth Care Inspectorate (IGJ).

Not acting in accordance with the professional standard—failing as a healthcare provider—has different consequences in different legal contexts. Under civil law, it can lead to an obligation to pay damages. In disciplinary law, acting contrary to the professional standard can result in the imposition of a disciplinary measure. In administrative law it can bring about an order from the IGJ or a written instruction from the Minister of Public Health, and, finally, in criminal law, acting contrary to the professional standard resulting in death or physical injury due to negligence can lead to a prison sentence or fine.

The professional standard is primarily supplemented by professional rules. They can be artisan rules or they can refer to other aspects of the profession. These professional rules can be documented or undocumented. They can also be known by different names, such as 'protocol,' 'guideline,' 'recommendation,' 'directive,' 'rule of conduct,' etc. In the academic literature on quality of healthcare, these nouns have distinct meanings, but in reality a guideline can be adorned with the name 'protocol' and vice versa, and rules that are considered to be 'directives' may in fact be rules of conduct. Professional rules impact differently on members of the profession. Their weight depends on a number of factors: the level of scientific support, the authority of the issuing body, their scope, the way rules are worded, etc.

Furthermore, the range of application of a professional rule does not, by definition, cover only the members of the professional association if this organization is

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the issuing body. If a physician is not (or is no longer) a member of the KNMG, this does not mean that the rules defined by that association do not have any meaning for his or her professional conduct.[32]

The most important professional rules for Dutch pharmacists are issued by the KNMP and can be found on its website. The KNMP has developed rules on pharmaceutical professionalism: the *Pharmacist's Charter*, which sets out the principles, the *Professional Code*, in which the principles are elaborated, the *Dutch Pharmacy Standard (NAN)* and a *Social Media Code.* With regard to the technical aspects of the profession, the KNMP has issued rules that contain recommendations for providing good pharmaceutical care and descriptions of the conditions required to ensure it is provided: the *KNMP pharmaceutical care guidelines* and the *KNMP working practice guidelines.* Finally, the KNMP is involved in developing various multidisciplinary rules. One of the documents containing multidisciplinary rules is *Performing euthanasia and assisted suicide*, developed and issued together with the Royal Dutch Medical Association (KNMG).

When professional rules refer to standard practice, they apply *unconditionally* to the individual members of the relevant profession. If the body representing the medical profession has decided that the appropriate therapy for patients with condition *a* is therapy *y*, an individual doctor should, in principle, follow that rule and prescribe therapy *y* after having diagnosed *a.* That there is a rule that individual professionals must abide by does not depend on them. The professional rule is part of their professional standard, whether they agree with it or not. In that sense, the validity of the professional rule is unconditional.

The professional rules concerning euthanasia differ in that respect. These rules are only part of the professional standard if the individual doctor feels that they should be part of it. For professional rules applying to standard practice, the professional community decides; for professional rules applying to non-standard practice, such as those found in the KNMG/KNMP guideline *Performing euthanasia and assisted suicide*, the individual professional decides. In that sense, the validity of these rules is *conditional.*

Individual physicians are therefore free to not include these professional rules in their standard, also for reasons that have nothing to do with the profession. An individual doctor who never performs euthanasia out of principle is—legally speaking—not a less competent healthcare provider because of it. A doctor who does not grant requests for euthanasia due to religious beliefs cannot be accused of malpractice. A doctor who does not grant such requests because he feels that euthanasia ought not to be part of the medical profession has nothing to fear from the Health and Youth Care Inspectorate or the disciplinary courts.

This is all perfectly clear for physicians, because for them these professional rules are ultimately grounded in criminal law, in statutory provisions that provide an exception for physicians exclusively. The arrangement applies only to doctors and not to others. For pharmacists, the situation is not that clear. The lack of clarity they experience is not without practical consequences.

The Uncertainty of Pharmacists

The physician who decides to act on a request for euthanasia is performing a non-standard medical act that is governed by criminal law. The same is true of the pharmacist who complies with the doctor's request to issue lethal drugs. While it is

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perfectly clear for doctors that they have a choice about incorporating the relevant professional rules in the professional standard, the situation is much less clear for pharmacists. It is only in the guideline itself that one can find a reference to the possibility of them refusing on principle or for other reasons.[33] At the legislative level, it is not evident that the professional rules of the guideline are conditional.

Again, it is not immediately clear for pharmacists that the provision of lethal drugs means entering a field subject to criminal law, nor what the consequences are. By acting in line with the due care criteria and complying with the provisions of the notification procedure when performing euthanasia, the physician removes the criminality from the act—also for the pharmacist, in principle. If the doctor applies the rules correctly, the pharmacist has nothing to fear from prosecution for complicity in assisted suicide, termination of life on request, manslaughter, or murder—if he himself acted in accordance with the guideline. But the pharmacist will obviously not know in advance whether the doctor asking him to provide lethal drugs acted with due care (and will continue to do so later—once the drugs have been provided). It is not clear if and how he should verify this. The guideline only states that the physician must inform the pharmacist on request about the backgrounds relevant to the pharmacist. In a footnote, it states that the pharmacist can, for example, ask whether another independent doctor has been consulted.[34] But what are relevant backgrounds for the pharmacist? This lack of clarity affects the relationships between doctors and pharmacists involved in euthanasia and can lead to tension.

Recent research has revealed that non-standard pharmaceutical acts present pharmacists with dilemmas in practice.[35] In the cases studied, the completed questionnaires and the interviews have revealed that many different problems arise in the different stages of the process of performing euthanasia, in the trajectory to which the KNMG/KNMP guideline *Performing euthanasia and assisted suicide* refers.[36]

First of all, it frequently happens that a general practitioner asks a pharmacist who is not the patient's pharmacist to provide the drugs. For example, a general practitioner (GP) who collaborates with a pharmacist in a healthcare center may prefer that pharmacist even when it is not the patient's pharmacist. This may be easier for the doctor, but unlike the patient's own pharmacist, that pharmacist will have no knowledge of the patient. Although it makes perfect sense to ask the patient's own pharmacist to provide the lethal drugs, this does not always happen, not even when that pharmacist is known to the requesting physician and not known to him as someone who objects to euthanasia.[37]

Furthermore, not all pharmacists seem to be aware of the fact that they can refuse to provide lethal drugs on the grounds of principle. In addition, it is not always clear what should happen if a pharmacist does have such objections. Of course, it is best if the pharmacist makes his position well known. But who or what should be informed? Physicians and fellow pharmacists with whom he is unacquainted should also know in advance whether or not he is willing to cooperate.[38]

But even a pharmacist who does not have any conscientious objections can have doubts, for which there may be a number of reasons. For example, the prescribing physician is not known to the pharmacist. Usually, it is a GP with whom he is familiar. But this does not have to be the case. Doctors associated with a so-called End-of-Life Clinic are often perfect strangers to the pharmacist.[39] There will particularly be doubts when the pharmacist is aware that the patient's own

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physician refused the request for euthanasia. The pharmacist may also encounter requests for patients whom he does not know.[40]

And what if the pharmacist seriously doubts whether the legal due care criteria have been satisfied? Research has shown that this occasionally occurs with patients who suffer mentally—like the doctor, the pharmacist does not readily assess mental suffering as being hopeless—and with patients whose suffering is in part 'existential' (tired of living). And what if the doctor asks for substances that are not listed in the guideline?[41]

In all of these situations, the pharmacist is in need of information. But to which extent can he question the decisions made by the physician? How will a prescribing doctor receive a question from the pharmacist asking whether the due care criteria of the Euthanasia Act have been satisfied?[42] Is that not a matter for him and his patient? Is the physician accountable to the pharmacist?

Physicians seem to give pharmacists little time to come to a well-considered decision about providing lethal drugs. Usually, the doctor agrees on a time of death with his patient, and that time is presented to the pharmacist as a *fait accompli*. If there is only a short period between the doctor's request and the agreed time of death, pharmacists can feel that they are being put under pressure. Generally speaking, pharmacists who do not respond immediately to a request for the provision of lethal drugs, for whatever reason, can be confronted with authority. Such pressure is definitely inappropriate. A pharmacist who wants to act with due care is entitled to proper arguments, not easy references made by the requesting doctor to experience, special knowledge, or expertise. The argument that only the physician runs the risk of being charged with a crime is legally incorrect.[43]

The specific expertise of the pharmacist is not always called upon. A pharmacist has knowledge of the patient if it is one of his own patients. But the doctor prescribing the drugs has often already agreed with the patient how the euthanasia will take place. If, for example, a young woman with anorexia requests assistance in committing suicide by obtaining a drink from her GP, the latter should be receptive to advice from the pharmacist. The GP may have responded to his patient's specific wishes, but the pharmacist may feel it is necessary to point out to the GP that taking the drink may be difficult due to dehydration. The doctor should understand that the pharmacist only wants the right thing to happen in a difficult situation—as does he himself.[44]

Finally, the trust between pharmacists and doctors is at risk of being compromised when the former cannot properly monitor the deployment of the lethal substances by the latter. Research has revealed that GPs do not always return any remaining drugs after euthanasia has been performed. In one instance, a doctor prescribed lethal drugs although no euthanasia apparently took place. It seemed that the intention was to have lethal drugs available just in case. Of course, if a pharmacist becomes aware of such practices, trust is seriously compromised. Research has also shown that pharmacists do not always know what to do in these situations.[45]

What To Do?

As far as euthanasia in the Netherlands is concerned, the relationship between physicians and pharmacists is definitely in need of improvement. The lack of

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balance in the relationship can be partly rectified by better self-regulation, i.e., with improved professional rules.

First of all, the KNMG/KNMP guideline *Performing euthanasia and assisted suicide* should explicitly state that the guideline applies to non-standard practice and that its rules are conditional for everyone involved, including pharmacists. Unlike the rules employed in standard practice, the rules are only part of the professional standard when they are accepted by the individual professional. The decision to accept these rules as part of the professional standard (or not) requires due consideration, something that the guideline should encourage on the part of pharmacists. Once their position has been determined, pharmacists should be obliged to notify physicians, fellow pharmacists, employees, and patients, so that everyone concerned knows in advance whether or not they will cooperate. The guideline should at least provide an overview of the parties who need to be notified of the pharmacist's decision *not* to be involved in euthanasia. In addition, the guideline should specify that—as a rule—the patient's own pharmacist will be asked to provide the drugs.[46]

Furthermore, the guideline should be revised to ensure that the pharmacist is subjected to as few time constraints as possible. The guideline should also specify that the requesting physician will provide the pharmacist with all the information needed to come to a well-considered decision. The guideline should also oblige the doctor to keep the pharmacist informed about the way the euthanasia has progressed, especially when it has progressed in a way that neither of them expected. The guideline should also specify that the physician should inform the pharmacist about the decision of the regional euthanasia review committee. The guideline should also equip pharmacists with a procedure they should follow when residual drugs are not returned or when the provision of lethal drugs has taken place on the basis of a deliberately incorrect representation of the facts by the physician.[47]

Finally, the lack of clarity among pharmacists must be addressed at the source. The lack of balance is largely due to the applicable legislation. Physicians (but not just physicians) must understand that such a thing as non-standard pharmaceutical practice actually exists. Lack of recognition in law is the root of all evil. The results of the third evaluation of the Euthanasia Act were published in May 2017.[48] Once again, the researchers did not consider the concerns of pharmacists regarding their position and responsibilities when providing pharmaceutical care for the purpose of euthanasia. This is inexplicable, because the problems are patently obvious. The legislators would do well to seriously consider embedding the role of pharmacists in the Criminal Code and the Euthanasia Act.[49]

Notes

1. In Dutch criminal law, two distinct acts are considered punishable: termination of life on request and assisted suicide. See Criminal Code, Sections 293 and 294. When a physician terminates the life of a patient on the latter's request, he administers the lethal drugs. When he offers suicide assistance, the physician provides the lethal drugs and the patient takes the drugs himself. In the Netherlands, 'euthanasia' usually refers to termination of life on request by a physician. In this paper 'euthanasia' refers to both termination of life on request by a physician and physician-assisted suicide.
2. Oordeel 2016-85; available at https://www.euthanasiecommissie.nl/uitspraken-en-uitleg/o/onzorgvuldig/documenten/publicaties/oordelen/2016/niet-gehandeld-overeenkomstig-de-zorgvuldigheidseisen/oordeel-2016-85 (last accessed 12 Aug 2018).
3. See note 2, Oordeel 2016-85.
4. See note 2, Oordeel 2016-85, at 14.

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5. Euthanasia Act, Section 2, paragraph 1, under f.
6. KNMG/KNMP. Richtlijn *Uitvoering euthanasia en hulp bij zelfdoding* [*Guideline for performing euthanasia and assisted suicide*]. Utrecht/The Hague: Royal Dutch Medical Association/Royal Dutch Pharmacists Association; 2012; available at https://www.knmp.nl/downloads/richtlijn-uitvoering-euthanasie-en-hulp-bij-zelfdoding.pdf (last accessed 12 Aug 2018). An English translation of the guideline can be found on the website as well.
7. Even for the most experienced doctors, things can sometimes go wrong. For this reason, the doctor is required to bring an extra set of intravenous euthanatic agents and materials for the preparation and administration of the agents. The emergency set does not have to be ready for use straight away. See note 6, KNMG/KNMP 2012, at 22.
8. See note 6, KNMG/KNMP 2012, at 9.
9. See note 6, KNMG/KNMP 2012, at 9.
10. See note 6, KNMG/KNMP 2012, Appendix IX.
11. See note 2, Oordeel 2016-85.
12. See Onwuteaka-Philipsen B. *Derde evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding* [*Third evaluation study Euthanasia Act*]. The Hague: ZonMw; 2017.
13. Criminal Code, Sections 293 and 294.
14. Criminal Code, Sections 293 and 294 j° Euthanasia Act, Section 2, and Burial Act, Section 7, paragraph 2.
15. Euthanasia Act, Section 9, paragraph 1, under a.
16. See note 2, Oordeel 2016-85.
17. According to the Euthanasia Act itself, the Act must be evaluated every five years and Parliament needs to be informed. Three evaluation studies have been conducted so far. No criminal proceedings have been reported. All studies are available at https://www.zonmw.nl/search/?=toetsing (last accessed 12 Aug 2018).
18. This number is the sum of all annually reported cases of euthanasia in which the legal due care requirements were not satisfied according to one of the regional euthanasia review committees. The annual reports are available at https://www.euthanasiecommissie.nl/de-toetsingscommissies/jaarverslagen (last accessed 12 Aug 2018).
19. See RTG Den Haag 24 July 2018 (ECLI:NL:TGZSGR:2018:33).
20. See for example the statement made by Royal Dutch Medical Association KNMG on 25 November 2015 in its weekly magazine *Medisch Contact*; available at https://www.medischcontact.nl/nieuws/federatienieuws/federatiebericht/knmg-euthanasie-is-bijzonder-medisch-handelen (last accessed 12 Aug 2018).
21. See *Kamerstukken II*, 1999-2000, 26 961, no. 6, at 33. ["Kamerstukken" is best translated as "Parliamentary Proceedings"].
22. These rulings are available at https://www.euthanasiecommissie.nl/uitspraken-en-uitleg (last accessed 12 Aug 2018).
23. Regionale toetsingscommissies euthanasie. *Code of Practice.* The Hague: Regionale toetsingscommissies euthanasie; 2015; available at https://euthanasiecommissie.nl/uitspraken/brochures/brochures/code-of-practice/1/code-of-practice (last accessed 12 Aug 2018).
24. Regionale toetsingscommissies euthanasie, *EuthanasieCode 2018.* The Hague: Regionale toetsingscommissies euthanasie; 2017; available at https://www.euthanasiecommissie.nl/uitspraken/brochures/brochures/euthanasiecode/2018/euthanasiecode2018 (last accessed 12 Aug 2018).
25. Civil Code Book 7, Sections 446–68.
26. Civil Code Book 3, Section 40, paragraph 2.
27. Civil Code Book 7, Section 446.
28. Civil Code Book 7, Section 468.
29. Civil Code Book 7, Section 453.
30. Buijsen M. Richtsnoeren voor artsen: Hun toepassing in de rechtspraak [Guidelines for doctors: Their application by the courts]. *Tijdschrift voor Gezondheidsrecht* 2000/1, at 19–33.
31. See Act on Professions in Individual Healthcare, Section 40, and Act on Quality, Complaints and Disputes in Care, Section 2, paragraph 2.
32. See note 30, Buijsen 2000.
33. See note 6, KNMG/KNMP 2012, at 11.
34. See note 6, KNMG/KNMP 2012, at 45.
35. Göttgens-Jansen W, Dees M, Leeuwen E van, Buijsen M, Horickx A. *De stem van de apotheker in levenseindezorg. Onderzoek naar de taken en verantwoordelijkheden bij euthanasie en hulp bij zelfdoding* [*The*

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voice of the pharmacist in end-of-life care. On the role and the responsibilities of the pharmacist involved in termination of life and assisted suicide]. Nijmegen: IQ Healthcare; 2017. This multidisciplinary study was commissioned by Royal Dutch Pharmacists' Association (KNMP).
36. The research was partly historical and partly legal. In addition, researchers held in-depth interviews with 21 pharmacists. They also included and studied casuistry brought forward by trainee pharmacists. Finally, they analyzed 3,223 questionnaires filled out by physicians and pharmacists after euthanasia had been carried out. Physicians and pharmacists are required to do so according to the guideline *Performing euthanasia and assisted suicide.* See note 35, Göttgens-Jansen 2017.
37. See note 35, Göttgens-Jansen 2017, at 45.
38. See note 35, Göttgens-Jansen 2017, at 45.
39. Physicians associated with the so-called End-of-Life Clinic can be called upon by patients whose doctors are unwilling to grant requests for euthanasia, for whatever reason. These physicians do not have a treatment relationship with the patients who contact them. They do not object to euthanasia as such, but they do have to meet the requirements of the Euthanasia Act, as all doctors do. See https://www.levenseindekliniek.nl (last accessed 12 Aug 2018).
40. See note 35, Göttgens-Jansen et al. 2017, at 46.
41. See note 35, Göttgens-Jansen et al. 2017, at 46.
42. See note 35, Göttgens-Jansen et al. 2017, at 46.
43. See note 35, Göttgens-Jansen et al. 2017, at 46.
44. See note 35, Göttgens-Jansen et al. 2017, at 46.
45. See note 35, Göttgens-Jansen et al. 2017, at 46–7.
46. See note 35, Göttgens-Jansen et al. 2017, at 47–8.
47. See note 35, Göttgens-Jansen et al. 2017, at 48–9.
48. See note 12, Onwuteaka-Philipsen 2017.
49. See note 35, Göttgens-Jansen et al. 2017, at 49–50.

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