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Expert report on the position of assisted dying in the Netherlands

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Signature:

1. I am a medical doctor and epidemiologist by training but have been working as a researcher since my graduation in 1990. I have been involved in research on end-of-life care and decision making since 1995. I have participated in six out of seven five-yearly nationwide research studies on end-of-life decision making practices and experiences that have been conducted in the Netherlands since 1990, in the last four as principal investigator. Since 2005, these studies include an evaluation of the Termination of Life at Request and Assisted Suicide Review Act. The evidence described in this report is mainly derived from the fourth evaluation that was published in 2023. In addition to my studies on assisted dying, I have performed many local and international research studies on palliative and end-of-life care. Further details of my expertise can be found in my CV that is attached to this report.

2. I have been instructed by Adams & Adams Attorneys on behalf of DignitySA to address a number of questions on the position of assisted dying in the Netherlands.

3. The particular questions that they asked me to address in relation to assisted dying in the Netherlands are the following, with my responses added below each question:

4. **What is the legal position in respect of medical assistance in dying in the Netherlands? Specifically:**

   - When did the Termination of Life at Request and Assisted Suicide Review Act come into effect and what are the central elements and core objectives of this Act?

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4.1. The Termination of Life at Request and Assisted Suicide Review Act came into force in 2002. The Act's objectives are to provide legal certainty to physicians who end a patient's life on this patient's request, to guarantee the carefulness of that action, to provide an accountability framework for physicians and to promote social transparency. The legal regulation requires physicians to report the provision of assistance in dying to the municipal coroner. Multidisciplinary review committees then assess whether the legal due care criteria have been met in the process.

5. What kinds of medical assistance in dying are permitted in the Netherlands, and who may access this?

5.1. The Termination of Life at Request and Assisted Suicide Review Act regulates both physician- administered termination of life ('euthanasia'), in which the physician administer lethal drugs to the patient, and physician-assisted suicide, in which the physician provides the patient with lethal medication that can be self-administered by the patient. Patients from the age of 12 and older can access physician assistance in dying, if the physician can comply with the legal due care criteria.

6. Who may provide medical assistance in dying?

6.1. In principle all physicians attending patients requesting them to do so.

7. What are the criteria that must be met before assisted dying can be accessed?

7.1. The legal due care criteria the physician must adhere to are:

- Be satisfied that the patient's request is voluntary and well considered;
- Be satisfied that the patient's suffering is unbearable, with no prospect of improvement;
- Have informed the patient about his situation and his prognosis;
- Have come to the conclusion, together with the patient, that there is no reasonable alternative in the patient's situation;
- Have consulted at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled;

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- Have exercised due medical care and attention in terminating the patient's life or assisting in his suicide.

8. Are there additional procedural safeguards that protect against abuse? If so, what are these?

8.1. The Royal Dutch Medical Association has implemented a programme to train physicians who act as the independent physicians that need to be consulted before the act. These physicians are required to regularly attend meetings to discuss experiences and be educated about specific topics that are relevant for their role.

8.2. The multidisciplinary review committees have developed extensive guidance for physicians on how to follow the due criteria, especially in complex cases.

9. What are the monitoring and reporting obligations?

9.1. The legal regulation requires physicians to report the provision of assistance in dying to the municipal coroner. Multidisciplinary review committees then assess whether the legal due care criteria have been met in the process.

9.2. The report of the physician must explain how the due care criteria were met. A report of the consulting physician must be added. The review committee can request additional information or invite the reporting physician to explain their case in a meeting.

10. How is conscientious objection handled?

10.1. Physicians are free to decide if they are or are not willing to engage in the practice of physician- assistance in dying. They can refuse any request to assist in a patient's dying, even if the due care criteria can in principle be met. There is no legal obligation to refer the patient to another physician in case he has conscientious objections, but professional ethical standards require him to do so.

11. How has assisted dying worked in practice in the Netherlands? In particular:

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Who is accessing medical assistance in dying? Please consider addressing specifically:

- **The demographics, age, levels of education and socio-economic status of people seeking assisted dying**
- **The most common illnesses demonstrated by those seeking medical assistance in dying**

11.1. Data on the year 2021 based on our latest five-yearly research study:

	All deaths in the Netherlands 2021 %	Physician-assistance in dying 2021 %
Age		
Under 65	13	18
65-79	32	53
80 or over	54	29
Gender		
Male	50	52
Female	50	48
Main diagnosis		
Cancer	26	62
Cardiovascular disease	17	5
Nervous system disease	10	10
Pulmonary disease	18	5
Other	29	18

Education and socio-economic status: no data available.

12. Whether those seeking assisted dying have been utilising palliative care before they request medical assistance in dying?

12.1. Palliative care is not a specific or distinct discipline the Netherlands: all healthcare providers attending patients in the last phase of life are expected to be able to provide palliative and end-of-life care, with expert advice being available if needed in all healthcare settings. It is therefore not possible to determine the proportion of recipients of physician-assistance in dying that utilised palliative care before requesting assistance in dying. However, in our 2021 study we found that recipients of physician- assistance in dying slightly more often than the total population of dying patients utilised a palliative care expert team (19% vs. 12%); a pain specialist (5% vs.

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2%); or a psychologist (8% v. 6%). A spiritual counsellor was less often involved for recipients of physician-assistance in dying as compared to the total population of dying patients (6% vs. 11%).

13. What are the most common reasons given by patients for why they are requesting medical assistance in dying?

13.1. The most common reasons for physicians to provide assistance in dying are that patients requested such assistance because: they lacked prospect that their situation would improve (89%); loss of dignity (64%); severe symptoms other than pain (63%); expected suffering (55%); or severe pain (41%).

14. What are the barriers to accessing medical assistance in dying?

14.1. In principle there are few barriers, because the Netherlands is a small country with universal healthcare insurance arrangements. It is known that physicians are often more reluctant to provide assistance in dying in complex cases (young patients, patients with a psychiatric illness, patients with cognitive problems) than in relatively straightforward cases. According to physicians in the 2001 study, requests for physician-assisted were not granted because:

- the patient died before the procedure could be completed (59%);
- the physician thought that he could not comply with the legal criteria of due care (29%);
- the patient withdrew their request (12%);
- the physician had conscientious objections (2%);
- granting the request did not comply with the policy of the healthcare institute where the patient was attended (2%).

15. What developments have been observed in clinical practice since assisted dying was legalised in 2002?

15.1. In our nationwide studies we found that the number of cases has increased from 1.8% of all deaths in 2005 to 5.4% in 2021.

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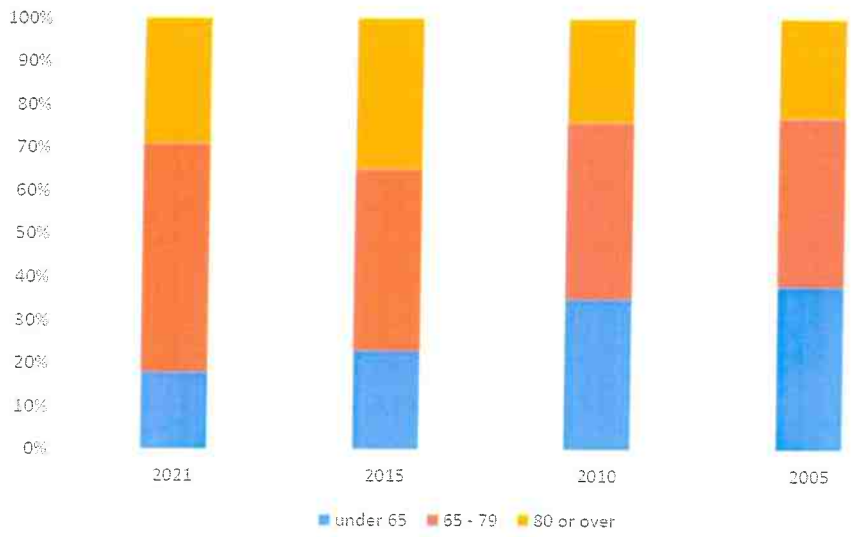
15.2. The most common illness among recipients of physician-assistance in dying is still cancer (2005: 84%; 2021: 62%), but other diseases tend to become more common. According to the annual report of the Multidisciplinary Review Committee for 2023, the number of cases of patients with dementia has increased from 162 in 2019 (2.5% of all reported cases in 2019) to 336 in 2023 ((3.7% of all reported cases in 2023). The number of cases of recipients with a psychiatric illness increased from 68 in 2019 (1.1%) to 138 in 2023 (1.5%).

15.3. Physician-assistance in dying tends to become slightly more common in older age groups. In our nationwide studies we found the following trend:



16. What, if anything, has been observed in the trend of the use of palliative care and/or palliative sedation since the legalisation of assisted dying?

16.1. The use of palliative care cannot be easily assessed, as explained in my response to question 2.1.3. The use of palliative sedation has increased from 8% of all deaths in 2005 to 23% in 2021.

17. In the latest reporting period, what was the number and percentage of reported cases where a physician did not follow due care criteria, and which due care criteria were mostly not adhered to?

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17.1. Between 2017 and 2022, the review committees ruled in 44 out of a total of 42 396 reported cases (0.1%) that the physician did not adhere to the due care criteria when ending the life of a patient. In these 44 cases, the consultation requirement was violated most often, but the number of violations of the substantial due care criteria (concerning the voluntary and well-considered request and the hopeless and unbearable suffering) was also relatively high during this period. Violation of more than one requirement of due care typically involved a difference of opinion between the attending physician and advising consultant(s).

17.2. The numbers for 2023 as described in the annual report of the Multidisciplinary Review committees are:

- 9068 reported cases
- In five reported cases the physician was judged not to have complied with the due care criteria.
- The criteria that were judged as having been violated in these five cases are:
    - In one case, the physician who was consulted for an independent assessment was not considered fully independent, because he was registered as a patient within the GP practice of the physician who performed the act (thus, criterion e was violated).
    - In three cases, the physician was judged not to have exercised the necessary extra precautions that are needed for patients with psychiatric illnesses (criteria a, b and d were violated).
    - In one case, the physician had left after leaving behind the lethal medication with the patient (criterion f was violated).

18. What has the experience in the Netherlands revealed about the relationship between "doctor involvement" and "personal autonomy" in end-of-life decisions?

18.1. The moral duties for physicians underlying the Dutch regulation include the duty of relieving suffering and the duty of respecting a person' autonomy. Both values are considered important and necessary elements of the regulation. Physicians appreciate the Act because it gives them solid ground to discuss requests for

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assistance in dying with their patients; patients appreciate the Act because they trust physicians in assisting in dying for the 'right' reasons, with e.g. alternatives to relieve suffering also being adequately addressed and discussed.

19. What is your opinion on whether the Netherlands is experiencing a "slippery slope" since assisted dying was legalised in 2002?

19.1. The number of cases has increased and, broadly speaking, the illnesses underlying the practice have expanded from terminal cancer to other illnesses (although the majority of cases still involves terminal cancer). The overwhelming majority of cases are still considered to be in accordance with the legal due care criteria, that have not changed since 2002. The Dutch population is to a great extent satisfied with the current system and physicians generally feel that they can work with it. We see no development towards lower thresholds to access the practice or the practice becoming easier for physicians to engaged in. The number of cases of termination of life without an explicit patient request has remained very limited.

19.2. Based on the above observations, I see no evidence of a 'slippery slope'. Rising numbers are probably mainly the result of more widespread public awareness of the option, and possibly of a trend towards increased self-management, also in case of severe suffering at the end of life.

19.3. Having said that, the debate in the Netherlands focuses predominantly on whether the Act is too restrictive. Careful monitoring of the prevalence and characteristics of the practice is therefore important.

20. What is the interaction between palliative care and medical assistance in dying? In this regard, please address the following, based on your experience, expertise and research: What does palliative care entail? Specifically:

- **What kinds of medications are administered and what is the effect of these – from a medical perspective – on a patient's body, mind and quality of life?**

20.1. Palliative care is aimed at improving the quality of life of patients and that of their families who are facing challenges associated with life-threatening illness, whether

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physical, psychological, social or spiritual. Palliative care includes the provision of medication to alleviate symptoms and improve quality of life, such as opioids, sleeping medication, antipsychotic medication, medication to relieve nausea or itch, etc. As with all medication, these drugs may have side effects, including drowsiness.

21. What is palliative sedation?

21.1. Palliative sedation is 'the deliberate lowering of a patient's consciousness in the final stages of life'. The aim is to relieve suffering.

22. What are the limits of palliative care? Is control of pain to the satisfaction of a patient always possible?

22.1. Quality of life cannot always be improved to a level that is acceptable for the patient, and pain cannot always be fully relieved. Quality of life and pain are multidimensional concepts that are only partly responsive to pharmacological or other medical interventions. Loss of dignity, loss of meaning, loss of independence and loss of purpose are important challenges at the end of life, that cannot be addressed with even the highest quality palliative care in all cases.

23. Is there an inherent conflict between palliative care and assisted dying? Alternatively, do they share any characteristics or conceptual similarities?

23.1. Both palliative care and assisted dying are aimed at providing patients with an end-of-life trajectory that is consistent with their values and preferences. Assistance in dying can be the final act in a high-quality palliative care trajectory and is therefore not conflicting with the concept of palliative care.

24. Is palliative care a true alternative to medical assistance in dying? Please address:

24.1. The objectives of palliative care:

In principle, assistance in dying should follow high quality palliative care that truly focuses on patients' needs and preferences. The objective of palliative care is to relieve suffering by providing multidimensional care; the objective of assistance in dying is to relieve suffering by ending a patient's life.

24.2. The benefits and limits of palliative care:

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Palliative care has important and demonstrable benefits but cannot relieve all suffering at the end of life, as argued under question 21.

24.3. **Whether, and to what extent, palliative care can ease or erase suffering at the end of life:**

Please see my response to previous questions.

25. **What has been the effect of the legalisation of assisted dying on palliative care services in the Netherlands?**

25.1. Before and after the legalisation of physician-assistance in dying in the Netherlands, much has been invested in improving access to and quality of palliative care. The second national programme to promote palliative care is now running, with investments of the government of 150 billion euro to raise awareness of palliative care and further improve the quality and accessibility of palliative care.

26. **How can, or do, palliative care and assisted dying work together in practice? How has assisted dying and palliative care been integrated in palliative care units or hospices in the Netherlands?**

26.1. That is not really an issue in the Netherlands, because physicians providing assistance in dying are aware of the options for palliative and end-of-life care and most physicians working in palliative care units or hospices are willing to engage in the practice if requested.

27. **What is the overall conclusion of the latest evaluation study on the current position of assisted dying in practice in the Netherlands? What recommendations were made following this evaluation?**

27.1. The overall conclusion of the fourth evaluation study was that the objectives of the Act regarding legal certainty, due care and transparency are still sufficiently achieved.

27.2. The evaluation study gave rise to the following recommendations, mostly on procedures:

- Organise more opportunities for physicians to get advice and support from expert colleagues when deciding on complex requests, such as those of people with dementia or mental illness, also because referral to the Centre

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of Expertise on Euthanasia may not always be a solution (medical profession).

- Inform physicians about practical aspects of assisting in suicide, to prevent them from not discussing this option with patients for whom it might be an option, due to lack of knowledge (medical profession).
- Investigate how physicians deal with pressure from patients, family and from society in their decision- making on requests for assistance in dying, for example in future evaluations of the law (research funders).
- Regularly inform citizens in the Netherlands about possibilities and impossibilities of euthanasia as well as assisted suicide in the Netherlands and about the usefulness of 'talking about the end of life in a timely manner' with relatives and caregivers; the medical profession also has a responsibility in promoting timely and anticipatory discussion of care and decision-making in the last phase of life (government, medical profession, interest groups of citizens and patients).
- Provide information that benefits citizens of different backgrounds, so that appropriate choices regarding care in the last phase of life are facilitated for everyone (government, medical profession, citizens' and patients' interest groups).
- Investigate the possibility of amending the structure of articles 293 and 294 paragraph 2 of the Penal Code in such a way that a reporting physician is presumed to have acted lawfully, unless further investigation by the Public Prosecution Service gives cause to regard him as a suspect (legislator).
- Organise the relationship between the Criminal Code and the Act in such a way that the violation of due care criteria becomes a separate offence; consider differentiating between due care criteria that are more or less relevant under criminal law (legislator).
- Clarify the distinction between acts covered by Act and acts not covered by it, by adding a provision to the Act to this effect and/or by other steps or activities, including education of physicians (legislator, government, medical profession).

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- Initiate research aimed at further identifying the developments occurring with regard to the interpretation of the due care criteria by physicians and review committees (government).
- In consultation with civil society organisations, provide information to citizens on the importance of a clear written euthanasia request, on the importance of regularly updating and reaffirming this request and on the limitations of such a request; provide opportunities for citizens to receive support in drafting a written euthanasia request (government, field).
- Consider further elaboration of Art. 2(2) Act, either in that statutory provision itself or in an Order in Council to be made possible in that provision (legislator).
- Increase the capacity of review committees - members and supporting apparatus (government).
- Publish the checklist that guides the review committees in distinguishing questionable and non- questionable notifications on the website of the review committees referred to in art. 14 of the Guidelines on Review Committee Working Methods (review committees).
- Encourage public debate on the future regulation of end-of-life issues and consider further research and/or initiation of an advisory process on the matter (government).

28. Please set out the noteworthy successes, failures and/or lessons learnt from medical assistance in dying in the Netherlands that would be useful for South Africa to know as it embarks on this journey.

28.1. We have learnt that it is possible to regulate physician-assistance in dying without this resulting in unwanted practices. Despite increased emphasis on self-direction and self-management in many areas, people in general feel safe with physicians being the guardians of the system. Careful monitoring of trends in the practice and implementation of criteria is very helpful in understanding the impact of regulating assistance in dying. A system that closely matches what physicians want and need seems a pretty good guarantee that they stick to the agreed criteria. Assisting in dying

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has not and probably will never become 'normal practice'. Professional but also public and political debates continue, also more than 20 years after the Act came into force.

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Curriculum Vitae Prof. dr. Agnes van der Heide

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General information

Academic education	1982-1990
	Medical School, University Medical Centre Nijmegen, St Radboud
	Epidemiology, Wageningen University
	1990: MD exam
Doctorate	1990-1994
	University Medical Centre Utrecht
	Graduation: 13 September 1994
	Promotor: Prof. Dr. J.W.J. Bijlsma
	Thesis: Properties and priorities. On the assessment of early rheumatoid arthritis
Work experience since doctorate graduation	1994-2006: Erasmus MC, dept. of Public Health, senior scientific researcher
	2006-2012: Erasmus MC, dept. of Public Health, associate professor
	2013-now: Erasmus MC, dept. of Public Health, full professor
	2021-2022: Lund University, Palliative Care Unit and Region Skane, guest professor

Research grants during the past 10 years

2024	Palliative sedation: how to proceed?	ZonMw
	A rainbow's end: Towards optimizing LGBTQ+ inclusive palliative and end-of-life care	KWF
	To go or not to go? When patients with a Turkish background are considering treatment for incurable cancer in Turkey	KWF
	Personalized and culture-sensitive palliative care within Erasmus MC	Roparun
	TRANSCEND-XR: Co-creation and implementation of an intervention to improve the understanding of TesticulaR cANcer late effects and unmet Supportive CarE NeeDs of AYA survivors using eXtended Reality	Horizon Europe
2023	The added value of a POH oncology in general practice	Rijnmond Dokters
2022	Self-directed dying	Steunfonds Laatste Wil/NVVE

	Inzet van proactieve zorgplanning in de praktijk	ZonMw
2021	Fourth evaluation of the euthanasia law	ZonMw
	Seventh national study on the practice of end-of-life decision making	ZonMw
2020	End-of-life care during the COVID-19 epidemic	ZonMw
2019	Advance care planning in geriatrics	Erasmus MC
2018	iLIVE: Live well, die well	EU: H2020
	DIAdIC: Evaluation of Dyadic Psychoeducational Interventions for People with Advanced Cancer and their Informal Caregivers: An international randomized controlled trial	EU: H2020
	Prudent use of medication in the last phase of life	ZonMw
2017	Palliative sedation: how to proceed?	ZonMw
	Shared decision making in the palliative phase for patients with mental disabilities	ZonMw
2016	Dementia and palliative care in general practice	ZonMw
	Spiritual care and rituals in the last phase of life	ZonMw
	Advance care planning: development of a decision aid	ZonMw
	MuSt: a strategy to manage multiple symptoms in the last phase of life	ZonMw
	Towards a quality system for palliative care	ZonMw
2015	Transmural palliative care in southwest Netherlands	ZonMw
	ICD deactivation	ZonMw
	Predicting the last phase of life	ZonMw
	Prevention of death rattle	ZonMw
	End-of-life decision for minors	Dutch Ministry of Health
	Third evaluation of the Euthanasia Law	ZonMw
	Sixth national study on the practice of end-of-life decision making	ZonMw

Teaching during the past 10 years

- Annual lectures about end-of-life decision making for medical bachelor students
- Public Health education program for medical bachelor students: supervision of community projects and teaching epidemiology skills
- Regular: Public Health education program for medical master students: e-module and practical skills training 'social autopsy'
- Annual participation in Bachelor Essay program for medical bachelor students
- Regular: Supervision of scientific internships of students of Erasmus MC and other universities
- Regular: Lecture in course on research integrity for PhD students Erasmus MC

Publications in the past 10 years

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1. Becqué YN, Rietjens JAC, van der Heide A, Witkamp E. Failed implementation of a nursing intervention to support family caregivers: An evaluation study using Normalization Process Theory. J Adv Nurs. 2025 Feb;81(2):937-952. doi: 10.1111/jan.16261.
2. Heidinger B, Webber C, Chambaere K, Close E, Deliens L, Onwuteaka-Philipsen B, Pope T, van der Heide A, White B, Downar J. International Comparison of Underlying Disease Among Recipients of Medical Assistance in Dying. JAMA Intern Med. 2025 Feb 1;185(2):235-237. doi: 10.1001/jamainternmed.2024.6643.
3. Schelin MEC, Hedman C, Barnestein-Fonseca P, Egloff M, Ellershaw J, Faksvåg Haugen D, Fischer C, Joshi M, Korfage IJ, Lunder U, Mason S, Simon J, Tripodoro VA, Yildiz B, Zambrano SC, Eychmueller S, van Zuylen L, van der Heide A, Fürst CJ; iLIVE Consortium. Recruitment, follow-up and survival in an 11-country cohort study of patients at the end of life and their relatives. PLoS One. 2025 Jan 9;20(1):e0317002. doi: 10.1371/journal.pone.0317002.
4. Vieveen MJM, Yildiz B, Korfage IJ, Witkamp FE, Becqué YN, van Lent LGG, Pasman HR, Zee MS, Onwuteaka-Philipsen BD, van der Heide A, Goossensen A. Meaning-making following loss among bereaved spouses during the COVID-19 pandemic (the CO-LIVE study). Death Stud. 2025 Jan;49(1):59-67. doi: 10.1080/07481187.2023.2186979.
5. Zambrano SC, Egloff M, Gonzalez-Jaramillo V, Christen-Cevallos Rosero A, Allan S, Barnestein-Fonseca P, Ellershaw J, Fischer C, Haugen DF, Lunder U, Martin-Rosello M, Mason S, Rasmussen B, Sigurðardóttir V, Simon J, Tripodoro VA, van der Heide A, van Zuylen L, Voltz R, Fürst CJ, Williamson PR, Eychmüller S; iLIVE. A core outcome set for best care for the dying person: Results of an international Delphi study and consensus meeting. Palliat Med. 2025 Jan;39(1):163-175. doi: 10.1177/02692163241300867.

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6. Barnestein-Fonseca P, Nebro-Gil A, Aguiar-Leiva VP, Víbora-Martín E, Ruiz- Torreras I, Martín-Rosello ML; on behalf iLIVE Group (PI: Van der Heide A). Barriers and drivers of public engagement in palliative care, Scoping review. BMC Palliat Care. 2024 May 7;23(1):117. doi: 10.1186/s12904-024-01424-4.
7. Bosma F, Mink KR, van Delden JJM, van der Heide A, van de Vathorst S, van Thiel GJMW. The Dutch practice of euthanasia and assisted suicide in patients suffering from psychiatric disorders: a qualitative case review study. Front Psychiatry. 2024 Oct 28;15:1452835. doi: 10.3389/fpsyt.2024.1452835.
8. Bosma F, Stoppelenburg A, van der Heide A, van de Vathorst S. Frequency of self-directed dying in the Netherlands: research protocol of a cross-sectional mixed-methods study. BMJ Open. 2024 Apr 29;14(4):e085240. doi: 10.1136/bmjopen-2024-085240.
9. Coers DO, Sizoo EM, Bloemen M, de Boer ME, van der Heide A, Hertogh CMPM, Leget CJW, Hoekstra T, Smalbrugge M. Navigating Dilemmas on Advance Euthanasia Directives of Patients with Advanced Dementia. J Am Med Dir Assoc. 2024 Dec;25(12):105300. doi: 10.1016/j.jamda.2024.105300.
10. Elsten EECM, Pot IE, Geijteman ECT, Hedman C, van der Heide A, van der Kuy PHM, Fürst CJ, Eychmüller S, van Zuylen L, van der Rijt CCD. Recommendations for Deprescribing of Medication in the Last Phase of Life: An International Delphi Study. J Pain Symptom Manage. 2024 Nov;68(5):443-455.e2. doi: 10.1016/j.jpainsymman.2024.07.029.
11. Gans EA, de Ruijter UW, van der Heide A, van der Meijden SA, van den Bos F, van Munster BC, de Groot JF. A Grounded Theory of Interdisciplinary Communication and Collaboration in the Outpatient Setting of the Hospital for Patients with Multiple Long-Term Conditions. J Pers Med. 2024 May 16;14(5):533. doi: 10.3390/jpm14050533. PMID: 38793115.
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13. Huisman BAA, Geijteman ECT, Dees MK, van Zuylen L, van der Heide A, Perez RSGM. Better drug use in advanced disease: an international Delphi study. BMJ Support Palliat Care. 2023 Oct;13(e1):e115-e121. doi: 10.1136/bmjspcare-2018-001623.
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Healthcare use and healthcare costs for patients with advanced cancer; the international ACTION cluster-randomised trial on advance care planning. Palliat Med. 2023 May;37(5):707-718. doi: 10.1177/02692163221142950.

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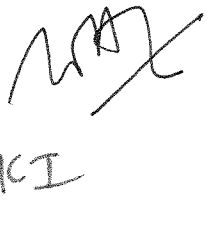

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Societal impact

Regular contributions to the societal debate about end-of-life decision making. Some examples:

- 2023: Publication report on the 4th evaluation of the euthanasia law
- 2023: Publication of booklet for the general public on experiences of end-of-life care during the COVID-19 pandemic (Achter een masker van verdriet)
- 2021: Publication of a report on the legal regulation of end-of-life decision making for children aged 1-12 years, which resulted in the assignment of the minister of health to develop such regulation.
- 2020: Initiation of a study on end-of-life care during the COVID-19 pandemic, which resulted in articles in several newspapers. The study is replicated in about 10 countries all over the world.
- 2021: We developed a publicly available website for advance care planning, that is now embedded in thuisarts.nl and visited over 1000 times per month.

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- 2017: I was a member of the committee to provide the government with a advice on how to regulate ending of life for people who are tired of life.
- 1990-2021: I am the co-PI of the five yearly nationwide studies to investigate the practice and public oversight of euthanasia and assisted suicide.
- 2015-2023: I am a member of the steering committee of the regional consortium for palliative care that aims at improving palliative and end-of-life care for all patients in all settings in the southwest region of the Netherlands.
- My research group publishes at least one paper in a Dutch healthcare journal per year.
- We have recently started a longterm collaboration with ZEZZ, a publishing house with the aim of informing the general public about health and healthcare.
- I am a member of the executive committee of the international collaborative of best care for the dying person, a group of leading thinkers, practitioners, and researchers from 24 countries, united by the common goal of improving care for dying people and their families.

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