

Written directive of decisionally incompetent patients: A study of case law

Summary

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Assisted suicide and termination of life on request are criminal offences under article 293 and 294 of the Dutch Criminal Code. According to the same provisions these acts are not punishable if statutory due care criteria, laid down in section 2 of the Termination of Life and Assisted Suicide Act (Wtl), have been met. The second paragraph of section 2 Wtl focusses on the specific situation in which a patient is no longer capable of expressing his will, despite the fact that a written directive has been made by him at a time when he was still decisionally competent. Section 2 par. 2 Wtl provides that in that particular case the doctor *can* rely on the earlier written directive of the patient. The due care criteria likewise apply here. The implicit legal necessity and discretion to make an assessment are the reasons for this research.

The scope of case law is limited. This could be caused by doctors' restraint to comply with a request of life termination in such cases. Explanation can be found in the nature of the matter as well. Euthanasia can be considered as emotional events for next of kin, and others involved usually very in-depth experiences which do not give rise to start intensive legal procedures.

The various illnesses that can lead to a situation in which a patient is no longer capable of expressing his will, as mentioned in the second paragraph of section 2 Wtl, is discussed with in the first sub-question. There is no possibility to differentiate to the specific illnesses. Attention is required for the coma and reduced consciousness. In the annual reports the regional euthanasia review committees (RTE's) point out that a patient in the state of coma, meaning a condition in which consciousness is completely absent, cannot experience suffering. In such a situation euthanasia cannot be performed. An exception can be made to this principle: the use of a written directive to comply with the request for euthanasia by a patient in the state of a reversible coma, a coma not originated (spontaneously) as result of illness and additional complications but caused by medical treatment, namely administering medication for pain and symptom control.

If a patient is unable to express his will as a result of aphasia and/or an (advanced) state of dementia or Huntington's disease, compliance with a request for euthanasia can be granted. In such cases the RTE generally, mainly assesses whether the request was voluntary and well-considered and that no prospect of improvement was determined and, in particular, that suffering was unbearable. In an 'ideal situation' an up-to-date handwritten directive is available, which content is confirmed in conversations with the doctor (preferably with another independent physician).

As far as illnesses are concerned resulting in a changing ability to fully grasp the implications of his requests, the following can be stated: in case a written directive is available, and the ability to understand the consequences of a request varies, referred to in section 2 par. 2 Wtl, contact between a doctor and a patient influences the meaning of the directive in two respects. On the one hand contact with a patient when he is considered competent to make a reasonable appraisal of his interests and able to understand the consequences of his request can be used as confirmation of the earlier made written directive. Such a confirmation contributes strongly to the actual execution of the directive. On the contrary: behaviour of the patient on the moment he is considered decisionally competent, can give rise to question the request for euthanasia

stated in the written directive. If later behaviour casts doubt on the request priority is given to the latter. This can lead to conclude that, despite availability of a directive, the due care criteria are not fulfilled.

Sub-question 2 deals with the relation between the law and the standard of the Royal Dutch Medical Association (KNMG) according to case-law. It is of vital interest to guard for a self-reinforcing effect of case-law verdicts: the fact that in a specific case certain factors are of interest for judging them as 'due care' does not necessarily mean that these factors have to be complied with in general. The RTE does not approach cases in this manner. The approach of the review committee, as far as this is concerned, is more law-abiding (or better: abiding the standards set by the law) than the further-reaching (thus law-limiting) approach of the KNMG.

The RTE's take the compliance of KNMG-standards into account in assessing whether due care criteria have been fulfilled. The KNMG-standards offer doctors tools for their practice and contain visions on ways to assess if the criteria of due care, mentioned in the WtI, have been fulfilled. The KNMG-standards are however not set as a normative priority. Thus verdict cannot be interpreted backwards. When the KNMG-standard have not been fulfilled, this does not necessarily imply the verdict will be that criteria of due care have not been met.

The third sub-question provides the answer to the question how much weight is given to (later) behaviour inconsistent with what has been laid down in the written directive and in which fashion this should be interpreted. On the merits of the specific case, mentioned in this sub-question, a cautious conclusion that a doctor should be satisfied that the request for termination of life by a patient is still desired at the moment he can no longer fully grasp the implications of his request, can be drawn. If the 'behaviour' of a patient shows that the request for euthanasia is either lacking or eliminated, the request for termination of life will be refused. Later behaviour inconsistent with the written directive cannot be ignored on the ground of an earlier written directive. It, however, rather appears to create ground for a contraindication, which in itself could lead either the doctor or the independent physician to conclude that criteria of due care, referred to in section 2 paragraph 2 WtI, have not been met. If criteria of due care have not been fulfilled, it is reasonable to argue that the doctor will refuse the request for euthanasia. In a research of judgments in euthanasia-cases refusals of requests do not show.

The role of the independent physician is addressed in sub-question 4. Before the attending physician complies with a request for euthanasia, referred to in the WtI, he must first consult a colleague who has no personal or other connection with him and is not involved in treating the patient. The independent physician must *see* the patient for himself and establish (preferably by conversation with the patient) whether all the due care criteria, referred to in article 2 first paragraph WtI have been fulfilled, including whether the request for euthanasia is both voluntary and well-considered, and communicate his findings in writing.

The judgments of the RTE's do not provide an answer for the weight that should be given to the written findings of the independent physician. This could be related to the fact that it is not explicitly ordered to take note of the written directive, despite the facts that this arises from the regulations.

This however does not mean that the written directive does not play a part in the role and position of the independent physician in a situation referred to in section 2 paragraph 2 Wtl. It goes without saying that it does. In general the independent physician will have taken note of the written directive.

The significance of an earlier written directive requires a formal status where it forms an important counterbalancing factor for lack of communication between independent physician and patient, communication which generally is required as a criteria of due care.

After having dealt with the aforementioned specific questions, more general issues of research have been addressed. The fifth sub-question was: what are the case law findings on the written directives of patients who are no longer able to fully grasp the implications of their request, referred to by the Wtl, on the ground of criminal law cases, medical disciplinary committee and the verdicts of the five regional review committees euthanasia and their account to that in the annual reports?

The Supreme Court accepted that if criteria of due care were fulfilled a doctor could successfully argue that he was not punishable on ground of justification in the Schoonheim-case. It was emphasized by the Supreme Court the specific patients' suffering was unbearable with no prospect of improvement. Other paths (interpretations) of the legal terms of termination of life or recognition of the professional rights of the doctors as (unwritten) justification grounds, were not taken by the Supreme Court.

The written directive functions as starting point of the process. The form and content of the written directive are, according to case law, important for the significance of the written directive. The more detailed, specific and clear the directive is the more weight it has. A handwritten directive appears to make a bigger impression. Next to form and content of the directive itself, the actions thereabout are of interest for weighing and balancing their importance.

The significance of the written directive is, according to case law, situated in the interaction with the doctor. For the significance of the written directive in the Wtl it is of importance that interaction with the doctor is found as soon as the written directive has been drafted. Conversely, the doctor has an obligation to communicate with the patient from that moment.

The written directive is no 'vault-document', like a testament. On the contrary: the document requires permanent updating. A vital aspect of this interaction, as stems from the case law, is hidden in the point that the existence of an old written directive, without updating (in contact with the doctor) can easily be assessed as insufficient for a doctor to establish that the request can be legitimated. The latter can be deducted from a single case in which the RTE assessed that criteria were not fulfilled. The Wtl however does not impose an obligation to update nor can a period been determined by the researched case law.

Besides clear formulation, name, date and signature no specific requirements follow from the aforementioned, regarding the written directive. Desirable and of interest is, however, that the written directive, regardless in what form, is updated by the patient and preferably discussed with the doctor.

Case law shows that in specific cases the doctor can make personal assessments. There is certain liberty for the doctor in weighing the different interests. For example, the way in which specific facts and circumstances can confirm the earlier written directive, which can enforce his assessment, despite the facts that indications are limited.

Sub-question 6 sets out the line that can be distilled from case law. The limited number of judgments and verdicts regarding 'the written directive of decisionally incompetent patients' is mostly covered by assessments of RTE's. Next to that, medical disciplinary committees have made scattered decisions on this topic. A small part of the case law is covered by criminal cases dealing with euthanasia in a more general framework. Civil cases were not found.

Even before the introduction of the Wtl in assessing the ground of justification, referred to in article 40 Criminal Code, the aspect of the experience of unbearable suffering without prospect of improvement was regarded to determine whether or not the doctor had acted in a medical responsible way as well as medical ethical standards. According to which standards the fulfilling of the request had to be subsidiary and an independent physician must see the patient for himself and establish that the request was both voluntary and well-considered. The current requirements, at least in par. 1 of section 2 Wtl, are closely related to the previous criteria, as developed by the Supreme Court. Continuous case law by codification of legal developments can be detected, inconsistencies cannot be detected.

Significant differences between the various sources cannot be reported. No case law is available which provides a general ruling on the meaning of 'shall apply mutatis mutandis'. Apparently we are looking for the answer to the question whether or not all criteria of due care have been satisfied.

The seventh sub-question answers in which way case law provides procedural and material interpretations for the criteria of due care, referred to in the second sentence of the second paragraph of article 2 Wtl. A uniform ruling regarding the interpretation of the various criteria of due care can neither in procedural nor in material respect be provided on the grounds of the present case law

The case law comprises assessments, whether the doctor in question has satisfied the due care criteria. Existence of a written directive can be of importance. A written directive can function as the starting point for a request, referred to in section 2 paragraph 1 sub a Wtl, however later circumstances can lead to conclude that, despite a written directive, a request is out of the question. Unbearable suffering with no prospect of improvement is established not only with the patients' situation, but also (more so) with the patients' point of view. The interpretation of this criterion is looked after for by the acknowledging the patient's suffering as palpably unbearable in the phase of terminating his life. In these cases as well the written directive can assist in deciding whether or not the patient no longer capable of fully grasping the implications of his request, suffers unbearably. The written directive (and further communication between doctor and patient) make it possible for patients in advance that that they wish their lives to be terminated if they eventually find themselves experiencing unbearable suffering with no prospect of improvement, in circumstances which render them incapable of expressing their wishes

personally and for doctors to find confirmation, despite the absence of indications of actual severe suffering.

The requirement of section 2 paragraph 1 sub c and d appear to have a less important role in case law. This possibly justifies the conclusion that satisfaction of these requirements is less emphasized in order to progress with the request for life termination. As far as the requirement of involving an independent physician is concerned, it is important to note that the written directive of a patient can replace personal contact with that patient as a part of satisfying the criteria of due care. Furthermore it is procedurally important to mention that the requirement that an independent physician must see the written directive and communicate his findings in writing is not explicitly ordered.

Bottlenecks determined from case-law investigation are discussed in sub-question 8. Due to the limited number of verdicts regarding euthanasia significant, practically representative, conclusions cannot easily be drawn. Few standard setting verdict containing, specific considerations, directive or points of view, which doctors have to take into account are to be found in case law and it contains even less verdicts which confirm standards, which could offer the doctor a higher degree of legal certainty.

Further it needs to be remarked that legal certainty is not improved by differentiating verdicts of the RTE's on the one hand and the viewpoints and directive of the KNMG on the other hand. Some criteria of due care, such as the requirement of verbal or non-verbal communication between patient and independent physician, are interpreted differently by the KNMG and the RTE's.

The ninth sub-question exposes the legal questions, regarding the written directive of patients considered decisionally incompetent, that could not be answered based on the research. Until today no (civil) cases are known in which doctors were held liable by the next of kin as a consequence of acting contrary to the criteria of due care. Specific conditions for unlawful liability for damages for doctors is accepted, cannot be summoned up as a result hereof. Competence of decision, abiding and execution of the written directive has never been claimed in interim proceedings.

Case law provides an image of the way – in most cases – ‘criteria of due care’ are assessed. It became clear that the written directive has no overriding importance, but is considered a determining factors amongst others to answer whether or not the criteria of due care were satisfied. Whether this implies that the legal effect of the written directive is the same as intended by the legislator does not become clear. The same goes for the more general response to the question to what extent the individual criteria for due care apply to the situation, referred to in section 2 par. 2 Wtl.

The final sub-question led to recommendations that could be made on the grounds of the findings and conclusions regarding the unanswered legal questions.

1. Create clarity on the meaning of ‘shall apply mutatis mutandis’ referred to in section 2 par. 2 Wtl.

2. Express, that the independent physician should take the written directive into account and state whether or not criteria of due care were, on grounds of the written directive as well, satisfied and if not why this was not the case.
3. Regard if case law already offers enough support for more detailed interpretation of 'shall apply mutatis mutandis', and in what way it (can or) should be determined that criteria of due care are satisfied.
4. Clarify if, and if so, which standards are applicable to the answer of the question whether a written directive can or cannot be used. This comprises at least the situation in which at a later stage circumstances dictate to refuse a request for termination of life due to personal objections. Make it clear that, as follows from case law, that confirmation is of importance however not decisive to assess that criteria of due care were satisfied.
5. Enforce the law-making and illuminating function of the assessments of the RTE's. Motivations of assessments or annual reports can be used to fulfill this task. Provide the RTE's with a comprehensive provision for legal uniformity for legal questions which are not answered yet.