Review Committee
on Late-term Abortions and
Neonatal Termination of Life

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1. Foreword

This is the 2019 annual report of the Review Committee on Late-term Abortions and Neonatal Termination of Life ('the Committee').

The Committee determines on the basis of due care criteria whether a late-term abortion (category 1 and 2) or neonatal termination of life was carried out with due care, legally and medically speaking. The due care criteria are set out in the Order establishing the Review Committee on Late-term Abortions and Neonatal Termination of Life ('the Order').

In the reporting period the Committee received three notifications of late-term abortion. No notifications were received of neonatal termination of life. Of the three notifications of late-term abortion, one fell in category 1 and two in category 2.

This annual report discusses the notifications received by the Committee, the Committee's findings and activities, the issues discussed at the plenary meeting and the legislation.

In December 2019 committee member Mark van der Hoeven died following an illness. Mark was involved with the Committee in his capacity as physician, with particular expertise in the field of neonatology. He had been an alternate member of the Committee since 2016, was always fully committed to the Committee's principles and worked tirelessly towards the achievement of its aims. The Committee will greatly miss him and the contribution he made.

Professor Eva Pajkrt
Chair

August 2020

2. The Review Committee's work in 2019

2.1 Three notifications

In 2019 the Committee received three notifications of late-term abortion. One of these fell in category 1 and two in category 2. The Committee considered itself competent to review these notifications.

2.2 Observations and lessons learned

As it did in previous years, the Committee would like to express its appreciation of physicians' efforts in 2019 to fill in the reporting forms as comprehensively as possible, and of the detailed nature of the accompanying documentation (examinations: prenatal, serological, cytogenetic, DNA, postnatal, MRIs; reports: multidisciplinary consultations, second opinions, social work, conversations). Providing complete documentation enables the Committee to review notifications promptly and thoroughly.

In 2018 the Committee received 11 notifications of late-term abortions. In this reporting period it received three, significantly fewer than in 2018, but on a par with 2016 and 2017.

	Total number of notifications	Category 1	Category 2	Neonatal terminations of life
2016	3	2	1	-
2017	4	1	2	1
2018	11	5	6	-
2019	3	2	1	-

The Committee has no explanation for the higher figures for 2018.

2.3 The Committee's activities and issues discussed

Plenary meeting in Utrecht

The Committee held a plenary meeting in this reporting period to exchange ideas on the evaluation of the Order planned for 2020. The Committee takes the view that the definitions of 'physician' and 'late-term abortion' in the Order should be amended, because they give rise to questions in practice, such as whether the term 'physician' refers to the physician who bears ultimate accountability for the procedure or the physician who performs it. The Committee would also like to see future suffering on the part of the child included in the Order. Although article 6 (b) of the Order states that the physician has acted with due care if he was satisfied that the unborn child was currently suffering or could be expected to suffer, without prospect of improvement, there is no such qualification in article 7 (a). The Committee has submitted these and other proposals to the Ministry of Health, Welfare and Sport.

At the meeting, the Committee also modified the reporting forms to clarify what information and supplementary documentation it would like the physician to submit in each category of notification. There is now a checklist for this purpose, enabling the physician to see what information the Committee needs in order to review a notification.

In addition, the Committee has requested that from now on its annual reports be translated into English, and possibly into French and German, to make them accessible to a broader audience. By the time this annual report is published, the English translation of the 2018 annual report will be available on the website. In any event, this report and subsequent reports will be translated into English.

Website update

The Committee has taken a critical look at its website, with the help of a communication adviser and a website developer from the Ministry of Health, Welfare and Sport. The Committee wishes to present the information on the website clearly, divided into categories. It should be easy for physicians to find information on submitting notifications and the role of the Committee, and to access previous findings and annual reports. The Committee also wishes to provide information about its work to parents and other people involved. The Committee is aware that a late-term abortion or termination of the life of a neonate is a difficult and intense process. It believes that the way it reviews notifications should be transparent. The new website is now online (www.lzalp.nl).

Discussion of draft protocol on perinatal palliative care

In the reporting period, a number of paediatricians invited members of the Committee to discuss a local protocol on perinatal palliative care at the University Medical Centre Groningen (UMCG). The aim of the protocol is to provide the best possible end-of-life care for neonates who are expected to die within a relatively short time. The protocol makes a clear distinction between palliative care followed by a natural death and active termination of life. Current practice is that, in consultation with the parents, paediatricians opt for palliative care in situations where further treatment is regarded as futile.

Also discussed was a study entitled 'Medical decisions at the end of life regarding children between the ages of 1 and 12'. As is known, at present the Committee concerns itself solely with such decisions in the cases of children up to the age of one year.

Distinction between category 1 and category 2 notifications

The distinction between category 1 and category 2 notifications of late-term abortion would seem to be clear. However, this distinction is not always easy to draw in practice and sometimes makes a notification difficult to categorise.

In this reporting period one notification was submitted as a category 1 late-term abortion but in a meeting the Committee came to the conclusion that it should have been a category 2 notification. The physician was asked to complete the documentation again, taking account of the change in status. In certain cases, the Committee itself has difficulty with categorisation and understands that physicians do not always find it clear.

The Committee notes that the category into which a notification falls affects the procedures to be followed, as explained in chapter 3 of this report.

2.4 Overview of notifications including findings

The notifications received in 2019 have been anonymised and summarised in this report, and are accompanied by the Committee's findings.

Notification 1
Late-term abortion – category 1

Diagnosis and prognosis

In this case, the child had been diagnosed with trisomy 13, a condition in which there are three instead of two copies of chromosome 13. The condition has an infaust prognosis: this serious chromosomal abnormality usually causes brain, heart and kidney defects. In addition there may be facial malformations, cleft lip and palate and in all cases severe intellectual disability. Children with this condition also often have more than 10 fingers or toes (polydactylism). Most of them die in the womb. Of the infants that are born alive, only around 10% survive their first year.

There were no treatment options that would have improved this prognosis.

The mother's suffering

Immediately after discovering that she was pregnant and before she was aware of the diagnosis and prognosis for the child, the mother had stated that her family was complete. Had she realised at an earlier date that she was pregnant, she would have had an abortion.

The mother and her partner were informed of the diagnosis and prognosis. The question of carrying the child to term was discussed with her; she said that the psychological burden of completing the pregnancy would be too great.

In view of the infaust prognosis, at 24 weeks and three days of pregnancy the mother and her partner made an oral request for termination of the pregnancy.

Discussion within the attending team

The decision to terminate the pregnancy was taken after ad hoc consultations within the multidisciplinary team. There was general agreement on the diagnosis and prognosis and on whether the mother's request should be complied with.

Procedure

At 26 weeks and five days of pregnancy fentanyl was administered to the child, after which fetal demise was induced. Labour was then induced through the administration of mifepristone and misoprostol. The child was stillborn the following day.

The Committee's considerations

Category 1

The child was diagnosed with trisomy 13. The Committee therefore concluded that this was a late-term abortion in category 1.

The mother's request

The Committee noted that it was clear from the documentation that the mother and her partner had made an oral request for termination of the pregnancy. It concluded that the request was careful and well considered.

Fully informed of diagnosis and prognosis and no reasonable alternative

The Committee noted that the mother and her partner had been fully informed. The physician came to the conclusion, together with the mother and her partner, that there was no reasonable alternative.

Consultations within attending team

The Committee noted that the request for termination was discussed and assessed in multidisciplinary consultations. This was recorded in writing. There was general agreement on the diagnosis and prognosis and on whether the mother's request should be complied with.

Due medical care

The Committee held that the decision to induce fetal demise was careful and well considered and the procedure was performed with due medical care.

Findings

The Committee found that the physician had acted in accordance with the due care criteria.

Notification 2
Late-term abortion - category 2

Diagnosis and prognosis

The mother in this case was pregnant with twins. She was diagnosed with oligohydramnios and both foetuses had enlarged hypoechoic kidneys, consistent with polycystic kidney disease. There were two pathogenic variants in the PKHD1 gene, consistent with autosomal recessive polycystic kidney disease (PKD4). The prognosis was poor. The children had a very limited chance of survival. As they were not producing urine, there was no amniotic fluid and their lungs could not develop properly. The lung developmental disorder meant that it was highly likely the children would die shortly after birth as a result of respiratory difficulties. In addition, they would suffer from severe, irreversible kidney function disorders. Depending on severity, they would have extremely limited chances of survival (if the kidneys were not functioning) or, if there was a degree of kidney function, they would require kidney replacement therapy in the form of dialysis or a kidney transplant while still very young. In the latter case, the children would be dependent on medical care from birth and for the rest of their lives.

The suffering of the children and mother

If the children survived their lung function disorder, they would be kidney patients for the rest of their lives. This involves very burdensome, lifelong treatment. The mother and her partner were experiencing mental suffering. The knowledge that the children's prognosis was extremely poor meant that they did not wish the pregnancy to be carried to term. They wanted to spare the children the suffering described above.

Discussion within the attending team and second opinion

The decision to terminate the pregnancy was taken after consultations in the multidisciplinary team. A second opinion was also requested from a medical centre outside the region. There was general agreement on the diagnosis and prognosis.

Procedure

At 27 weeks and five days of pregnancy, fetal demise was induced through the administration of potassium chloride via the umbilical cord. Labour was then induced through the administration of mifegyne and misoprostol. That same day both children were stillborn.

Category 2

The Committee noted that the diagnosis and prognosis in this case were such that medical treatment following birth would have been considered futile. There could be no reasonable doubt regarding the prognosis and the diagnosis on which it was based.

Current or expected suffering without prospect of improvement on the part of the unborn children

On the basis of the information provided by the physician, the Committee concluded that, even if the children survived the first few days following birth, they could be expected to experience suffering without prospect of improvement, consisting of lung function disorders and severe kidney disease. If they survived these disorders, they would be totally dependent on medical care from the moment of birth and would have to undergo extremely burdensome medical treatment throughout their lives.

There were no treatment options that would have improved this prognosis.

Fully informed of diagnosis and prognosis and no reasonable alternative

The Committee noted that the mother and her partner had been fully informed of the diagnosis and prognosis and given detailed information, including about the possibility of carrying the children to term. This was clear from the physician's report. The physician came to the conclusion, together with the mother and her partner, that there was no reasonable alternative in light of the situation of the children and the mother.

Explicit request by the mother for termination of the pregnancy

The Committee noted that it was clear from the documentation that the mother and her partner had made a written request for termination of the pregnancy. It concluded that their request was careful and well considered.

Consultation of at least one independent physician

The Committee noted that the request to terminate the pregnancy was discussed on two occasions in a multidisciplinary consultative team: once at the hospital itself and once in connection with a second opinion. The members of the multidisciplinary consultative teams agreed independently of each other and unanimously that there was no doubt about the diagnosis and the associated, extremely poor prognosis.

Due medical care

The Committee held that this late-term abortion was performed *lege artis* and with due medical care.

Findings

The Committee found that the physician had acted in accordance with the due care criteria.

Notification 3
Late-term abortion - category 2

Diagnosis and prognosis

In this case the child was diagnosed with rhizomelic chondrodysplasia punctata type 1. This is a severe peroxisomal metabolic disorder characterised by rhizomelic shortening of the limbs, severe growth disorders, bilateral cataracts (congenital or developing in early infancy; severe), respiratory problems, spinal abnormalities, joint contractures, skeletal deformities, stiff and painful joints, dependency on tube feeding, epilepsy and severe developmental delay.

The prognosis was extremely poor. The child's prospects consisted of severe developmental delay and reduced life expectancy. Following birth the child would be totally dependent on medical care and would not develop self-reliance or be able to communicate.

There were no treatment options that would have improved this prognosis.

The suffering of the child and mother

The child was expected to suffer from severe developmental delay and to require chronic pain relief throughout life, while undergoing intensive, burdensome treatment.

The mother and her partner were experiencing mental suffering caused by the knowledge that their child was suffering from a severe developmental disorder, would suffer chronic pain and had reduced life expectancy. They received support from a medical social worker.

Consultations within attending team and second opinion

The decision to terminate the pregnancy was taken after two discussions in the multidisciplinary team. In addition, a second opinion was requested from a medical centre outside the region. There was general agreement on the diagnosis and prognosis.

Procedure

At 34 weeks and four days of pregnancy the child received intramuscular pain relief, after which fetal demise was induced through an intracardial injection of lidocaine. Labour was induced through the administration of misoprostol, after which the child was stillborn.

Category 2

The Committee noted that the diagnosis and prognosis in this case were such that medical treatment following birth would have been considered futile. There could be no reasonable doubt regarding the prognosis and the diagnosis on which it was based.

Current or expected suffering without prospect of improvement on the part of the unborn child

On the basis of the information provided by the physician, the Committee concluded that the child could be expected to experience suffering without prospect of improvement consisting of severe developmental delay, epilepsy, skeletal abnormalities, respiratory problems and dysphagia.

After birth, the child would have suffered chronic pain, would have been totally dependent on medical care, and would have been unable to communicate or develop self-reliance.

There were no treatment options that would have improved this prognosis.

Fully informed of diagnosis and prognosis and no reasonable alternative

The Committee noted that the mother and her partner had been fully informed of the diagnosis and prognosis and given detailed information, including about the possibility of carrying the child to term. This was clear from the physician's report. The physician came to the conclusion, together with the mother and her partner, that there was no reasonable alternative.

Explicit request by the mother for termination of the pregnancy

The Committee noted that it was clear from the documentation that the mother and her partner had made an oral request for termination of the pregnancy. The reports showed that this request was voluntary and consistent, and that the decision to terminate the pregnancy was well considered.

Consultation of at least one independent physician

The Committee noted that the request to terminate the pregnancy was discussed on three occasions in a multidisciplinary consultative team: twice in the medical centre itself and once outside the region in connection with a second opinion. This was recorded in writing. The members of the multidisciplinary consultative teams agreed independently of each other and unanimously that there was no

doubt about the clinical presentation and the associated, extremely poor prognosis.

Due medical care

The Committee held that the procedures were performed with due medical care.

Findings

The Committee found that the physician had acted in accordance with the due care criteria.

3. Legislation and the legal framework

3.1 General

The Order establishing the Review Committee on Late-term Abortions and Neonatal Termination of Life was amended as of 1 February 2016, setting out the due care criteria in more detail and in addition clarifying certain medical and legal aspects and empowering the Committee to review category 1 late-term abortions.

Relevant definitions

'Late-term abortion' means a procedure that is intended to terminate a pregnancy of more than 24 weeks involving a viable fetus, with the aim of ending the life of the fetus, on account of diagnosed severe fetal disorders.

A 'category 1 late-term abortion' is a case in which it may reasonably be expected that the unborn child cannot live outside the mother's body. The fetus is suffering from an untreatable condition which is expected to lead inevitably to death during or directly after birth.

A 'category 2 late-term abortion' is a case in which the unborn child is suffering from one or more conditions which will lead to severe and irreversible functional disorders, or in which the unborn child has little reasonable chance of survival.

A 'neonate' is a child that has not yet attained the age of one year.

'Neonatal termination of life' means the deliberate shortening of a newborn infant's life where the child is suffering unbearably and is without prospect of improvement (current suffering) or can be expected to suffer unbearably and have no prospect of improvement in the future (future suffering). The child's state of health precludes any prospect of an independent life.

'The physician' is the doctor who performs the procedure that leads to a late-term abortion or termination of life of a neonate. In many cases this is the lead attending physician. In the event that the lead attending physician instructs another physician, a registrar or another care professional involved in the case to perform the procedure, the lead attending physician is accountable for

compliance with the due care criteria. This does not apply if the case is transferred to another physician. The latter is then considered to be the lead attending physician and is accountable for compliance with the due care criteria.

A 'notification' is the compulsory reporting by the physician of a category 1 or 2 late-term abortion or neonatal termination of life to the Committee using the model form.[1]

An 'independent physician' is a doctor who is not attached to the hospital or medical centre where the late-term abortion or neonatal termination of life is performed, who has expertise relating to the condition from which the fetus or neonate is suffering and who has no treatment relationship with the patient.

The 'findings' are the result of the Committee's review of the physician's compliance with the due care criteria in performing a late-term abortion or terminating the life of a neonate.

Review

Performing a category 1 or 2 late-term abortion and terminating the life of a neonate are in principle offences under articles 82a, 289 and 296 of the Criminal Code. Invoking necessity as a justification can however remove criminal liability. Necessity is only present if according to prevailing medical opinion the disorders affecting the child are of such a nature that medical intervention after birth would be medically futile. The Committee determines in light of the due care criteria set out in articles 5, 6 and 7 of the Order whether this is indeed the case.

Due care criteria

Article 5 of the Order

A physician who performs a category 1 late-term abortion has acted with due care if he has complied with the requirements laid down in the applicable legislation and in prevailing professional standards (Termination of Pregnancy Act and the model protocol of the Dutch Society of Obstetrics and Gynaecology (NVOG)).

1 Model forms can be downloaded from www.lzalp.nl.

Article 6 of the Order

In performing a category 2 late-term abortion, the physician has acted with due care if:

a. the physician was satisfied that the unborn child was suffering from a disorder or a combination of disorders of such a nature that medical treatment would be withheld after birth on the grounds that intervention was futile according to prevailing medical opinion, and there was no reasonable doubt, according to prevailing medical opinion, regarding the diagnosis and associated prognosis;
b. the physician was satisfied that the unborn child was currently suffering or could be expected to suffer, without prospect of improvement;
c. the physician fully informed the parents of the diagnosis and associated prognosis. This means that together with the parents the physician came to the firm conclusion that there was no reasonable alternative in light of the unborn child's situation;
d. the mother made an explicit request for the pregnancy to be terminated because of physical or mental suffering caused by the situation;
e. the physician consulted at least one other, independent physician, who gave a written opinion on the above due care criteria. Alternatively, if no independent physician could reasonably have been consulted, the physician consulted the attending medical team, which gave a written opinion on the above due care criteria;
f. the pregnancy was terminated with due medical care.

Article 7 of the Order

In terminating the life of a neonate, the physician has acted with due care if:

a. the physician was satisfied that the newborn child was suffering unbearably and without prospect of improvement, which means, *inter alia*, that the decision to withhold medical treatment was justified; in other words, it was established that intervention would be futile according to prevailing medical opinion, and there was no reasonable doubt, according to prevailing medical opinion, regarding the diagnosis and associated prognosis;
b. the physician fully informed the parents of the diagnosis and associated prognosis and together with the parents came to the firm conclusion that there was no reasonable alternative in light of the unborn child's situation;
c. the parents gave their consent for the termination of life;
d. the physician consulted at least one other, independent physician, who gave a written opinion on the above due care criteria. Alternatively, if no independent physician could reasonably have been consulted, the physician consulted the attending medical team which gave a written opinion on the above due care criteria;
e. the termination of life was performed with due medical care.

No duty to notify the Committee when a late-term pregnancy is

terminated for reasons relating to the mother's health

Terminating a pregnancy after 24 weeks as a necessary and only possible response to a serious medical condition presenting in the mother constitutes acceptable, appropriate and unavoidable medical treatment. In general, such a termination will be covered by the legal justification of necessity, which means the physician is not criminally liable. The ministers saw no reason to have such cases reviewed in the context of terminations on grounds of the health of the child and there is thus no need to notify the Committee.

However, should the fetus die, this must be reported like any other such death to the municipal pathologist, who in turn informs the public prosecutor. In addition, the Health and Youth Care Inspectorate (IGJ) has a supervisory role. In the event of a serious breach of professional standards the inspector can send a report to or lodge a criminal complaint with the Public Prosecution Service. In that case and in the event that the public prosecutor receives a criminal complaint or report from another source, the Public Prosecution Service has a role to play. In all other cases of late-term abortion for reasons relating to the mother's health, the public prosecutor's role is confined to assessing the request for permission to bury or cremate the child.[2]

3.2 Procedures and the Committee's findings

If the decision has been made to perform a late-term abortion or terminate the life of a neonate, the physician informs the parents of the procedures involved. The parents need to consent to the procedures and to the sending of the relevant case file to the competent authorities. If the parents do not give their consent for this, the physician may decide not to proceed. In the case of a category 2 late-term abortion or neonatal termination of life, an independent physician should be consulted unless this is not reasonably possible.

The physician notifies the municipal pathologist that he or she has performed a category 1 or 2 late-term abortion or has terminated the life of a neonate. The municipal pathologist carries out an external postmortem and determines how and with what substances the termination was carried out. The municipal pathologist then contacts the public prosecutor, who gives permission for burial or cremation. The pathologist plays no further role in the notification procedure.

2 Instructions on Prosecution Decisions in the Matter of Late-term Abortions and Neonatal Termination of Life, registration number 2017A003, Government Gazette no. 68445, 1 February 2017.

The physician sends the completed reporting form and all relevant supplementary documentation to the Committee.

Within six weeks of receiving the notification the Committee sends its written findings to the physician and, in the case of a category 2 late-term abortion or neonatal termination of life, to the Board of Procurators General ('the Board'). The six-week period can be extended by a maximum of six weeks.

Authoritative opinion

The Committee's findings have the status of an authoritative opinion issued to the Board. The latter nevertheless reaches an independent decision concerning category 2 late-term abortions and neonatal termination of life.

Category 1 late-term abortion

If the Committee concludes that a category 1 late-term abortion has been performed in compliance with the due care criteria, that means the case has been disposed of. If it decides that the physician has not acted in accordance with the due care criteria, it sends its findings to the IGJ. The IGJ may decide to conduct an investigation to determine whether and, if so, what measures should be taken in respect of the physician.

Category 2 late-term abortion and neonatal termination of life

If the Committee concludes that a category 2 late-term abortion or neonatal termination of life has been performed in compliance with the due care criteria, it sends its findings to the Board of Procurators General, which decides on whether or not to prosecute. If the Committee decides that the physician has not acted in accordance with the criteria, it sends its findings to the Board and to the IGJ. These bodies then decide according to their own competence and responsibility whether and, if so, what measures should be taken in respect of the physician.

3.3 Legal scrutiny and final decision of the Board of Procurators General

The Committee believes it is important to explain in greater detail the Board's scrutiny and final decision regarding category 2 late-term abortion and neonatal termination of life.

Criminal liability

The Board assesses a physician's criminal liability relating to a late-term abortion or neonatal termination of life. If it determines that criminal liability is at issue, it decides whether prosecution would be in the public interest. If the physician has complied with the due care criteria, he or she is in principle not criminally liable. Where physicians have not complied with the due care criteria, criminal liability is more likely. Whether or not criminal proceedings are instituted depends on the facts and circumstances of the individual case.

For many physicians category 2 late-term abortions and terminating the life of a neonate are difficult issues. These are often complex cases that confront the physician with intractable ethical considerations. The procedures surrounding termination cost time and energy and there is legal scrutiny based on criminal law (articles 82a, 286 and 296 of the Criminal Code). The ethical, social and political sensitivity of the issue makes it imperative that physicians' actions are transparent and subjected to review.

The Order defines the boundaries within which physicians' actions in relation to late-term abortion and neonatal termination of life must take place. In brief, the physician's actions must be in conformity with medical professional standards. Insight into the cases which have undergone legal scrutiny can contribute to the development of medical knowledge within the profession. Issues giving rise to discussion become more transparent. If the profession as a whole can arrive at common standpoints with regard to these issues, they then become part of medical professional standards.

Serious breaches of the due care criteria or abuses will be subject to further criminal investigation, which may lead to prosecution. To date, the Board has not decided to conduct further criminal investigation or to institute criminal proceedings in any of the notifications it has reviewed.

Instructions

Further information on what decisions the Board may make and the circumstances that may give rise to prosecution can be found in the Instructions on Prosecution Decisions in the Matter of Late-term Abortions and Neonatal Termination of Life (2017A003). The Instructions are published on the Committee's website (www.lzalp.nl) under the heading *Wet en Regeling* (available in Dutch only).

Evaluation

The Board and the Committee conduct an annual evaluation of the notifications received. Being determined by the specific circumstances, each case is unique. Should a case give rise to questions (for example, certain difficulties experienced) the Committee and the Board will consult with each other and suggest possible solutions. These solutions will then be considered and if necessary further developed by those involved.

4. The Committee

The Committee consists of six members. The chair is a physician. Four members are physicians from a number of disciplines related to the issues at hand (gynaecology, neonatology and child neurology) and/or working in those fields. One member is an expert in ethical and moral issues and one is a lawyer. There is an alternate member for each of the members. The Committee is assisted by a secretary.

Members

- Professor E. Pajkrt, gynaecologist (chair)
- A.C. de Die, LLM (lawyer, also deputy chair)
- Professor O.F. Brouwer, child neurologist
- Professor J.H. Kok, paediatrician/neonatologist (non-practising as of June 2019)
- F.J.C.M. Klumper, gynaecologist
- Professor M.A. Verkerk, ethicist

Alternate members

- Dr A. Coumans, gynaecologist
- Dr R.P. Wijne, LLM, lawyer
- Professor M.A.A.P. Willemsen, child neurologist
- Dr M.A.H.B.M. van der Hoeven, paediatrician/neonatologist (passed away in December 2019)
- Dr G.T.R. Manten, gynaecologist
- Professor M.C. de Vries, medical ethicist

Secretariat

- S. van Leeuwen LLM, secretary (until 28 February 2019)
- M.W.F. Eltink, LLM, secretary (as of 1 March 2019)
- C.J.M. Manders, LLM, deputy secretary (as of 1 March 2019)
- K. van Maaren-Heijmans, administrative support