

Euthanasia in the Netherlands: balancing autonomy and compassion



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Introduction

In the context of the conferences on End-of-Life Questions organised by the World Medical Association (WMA) as part of a review of its policy on euthanasia and physician-assisted suicide, we would like to contribute to the discussion on this topic by presenting an overview of the current situation in the Netherlands. Articles by Keown and Reuena have highlighted the arguments against decriminalisation of euthanasia and physician-assisted suicide, thus supporting the current position of the WMA on these issues. We would like to put forward the main reasons why we think a reconsideration of this position is justified. We will do so by describing the current Dutch Termination of Life on Request and Assisted Suicide Act (hereafter referred to by its Dutch abbreviation, WtI) and the principles underlying it. This is important, because there are various misconceptions about the situation in the Netherlands, which do not contribute to an open and respectful debate on this difficult and con-

troversial topic. After presenting the Dutch legal situation, we will discuss some of the main arguments against euthanasia put forward by Keown and Reuena.

To be clear, our aim is not to convince others or settle the debate on euthanasia and physician-assisted suicide, but rather to enrich that debate and to show that different views are possible and worth considering.

For reasons of readability we will use the term 'euthanasia' to mean both termination of life on request and physician-assisted suicide. Termination of life on request means that a physician ends the life of a patient at his or her express request in case of unbearable suffering without any prospect of improvement. In this case, the physician administers a lethal substance to the patient. In the case of assisted suicide, the physician supplies a lethal substance that the patient takes in the physician's presence. We will address the two separately only when necessary for the sake of the discussion.

The legislation on and procedure for euthanasia in the Netherlands

Legislation

The WtI came into force in 2002, after many decades of intensive discussion in Dutch society and parliament. The WtI was in fact mainly a codification of long-standing practice and jurisprudence regarding euthanasia. Physicians in the Netherlands and their professional organisations were very much involved from the beginning in the practice and debate regarding the law on euthanasia.

Physicians were confronted with patients' requests for euthanasia to help them end their suffering. They struggled with these requests, and sometimes concluded that they would support their patients best by performing euthanasia at the patient's voluntary and well-considered request. The jurisprudence in the Netherlands was built on such cases of euthanasia that were taken to court, and this is how the current due care requirements for euthanasia were developed.

The aims of the WtI included providing legal certainty for all parties involved, ensuring prudent practice with regard to euthanasia by physicians, providing an adequate framework for physicians to be held accountable, and ensuring increased transparency and public scrutiny.

Before the WtI came into force, physicians occasionally performed euthanasia and if they were prosecuted they had to claim necessity (*force majeure*), invoking an intolerable situation, circumstances beyond their control or another statutory defence. With the introduction of the WtI a specific ground for immunity from punishment for physicians, and only for physicians, who perform euthanasia was legally regulated.

Contrary to what is sometimes suggested, the WtI does *not* entail that physicians or other

citizens can offer euthanasia with impunity: euthanasia has remained a punishable offence under the Dutch Penal Code (Sections 293 and 294). Any person, who performs euthanasia, including physicians, can be punished and risks imprisonment for a maximum of twelve years or a fine of at most €82,000.

Although euthanasia is a punishable offence in the Netherlands, the WtI provides immunity from punishment under strictly defined circumstances. Euthanasia is not punishable if performed by a physician who meets the due care requirements of the WtI and provides notification of the procedure. The WtI enumerates the requirements that must be met to be able to invoke the exemption from punishment provided for by the law. These requirements are that the physician:

- a) is convinced that the patient's request is voluntary and well-considered;
- b) is convinced that the patient's suffering is unbearable and that there is no prospect of improvement;
- c) has informed the patient about the situation he/she is in and about his/her prospects;
- d) is convinced, together with the patient, that there is no other reasonable solution for the patient's situation;
- e) has consulted at least one other independent physician who has seen the patient

and has provided a written opinion on the due care requirements referred to in a)–d); and

- f) has terminated a life or assisted in a suicide with due care.

Requirements a) and b) are usually referred to as the substantial criteria, whereas c), d), e) and f) are the more procedural criteria.

All six requirements have to be met in order to be able to invoke the exemption from punishment under the WtI. They have to be met both in the case of termination of life on request and in the case of assisted suicide.

Procedure after death by euthanasia

According to a statutory guideline, physicians who perform euthanasia have to report the death of the patient concerned to the municipal pathologist. They do so instead of issuing a certificate of death by natural causes, as they would otherwise do.

The physician who performs euthanasia has to report every case to a Regional Review Committee on Euthanasia (RTE), of which there are five in the Netherlands. The RTEs

consist of at least a lawyer (who also acts as chair), a physician and an ethicist. The members of the RTEs are appointed by the Ministers of Health and of Justice for four years and, at the end of their term, can be reinstated for another four years.

The RTE has to judge whether the euthanasia reported was performed according to all the requirements mentioned above. The RTE has to report its motivated judgement to the physician who performed the euthanasia. If the RTE concludes that the euthanasia was not performed according to the legal due care requirements, it will forward the case and the RTE judgement to the Public Prosecution Service (PPS) and the Health Care Inspectorate (HCI). Both the PPS and HCI can take further formal steps: the PPS can decide to prosecute the physician concerned, while the HCI can start a disciplinary procedure.

The RTEs are obliged to publish a complete report on their activities and cases handled every year, and send it to the Ministers of Health and of Justice, who in turn submit it to parliament with their comments. As such, the practice of euthanasia in the Netherlands is subject to public scrutiny. Moreover, the WtI has already been evaluated by independent committees of experts three times since it came into force.^{1,2}

Ten facts about euthanasia in the Netherlands

1. Euthanasia is a punishable offence under the Dutch Penal Code.
2. Patients do not have a right to euthanasia.
3. Physicians are not under any obligation to perform euthanasia. Physicians have a right to conscientious objection.
4. Only physicians are allowed to perform euthanasia, and only under strictly specified circumstances.
5. Euthanasia can only be performed after a voluntary and well-considered request from the patient himself or herself.
6. Euthanasia can only be performed in the case of unbearable suffering without any prospect of improvement and when there is no reasonable alternative.
7. There does not necessarily have to be a terminal disease and/or a limited life-expectancy to meet the due care criteria.
8. Euthanasia in Dutch law is based on the principle of respect for persons and the principle of compassion.
9. Every case of euthanasia is assessed by a Regional Review Committee on Euthanasia.
10. In 2016, 6,091 cases of euthanasia were reported, which equals 4% of the total number of deaths.

The due care requirements

A physician can, but does not have to, grant a request for euthanasia if all due care requirements have been met. We will discuss the two substantial criteria below in some more detail. Of the procedural criteria, only the requirement to consult another independent physician will be discussed.

1 These evaluations can be consulted on <https://www.rijksoverheid.nl>.

2 For more detailed information about the WtI, see also: www.knmg.nl/euthanasia-netherlands.

Unbearable suffering without any prospect of improvement

Of the six due care requirements mentioned above, there is one in particular that has proved controversial, namely that the physician has to be convinced that the patient's suffering is unbearable and there is no prospect of improvement. This is not to say that the other requirements are simple or straightforward, but the focus in this article will be on these two aspects of suffering being unbearable and there not being any prospect of improvement. It is no coincidence that these two conditions are mentioned together, because they are inextricably connected. When a physician has to judge whether there is any prospect of improvement, he or she has to take into account the treatment and care options that are available for the patient. This calls for a professional medical opinion on the questions if, to what degree and in what sense the patient's condition can improve; if his or her condition is more likely to deteriorate; at what burden to the patient an improvement of his or her condition can be achieved; how reasonable and acceptable that burden is for the patient, and how it weighs up against the degree of improvement. The physician will discuss these issues thoroughly with the patient in multiple consecutive conversations. Finally, the physician has to assess and weigh these issues in order to appraise whether improvement is likely or possible.

The question of whether the suffering is unbearable should in first instance be answered by the patient. As it is the patient's own experience of pain or distress that causes the suffering, it is up to the patient to indicate what the nature and degree of this suffering is. Suffering can take several forms and have multiple causes: the unbearableness of suffering may be – and in fact mostly is – caused by somatic problems and ailments, most of which stem from malignancies.³ But suffer-

ing can also have other dimensions stemming from, for example, mental and psychiatric ailments. In fact, the unbearableness of suffering is often the result of a combination of the various dimensions of suffering.

Although it is the patient who determines whether the suffering is unbearable or not, this in itself is not determinative for the decision to perform euthanasia or not. Of course the patient's perspective is relevant, but this does not imply that his or her own assessment is authoritative.⁴ The physician who is confronted with the request to perform euthanasia also has to be convinced both that the suffering is unbearable and that there is no prospect of improvement for this particular patient. Therefore, the unbearableness of the suffering is not determined exclusively by the patient's subjective experience; the physician has to be able to 'understand' or empathise with this specific form of suffering as well.

Voluntary and well-considered request by the patient

Another very important requirement is that the patient's request for euthanasia is voluntary and well-considered. The phrase 'voluntary euthanasia' (VE) as used by Keown is strange and confusing in relation to the situation in the Netherlands, as it suggests that there is also such a thing as *involuntary* euthanasia. There is not, at least not in the Netherlands, where euthanasia can only be performed when there is an explicit, well-considered and voluntary request by the patient himself or herself. Such a request can

only be made by a competent person, which means that the patient's competency will have to be judged.

Under Dutch law, persons aged 16 or over can make their own decisions regarding healthcare issues, including a request for euthanasia. Still, regardless of their age, it has to be clear that a person's request is voluntary and well-considered.

The aspects of voluntariness and being well-considered have to be assessed with specific care in patients with dementia or a psychiatric disease, since their condition may influence both. In addition, in these cases the question of whether there is any prospect of improvement also needs special attention, as this may be difficult to assess. Given the complexity of these cases, physicians are advised to be cautious and take particular care when assessing a request for euthanasia by patients with dementia or a psychiatric disease.

Dutch law also recognises a so-called advance directive as being a valid expression of a person's voluntary and well-considered request. An advance directive is a written statement of a person's wishes regarding medical treatment or, in this case, regarding the circumstances under which this person requests euthanasia. Such a statement can be made to ensure that one's voluntary and well-considered request is known and carried out should one be unable to communicate this request to a physician later on. However, the advance statement is not a guarantee that euthanasia will be carried out if the circumstances described in it actually occur. The physician will still have to ascertain that this specific situation involves unbearable suffering for this particular patient and that there is no prospect of improvement, and will have to take special care to come to this conclusion. For instance, the simple assertion that the patient requests euthanasia when admittance to a nursing home is inevitable is not sufficient for the request to be granted. Therefore, the assertion which is sometimes made that in these cases patients with dementia are

wsbericht/euthanasia-in-the-netherlands.htn. RTE (2017). Jaarverslag 2016. <https://www.euthanasiecommissie.nl/de-toetsingscommissies/uitspraken/jaarverslagen/2016/april/12/jaarverslag-2016>.

4 Den Hartogh, G. Euthanasia: Reflections on the Dutch Discussion. *Annals of the New York Academy of Sciences* 2000; October:174-187. doi: 10.1111/j.1749-6632.2000.tb05170.x. https://www.researchgate.net/publication/12283297_Euthanasia_Reflections_on_the_Dutch_Discussion.

3 KNMG 2011. Position paper: The role of the physician in the voluntary termination of life. <https://www.knmg.nl/actualiteit-opinie/nieuws/nieuw>

killed without their involvement and consent, or even that their relatives require the physician to do so, does not reflect Dutch law and practice. In practice, physicians are very reluctant to grant a request for euthanasia if they cannot communicate adequately with the patient. Euthanasia in these cases remains highly controversial and is rarely performed.

Consultation of an independent physician

An important procedural requirement for euthanasia is that at least one other independent physician personally sees the patient and provides a written opinion on the due care criteria for euthanasia.

In view of the fact that individual physicians may rarely deal with medically assisted death and may also have little experience conducting consultations in situations where a patient has asked for euthanasia, the Royal Dutch Medical Association (KNMG), as far back as in 1997, established a network of independent, expert physicians whom fellow physicians can contact with questions about medically assisted death or to pre-assess a euthanasia request. The physicians in this network, known as SCEN physicians,⁵ work in accordance with the law and the KNMG guidelines and undergo continuous training, systematically building their knowledge and experience. The SCEN programme is funded by the government in the vital interest of safeguarding the quality of the consultation with an independent physician in the euthanasia procedure. In 2017 there are some 650 SCEN-certified physicians who perform these consultations alongside their own medical practice. SCEN physicians only provide information; they can offer support or hold a consultation, but they will never perform the euthanasia. This always remains the responsibility of the treating physician.

5 SCEN is the abbreviation of 'Steun en Consultatie bij Euthanasie in Nederland', which can be translated as Support and Consultation for Euthanasia in the Netherlands.

The justification for euthanasia

In the following section we will briefly reflect on the main arguments against euthanasia as noted by Requena and Keown.⁶ Of course, the papers of both authors deserve a more extensive discussion, but we think that the two upcoming WMA conferences will provide a more appropriate occasion for this; not only because they allow for more detailed and in-depth discussion, but also because they can facilitate a broader debate and a search for proper solutions to the serious issues faced in end-of-life care.

The principles of respect for persons/ autonomy and of compassion

As Keown rightly indicates, the case for euthanasia can be based on two basic principles: the principle of respect for persons or autonomy and the principle of compassion. In our view, respect for persons is derived from a notion of the individual as an autonomous agent⁷ having the 'right to hold views, to make choices, and to take actions based on their personal values and beliefs.'⁸ Therefore, respect for persons can also be referred to as respect for autonomy. The requirement in the WtL that euthanasia can only be performed after a voluntary and well-considered request from the patient himself or herself aims to ensure that the request is indeed an autonomous choice. As such, it also guarantees that a request that is made involuntarily, for example because it is influenced or prompted by others, be it by relatives or implicit social expectations, will not be granted.

6 Requena, P. The Role of Physicians Fighting Children Trafficking and Illegal Adoptions. *WMJ* 2016; 62(3):99-103. Keown, J. Voluntary Euthanasia and Physician-assisted Suicide: Should the WMA Drop its Opposition? *WMJ* 2016; 62(3):103-107.

7 Dworkin, G. The theory and practice of autonomy. Cambridge: Cambridge University Press, 1988.

8 Beauchamp, T.L. & Childress, J.F. Principles of Biomedical Ethics. New York/Oxford: Oxford University Press Inc, 2009.

It is important to make a distinction between external and internal voluntariness. External voluntariness means that the patient is not under any pressure to ask for euthanasia. To ensure external voluntariness, both the physician and the independent consulting physician will speak with the patient in private, without relatives present. Internal voluntariness means patients should be able to understand information about their situation and prognosis, consider any alternatives and assess the implications of their decision.

Of course, people cannot be completely autonomous in the sense that they are not influenced by others, their culture or society. We recognise that a person does not live in a social vacuum but is influenced by personal relationships and their cultural, social and political context. But even then, persons can still be regarded as autonomous insofar as they have the ability and opportunity to choose their own course of action without being coerced in any way, based on a personal assessment of the situation and options at hand. To ensure such autonomy in the case of euthanasia, it should be guaranteed that appropriate medical and palliative care is available and affordable to all, and especially to those persons who can be regarded as specifically vulnerable. Euthanasia should not be introduced as an option when appropriate healthcare, and especially appropriate end-of-life care, is not guaranteed. However, concern for the vulnerable in itself is not a valid argument to oppose euthanasia. Still, it certainly is an important reason to ensure that the due care requirements regarding euthanasia are observed. The principle of respect for persons and autonomy requires just that. Therefore, a request for euthanasia will never be granted easily. Physicians will, and indeed are required to, first thoroughly assess whether the suffering can be alleviated by other means and whether options for meaningful medical or other care are available. In that regard, euthanasia will always be a last resort for patients after having been offered appropriate end-of-life care.

People do indeed have a right to live. This is acknowledged in many international treaties and in the legislation of many countries. However, the right of persons to live does not mean that they also have an *obligation* to live on, whatever the circumstances and regardless of their autonomous opinion or choice in this regard. In various countries, the act of suicide or attempted suicide is a punishable offence. In other countries, including the Netherlands, it is not a punishable offence, based on the view that every person has the fundamental right to end his or her life. Indeed, the right of a competent person to choose to avoid what that person considers an undignified and distressing end to his or her life and to decide by what means and at what point his or her life will end, has been legally recognised by the European Court of Human Rights.⁹ This does not mean, however, that a person has a right to be assisted by others, including physicians, in the act of ending his or her own life. Physicians can never invoke the mere request of a patient in justification of their own action, medically or otherwise, as this would be in conflict with their duty to offer due care. Dutch law acknowledges this specifically in the case of euthanasia through the requirement that the physician must be convinced that the patient's suffering is unbearable without any prospect of improvement.

It is exactly at this point that the principle of compassion comes in. If a person is suffering unbearably without any prospect of improvement and there is no alternative course of action, it can be an act of compassion to help this person end his or her suffering, even if this means ending this person's life at his or her explicit and autonomous request.¹⁰ In this light, the principle of compassion does

not conflict with the principle of respect for autonomy. On the contrary, in this situation it explicitly is in accordance with the principle of respect for persons or autonomy. And as such, we indeed think that the principal rule of 'doctors must not kill', to which Requena refers, is a *prima facie* principle that can be overridden in specific circumstances if other principles, e.g. that of compassion and of respect for autonomy, so require. The principal rule that physicians should not kill may, in specific situations, conflict with the principle of compassion. In such situations they find themselves confronted with conflicting duties, and these situations are difficult to resolve.

Indeed, the first rule of medicine is to do no harm (non-maleficence). However, in some exceptional cases there can be greater harm in allowing unbearable suffering to continue than there is in honouring a voluntary and well-considered request from a competent person to end this suffering by way of euthanasia (as a compassionate act of beneficence).

The importance of adequate, accessible and affordable end-of-life care

Both Requena and Keown assert that the legalisation of euthanasia is contrary to and may even be a threat to adequate end-of-life care, including palliative care. However, we fail to see why legalised euthanasia and adequate end-of-life care should be incompatible. It is of the utmost importance that adequate end-of-life care is offered to all patients who are in need of it and that this care is given by physicians if necessary. The need and the possibility to arrange this is by no means contradicted by the possibility of euthanasia. In fact, in certain circumstances, euthanasia itself must be seen as a means of giving appropriate care, based on the principles of respect for autonomy and compassion. This does not mean that euthanasia should be regarded as a therapeutic intervention or as 'regular medical care'. It is neither. Indeed, it is exactly because it is *not* part of

regular medical care that euthanasia is still a punishable offence under the Dutch Penal Code. In this way, Dutch law acknowledges the very specific character of euthanasia. To assert otherwise does not correspond with the reality of the situation in the Netherlands, neither legally nor in the experience of physicians and the broader public in this country, as reflected in the recent third evaluation of the WtL.¹¹ This is also evident from the fact that euthanasia is not a right that patients have, and the fact that doctors are never obliged to honour a request for euthanasia.

The importance of end-of-life care is undisputed, and we see no reason why it should not be possible for such care to co-exist with the possibility of euthanasia. In this regard, we do not concur with Requena's conclusion that euthanasia will undermine the physician-patient relationship and the 'trust that the physician is working wholeheartedly for the patient's health and welfare'. The option of performing euthanasia does not necessarily undermine this trust in and relationship with the physician. This is also shown in the third evaluation of the WtL, which concludes that both the general public and physicians support the current regulation and practice of euthanasia: all actors are satisfied with the content of the law and its functioning.¹²

The nature of the physician-patient relationship is also bound by the principle of respect for autonomy. This means that the physician has to take into account (but does not blindly follow) the opinion of the patient on what actually constitutes good care for their own health and welfare. To ignore the patient in this regard would be an act of disrespect for the patient's autonomy. As such, the physi-

9 ECHR 31322/07, Haas vs Suisse; ECHR 2346/02, Pretty v. United Kingdom. Available at the website of the European Court of Human Rights: <https://hudoc.echr.coe.int>.

10 Den Hartogh, G. Euthanasia: Reflections on the Dutch Discussion. *Annals of the New York Academy of Sciences* 2000; October:174-187. doi: 10.1111/j.1749-6632.2000.tb05170.x.

11 Onwuteaka-Philipsen, B. et al. *Derde evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding*. Den Haag: ZonMw, 2017. <https://publicaties.zonmw.nl/derde-evaluatie-wet-toetsing-levensbeëindiging-op-verzoek-en-hulp-bij-zelfdoding>

12 Ibidem.

cian–patient relationship may actually be strengthened if patients know they can rely on the physician not to force any care upon them contrary to their autonomous wish and decision. The physician–patient relationship may also be strengthened if patients know that the physician will eventually, if the situation arises, acknowledge and possibly support their request for euthanasia.

Slippery slope arguments

Finally, we wish to reflect on the ‘slippery slope’ argument put forward by both commentators. The core of this argument is that as soon as euthanasia is allowed at all, even if only under certain conditions, it will necessarily follow that euthanasia will in future be performed under less stringent conditions and will eventually degenerate into an absolutely abject form of euthanasia, such as killing people involuntarily. There are two versions of this argument: one asserts that taking the first step (allowing euthanasia under certain conditions) will in practice inevitably lead to another and again another step (and so on), because every step necessarily arises from the preceding step. The other version of the argument is that if one approves of euthanasia under certain conditions, one will logically have to approve of euthanasia under other conditions as well. In both versions of the argument, the conclusion is that if euthanasia is held to be justified under certain conditions, it necessarily follows (either for practical reasons or by the force of logic) that it will be justified under other conditions as well, thus leading to unintended and unwanted consequences.

We reject both versions of the slippery slope argument. Allowing euthanasia under the conditions regulated in the WtI does not in any way necessarily lead to a degenerated practice of euthanasia (either legally permitted or not) that will end up in the involuntary killing of persons, randomly or because they are, for example, considered vulnerable or disabled. To assert that this is the case is

to ignore that in the euthanasia procedure every step in the sequence can and has to be knowingly taken after a thorough assessment of the interests and principles at stake and only if this next step can be ethically and legally justified. Put differently, the argument ignores the fact that there is a difference between the first and subsequent steps and that when taking these steps, there is a transition from A to B which requires an explicit decision. This runs counter to the assumption of discrete transitions in the practice or regulation of euthanasia.

The Dutch practice of and regulations governing euthanasia, as described above, are aimed to ensure that each case of euthanasia is known and can be investigated and judged. The practice of euthanasia in the Netherlands is made transparent to any and all interested parties within or outside the Netherlands through the publication of yearly reports by the RTEs and the evaluation of the WtI, which has been evaluated three times so far. This allows for critical reflection on the practice and regulation of euthanasia and makes it possible to hold the persons responsible to account. The risk of unwanted consequences is not an argument to forbid euthanasia altogether, but rather an argument to carefully monitor and evaluate the practice of euthanasia – indeed, this is exactly the reason why the Dutch situation is strictly monitored and evaluated every five years.

Moreover, those who use the slippery slope argument to oppose euthanasia tend to ignore that this position has unwanted consequences as well. A categorical rejection of euthanasia because of its possible (but not necessary) consequences means that one denies patients the possibility to make a voluntary and well-considered request for euthanasia when they are in a situation of unbearable suffering without any prospect of improvement. In our view, this is incompatible with the principle of respect for autonomy and ignores the fact that the principle of compassion may require physicians to grant such a request for euthanasia.

Conclusion

Euthanasia is a complex and controversial issue, and we very much welcome the fact that the members of the WMA are willing to discuss it. In this paper we have outlined the current situation regarding euthanasia in the Netherlands, both in its legal aspects and in practice. We have also argued why we think that euthanasia can be ethically justified and that physicians can, under certain specifically described circumstances, act ethically when performing euthanasia. Ultimately, this stance is based on the principle of respect for autonomy and the principle of compassion. It is important that the conditions under which euthanasia can be legally performed are well-defined and controlled, to rule out possible abuse and unwanted practices.

To allow euthanasia does not obviate the need for effective, accessible and affordable end-of-life care. On the contrary, one of the main ethical conditions for euthanasia is that adequate end-of-life care is in place, in order to allow persons to make a truly autonomous, voluntary and well-considered request for euthanasia. In our view, euthanasia should be seen as a possible endpoint of appropriate end-of-life care and is in no way opposed to it.

We hope that the upcoming WMA conferences on End-of-Life Questions will be characterised by mutual respect for the various views that WMA members may have regarding these difficult questions. We are confident that this will provide an opportunity for in-depth discussion and for an open and valuable review process of the WMA’s policy on euthanasia and physician-assisted suicide.

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