Euthanasia in the Low Countries

A comparative analysis of the law regarding euthanasia in Belgium and the Netherlands.

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Introduction

In Belgium the legal conditions to practise euthanasia are governed by the act on euthanasia of 28 May, 2002 that entered into force on 23 September, 2002. There is no relevant jurisprudence and no guidance is offered by self-regulation made up by the medical profession itself before or after the enactment of the act. Thoughtful comments on the act are, understandably, lacking up to now while the discussions in parliament have been often unclear, contradictory and sometimes even misleading. In other words, the *law* on euthanasia in Belgium almost coincides with the *act* on euthanasia.

In this respect the situation in the Netherlands is totally different. The law on euthanasia is first of all governed by the "Termination of life on request and assisted suicide act" of 10 April, 2001 that entered into force on 1 April, 2002. This act is generally considered as the codification of the norms and procedures that have governed the practice of euthanasia in the Netherlands for almost three decades. These norms and procedures have largely emerged from within the medical profession itself and were later adopted by the courts in the context of criminal prosecutions.[1] There also exists a very important legal doctrine that offers guidance in understanding this act. In other words, studying the law on euthanasia in the Netherlands is more than merely studying the act on euthanasia. The act is only the ‘tip of the iceberg’.

While the Dutch act aims to *codify* existing practices, the Belgian act mainly aims to *modify* the behaviour of physicians when ending the life of their patients. It is hoped that a law that pretends to offer legal security to physicians and patients will stimulate patients to express a voluntary and explicit request and that physicians will abandon their practice of ending the lives of patients without their request. Research indeed had pointed out that Belgian (or at least Flemish) physicians frequently 'forget' to obtain the patient’s request before ending his life.[2]

Is should be made clear from the outset that a comparison of the Belgian and the Dutch law regulating the practice of euthanasia is a hazardous undertaking. Just comparing both acts — at first sight the Belgian act, although much more detailed, could be considered a 'clone' of the Dutch act — will lead to misleading and even incorrect results. Not only the acts, but also medical practice and legal practice (jurisprudence and doctrine) have to be considered when we try to compare the law on euthanasia in both countries. In this article I will make an attempt to do this. Lack of space requires omitting many details from the comparison.

The field of application of the Belgian and Dutch actst on euthanasia

First, I will compare both acts from the point of view of their field of application: what practices are regulated and whose behaviour is regulated?

I. Practices regulated

a) euthanasia

Section 2 of the Belgian act defines euthanasia as intentionally terminating life by another person than the person concerned, at this person's request. This definition had been proposed in the recommendation of the Belgian Advisory Committee on Bioethics of 12 May, 1997.[3] The great merit of this recommendation is that it ended the lack of clarity regarding the term 'euthanasia'. By offering a clear, strict and authorative definition of euthanasia, the committee fulfilled one of the necessary conditions for a fruitful ethical and legal discussion regarding this matter.[4] The definition opted for in the recommendation and confirmed in section 2 of the act is commonly known as the 'Dutch' definition of euthanasia because it was also used by the Dutch State Commission on euthanasia in 1985.[5] Ironically, the Dutch act on euthanasia does not contain this definition and even the notion 'euthanasia' is not mentioned. This act always refers to 'the termination of life on request', without giving a definition of this notion. Because termination of life on request coincides with the activity labelled as euthanasia in the Belgian act, both acts have the same field of application in this respect.

b) assisting suicide

The Belgian act is not applicable to assisted suicide, whereas the Dutch act treats termination of life on request and assisted suicide in exactly the same way. It defines assisted suicide as intentionally helping another person to commit suicide or providing them with the means to do so (section 1,b).

The Belgian legislature deliberately left assisted suicide out of the field of application of the euthanasia act. In its recommendation the Belgian Council of State pointed at the fact that there is no principal difference between euthanasia and assisted suicide and recommended to include assisted suicide. Also, from within the parliamentary majority itself, different amendments have been proposed with the same purpose. By not approving these proposals, the legislature has clearly opted not to regulate assisted suicide. One can only speculate on their motives.

One motive could be that in the current state of Belgian law, assisted suicide is not expressly prohibited, whereas it has been in the Netherlands for many years (section 294 of the Dutch Criminal Code). Because assisted suicide was not a (separate) crime, whereas ending another person's life, even at their request, was (and still is) a crime, the legislature could limit himself to regulating euthanasia. However, this reasoning can easily be reversed: because assisted suicide is not a crime and the difference between euthanasia and assisted suicide is minimal, both have to be submitted to the

same legal norms and procedures. Given that one of the motives for a change of the Belgian law has been the protection of patients against unrequested ending of life, one can even argue that the law should encourage physician-assisted suicide as a 'safer' alternative to euthanasia, because in the case of suicide it is the patient him/herself who has to act and this may be regarded as a stronger safeguard of autonomy. To sum up, I am not convinced that the Belgian legislature has left assisted suicide out of the euthanasia act because assisted suicide is actually not a crime. Moreover, and this complicates the matter, some argue that assisted suicide may be punishable as so-called "criminal negligence" or "failing to aid a person in grave danger" (section 422 *bis* of the Belgian criminal code). According to this argument, a patient with a suicide plan is for that very reason in grave danger. A physician has to offer him professional care, otherwise he commits criminal negligence. This is the case *a fortiori* when he not only fails to offer that help, but even provides his patient with the means to commit suicide. The problem with this argument is its supposition that any person with a suicide plan is in grave danger. Moreover, until now no physician has been prosecuted in Belgium for offering a patient aid in committing suicide. That may be explained by the legal uncertainty but also by the uncompromising condemnation of physician-assisted suicide by the Belgian Order of Physicians. Indeed, section 95 of the code on professional ethics states that a physician is not allowed to help a patient commit suicide. It is noteworthy that this prohibition has been integrated into the code only since 1992: in the previous version assisted suicide was not even mentioned. So it might be the case that the main motive for the Belgian legislature not the regulate physician-assisted suicide is that there is no social need for it. Whatever the motives may be, in this respect the Belgian and the Dutch act differ fundamentally. One wonders whether the Belgian act is not making an unjustified discrimination and how the Belgian Constitutional Court would deal with a complaint in this respect.

c) Other 'life-shortening medical action'

Neither the Belgian nor the Dutch act on euthanasia regulate other forms of life-shortening medical action, such as pain relief and withholding or withdrawing life-prolonging treatment.

II. Persons regulated

a) The physician

According to section 3 §1 and section 4 §2 of the Belgian euthanasia act, *the physician* who performs euthanasia “does not commit a criminal offence” when the norms and procedures prescribed by this act have been followed. Section 293 of the Dutch criminal code, amended by section 20 of the euthanasia act, provides that the act of terminating another person’s life at that person’s request is not a criminal offence if it is committed by *a physician* who fulfils the due care criteria set out in section 2 of the euthanasia act. Thus, in both Belgium and the Netherlands, euthanasia must be performed by a physician if it is to be legal. A remarkable difference between the Belgian and the Dutch act is that the former does not make explicit what criminal offence it is that a physician does not commit when he respects the norms and procedures, while the Dutch act does. This difference is all the more remarkable because the Belgian criminal code has never qualified killing someone at his own request as a separate offence, whereas the Dutch criminal code has done so for many

decades. This raises the question: what exactly is the criminal offence that a physician in Belgium does not commit when he respects the norms and procedures provided for in the euthanasia act? Because killing someone at his request is not a separate offence, it could be qualified as manslaughter (art. 393), murder (art. 394) or poisoning (art. 397). This is pure speculation however, because until very recently there have been no prosecutions of physicians who terminated the life of a patient.[6] Given the *nullum crimen sine lege* rule (no crime without a law), it is rather strange that a law explicitly considers an activity to be not a criminal offence under certain conditions, without referring to the offence that this activity would constitute if the conditions are not respected. At least in this respect, there is a marked difference between the act — and more generally the law — governing euthanasia in Belgium and the Netherlands. While under the Dutch law, a physician who kills a patient at this person's request and without respecting the due care criteria knows exactly what offence he commits and what sanctions he may expect, the Belgian law offers much less security to physicians in that respect. The original bill that formed the basis for the Belgian euthanasia act was very similar to the Dutch act. However, from within the parliamentary majority itself the explicit de-criminalization of euthanasia by changing the criminal code was severely criticized. For so-called psychological reasons, the authors of the bill decided to leave the criminal code unchanged. This resulted in the situation of uncertainty that I have described.

Another interesting point of discussion is what conclusion can be drawn about the status of euthanasia from the requirement that euthanasia must be practised by a physician. In the Netherlands the majority of health-care lawyers believe that euthanasia is not a 'normal medical act', although it must be administered by a physician. There is no medical indication for euthanasia and there exists no professional medical standard for its permissibility. Whether euthanasia is to be allowed or not is a matter for society, not for the medical profession. The same is true of, say, non-therapeutic abortion. Moreover, if euthanasia were a normal medical act, the physician should in principle administer it. Nobody is of that opinion in the Netherlands.[7] In Belgium there seems to exist more discussion on the status of euthanasia. Some regard it as a normal medical act and the legal requirement that euthanasia be performed by a physician is used as an argument for this point of view. This argument is not very convincing: if euthanasia is a normal medical act, then the act governing the practice of medicine stipulates that only a physician may perform it. So the explicit requirement in the euthanasia act would have been superfluous in that case. This dispute masks a more fundamental discussion with regard to the professional autonomy of hospital physicians and the competence of hospitals belonging to the Caritas Catholica network to place limits on this autonomy in the case of euthanasia.

Neither the Belgian nor the Dutch act requires additional conditions regarding the physician who performs euthanasia. He need not be the patient's attending physician nor is any special knowledge (in the field of palliative care, for instance) explicitly required.

What can make a difference in this respect is that one of the due care criteria provided for in the Dutch law is that the physician has terminated the patient's life "with due medical care and attention". The Belgian act does not contain such a prescription. It was debated in parliament but the majority considered it superfluous. If one looks at

the way this due-care criterion has been applied in the Netherlands before the act on euthanasia codified it, one may doubt this. Due medical care and attention means that euthanasia should be carried out in a professionally responsible way and that the doctor should stay with the patient continuously, or be immediately available until the patient dies.[8]

In the Netherlands the physician performing euthanasia should be a doctor who has "an established treatment relationship with the patient". This restriction is widely accepted.[9] In 70% of the cases of euthanasia in the Netherlands, it was the family doctor who administered it. Everybody has a family doctor, most of the time in a long-standing relationship. In Belgium (Flanders) euthanasia is in most cases performed by a hospital doctor. Necessarily, this practical difference will also have consequences with regard to the relationship the physician has with the colleague he is required to consult (see below).

b) The patient

The Belgian act requires the patient to be a person of age (i.e., over eighteen) or a so-called 'emancipated minor'. Emancipation of a minor is either the result of marriage (which is not really exceptional) or of a decision by a judge to declare him competent to deal with his own affairs (which is exceptional). The overall exclusion of 'mature' minors from the application of the Belgian act may be explained by the fear that no majority would have supported the inclusion of mature minors, and that could threaten the very approval of the bill itself. As a kind of compromise, emancipated minors have been included.

The Dutch act is in this respect totally different. If the patient is a minor aged between sixteen and eighteen and is deemed to be capable of making a reasonable appraisal of his own interests, the attending physician may comply with a request by this patient to terminate his life or provide assistance with suicide, after the parent or parents who has/have responsibility for him, or else his guardian, has or have been consulted (section 2.3). If the patient is a minor between twelve and sixteen and is deemed to be capable of making a reasonable appraisal of his own interests, the attending physician may comply with the patient's request if the parent or parents who has/have responsibility for him, or else his guardian, is/are able[10] to agree to the termination of life or to assisted suicide (section 2.4).

The request of the patient

The most important substantive norm in both acts is the request of the patient. The Belgian act makes a distinction between two forms of request: the request in the strict sense regulated in section 3 ('*het verzoek'*) and the declaration of a will regulated in section 4 ('*de wilsverklaring'*). I will refer to the former as the current request and to the latter as the advance directive.

The Dutch act also makes a distinction between a request (section 2.1) and a written declaration (section 2.2). To facilitate the comparison, I will use also here the expression current request and advance directive.

I. The current request

The Belgian act regulates in a very detailed way the substantive and formal requirements of a current request. A request has to be voluntary, considered and repeated, not resulting from any external pressure (section 3 §1) and have a durable character (section 3 §2,2°). Note that no explicit mention is made of a *well informed* request. The request has to be made up in writing. The document is drawn up, dated and signed by the patient himself. If the patient is not capable to do so, the document is made up by a major person, designated by the patient (section 3 §4). The request of the patient is kept in the medical file of the patient (section 3 §5). The patient can at any moment revoke his request, in which case it is taken out of his medical file and rendered to him (section 3 §4, last sentence).

The Dutch act requires a voluntary and carefully considered request (section 2.1. a). There are no formal requirements. When looking at the due care criteria developed in the jurisprudence and in self-regulation the Dutch euthanasia *law* is more developed. The request must be explicitly made by the person concerned; is must be voluntary (not the result of undue external influence); it must be well considered: informed, made after due deliberation and based on an enduring desire for the end of life (evidenced for instance by its having repeatedly been made over some period of time); the request should *preferably* be in writing or otherwise recorded. [11]

II. The advance directive

Section 4 §1 of the Belgian act regulates very detailed the formal requirements of an advance directive of will to obtain euthanasia when being uncapable to express a current request. It is noteworthy that the many substantive requirements (voluntary etc…) a current request has to satisfy, are not repeated here. An advance directive can be written at each moment. It has to made up in writing in front of two major witnesses, at least one of them having no material interest in the death of the patient and it has to be dated and signed by the drafter, both witnesses and, in case one or more person(s) of confidence have been appointed in the declaration, by this/these person(s). The role of this person of confidence is simply to inform the attending physician about the will of the patient. When a person who wants to make up an advance directive is in a permanent way physically incapable to write and sign a declaration, he can designate a major person, who has no material interest in his death, to draft an advance directive in front of two major witnesses, at least one of them having no material interest in the death of the patient.
The Crown determines the way an advance directive is drawn up, registered, confirmed, withdrawn and how it will be communicated to the physicians involved. This Royal decree has up to now not been enacted. Moreover, there will be no legal obligation to follow the rules laid down in the decree. Also advance directives drawn up in another way will be valid.
With regard to the validity of an advance directive the act provides that it can only be taken into account when is has been drawn up or confirmed less than 5 years before the person involved could no longer express his will. [12]

Section 2.2. of the Dutch act provides that in the case of a written declaration the due care criteria of section 2.1. apply mutatis mutandis, which means that the substantive requirements of voluntariness and careful consideration of the request are also

applicable. As I have remarked earlier, this is not the case with the Belgian law and I consider this as an important difference between both acts. On the other hand, the Dutch law does not contain formal requirements, except that the advance directive has to be made up in writing. Up to now euthanasia after an advance directive is rather exceptional in the Netherlands because before the act doubts existed whether it was legal. Also after the enactment of the law it is expected to remain exceptional (see also below)[13].This may explain why in the jurisprudence and self-regulation no additional due care criteria can be found.

The health condition of the patient

Now, the second main substantive condition will be analysed, namely the health condition of the patient requesting for euthanasia. Again, a distinction will be made between a current request and an advance directive

I. In case of a current request

The Belgian act requires the patient who currently requests for euthanasia to be "in a medically hopeless condition of continuous and unbearable physical and mental suffering that cannot be alleviated, and that is resulting from a serious and incurable disorder caused by illness or accident" (section 3 §1).
In this provision that has given rise to lengthy and confused debates in the Parliament, two elements, one objective and the other subjective, can be distinguished. The objective one is the serious and incurable disorder. Physicians have the knowledge and the skill to decide upon this condition. When a patient is not suffering from a disorder the Belgian act does not permit euthanasia. In the parliamentary discussion reference has been made to existential need. On the other hand the act covers both somatic and psychiatric diseases. Whether the disorder is curable or not has to be decided by the physician, having regarded the actual state of medicine. If the patient refuses a treatment for a curable disease, it does not become an incurable one. The subjective element is the continuous and unbearable physical and mental suffering. It is up to the patient himself and not to the physician or the relatives to evaluate whether his suffering is continuous and unbearable. When a patient refuses available treatment for his suffering, he may be in a state of unbearable suffering. This is also the case for mental suffering.
If both elements are present, the patient is in a medically hopeless condition. It is not sure whether this element has an autonomous meaning. From the debates in Parliament I got the impression it is not and that it exists when both the other elements (disorder and suffering) are present.

The Dutch act is again much more concise. It requires that the patient's suffering was unbearable and that there was no prospect of improvement (section 2, b). In the jurisprudence and the literature both elements are often brought together in the expression "unbearable and hopeless suffering". Since the second euthanasia judgement of the Supreme Court (21 October, 1986) it is generally accepted that the first element (unbearable suffering) is more or less a subjective one (like in the Belgian act) while hopeless suffering has a more objective meaning in the sense of irreversibility, lacking any prospect of improvement which is subjected to the

professional judgement of a physician. [14] Suffering includes but is not limited to pain and can be somatic or non-somatic in origin. This is also the situation in Belgium. What if the patient refuses an available treatment for his suffering? In its Chabot judgement (21 June, 1994) the Dutch Supreme Court has stated that the patient whose suffering is of a mental nature is not in a state of hopeless suffering if he or she refuses a meaningful treatment option. Thus, the Supreme Court rejects assisted suicide in cases of mental suffering if there is a realistic alternative to alleviate the suffering. This requirement is founded on the legal principle of subsidiarity. Almost all commentators agree that assisted suicide is not justified when a mentally ill patient rejects a meaningful treatment offer. [15] As I have stated before, the Belgian act leaves it entirely to the patient to refuse or accept an available treatment for his suffering, even a mental suffering. So, it seems that we are confronted here with another, important difference between both acts. Otherwise than is often pretended, the Dutch act is not more liberal than the Belgian act, at least not in this respect. During the parliamentary discussion in Belgium a member of the Christian democratic opposition has expressly pointed at this difference while from within the majority no efforts were made to dismiss his reasoning.

Before making final conclusions on this, one has to be extremely cautious for various reasons. First of all, for reasons that are not entirely clear, in the Netherlands euthanasia has never been seriously discussed as a possibility for psychiatric patients. All the known cases deal with assisted suicide by such patients and they amount to fewer than 5 cases per year.[16] As I stated before, assisted suicide is not regulated by the Belgian law and is for different reasons not a real option in Belgium. The question that raises then is: does the Belgian act allows for euthanasia on a psychiatric patient? In theory the answer could be yes. However –and this runs counter with what the Dutch Supreme Court has declared in the Chabot case namely that the wish to die of a person whose suffering is of a mental nature can be based on an autonomous judgement – the president of the Chamber Commission of Justice (Fred Erdman, a well respected lawyer belonging to the Flemish socialist party) concluded that psychiatric patients will never be entitled to euthanasia because mental suffering is not compatible with the condition of a free and voluntary expression of will.[17] It remains to be seen how medical practice will evolve but given the fact that Belgian physicians are not inclined to apply the euthanasia act, a medical practice that is not in line with these clear statements in the parliamentary discussion, seems beyond expectation. Finally, it may be that the difference between both acts is less great. It depends on the meaning of “hopeless suffering”. Unlike the Belgian act, the Dutch act does not refer to an “incurable disorder” because this condition is not regarded as a useful one. [18] However, this does not mean that the notion of an objective medical ground is totally absent in Dutch euthanasia law. In the so-called Brongersma case the Court of Appeal of Amsterdam has limited the scope of permissible cases of euthanasia and physician-assisted suicide to cases where the unbearable suffering is caused by a classifiable medical cause, either somatic or psychiatric. When the desire to die is caused by existential suffering, a physician is not permitted to end the life of the patient.[19] (Hopeless) suffering in the Dutch euthanasia act seems to have a meaning that combines the notions of suffering and disorder in the Belgian law. If this is true the difference (that as shown mainly exists on paper) becomes very small: refusal of a treatment of a disorder and refusal of a treatment for suffering have to be evaluated more or less on the same foot.

Neither the Belgian nor the Dutch act requires that the patient be terminally ill. However, regarding the procedural requirements the Belgian act makes a distinction between a patient who is obviously expected to die in the near future and a patient who is not (see below).

a) In case of an advance directive

The Belgian act contains specific conditions as to the health status of a patient who has requested euthanasia in an advance directive. The patient has to be unconscious and this condition has to be irreversible according to the actual state of medical science. Because in a situation like this a patient does not suffer any more (at least that is what we suppose) the condition of unbearable suffering is not required otherwise euthanasia would never been possible. For that reason the act requires, apart from the irreversible state of unconsciousness, only that the patient suffers from a serious and incurable disease, caused by illness or accident (section 4 §2). Although the condition of an irreversible state of unconsciousness leaves not much room for discussion – only patients in a persistent vegetative state respond to this condition – it has caused an intense debate in parliament. This has been provoked by a statement by one of the authors of the bill that the act would be applicable to *amongst others* comatose patients. This statement fuelled the opinion that the act could also be applied to patients suffering from dementia and Alzheimer disease who previously have made up an advance directive.

Unlike the Belgian act, the Dutch act does not contain specific conditions. It only provides that in the case of an advance directive "the due care criteria referred to in subsection 1 shall apply *mutatis mutandis"* (section 2.2.) One may wonder what this means regarding the condition of unbearable suffering. Under the Dutch act an advance directive may be applied when the patient "is no longer able to express his will". This is clearly much broader than the requirement in the Belgian act that the patient be irreversible unconscious. Nonetheless commentators of the Dutch law have expressed doubts whether section 2.2. can have effect in practice at all: "since the other requirements continue to apply – in particular the requirement of unbearable suffering – it is doubtful the provision (read section 2.2. HN) will have much practical effect and the rare case that falls within it would probably even in the absence of the statutory provision have been held by the courts to be covered by existing justification". [20]

The obligations of the physician with respect to the request and the health status of the patient

I will now consider the obligations that a physician who performs euthanasia has to respect in order not to commit an offence.

I. Obligations in case of a current request

The Belgian act again is very detailed in this respect. The physician has to reassure himself that the request and the health condition of the patient respond to the legal requirements (section 3 §1 and §2, 2°). Moreover he has to discuss with the patient the palliative care possibilities (section 3 §2, 1°). He also has to consult another physician with respect to the health condition of the patient. This physician has access

to the medical file, examines the patient and has to reassure himself about the continuous and unbearable physical and mental suffering that cannot be alleviated. The consulted physician has to be in an independent relation to the patient as well as to the physician (section 3 §2, 3°). If a nursing team has a regular contact with the patient, the physician has to discuss the request with the team or its members (section 3 §2, 4°). If the patient wishes so, the physician has to discuss his request with his relatives (section 3 §2, 5°). Finally the physician has to reassure himself that the patient had the opportunity to discuss his request with the persons he wanted to meet (section 3 §2, 6°).
If according to the physician the patient is obviously not expected to die in the near future (a so-called non-terminally ill patient) two additional conditions have to be respected (section 3 §3). First, the physician has to consult a second physician, who is a psychiatrist or specialist in the disorder in question. The consulted physician has access to the medical file, examines the patient and he has to reassure himself about the continuous and unbearable physical or mental suffering that cannot be alleviated and about the voluntary,considered and repeated character of the request. The consulted physician has to be in an independent relation to the patient as well as to the attending physician and the other consulted physician. Secondly, the attending physician must let pass one month between the written request of the patient and the act of euthanasia. [21]
A general requirement is that all requests formulated by the patient and also the actions of the attending physician and their results, including the reports of the consulted physician(s), are regularly noted down in the medical file of the patient (section 3 §5).

According to section 2.1.a) to d) of the Dutch act the attending physician must be satisfied that the patient has made a voluntary and carefully considered request; that the patient's suffering was unbearable and that there were no prospects of improvement; have informed the patient about his situation and have come to the conclusion, together with the patient that there is no reasonable alternative in the light of the patient's situation. According to section 2.1. e) the attending physician must have consulted at least one other, independent physician, who must have seen the patient and given a written opinion on the due care criteria mentioned in a to d).
Also these legal requirements have to be supplemented by the requirements of careful practice that are derived from self regulation. The physician has to discuss the matter with the immediate family and intimate friends (unless the patient does not want this or there are other good reasons for not doing so) and with nursing personnel responsible for the patient's care.[22] He also has to keep a full written record of the case (including information concerning the other elements of careful practice).

In general one may conclude that in this respect the difference between the Belgian act and the Dutch law (the act and the additional requirements) is from a substantive point of view rather small. The additional conditions provided in the Belgian act in case euthanasia is requested for by a non-terminally ill patient are the main exception. From a more formal point of view however, the difference is more important. Under the Belgian act all the requirements have to be respected in order that the euthanasia is no criminal offence. This is not the case with the Dutch law. Only the so-called due care criteria are enforceable through criminal law. The other requirements of careful practice are enforceable through disciplinary law. A possible explanation of this

difference is that Belgian medical disciplinary law differs in an important way from the Dutch medical disciplinary law and that the Belgian legislature did not really trust the medical disciplinary councils of the order of physicians in order to make them partially responsible for the enforcement of the euthanasia act. Because this point was never a real issue in the parliamentary discussions, it remains highly speculative

II. obligations in case of an advance directive

Because the Belgian act contains specific conditions when the request to euthanasia is formulated in an advance directive (see above), it also provides for different obligations for the physician in this respect. See section 4 §2 in this respect. Section 2.2. of the Dutch law states that in the case of an advance directive the due care criteria referred to in section 2.1. apply *mutatis mutandis.*

Notification of euthanasia

Section 5 of the Belgian euthanasia act requires a physician who has performed euthanasia to fill in a registration form and to send it within four working days after the act of euthanasia to the federal control- and evaluation commission. According to section 8 the commission has to control the completely filled in document. She has to evaluate whether the act of euthanasia has been performed according to the norms and procedures provided for in the act. In case of doubts, the commission can with a simple majority decide to hear the attending physician. She can also ask far any document in the medical file. However, according to the parliamentary discussions, the physician may refuse to give more information, referring to his obligation of medical secrecy. If the commission decides with a two third majority that the norms and procedures have not been respected, the file has to be sent to the public prosecutor.

Section 293.2 of the Dutch criminal code as amended by section 20 of the euthanasia act provides that termination of another person's life at that person's request is not an offence if (apart from the due care criteria already discussed) the physician notifies the municipal pathologist of this act in accordance with the provisions of section 7.2 of the Burial and Cremation Act. This subsection stipulates that if death is the result of euthanasia, the attending physician shall not issue a death certificate and shall immediately notify the municipal pathologist of the cause of death by completing a report form. The attending physician has to enclose with this form a detailed report on compliance with the due care criteria of the Euthanasia act. Section 10 of the Burial and Cremation Act obliges the municipal pathologist to report without delay to the competent regional review committee referred to in section 3 of the euthanasia act. This committee shall assess, on the basis of the report whether the physician has acted in accordance with the due care criteria. The committee may request the attending physician to supplement his report either orally or in writing, if this is necessary for a proper assessment of the attending physician's conduct. The committee may also obtain information from the municipal pathologist, the independent physician or the relevant health care providers, if this is necessary for a proper assessment of the attending physician's conduct (section 8 euthanasia act). The committee has to notify the Board of Procurators General of the Public Prosecution service and the regional health inspector of its findings if the attending physician, in the opinion of the committee, did not act in accordance with the due care criteria.(section 9.2). The

committee is obliged to provide the public prosecutor with all the information that he may require to assess the physician's conduct and for the purpose of a criminal investigation (section 10).

A striking convergence is that in both the Belgian and the Dutch act[23] notification is an explicit condition of legality: the physician, who does not respect the obligation to notify, commits a criminal offence (murder in Belgium; terminating another person's life at that person's request in the Netherlands).

Further, in both systems a buffer has been put in between the physician and the public prosecutor: a federal (this is one national, central) commission in Belgium and five regional committees in the Netherlands. For lack of space I cannot go into the details regarding the composition, working procedures and so on.

There are however also important differences. The Dutch notification system builds further upon a duty for physicians to report deaths that long *ante*dated the development of regulation concerning euthanasia.[24] In Belgium, a duty to report deaths only exists in the frame of population statistics. [25] The number of autopsies is very low while there is a high rate of exhumations in Belgium and this is probably caused by the lack of an efficient system of control on the veracity of the cause of death in the death certificates. Closely linked herewith is that in the Netherlands filing a certificate of natural death in case of euthanasia is now considered as an unacceptable practice[26] while in Belgium the discussion in this respect still has to start. Section 15 of the Belgian euthanasia act stipulates that a person who dies after euthanasia while all the norms and procedures have been respected, is considered to have died from a natural death for the application of all contracts he was involved in and especially regarding insurance contracts. *A contrario* this article can be seen as evidence that euthanasia is the cause of an unnatural death. However, the actual discussion in Belgium shows that not everyone is convinced of this.

Conclusion

A comparison of the Belgian and the Dutch law on euthanasia is a hazardous undertaking. At first sight both acts show little differences. However, on closer look and when not only the acts but also the law (jurisprudence; self-regulation and legal doctrine) are taken into account, there are some remarkable differences. At this moment it is too early however to judge whether these differences are of a structural or only temporary nature.

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[1] John Griffiths, "Self-regulation by the Dutch medical profession of medical behaviour that potentially shortens life". In *Regulating morality*, ed. H. Krabbendam and H.-M. Ten Napel (Antwerp: Maklu, 2000), pp. 177 and 183; Heleen Weyers. "Euthanasia: the process of legal change in the Netherlands. The making of the requirements of careful practice," In *Regulating physician-negotiated death,* ed. A. Klijn, M. Otlowski and M. Trappenburg ('s Gravenhage: Elsevier, 2001), p. 236.
[2] Mortier, Freddy and Deliens, Luc, " The prospect of effective legal control of euthanasia in Belgium," in *Regulating physician-negotiated death*, ed. A. Klijn, M. Otlowski and M. Trappenburg (s' Gravenhage: Elsevier, 2001), p. 180.
[3] See for the English text of the recommendation: Herman Nys, "Advice of the Federal Advisory Committee on Bioethics concerning legalisation of euthanasia," *European Journal of Health Law* 4(1997): pp. 389-393. See also the contribution of Tom Meulenbergs and Paul Schotsmans in this issue.
[4] Bert Broeckaert, "Belgium: towards a legal recognition of euthanasia," *European Journal of Health Law* 8(2001): p. 96.

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[5] This definition had been suggested already in 1977 by the Dutch professor in health law, Leenen. See Henk J.J. Leenen, "The development of euthanasia in the Netherlands," *European Journal of Health Law* 8(2001): p. 127.

[6] Maurice Adams, "Euthanasia: the process of legal change in Belgium. Reflections on the parliamentary debate," in *Regulating physician-negotiated death,* ed. A. Klijn, M. Otlowski and M. Trappenburg ('S Gravenhage: Elsevier, 2001), pp. 30-31. Adams adds that very recently a few cases have been prosecuted without mentioning on what offence the prosecutions have been based. These prosecutions did up to now not turn out in punishments.

[7] Henk J.J. Leenen, "The development of euthanasia in the Netherlands," *European Journal of Health Law* 8(2001): p. 126

[8] John Griffiths, Alex Bood and Heleen Weyers, *Euthanasia and Law in the Netherlands* (Amsterdam: Amsterdam University Press,1998), p. 106.

[9] Idem, 103 and note 41 where reference is made to so-called 'travelling euthanasia doctors" who made their services available to patients whose own doctors had failed to honour their requests. Given the fact that a large majority of Belgian physicians opposes the act and will not apply it and that the act does not contain a "due medical care" clause, one may expect that Belgian euthanasia practice will be more vulnerable to "specialised euthanasia physicians"

[10] Note that in the translation of section 2.4. of the Dutch act in the *European Journal of Health Law* (2001): p. 185 , in stead of " is /are *able* to agree" the expression "is/are *unable* to agree" is used which of course would lead to a situation that euthanasia can be practised against the will of the parents. This was indeed the purpose of the draft of the bill; see Henk J.J. Leenen. "The development of euthanasia in the Netherlands," *European Journal of Health Law* 8(2001): p. 130 who adds: "Actually, euthanasia against the will of the parents has not occurred in the Netherlands. If they object, intensive deliberations take place. This results in the child accepting the problem of the parents or the parents accepting the problem of the child. Parents who understandably do not want to lose their child are inclined to object. But, on the other hand, they do not want their child to suffer unbearably". See www. Minbuza.nl for a correct translation (visited on 3 November, 2002).

[11] John Griffiths, Alex Bood and Heleen Weyers, *Euthanasia and Law in the Netherlands* (Amsterdam: Amsterdam University Press, 1998), pp. 100-101.

[12] The intention of the Belgian legislature is to limit the validity of an advance directive to 5 years after it has been drawn up or confirmed. However, this result is not reached in the way this subsection of the act has been phrased. Suppose that someone draws up an advance directive on 1 January 2002. He becomes in a situation that he cannot express his will anymore two years later. Ten years later he becomes irreversibly unconscious – the situation required in order that euthanasia requested in an advance directive may be performed- . The advance directive, although at that moment 10 years old is still valid because less than 5 years have been lapsed since the advance directive was drawn up…When I confronted the members of the Commission of Justice of the Chamber during a hearing in february 2002, with this odd situation they admitted it; nonetheless the bill was not amended because otherwise it had to be sent back to the senate and apparently the majority did not wanted to "loose more time'.

[13] John Griffiths, "Important changes in euthanasia law," *Newsletter MBPSL* 4(2001): p. 2; also Albert Klein and John Griffiths, "Can doctor's hands be bound," www.rechten.rug.nl/mbpsl/milaanpa.html (accessed: November 18th, 2002), p. 4: "although there are a number of serious legal difficulties invoolved, euthanasia pursuant to an A.D. is probably legal in Dutch law. The bill (now: act, HN) includes a provision specifically providing for such a case. But this does not mean that the problems of implementing such an A.D. in medical practice will have been solved".

[14] M.A.J.M. Buijsen, "Kwaliteit van leven als maatstaf bij beslissingen rond het levenseinde: de zaak Brongersma [Quality of life as a criterion to end-of-life decisions: the case Brongersma]," *R & R* (2001): pp. 4-5.

[15] Sjef Gevers and Johan Legemaate, "Physician assisted suicide in psychiatry: an analysis of case law and professional options," in *Asking to die. Inside the Dutch debate about euthanasia*, ed. D.C. Thomasma et al. (Dordrecht: Kluwer Academic Publishers, 1997), pp. 77 and 85; see also Henk J.J. Leenen. "The development of euthanasia in the Netherlands," *European Journal of Health Law* 8(2001): p. 127: " but with non-somatical suffering special rules apply eg the patient is not entitled to refuse treatment"

[16] John Griffiths, "Self-regulation by the Dutch medical profession of medical behaviour that potentially shortens life," in *Regulating morality*, ed. H. Krabbendam and H.-M. Ten Napel (Antwerp: Maklu, 2000), pp.179-180

[17] Parl.doc, Report Comission of Justice, p. 217. The Chamber Commission on Health unanimously stated that the bill will not include psychiatric patients.

[18] Henk J.J. Leenen and J.K.M. Gevers, *Handboek gezondheidsrecht. Deel 1. Rechten van mensen in de gezondheidszorg* (Houten/Diegem: Bohn Stafleu Van Loghum, 2000), p. 331. As an example they refer to a diabetes patient who for the rest is in a healthy condition
[19] Donald Van Tol, "Physician-assisted suicide: the Brongersma case," *Newsletter MBPSL,* 5(2001): pp. 3-4. On 15 October 2002 the advocate-general to the Dutch Supreme Court concluded that the judgment of the Court of Appeal should be annuled and that the case should be referred to another Court of Appeal; see "A-G: zaak-Brongersma moet aan nieuwe euthanasiewetgeving worden getoetst," *Nederlands Juristenblad* 38(2002): pp. 1921-1922.
[20] John Griffiths, "Important changes in euthanasia law," *Newsletter MBPSL* 4(2001): p. 2
[21] In the beginning of October 2002, Mario Verstraete died after euthanasia; this case was widely mediatized by Belgian and foreign TV stations because Verstraete had more than once claimed to be the first patient dying from euthanasia in Belgium. Verstraete suffered from MS and was not terminally ill. Because the Belgian euthanasia act entered into force on 23 September 2002, the period of one month could not have been respected: a valid request for euthanasia coulc only be expressed from that day onwards. Supporters of the act claimed that if the letter of the act had not been respected, at least the spirit of it was because long before the 23 of September his physicians had had lengthy discussion with him. Legally, this is of course not relevant and because not all the procedures have been respected, the death of Verstraete was a criminal offence. To my knowledge no prosecution has been started. Whether the case has been reported to the Federal Control Committee is not known either.
[22] John Griffiths, Alex Bood and Heleen Weyers, *Euthanasia and Law in the Netherlands* (Amsterdam: Amsterdam University Press,1998), p. 106
[23] Non-reporting was previously in the Netherlands a separate, far more minor offence. See John Griffiths, "Important changes in euthanasia law," *Newsletter MBPSL* 4(2001): p. 2.
[24] John Griffiths, "Self-regulation by the Dutch medical profession of medical behaviour that potentially shortens life," in *Regulating morality*, ed. H. Krabbendam and H.-M. Ten Napel (Antwerp: Maklu, 2000), p. 177.
[25] See in this respect the plea of some members of the Belgian advisory committee on bioethics in the recommendation on euthanasia (see not 1) that "the answer on the question whether a legal regulation of euthanasia is desirable may not be separated from a legal regulation offering guarantees for a competent and independent establishment of death"
[26] Heleen Weyers, "Euthanasia: the process of legal change in the Netherlands. The making of the requirements of careful practice," in *Regulating physician-negotiated death,* ed. A. Klijn, M. Otlowski and M. Trappenburg ('S Gravenhage: Elsevier, 2001), p. 17.