L’eutanasia nei Paesi Bassi

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Aosta, 02.12.06

Cenni sullo sviluppo della legislazione olandese

1886: Codice Penale olandese

1984: sentenza della Corte Suprema sul caso Schoonheim

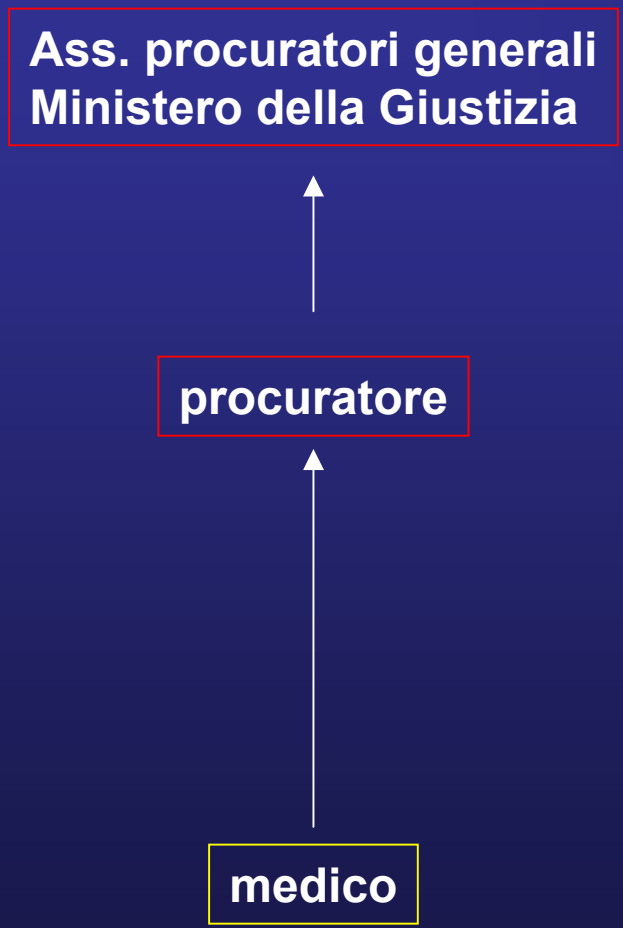
1991: introduzione del sistema di segnalazione e controllo dell'eutanasia

1994: I modifica parlamentare della Legge su seppellimento e cremazione

1998: II modifica parlamentare della Legge su seppellimento e cremazione

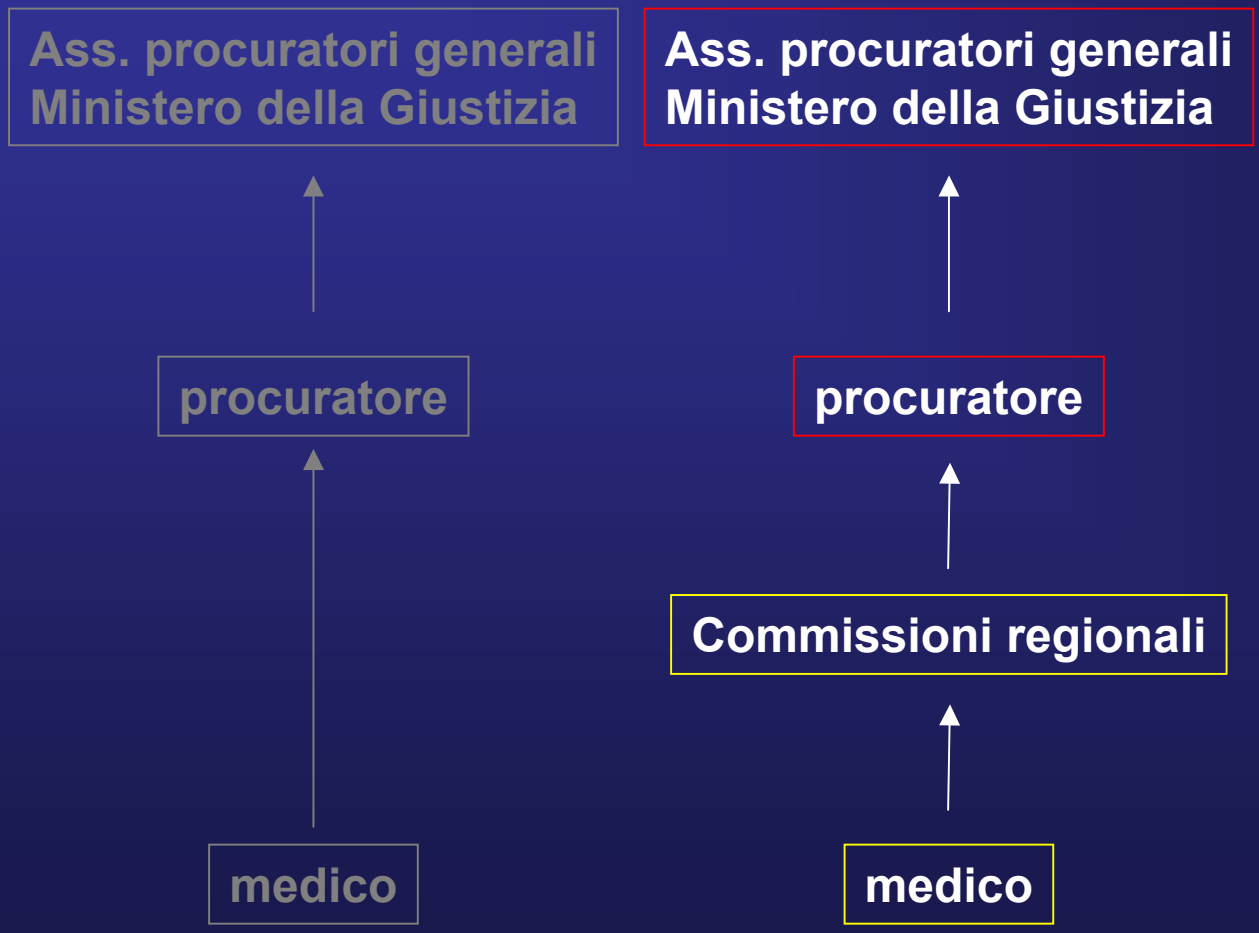
2002: approvazione della Legge sull'interruzione della vita su richiesta e sul suicidio assistito

Evoluzione del sistema di segnalazione e controllo dell'eutanasia volontaria

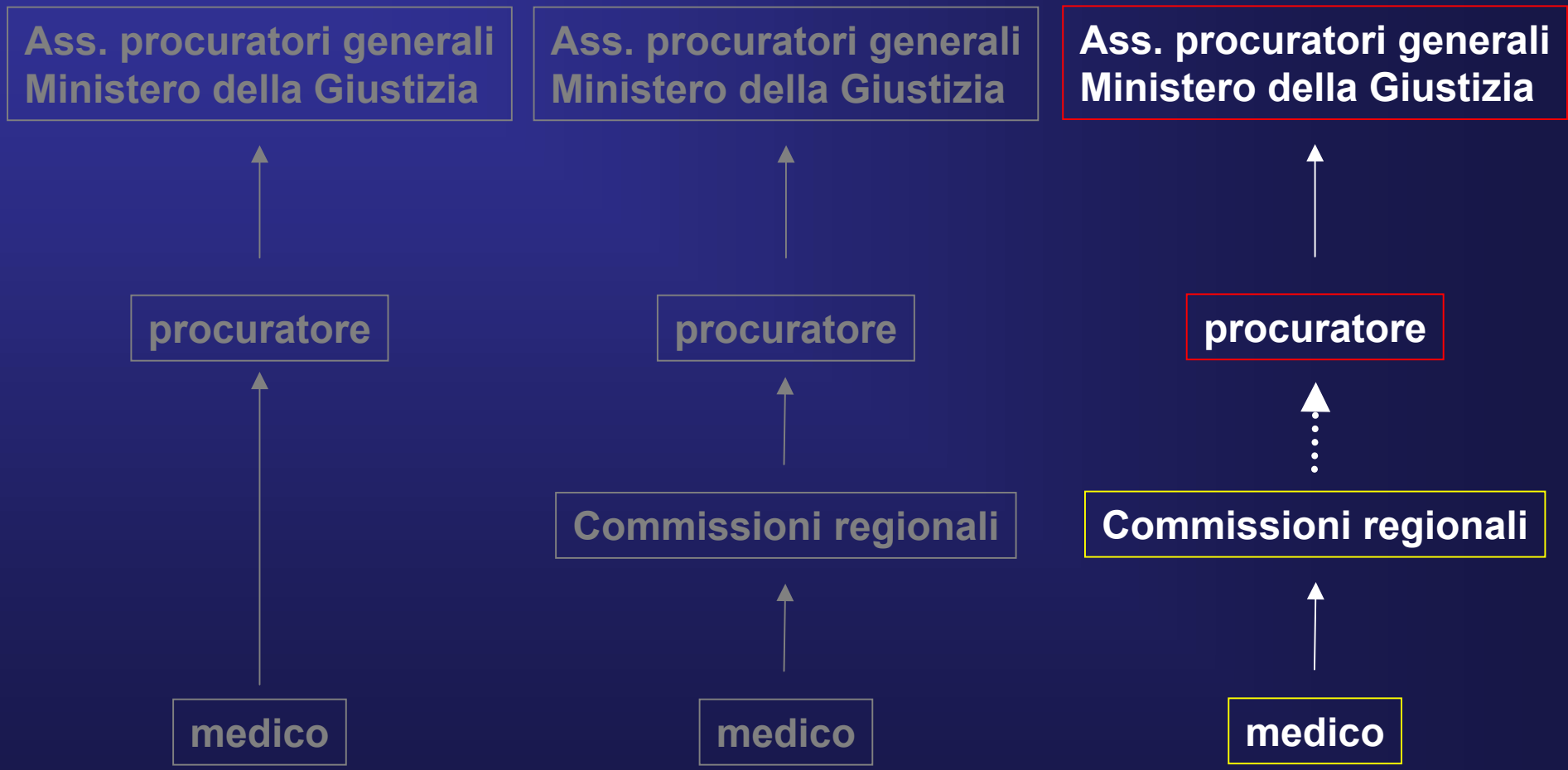


1994

Evoluzione del sistema di segnalazione e controllo dell'eutanasia volontaria



Evoluzione del sistema di segnalazione e controllo dell'eutanasia volontaria



La legge del 2002 – premessa ed obiettivo

Premessa

Il Governo olandese assume come presupposto che l'eutanasia (o simili comportamenti che accorciano la vita) si verifichi già, nei Paesi Bassi (apertamente) e nel resto del mondo (in segreto).

Obiettivo

Il governo olandese spera che la legge stimoli i medici a segnalare più casi, possibilmente tutti i casi di eutanasia.

La legge del 2002 - articoli

Art. 20 (modifica del Codice Penale)

Art. 293(1): Qualsiasi persona che termini la vita di un'altra persona su espressa e ponderata richiesta di quell'altra persona è passibile di prigione per non più di dodici anni o di una multa di 5° categoria.

Art. 293(2): L'atto di cui alla subsezione 1 non costituirà crimine se commesso da un medico che soddisfi i criteri di debita cura disposti nella sezione 2 della Legge, e se il medico notifica quest'atto al Medico Legale responsabile in accordo colle disposizioni della sez. 7, subsezione 2 della Legge sul Seppellimento e sulla Cremazione.

La legge del 2002 - articoli

Art. 2

1. **Sui criteri di debita cura**
2. **Sulle volontà anticipate**
3. **Per i pazienti tra i 16 ed i 18 anni**
4. **Per i pazienti tra i 12 ed i 16 anni**

La legge del 2002 - articoli

Art. 2

1. I requisiti di debita cura [...] significano che il medico:

a. ha la convinzione che la richiesta da parte del paziente sia volontaria e ben ponderata,

b. ha la convinzione che la sofferenza del paziente sia persistente ed insopportabile,

c. ha informato il paziente sulla situazione in cui si trova e sulle prospettive,

d. ed il paziente hanno la convinzione che non ci sia altra ragionevole soluzione per la situazione in cui [il paziente, nota mia] si trova,

e. ha consultato almeno un altro medico, indipendente, che ha visitato il paziente e ha fornito la sua opinione per iscritto sui requisiti di debita cura, di cui alle parti a-d, e

f. ha terminato una vita o assistito in un suicidio con la debita cura.

Eutanasia volontaria – come viene attuata

Chapitre 2 État des lieux

Période du 1er janvier 2004 au 31 décembre 2004

Signalements
Les commissions ont enregistré 1 886 signalements.

Euthanasie. Aide au suicide
Dans 1 714 cas, il s'agissait d'euthanasie, dans 141 cas d'aide au suicide et dans 31 cas d'une combinaison des deux.

Les médecins signaleurs
Dans 1 646 cas, le médecin signaleur était un médecin de famille, dans 188 cas un spécialiste hospitalier et dans 52 cas un médecin de long séjour.

Affections
Les pathologies se répartissaient comme suit :

Cancer	1 647
Pathologies cardiovasculaires	24
Pathologies du système nerveux	63
Pathologies pulmonaires non cancéreuses	34
Sida	4
Autres pathologies	73
Polypathologies	41

Lieu où a été pratiquée l'interruption de la vie
Dans 1 530 cas, l'interruption de vie a eu lieu au domicile du patient, dans 177 cas dans un hôpital, dans 65 cas dans un établissement de long séjour, dans 62 cas dans une maison de retraite, dans 5 cas dans un autre établissement et dans 47 cas ailleurs (par exemple dans une unité de soins palliatifs ou au domicile d'un membre de la famille).

Eutanasia volontaria – come viene attuata

f. Rigueur médicale

Le médecin a pratiqué l'interruption de la vie ou l'aide au suicide avec toute la rigueur médicale requise.

Les médecins qui pratiquent l'euthanasie ou l'aide au suicide utilisent en principe les méthodes, moyens et dosages préconisés dans l'avis de la société royale néerlandaise pour l'avancement de la pharmacie (KNMP)[8]. Dans le cas de l'euthanasie, c'est le médecin qui pratique l'acte en administrant au patient un produit euthanasiant, généralement par voie intraveineuse. Certains patients souhaitent absorber eux-mêmes la substance – un breuvage contenant un barbiturique[9] – par la voie orale. Juridiquement, on se trouve alors en présence d'un cas d'aide au suicide. Il est essentiel que le médecin reste auprès du patient, car celui-ci peut être pris de vomissements et rejeter le produit. Le médecin peut alors intervenir et pratiquer l'euthanasie. Il est par ailleurs essentiel de ne pas laisser ce type de produits sans surveillance, car ils peuvent mettre en danger la vie d'autrui.

Eutanasia volontaria – come viene attuata

TABLE 2. MEDICATION USE DURING EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE AND PRESENCE OR ABSENCE OF THE PHYSICIAN WHO WAS INTERVIEWED.

VARIABLE	EUTHANASIA INTENDED (N=535)	ASSISTED SUICIDE INTENDED (N=114)
	no. of cases (%)	
Medications*		
Neuromuscular relaxant†	367 (69)	16 (14)
Potassium chloride	10 (2)	—
Barbiturate	56 (10)	81 (71)
Opioid	70 (13)	9 (8)
Other drugs or drug combinations	19 (4)‡	3 (3)§
Unknown	13 (2)	5 (4)
Person who administered drugs		
Physician¶	485 (91)	21 (18)
Nurse¶	23 (4)	—
Person other than physician or nurse¶	6 (1)	3 (3)
Patient only	—	85 (75)
Unknown	21 (4)	5 (4)
Presence or absence of physician		
Continuously present	384 (72)	59 (52)
Present at intervals	61 (11)	18 (16)
Present after being called	39 (7)	20 (18)
Absent	10 (2)	11 (10)
Unknown	41 (8)	6 (5)

Groenewoud JH et al. N Engl J Med 2000;342: 551-6.

Eutanasia volontaria – come viene attuata

TABLE 4. SPECIFIC TECHNICAL PROBLEMS, COMPLICATIONS, AND PROBLEMS WITH COMPLETION.

SPECIFIC PROBLEM	EUTHANASIA INTENDED (N=535)	ASSISTED SUICIDE INTENDED (N=114)
	no. of cases	
Technical problems		
Difficulty finding vein in which to inject drug	10*	1†
Problem with the intravenous catheter	4	0
Difficulty administering oral drug	4	7
Other‡	3	3
Not specified	3	0
Complications§		
Spasm or myoclonus	6	1
Cyanosis	4	1
Nausea or vomiting	2	4
Other	7¶	4‖
Not specified	1	0
Problems with completion		
Time to death was longer than expected or patient did not become comatose	23	14
Patient awoke from coma	5	2

Groenewoud JH et al. N Engl J Med 2000;342: 551-6.

Eutanasia volontaria – come viene attuata

TABLE 5. INTERVAL FROM THE ADMINISTRATION OF THE FIRST DRUG TO DEATH AND THE PHYSICIAN'S ASSESSMENT OF THE INTERVAL.

PHYSICIAN'S ASSESSMENT	NO. OF CASES (%)	INTERVAL*	
		MEDIAN	RANGE
		min	
Euthanasia intended†			
All cases	535	10	0.5 min–7 days
As expected	449 (84)	10	0.5 min–4 days
Shorter than expected	18 (3)	5	0.5 min–12 hr
Longer than expected	51 (10)	180	5 min–7 days
Physician-assisted suicide intended‡			
All cases	114	30	1 min–14 days
As expected	67 (59)	30	2 min–14 days
Shorter than expected	13 (11)	8	1 min–2 hr
Longer than expected	22 (19)	180	45 min–7 days

Groenewoud JH et al. N Engl J Med 2000;342: 551-6.

Eutanasia volontaria – alcuni numeri

Total number of cases of euthanasia and physician assisted suicide, number of reported cases, and notification rates, Netherlands 1990, 1995, and 2001

	Specialty			
	General practitioners	Medical specialists	Nursing home physicians	Total
1990:				
All cases	NA	NA	NA	2700
Reported cases	NA	NA	NA	486
Notification rate (95% CI)	NA	NA	NA	18 (16 to 23)
1995:				
All cases	2625	900	75	3600
Reported cases	1163	274	26	1463
Notification rate (95% CI)	44	30	35	41 (35 to 49)
2001:				
All cases	2925	775	100	3800
Reported cases	1761	252	41	2054
Notification rate (95% CI)	60	33	41	54 (50-67)

NA=not available.

Onwuteaka-Philipsen BD et al. BMJ 2005;331:691-3.

Eutanasia – alcuni numeri

	Country					
	Belgium	Denmark	Italy	Netherlands	Sweden	Switzerland
Number of studied deaths	2950	2939	2604	5384	3248	3355
Sudden and unexpected death*	34 (32–36)	33 (32–35)	29 (27–31)	33 (32–34)	30 (29–32)	32 (30–34)
Non-sudden death, no end-of-life decision	27 (26–29)	26 (24–28)	48 (46–50)	23 (22–25)	34 (32–36)	17 (16–19)
Total end-of-life decisions	38 (37–40)	41 (39–42)	23 (22–25)	44 (42–45)	36 (34–37)	51 (49–53)
Doctor-assisted dying	1·82 (1·40–2·36)	0·79 (0·53–1·18)	0·10 (0·03–0·34)	3·40 (2·95–3·92)	0·23 (0·11–0·47)	1·04 (0·75–1·45)
Euthanasia	0·30 (0·16–0·58)	0·06 (0·01–0·26)	0·04 (0·00–0·27)	2·59 (2·19–3·04)	..	0·27 (0·14–0·51)
Doctor-assisted suicide	0·01 (0·00–0·28)	0·06 (0·01–0·26)	0·00 (..)	0·21 (0·12–0·38)	..	0·36 (0·20–0·63)
Ending of life without the patient's explicit request	1·50 (1·12–2·01)	0·67 (0·44–1·04)	0·06 (0·01–0·29)	0·60 (0·43–0·84)	0·23 (0·11–0·47)	0·42 (0·25–0·70)
Alleviation of pain and symptoms with possible life-shortening effect	22 (21–24)	26 (24–28)	19 (17–20)	20 (19–21)	21 (20–22)	22 (21–23)
Non-treatment decisions	15 (13–16)	14 (13–15)	4 (3–5)	20 (19–21)	14 (13–16)	28 (26–29)

Data are weighted % (95% CI). *Including all people for whom the reporting doctor had his or her first contact with the patient after he or she had died.

Table 2: **Frequency of end-of-life decisions**

Van der Heide A et al. Lancet 2003;362:345-50.

Eutanasia – alcuni numeri

Table 3 Frequency of ELDs for non-sudden deaths: European countries compared; percentage of deaths and 95% CI

	UK (2004)	Belgium (2001–2002)	Denmark (2001–2002)	Italy (2001–2002)	Netherlands (2001–2002)	Sweden (2001–2002)	Switzerland (2001–2002)
Number of non-sudden deaths	629 (extrapolated to 20 235)	1942	1963	1852	3574	2248	2282
No ELD	29.8 (23.1–36.5)	**41.0 (38.8–43.2)**	**38.9 (36.7–41.1)**	**67.5 (65.4–69.6)**	34.6 (33.1–36.2)	**49.1 (47.0–51.2)**	25.0 (23.2–26.8)
Total ELDs	70.2 (63.6–76.8)	*59.0 (56.8–61.2)*	*61.1 (58.9–63.3)*	*32.5 (30.4–34.6)*	65.4 (63.8–67.0)	*50.9 (48.8–53.0)*	75.0 (73.2–76.8)
Doctor-assisted dying	0.54 (0–1.16)	**2.78 (2.05–3.51)**	1.17 (0.7–1.64)	0.16 (0–0.34)	**5.12 (4.4–5.84)**	0.31 (0.08–0.54)	1.53 (1.03–2.03)
Euthanasia (voluntary)	0.17 (0–0.51)	0.46 (0.17–0.75)	0.10 (0–0.24)	0.05 (0–0.15)	**3.89 (3.49–4.29)**	–	0.39 (0.13–0.65)
Physician-assisted suicide	0.00	0.05 (0–0.15)	0.10 (0–0.24)	0.00	**0.31 (0.13–0.49)**	–	0.52 (0.22–0.82)
Ending life without an explicit request from patient	0.36 (0–0.87)	**2.26 (1.59–2.93)**	1.02 (0.57–1.47)	0.11 (0–0.26)	0.90 (0.59–1.21)	0.31 (0.08–0.54)	0.61 (0.29–0.93)
Alleviation of symptoms with possible life-shortening effect	36.3 (29.9–42.6)	33.4 (31.2–35.6)	38.9 (36.7–41.1)	*26.7 (24.7–28.7)*	30.1 (28.6–31.6)	30.3 (28.4–32.2)	32.3 (30.4–34.2)
Non-treatment decisions	33.4 (27.1–39.8)	*22.8 (20.9–24.7)*	*20.9 (19.4–22.4)*	*5.6 (4.6–6.6)*	30.1 (28.6–31.6)	*20.2 (18.5–21.9)*	41.1 (39.1–43.1)

Figures where the UK is significantly lower are marked in bold type; figures where the UK is significantly higher than that country are italicized and underscored. Figures for countries other than the UK calculated from van der Heide *et al.*,[9] table 2.

Seale C. Pall Med 2006;20:3-10.

Reasons often given for legislation include evidence of covert euthanasia, the need to regulate end-of-life decision-making and to ensure reporting of the serious act of ending life. However, the research used to support the claim that covert euthanasia is widespread may be inaccurate because some doctors (whose responses formed the basis of this research) confuse one of the following with intentional killing: [...]

Although similar accusations were made of British medicine by the Voluntary Euthanasia Society, there was no evidence offered to the Committee to substantiate the claim that deliberate killing of patients by lethal injection is happening in the UK. The GMC denied that they were receiving cases on the subject and the BMA said that, in the highly regulated environment of a modern hospital and with team working, covert euthanasia other than at the margin was unlikely to be happening.

Finlay IG et al. Palliative Medicine 2005; 19: 444-453

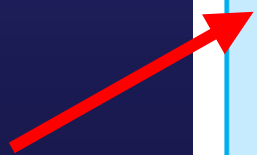
Summary points

The Netherlands has had a review procedure for euthanasia and physician assisted suicide since 1991

Although the system has increased reporting, around half of cases remain unreported

Non-reporting seems to be associated with a lack of consultation with another doctor

Introduction of reporting to review committees rather than the public prosecutor has had a limited effect on notification despite doctors' positive opinions



Onwuteaka-Philipsen BD et al. BMJ 2005;331:691-3.

Art. 2

1. I requisiti di debita cura [...] significano che il medico:

a. ha la convinzione che la richiesta da parte del paziente sia volontaria e ben ponderata,

I malati di Alzheimer?

Art. 2

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TABLE 4. DESCRIPTION OF 11 PATIENTS WHOSE PSYCHIATRISTS HELPED THEM COMMIT SUICIDE.

PATIENT NO.	SEX/ AGE (YR)	DIAGNOSIS*		PSYCHIATRIC HISTORY		PSYCHIATRIST'S MAIN REASONS FOR ASSISTING
		PSYCHIATRIC	MEDICAL	DURATION	PREVIOUS INPATIENT TREATMENT	
1	F/28	Mood disorder, personality disorder	None	~3 yr	Yes	Unknown
2	F/40	Personality disorder	Whiplash, post-traumatic epilepsy	6 mo	No	Failure of all treatment
3	M/60	Mood disorder, personality disorder	Severe respiratory disease	~7 yr	Yes	Unbearable or hopeless mental suffering, prevention of violent suicide
4	M/Unknown	Mood disorder, personality disorder	Respiratory disease, terminal phase	3 mo	Yes	Unbearable or hopeless physical suffering
5	F/57	Somatization disorder, personality disorder	Suspected neurologic disease	3 yr	Yes	Unbearable or hopeless physical suffering, failure of all treatment, prevention of violent suicide
6	F/47	Mood disorder	Terminal cancer	~12 mo	No	Unbearable or hopeless physical suffering, failure of all treatment, prevention of further physical and psychological deterioration
7	M/34	Organic mental disorder	AIDS	4 mo	No	Unbearable or hopeless physical suffering, failure of all treatment
8	F/32	Psychosis	Terminal renal disease	12 yr	Yes	Unbearable or hopeless physical suffering
9	F/38	Mood disorder	Terminal cancer	Unknown	Yes	Unbearable or hopeless physical suffering, unbearable or hopeless mental suffering, failure of all treatment
10	M/41	None	AIDS	3 mo	No	Unbearable or hopeless physical suffering
11	M/~80	None	Neurologic disease, terminal phase	Unknown	No	Failure of all treatment

*AIDS denotes acquired immunodeficiency syndrome.

Groenewoud et al. N Engl J Med. 1997;336:1795-801.

Art. 2

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a. ...

b. ha la convinzione che la sofferenza del paziente sia persistente ed insopportabile,

c. ...

d. ed il paziente hanno la convinzione che non ci sia altra ragionevole soluzione per la situazione in cui [il paziente, nota mia] si trova,

- **Il caso Chabot**

- **Il caso Brongersma**

Eutanasia involontaria?

TABLE 1. ESTIMATED INCIDENCE OF MEDICAL DECISIONS RELATED TO THE END OF LIFE.*

VARIABLE	INTERVIEW STUDY				DEATH-CERTIFICATE STUDY	
	1995		1990		1995	1990
No. of requests for euthanasia or assisted suicide later in disease	34,500	(31,800–37,100)	25,100	(23,400–27,000)	ND	ND
No. of explicit requests for euthanasia or assisted suicide at a particular time	9700	(8800–10,600)	8900	(8200–9700)	ND	ND
End-of-life practices — % of deaths†						
Euthanasia	2.3	(1.9–2.7)	1.9	(1.6–2.2)	2.4 (2.1–2.6)	1.7 (1.4–2.1)
Physician-assisted suicide	0.4	(0.2–0.5)	0.3	(0.2–0.4)	0.2 (0.1–0.3)	0.2 (0.1–0.3)
Ending of life without patient's explicit request	0.7	(0.5–0.8)	ND		0.7 (0.5–0.9)	0.8 (0.6–1.1)
Opioids in large doses	14.7	(13.5–15.7)	16.3	(15.3–17.4)	19.1 (18.1–20.1)	18.8 (17.9–19.9)
Decision to forgo treatment	ND		ND		20.2 (19.1–21.3)	17.9 (17.0–18.9)
All of these	—		—		42.6 (41.3–43.9)	39.4 (38.1–40.7)

*Numbers in parentheses are 95 percent confidence intervals. ND denotes not determined, because the study data did not permit these estimates to be calculated.

†Percentages are based on the total number of deaths in the Netherlands: 135,546 in 1995 and 128,786 in 1990.

Van der Maas et al. N Engl J Med 1996;335:1699-705

Eutanasia involontaria?

- **Secondo l'Associazione Medica Reale Olandese ca. 900 casi di eutanasia involontaria si verificano ogni anno in Olanda**

- **Il caso van Oijen: di sentenza in sentenza...**

BMJ 2003;326:1351 (21 June), doi:10.1136/bmj.326.7403.1351-c
BMJ 2004;329:1206 (20 November), doi:10.1136/bmj.329.7476.1206-e


Su pendii scivolosi...

Grazie!