

# EUTHANASIA in Belgium : 10 years on



**M**ay 28, 2012 marks the 10<sup>th</sup> anniversary of the

**legalisation of euthanasia in Belgium**, with the **Netherlands** following suit a year earlier<sup>1</sup> and Luxembourg doing the same in 2009<sup>2</sup>. To date, these three Benelux countries are **the only ones to have legalised the act of intentionally killing a person who makes such a request**. At a time when legalisation of euthanasia is being debated in several European countries, notably in France, it would appear appropriate to take stock of the last 10 years of implementation of the law on euthanasia in Belgium.

## 1. Background review of the law on euthanasia and the initial spirit of the text

On December 20, 1999, a private members bill on euthanasia was put before the Senate. After lengthy discussions, reports and many hearings, the text was passed by the Chamber in May 2002 by 86 votes for, 51 against and 10 abstentions, making the most of the unusual political context which had relegated the Christian democratic parties to the opposition.

The real objective, as declared by the authors of the law, was **to put an end to semi-clandestine practices** thereby ensuring **legal safety**. Legal safety, first of all, **for the patient** who would see **their request for euthanasia respected**, while benefiting from the **protection with regard to acts of euthanasia which were not permitted** thanks to the introduction of criteria concerning the intervention of doctors. This would also provide legal safety for the **medical practitioner** who would be able to avoid facing any legal proceedings in the event of carrying out euthanasia within the **strict confines of the law**. The authors of the text felt that this law would help to create a climate of confidence between the medical practitioner, the patient, the medical team and family members and that it would enable a better understanding of the situation thanks to an objective assessment of medical practices.

All these discussions were underpinned by lengthy debates and proposed **parallel bills on palliative care**, as well as the access to and funding of such care. However, the two related aspects were never brought together

although the members of the Health Commission did agree on saying that the bill on euthanasia did not sufficiently stress the importance of palliative care<sup>3</sup>, **this being only very briefly mentioned in the margins**. For instance, the Health Commission wished unanimously to integrate an *a priori* filter regarding palliative care. In spite of this, and highly symbolically, the law on palliative care was passed on the same day as the law on legalized euthanasia.

The Health Commission also wished, nearly unanimously, to allow family doctors to have a say when a patient had requested the hospital to carry out euthanasia or had asked an external doctor to do so<sup>4</sup>. However, this suggestion was not retained in the final text. As to the possibility of carrying out euthanasia because of the patient's physical suffering, the Commission felt **"unanimously, that purely physical suffering could never justify euthanasia"**<sup>5</sup>. The law on euthanasia clearly excludes cases of depression.

In 2002, at the time the law was passed, it had been decided to exclude all minors, at least temporarily, from the debate on euthanasia because they are unable to express their wishes validly and because it was a very delicate matter to allow third parties to request euthanasia on their behalf. Furthermore, the potential for any medical improvements in minors is quite frequently more significant than in adults.

## 2. A summary of the legal framework surrounding the law of May 28, 2002 <sup>6</sup>

### 2.1 The Belgian law provides for two specific instances of euthanasia

#### a) Patients who are conscious

In the case of a patient in **the final stages** of his/her illness, euthanasia may take place if :

- the patient is an adult or a minor who has been granted adult legal status and is deemed to be in his/ her right mind and therefore able to express his/her wishes;
- the request has been made on a voluntary, thoughtful and repeated basis and does not arise from being pressured into it; the request has to be made in writing;
- the medical situation does not allow for a positive outlook and causes constant and unbearable physical or psychological suffering which cannot be alleviated and is caused by a life-threatening and incurable accidental or pathological illness;
- the medical practitioner has talked to his/her patient on various occasions about his/her state of health, his/her life expectancy, his/her request for euthanasia; the medical practitioner must discuss the possible options available to his/her patient regarding both therapeutic treatment of the illness and the palliative care available and the consequences thereof;
- the medical practitioner has consulted another independent and competent medical practitioner who has drawn up a report setting out his/her findings;
- the medical practitioner has discussed his/her patient's request with the medical team treating the patient and with the patient's close family, if the patient so requests;
- after euthanasia, the medical practitioner fills out both pages of the form designed to ascertain the legality of the afore-mentioned act.

If the patient is **not in the final stages** of his/her illness, **two further conditions apply**, as set out below :

- the medical practitioner must consult a second independent medical practitioner, psychiatrist or a medical practitioner specialized in the relevant pathology;
- the period of reflection required between the patient's written request and the act of euthanasia has to be at least one month.

#### b) Patients who are NOT conscious

Euthanasia can take place if :

- the person is an adult or a minor who has been granted adult legal status;
- the person is not conscious and the situation is irreversible according to current medical knowledge;
- the person is suffering from a life-threatening and incurable accidental or pathological illness;
- the person has drawn up and signed a declaration in advance requesting euthanasia; this declaration is valid for a period of 5 years and may appoint one or several reliable individuals who have been entrusted with voicing the patient's wishes;
- the medical practitioner has consulted another independent doctor;
- the medical practitioner has discussed the declaration, which was drawn up and signed by the patient in advance, with the patient's medical team and any close family members;
- after euthanasia, the medical practitioner fills out both pages of the form designed to ascertain the legality of the afore-mentioned act.



In all events, the law also includes a “conscience clause”, which states that no medical practitioner is obliged to carry out euthanasia and that no other person is obliged to be a party thereto (Article 14 )<sup>7</sup>

## 2.2. Delivery by the pharmacist of euthanizing substances

The law, as drawn up in the Royal Decree, obliges the pharmacist to provide the euthanizing substance in person to the medical practitioner on the basis of a prescription which explicitly mentions that the medical practitioner has acted in accordance with the law on euthanasia<sup>8</sup>.

The medical practitioner must, moreover, return any surplus and unused substances to the pharmacy for elimination. It is acknowledged that the pharmacist may refer to the conscience clause as provided for in the law of May 28, 2002<sup>9</sup>.

## 2.3. The setting up of a Federal Control and Assessment Commission

In order to reassure public opinion regarding the application of the law on euthanasia, a Federal Control and Assessment Commission has been set up. It is made up of 16 full members and 16 deputy members, medical practitioners, philosophers, legal experts as well as members from other fields dealing with the medical follow-up of patients suffering from an incurable disease. This Commission carries out a control after the event (*a posteriori*) with regard to compliance with the conditions

and the procedures laid down by the law on euthanasia. To this end, it examines the anonymous section of the forms filled out by the medical practitioners who carried out euthanasia. Should the Commission feel that these conditions have not been complied with, it opens up the second section - this one being nominative - and, based on a majority decision of two-thirds of its members, forwards the dossier to the Crown Prosecution Service of the patient's place of death.

## 3. Some figures laid out in the Commission's report

According to the report drawn up by the Federal Commission for Control and Assessment regarding the implementation of the law on euthanasia, the total number of declared cases of euthanasia was 5.537 for the period between September 2002 and December 2011. The annual figure is constantly rising.

In 9 % of declared cases of euthanasia, death was not envisaged in the very short term<sup>13</sup>. The most often declared illnesses mentioned to justify this type of request are first and foremost neuropsychiatric diseases, followed by degenerative neuromuscular diseases and a combination of non-fatal "multiple pathologies".

### NUMBER OF DECLARED CASES OF EUTHANASIA

<b>2003</b>	235	<b>2008</b>	704
<b>2004</b>	349	<b>2009</b>	822
<b>2005</b>	393	<b>2010</b>	953
<b>2006</b>	429	<b>2011</b>	1133
<b>2007</b>	495		

In the report for 2010 and 2011<sup>10</sup>, in 98 % of declared cases euthanasia had been requested by a patient who was conscious while in 2 % of cases it had been carried out on patients who were not conscious but who had drawn up an advance directive. A slight majority of patients were male and half of them were aged between 60 and 79 years.

In 91 % of requests, death was considered as expected in the short term and among these requests, 75 out of 100 concerned pain relating to cancer while 5 out of 100 requests related to pain due to a neuropsychiatric disease, a non-degenerative neuromuscular disease (following an accident...) or a combination of multiple pathologies.

This report also indicates that only 10 % of medical practitioners who receive a request for euthanasia have been trained in palliative care whereas 50 % of requests were addressed to general practitioners and 40% to specialists<sup>14</sup>.

A more surprising figure : 82 % of cases of euthanasia were declared in Flanders<sup>11</sup>. The majority of patients mentioned that they were suffering both physically and psychologically<sup>12</sup>.



## 4. Bills which aim to widen the scope of the law on euthanasia

### 4.1. The influence of the Groningen Protocol in force in the Netherlands relating to premature or handicapped children

Several neonatologists have drawn up a **procedure which enables euthanasia of premature new-born infants or those presenting a handicap** in one of the three following instances: either the infant has no chance of survival, or it is deemed to only have a very mediocre quality of life, or the outlook is poor and it is felt that the infant will suffer unbearable pain.

The Groningen Protocol<sup>15</sup> caused quite a stir in Belgium and a great many medical practitioners are of the opinion that since a “therapeutic” abortion is possible right up to the day before birth in the event of the child being handicapped, euthanasia of new-borns ought also to be allowed under the same conditions.

### 4.2. Euthanasia of patients suffering from dementia

Among other things, the private members bill 53 0498/001<sup>16</sup> submitted to the Chamber of Representatives on October 28, 2010 aims to offer the possibility of euthanasia **to patients who are incapacitated and suffering from dementia**.

At a time when they are still able to manifest their wishes, they would be able to draw up a **declaration in advance which would not be restricted in time** and in which they could specify the moment when they wish their life to be ended.



### 4.3. Conscience clause and the obligation of referral

Among other things, the private members bill 5-22/1 submitted to the Senate on August 16, 2010<sup>17</sup> aims to **oblige a medical practitioner** who refuses to acquiesce to a request for euthanasia **to refer the medical file to another medical practitioner who is in favour of euthanasia** with a view to “ensuring continuing care” of the patient.



### 4.4. Euthanasia of minors<sup>18</sup>

Three private members bills have been put forward to widen the scope of application of euthanasia with respect to patients who are minors.

- Private Members bill 5-21/1 came before the Senate on August 16, 2010<sup>19</sup>. It envisages **providing the possibility of requesting euthanasia for all minors, regardless of age, on condition that he/she is deemed to be of sound mind and capable of reason**. Before the age of 16 years, the decision has to be made **with parental approval**.
- Private members bill 5-7-179/1 came before the Senate on September 23, 2010<sup>20</sup>. It aims **to make euthanasia available to minors aged 15 years and who are expected to die very shortly, on condition that they are conscious and are capable of reason**. Their parents would **have to be informed** but would **not be able to be involved in any decision** regarding euthanasia.
- Private members bill 53 0496/001 was submitted to the Chamber of Representatives on October 28, 2010<sup>21</sup>. It aims **to offer the possibility of euthanasia to minors, regardless of age**. If the child is “*capable of reason*”, **it would be able to formulate the request itself; if this is not the case, its parents would be allowed to do so on its behalf**.

The decision would be taken by a medical team in conjunction with the child and its parents. **A decision regarding euthanasia could also be taken in the event of premature infants or those suffering from serious complications**.

## 5. Assessment of the enforcement of the law

Ten years after the adoption in 2002 of the law on euthanasia, an objective assessment of its application is appropriate.

### 5.1. Ineffective control by the Commission

From the time of its initial report and subsequent reports, the Commission for Control and Assessment acknowledged its inability to act<sup>22</sup>, going on to say that it is not capable of *assessing the proportion of declared cases of euthanasia compared with the number of real cases which have actually taken place*<sup>23</sup>. Yet, in 2002 the stated objective of bringing euthanasia out of the shadows was a major argument made by those in favour of its legalization. From the time of the very first report for 2002 and 2003, the Commission acknowledged that *“it was aware of the limits of control with which it had been entrusted regarding the implementation of the law of May 28, 2002”*. It goes on to say that *“it is quite evident that the effectiveness of its mission resides, on the one hand, in the medical profession’s respect for the obligation to declare actual cases of euthanasia and on the other, in the manner in which the declarations are*

*drafted”*<sup>24</sup>. This is, in a nutshell, the problem of how to carry out control after the event (death of the patient), based on the medical practitioner’s declaration. Is it not illusory to expect a medical practitioner to denounce him/herself when he/she has failed to comply with one or several basic rules and regulations? Can one seriously imagine that he/she will scrupulously comply with the rules in such instances when he/she is actually unaware of one or several rules and regulations? Is it not more likely that he/she will refrain from declaring euthanasia or that he/she will act in such a manner that he/she is not directly implicated<sup>25</sup>? Nonetheless, nearly 10 years after the implementation of the law, the Commission continues to consider that the legal conditions have been met. It has never felt the need to refer a single medical file to the Crown Prosecution Service.

### 5.2. Comprehensive interpretation of the terms of the law

*Although the text of the law legalizing euthanasia provides for compliance with conditions which were seen to be extremely stringent, and without which the law would not have received a majority vote in 2002, there is no question today that these conditions have shifted. As early as 2006, the Commission included a “brochure for the medical profession” which explains the new interpretations to be given to the legal conditions. The Commission, in effect, interprets the law very freely, even going so far as to void any control it is supposed to carry out with regard to some of the legal conditions mentioned below :*

#### a) Requirement regarding a **written declaration**

From the moment of the first report for 2002 and 2003, the Commission observed that out of 14 declarations, there was no mention of a written request having been made by the patient. In some of these cases, the Commission freely estimated that *“the urgency of the situation and its dramatic nature could explain the absence of any written document”*<sup>26</sup>. In other cases, the medical practitioners felt that, where a prior document did exist or where death was imminent, a written request was superfluous. The Commission decided to accept the validity of all these cases. However, the requirement for a written declaration is formally upheld by the law which states, moreover, that when a patient is incapacitated, there is the possibility of a third party being allowed to draw up this document in compliance with certain legal conditions.

#### b) The requirement according to which the patient must suffer from a **life-threatening and incurable illness**

From the time of the Commission’s second report covering 2004 and 2005, a reference to *“multiple pathologies”* authorizing euthanasia was observed. Originally, cases of patients suffering from various life-threatening and incurable diseases were mentioned in this category. In its most recent report showing the figures for 2008 and 2009, the Commission also decided to include in this category cases of patients suffering from various non-fatal pathologies, those which are not life-threatening in themselves but whose serious nature the Commission considers to be sufficiently established due to their co-existence. This includes those patients suffering from various pathologies due to their great age (for instance their mobility is reduced due to arthritis, they do not see well and have become deaf). This interpretation has resulted in discussions within the Commission, but a majority opinion prevailed<sup>27</sup>.

« *The law shall obey its own nature and not the will of the legislators, and it shall inevitably bear the fruit we have sown in it.*

G.K. Chesterton



c) The requirement of **unrelievable, unremitting** and unbearable pain

In its first report, the scene is set : the Commission considers that the assessment of the **unbearable** nature of the pain is in large part *“subjective and depends on the patient’s personality, their own ideas and values”*<sup>28</sup>. As to the **unrelievable** nature of the pain, the Commission states that consideration must be given to the fact that *“the patient has the right to refuse pain treatment, even palliative care, for instance when this treatment causes side effects or medical procedures which the patient deems unbearable”*<sup>29</sup>. **In practice, the Commission has, therefore, decided not to carry out its mission - so central to the law - of verifying the unbearable and unrelievable nature of the suffering.**

d) The notion of **psychological suffering**

Whereas during the course of the law’s preparatory stages, the authors were seen to be very cautious as to the idea of authorizing euthanasia when the suffering endured by the patient was mostly psychological<sup>30</sup>, the Commission had, on various occasions, already endorsed cases of euthanasia carried out on patients suffering from depression and those suffering from Alzheimer’s disease<sup>31</sup>. Following a good deal of very animated discussions, a majority of the Commission also decided that *“future dramatic developments (such as a coma, a loss of independence or progressive dementia) are sufficient to be qualified as unbearable and unrelievable psychological suffering under the terms of the law”*<sup>32</sup>. The fourth report, nevertheless, mentions in its conclusions that some of the Commission’s members felt

that the notion of psychological suffering had been too widely interpreted<sup>33</sup>. This viewpoint was not, however, accepted by a majority of the Commission’s members.

e) Cases of **medically assisted suicide**

The Commission has observed in several documents that the procedure used in euthanasia consisted in providing the patient with a lethal dose of barbiturates which he/she then ingested. This does not constitute euthanasia but rather medically assisted suicide which does not explicitly form part of the scope of the law of May 28, 2002. The Council of State did indeed debate *“the pertinence of not including assisted suicide within the scope of the law”*<sup>34</sup>. **Indeed, the legislator had not seen the need of including the possibility of medically assisted suicide in the law.** And yet one can see that from the time of the very first report, the Commission freely considered that this manner of proceeding was authorized by the law in as far as the conditions and legal procedures applying to euthanasia had been complied with and that the act of euthanasia was carried out under the responsibility of the medical practitioner present at the time and ready to intervene<sup>35</sup>. It ought, however, to be pointed out that it was only a matter of legalizing an “act”, practiced by a medical practitioner, which intentionally brings about the death of a person at their specific request (Article 2 of the law)<sup>36</sup>.



### 5.3. Composition of the Commission

The legislator wanted the 16 members of the Federal Commission of Control and Assessment of the law on euthanasia all to come from the medical, legal and social professions. The members are put forward by the Senate and are appointed by the Council of Ministers (Cabinet). The legislator also wished the members of the Commission to be appointed on the basis of linguistic parity and explicitly provided for the *“assurance of a pluralistic representation”*<sup>37</sup>. In spite of all these precautions, one may be surprised by the fact that nearly half the Commis-

sion’s full members are also members or associates of the “Association pour le Droit de Mourir dans la Dignité (ADMD)” (Association for the Right to Die in Dignity), which openly campaigns in favour of euthanasia and the widening of the legal conditions. In view of the Commission’s composition, one can understand the absence of any effective control and the every-widening interpretation which the Commission intends to give the law. One may also be very worried by this.

### 5.4. Delivery by pharmacists of euthanizing substances

In the case of euthanasia in the home, it is up to the **medical practitioner** carrying out euthanasia to go **in person** to the pharmacy to collect the euthanizing substances **from the pharmacist** and **to bring back the surplus amount which was not used**. Control of this obligation is not carried out. In practice, the lethal substances

are sometimes supplied to the family or they are handed out over the counter by trainees or assistant pharmacists faced with such a request at the chemist shop. As to the return of surplus substances, to date no actual control has ever been carried out.

## 6. Some of the consequences of the absence of any real control of the implementation of the law

### 6.1. The trivialization of euthanasia

Initially legalized under very strict conditions, euthanasia has gradually become a very normal and even ordinary act to which patients are deemed “to have a right”. In the face of certain high profile cases, the evident relaxation of the very strict conditions has caused many reactions but also a total absence of any sanctions on the part of the Commission and a very conciliatory silence from the political establishment has given rise to a feeling of impunity on the part of some concerned medical practitioners, and to a feeling of powerlessness in those worried about where things are leading.

### 6.2. Has the debate been hijacked ?

Any organized work on attitudes contributes to modifying the image of the medical profession and to evolving perceptions by medical practitioners of the act of euthanasia. In Wallonia, the EOL Forum<sup>38</sup> (End-of-life doctors) was set up in 2003 with the help of the ADMD (Association pour le Droit de Mourir dans la Dignité<sup>39</sup> - Association for the Right to Die in Dignity) and is subsidized by the Walloon Region. Its mission is to train general medical practitioners in end-of-life management and palliative care, as well as in the conditions and procedures to be followed in the event of a request for euthanasia. This being the ADMD’s hobby horse, one may indeed be concerned about the overt lobbying carried out by this forum in favour of euthanasia and the ever widening scope of application of the legal conditions. In view of the fact that the ADMD’s members are also EOL Forum instructors, with these also being extensively represented within the Commission for the Assessment of the Law and therefore also providing expert opinion during the discussions within the legislative assemblies, one can only deplore the fact that any real attempt at discussion would appear to have been hijacked. It is often only a very short step from information to education and then to incitement<sup>40</sup>.



« If thought corrupts language, language can also corrupt thought.

George Orwell



### 6.3. A confusion of terminology ?

Changing attitudes also concerns a confusion of terminology. There is no real need to make a distinction between passive euthanasia and active euthanasia in view of the fact that it is the criterion of **intentionally killing a person which is decisive**. Consequently, neither halting disproportionate medical treatment nor palliative sedation, which only aims to alleviate pain, is considered as constituting **euthanasia**. And yet, the idea that euthanasia is an option afforded within the confines of **palliative care**, referred to as integrated care, continues to gain ground. This shows the extent of the misunderstanding of what is actually concerned by the term “palliative care” which does not consist in deciding the day and the manner in which death should take place but to accept this eventuality when it occurs while at the same time ensuring that care is taken to provide the patient and his/her entourage with comprehensive care and pain management. By its very nature, palliative care does not include any form of euthanasia.



### 6.4. A further associated ethical matter : organ donation

The confusion tends to become more wide-spread as a further step has on several occasions been taken from euthanasia to **immediate organ harvesting with a view to transplantation**<sup>41</sup>. Indeed, there is a new practice of **accompanying a request for euthanasia with a form for organ donation to be filled out by the patient**. To what extent does this possibility risk **weighing on the decision taken by a patient who thinks that their existence is worthless** ? Does the patient still meet the conditions required by the law – i.e. without any external pressure – in order to formulate a request for euthanasia, when he/she is invited at the same time to agree to organ donation ? By suggesting that the patient’s organs would be more useful to someone else, does this not belie a form of utilitarianism ?

## 6.5. Are there risks of serious transgression ?

In some cases where the patient is deemed not to be able to discern matters for him/herself as required for an informed request for euthanasia, because of his/her young age or mental deficiency, the medical teams appear to invoke “*a case of necessity*”. This refers to the **possibility of ending a person’s life in the event of unbearable or unremitting suffering, without the patient having made such a request**. Dr M. Englert <sup>42</sup>, an instructor with the EOL Forum writes : “*In the case of a new-born infant or very young patients who are unable to make such a request, the active ending of life is not considered to be euthanasia but rather an act which arises out of the observation that one is faced with a case of necessity, as is the case of active ending of the life of an adult patient who is not conscious and has not made a prior request for euthanasia*”.

What is the difference between the active ending of a person’s life and euthanasia ? Does the state of necessity arise out of extreme suffering or the **extreme powerlessness of the medical profession who are confronted with this extreme suffering** ?

Authorizing the medical team to invoke a case of necessity, thereby justifying euthanasia, **beyond all the conditions provided for by the law, gives the medical team arbitrary and uncontrollable power**.

Already mobilized to justify euthanasia of new-born infants and young children, the state of necessity is also invoked to justify euthanasia of adult patients who are not conscious and who have not drawn up a prior declaration. It may be that these patients are unconscious, or that, even though conscious, they are irreversibly deprived of the faculties required to make a request for euthanasia (mainly in the case of neuropsychological illnesses).

Far from strengthening the patient’s rights since they are not in a position to give consent, recourse to a state of necessity gives the medical profession enhanced powers of decision over life and death issues concerning the most vulnerable patients. Besides dialogue with close family members, how is one to assess the degree of “necessity” invoked and to ensure that the patient’s interests always come first ? Do not such practices not bear witness to a form of abdication on the part of the medical sector when faced with certain pathologies ?

## Conclusion

It ought, once again, to be pointed out that, far from establishing a right to euthanasia, the law of May 28, 2002 has only partially legalized euthanasia, under stringent conditions, in order to ensure the legal security of those engaged in the process and of providing such medical practices with a legal framework. Legal action will not be brought against medical practitioners for having intentionally killed a patient who had made such a request if the conditions provided for by the law are met.

As is the case in all penal laws, this law has to be strictly interpreted lest it be of seeing it stripped of any substance. It is not for the Commission, appointed to control and assess the law, to provide an ever-widening interpretation of its terms, with this going so far as to negate the initial spirit of the text and of doing away with the control of decisive legal criteria.

Ought one not also to reflect on the relevance of upholding a system of control after the event ( *a posteriori* ) based on the medical practitioner’s declarations,

with this no doubt being a fairly unreliable system for ending clandestine practices ?

But above all, would it not be more appropriate for the legislator to once again take his rightful place ? He would, then, have been in a position to hear the recent appeal by the Council of Europe’s parliamentary Assembly <sup>43</sup> in favour of an absolute ban on euthanasia. In all events, one may hope that the legislator would intervene to redefine the criteria enabling euthanasia to be carried out within the confines of the law.

A truly pluralistic debate would help to stem the growing trivialization of euthanasia in Europe where, let us not forget, Belgium, the Netherlands and Luxembourg are the exception.



## Notes

- <sup>1</sup> Law of April 12, 2001, houdende toetsing van levensbeëindiging op verzoek en hulp bij zelfdoding. (Netherlands)
- <sup>2</sup> Law of March 16, 2009 on euthanasia and assisted suicide.
- <sup>3</sup> Doc 50 1488/005 of Belgium's Chamber of Representatives passed on March 1, 2002. A bill on euthanasia, amendments, p9: *"The Chamber's Public Health Commission unanimously voted in favour of the inclusion of a palliative filter at the preliminary procedural stage (...). Palliative care is not considered as constituting a real alternative and (...). The bill does not recognize the possibilities currently provided by palliative care"*.
- <sup>4</sup> Doc. 50 1488/005 of Belgium's Chamber of Representatives of March 1, 2002, bill on euthanasia, amendments, p.13
- <sup>5</sup> Doc 50 1488/005, p.9. *"The subjective nature of psychological suffering was too wide and may therefore leave the door open to abuse. Patients suffering from depression, mental disorders, dementia and Alzheimer's disease ought not to be included in the scope of the proposed law."*
- <sup>6</sup> Law of May 28, 2002 on euthanasia, published in the *Moniteur belge* on June 22, 2002.
- <sup>7</sup> See in this respect the brochure "Conscience clauses for health professionals", drawn up by the European Institute on Bioethics, Brussels 2011.
- <sup>8</sup> Law of November 10, 2005, completing the law of May 28, 2002 on euthanasia via provisions concerning the pharmacist's role and the use and availability of euthanizing substances.
- <sup>9</sup> Answer given by Mr Jef Tavernier, at the time Minister of Consumer Protection, Public Health and the Environment, session of December 12, 2002, Annales, Senate, No 2-251, p.29: the proposed amendment explicitly providing for the conscientious objection by pharmacists was thrown out on the grounds that it was a repetition of what was already the situation under Article 14 of the law.
- <sup>10</sup> The fifth report (2010-2011) to the legislative chambers drawn up by the Federal Commission for Control and Assessment of Euthanasia.
- <sup>11</sup> p.13-14 of this report.
- <sup>12</sup> p.16 of this report.
- <sup>13</sup> In its brochure published for the medical profession, the Commission defines death "which cannot be foreseen in the short term" as being not foreseen in the coming months. And so in practice, "only for illnesses which do not evolve or evolve only very slowly".
- <sup>14</sup> The fifth report to the legislative chambers (2010-2011), drawn up by the Federal Commission for Control and Assessment of Euthanasia, p.8.
- <sup>15</sup> A.A.E. VERHAGEN and P.J. SAUER, 2005, "The Groningen Protocol – Euthanasia in severely ill new-borns", *The New England Journal of Medicine*, vol. 352, March 10, No 10, p 959 – 962.
- <sup>16</sup> "Private members bill modifying the law of May 28, 2002 on euthanasia".
- <sup>17</sup> "Private members bill modifying Articles 3 and 14 of the law of May 28, 2002 on euthanasia with regard to the obligation of the medical practitioner who is opposed to euthanasia to refer the patient to another medical practitioner".
- <sup>18</sup> Some authors are of the opinion that since euthanasia is available to minors who have been granted adult legal status, this constitutes discrimination of minors who have not been granted adult legal status. However, it is a matter of on-going jurisprudence that there is no discrimination in treating objectively different situations differently.
- <sup>19</sup> "Private members bill modifying Article 3 of May 28, 2002 on euthanasia with regard to minors".
- <sup>20</sup> "Private members bill modifying the law of May 28, 2002 on euthanasia with regard to minors over the age of 15 years".
- <sup>21</sup> "Private members bill completing the law of May 28, 2002 on euthanasia with regard to minors".
- <sup>22</sup> It would appear from a detailed study undertaken in the Netherlands by H. HENDIN (Professor of psychiatry at the New York Medical College and Medical Director of the American Foundation for Suicide Prevention, New York, USA) that once euthanasia has been legalized, it is extremely difficult, if not impossible, to control the practice. See H. HENDIN, *Seduced by death. Doctors, patients and assisted suicide*, New York, W.W. Norton, 1998.
- <sup>23</sup> Notably, the first report to the legislative chambers (September 22, 2003 – December 31, 2003) drawn up by the Federal Commission for Control and Assessment of Euthanasia.
- <sup>24</sup> The same report for the years 2002 – 2003, p.23.
- <sup>25</sup> By way of example and subject to reservations, an enquiry carried out in 2007 involving medical practitioners in Flanders based on death certificates, observed that 53 % of cases of euthanasia had effectively been declared. See *"A post mortem survey of end-of-life decisions using a representative sample of death certificates in Flanders"*, BMC Public Health, 2008, August 27, 8; 299.

<sup>26</sup> The first report to the legislative chambers (September 22, 2002 – December 31, 2003), drawn up by the Federal Commission for Control and Assessment of Euthanasia, p.18.

<sup>27</sup> The fourth report to the legislative chambers (2008-2009), p.22.

<sup>28</sup> The first report to the legislative chambers, p. 18.

<sup>29</sup> Ditto.

<sup>30</sup> Doc 50 1488/005, p. 9. The Chamber's Public Health Commission was of the opinion that *"the subjective nature of psychological suffering was too wide and may therefore leave the door open to abuse. Patients suffering from depression, mental disorders, dementia and Alzheimer's disease ought not to be included in the scope of the proposed law"*.

<sup>31</sup> In the third report to the legislative chambers, p. 18, the Commission endorsed euthanasia of two patients suffering from Alzheimer's disease, one patient suffering from insurmountable depression, one patient suffering from psychosis, as well as four patients suffering from Huntington's chorea.

<sup>32</sup> The third report to the legislative chambers, p. 24. This interpretation was confirmed in the 4<sup>th</sup> report in spite of opposition from some of the Commission's members.

<sup>33</sup> The fourth report to the legislative chambers, p. 33.

<sup>34</sup> Opinion handed down by the Council of State regarding the private members bill *"on euthanasia"*, 31.441 (AV-AG), p. 12 where the Council of State *"wondered about the pertinence of having ensured that assisted suicide fell outside the scope of the law"*.

<sup>35</sup> The first report to the legislative chambers, p. 17.

<sup>36</sup> G. SCHAMPS and M. VAN OVERSTRAETEN, *"La loi belge relative à l'euthanasie et ses développements"*, (Belgian law and its evolution), *Liber amicorum Henri-D. Bosly. Loyauté, justice et vérité*, La Charte, 2009, p. 337-355, specifically p. 340.

<sup>37</sup> Article 6, paragraph 2 of the law of May 28, 2002.

<sup>38</sup> Its Flemish equivalent is called LEIF (LevensEinde Informatie Forum).

<sup>39</sup> Its Flemish equivalent is called Recht of Waardig Sterven (RWS).

<sup>40</sup> By way of example, a mobile pluridisciplinary team was recently set up within the Academisch Centrum Wemmel, with this team wishing to play a back-up role of consultation for terminally ill or incurably sick patients, including psychiatric disorders. In view of the fact that two thirds of its members or instructors belong to the LEIF Forum and members of RWS's Board of Directors, one is quite likely to see euthanasia gaining considerably more ground in patients suffering from psychiatric illnesses.

<sup>41</sup> See notably : YSEBAERT D., VAN BEEUMEN G., DE GREEF K. et al. : *"Organ procurement after euthanasia : the Belgian experience"*, *Transplant Proc* 2009, 41:585-586.

<sup>42</sup> Site of the *"Association pour le droit de Mourir dans la Dignité"* (Association for the Right to Die in Dignity) (<http://www.admd.be/medecins.html>).

<sup>43</sup> Resolution 1859 (2012), Protection of human rights and personal dignity by taking patients' previously expressed wishes into consideration.

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**See also EIB File : "Ethical indicators regarding the end-of-life management of the dying"**  
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