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COMPARATIVE REFLECTIONS ON THE BELGIAN EUTHANASIA ACT 2002

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I. INTRODUCTION

On 28 May 2002, the *Act Concerning Euthanasia* (Euthanasia Act)[1] was passed by the Belgian House of Representatives, the lower house of Parliament. A year before, the Belgian Senate had also approved the Act. On 23 September 2002, the Act came into force. This brought to an end a relatively brief legislative process that had begun in the summer of 1999.[2] That the Euthanasia Act emerged so quickly is all the more noteworthy given that the legislative process was in no way legally pre-structured: there existed no relevant case law and until very recently the public prosecutor's office had not initiated proceedings against anyone. Because of this, it was not known, for example, whether the concept of so-called 'state of necessity',[3] as had been accepted by the Dutch Supreme Court ('Hoge Raad') in the context of euthanasia, would also be applicable in Belgium. This led to a situation where physicians were extremely uncertain of the legal situation, and from this point of view there was need for legislation. However, since 2000, the public prosecutor did begin to investigate cases of possible euthanasia. In January 2000, following

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1 An English translation of this Act can be consulted at www.kuleuven.ac.be/cbmer, and also in the *European Journal of Health Law* (2003) in press. An official version of the Act in French can be consulted at http://www.gbs-vbs.org/legislation/2002009590.htm

2 On this M. Adams, 'Euthanasia: the Process of Legal Change in Belgium: Reflections on the Parliamentary Debate' in A. Klijn, M. Otlowski and M. Trappenburg (eds), *Regulating Physician-Negotiated Death* (Elsevier 2001) at 29–47.

3 The concept of the state of necessity can be invoked by a person who finds himself in a situation of a conflict of duties. If the person chooses to prefer the value that from an objective point of view is more important, even if this means doing something that in itself is forbidden, his conduct is legally justifiable. The two conflicts in case of euthanasia are of course the protection of life on the one hand, and the obligation to relieve the suffering of the patient on the other hand. The concept seems to exist in almost all countries. In the United Kingdom, Glanville Williams has in 1957 already pointed to something similar as being a 'solution' for euthanasia, although he didn't believe it would be accepted by English judges in this context. G. Williams, *The Sanctity of Life and the Criminal Law* (New York 1957) at 322.

reports by nursing personnel, two physicians (a cardiologist and an anaesthetist) in the city of Liège, were arrested on suspicion of administering lethal barbiturates to a man suffering from a long-term chronic lung condition at his own request and in consultation with his family. On 6 February 2003 the Criminal Court of Liège decided not to prosecute both physicians, because under the Euthanasia Act—which then had come into force—their behaviour could not be considered an offence.

All this is in sharp contrast to the situation in the Netherlands where the recent Termination of Life on Request and Assisted Suicide (Review Procedures) Act,[4] which came into force on 1 April 2002, is generally considered to be a summary *codification* of case law concerning euthanasia and assisted suicide. The Dutch case law has evolved over some 25 years along with the profession (physicians), patients' organisations, the public prosecutors' office, advisory bodies, etc.[5] Whereas the law in Belgium is intended primarily to *modify* physicians' behaviour by way of a political process,[6] in the Netherlands this was clearly not the case. One of the consequences of this difference is that in the Netherlands one can appeal to a qualitatively and quantitatively significant amount of case law and legal doctrine when interpreting the legislation. In Belgium, this is not possible. As a result, a great deal of caution must be exercised when interpreting the Belgian Euthanasia Act, which is even more the case since the parliamentary debates sometimes lacked clarity.

It is precisely the lack of case law in Belgium that is one of the reasons why the Belgian Act, unlike the Dutch Act, contains so many detailed provisions. This is not merely an empirical observation. Although non-compliance with the conditions explicitly stipulated in both Acts can lead to criminal proceedings, in the Netherlands many detailed conditions of 'the law' of euthanasia and assisted suicide are not defined in the Act, but are rather concretised in case law or by norms generally accepted by the medical profession. In principle, such conditions have only disciplinary consequences.[7]

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[4] An English translation of this Act can be found in (2002) Med. L. Rev. 68–75.

[5] See on this H. Weyers, 'Euthanasia: the Process of Legal Change in The Netherlands: The Making of Requirements of Careful Practice' in A. Klijn *et al.* (eds), *op.cit.* at 1–27. Also J. Griffiths, A. Bood and H. Weyers, *Euthanasia and Law in the Netherlands* (Amsterdam University Press 1998).

[6] It is not certain whether the Belgian legislature will succeed in this, since the Act seems to lack broad-based support among physicians themselves. A survey ordered by the Belgian *Journal des Médicine: Artsenkrant* (*i.e.* Physicians Journal), showed that only 42 per cent of the physicians polled were willing to perform euthanasia conditionally, and only 15 per cent would perform euthanasia on patients who would not die within a foreseeable period of time. (2001) *Market Analysis & Synthesis* 6–9.

[7] Of course, this does not preclude that case law dealing with the conditions of application explicitly concerned with the meaning of Dutch Act can also have consequences in criminal proceedings.

In this article we attempt two things: first, to compare the respective Belgian and Dutch Acts concerning euthanasia (with a focus on the Belgian Act) and, secondly, to situate the differences between them in a broader (mainly political) context. The latter is of course always important in any study of law. But particularly in the case of the Belgian Euthanasia Act, there would seem to be good reasons to invoke part of its political context, explicating some of the (sometimes surprising) choices that were made by the legislature.

II. THE MATERIAL SCOPE OF APPLICATION

A. Euthanasia

Section 2 of the Belgian Act defines euthanasia as the 'intentional life-terminating action by someone other than the person concerned, at the request of the latter'. The Belgian Consultative Committee on Bioethics had previously proposed this definition in its recommendation of 12 May 1997, regarding 'The desirability of a legal regulation of euthanasia'.[8] This Committee was established in 1993 following years of political wrangling, and only officially began work in 1996. Its mandate is to provide advice and information to society and governmental authorities on problems which arise 'as a result of research and its application in the fields of biology, medicine and health care . . . The ethical, social and legal aspects of these problems are investigated, particularly as regards human rights' (according to section 1 of the committee's founding statutes). The Committee comprises 35 members—physicians, lawyers, ethicists, psychologists and sociologists—who are appointed with a view to linguistic and ideological parity, as is the custom in Belgium. One of the most important features of the Committee's recommendation is that it established for the first time in Belgium a clear, strict and authoritative definition of euthanasia, thus fulfilling a condition *sine qua non* for any meaningful social–political or legal debate about regulating euthanasia. The definition had its origin in a 1985 Dutch state commission on euthanasia, and had already been suggested in 1977 by a leading Dutch health care lawyer, Henk Leenen. Interestingly, the Dutch Act itself contains no definition of euthanasia, nor is the term mentioned in the Act.

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[8] The text of this recommendation can be consulted in Dutch and French at www.health.fgov.be/bioeth/ See for an English translation of this recommendation, H. Nys, 'Advice of the Federal Advisory Committee on Bioethics Concerning Legalisation of Euthanasia' (1997) *European Journal of Health Law* 389–93. On the recommendation itself, see J. Jans, 'Euthanasiegesetzgebung in Belgien: Eine Übersicht über die politisch-ethische Debatte 1997–1999' in A. Bondolfi and S. Grotenfeld (eds), Ethik und Gesetzgebung: Probleme—Lösungsversuche—Konzepte (Verlag W. Kolhammer 2000) at 175–87.

The Dutch Euthanasia Act only refers to termination of life by request, without explicitly defining this concept. However, based simply on the use of the phrase 'termination of life *by request*' and the Dutch Act's application conditions, it is clear that the scope of application of the two Acts is identical, at least in this respect. Moreover, section 293 §1 of the Dutch Criminal Code contains a crime that strongly resembles the Belgian definition of euthanasia: 'A person who terminates the life of another person at that other person's express and earnest request is liable to a term of imprisonment of not more than twelve years or a fine of the fifth category.'

B. Assisted Suicide

The Belgian Euthanasia Act, in contrast to its Dutch counterpart, does not apply to assisted suicide. This is surprising since it is generally accepted that the differences between euthanasia on the one hand and assisted suicide on the other, are ethically irrelevant, or at least minimal. So it would be logical for both types of action to be tied to the same legal standard. Why regulate the 'greater' but not the 'lesser'? Nevertheless, it *seems* that the Belgian legislature made this choice deliberately, in spite of the fact that advice by the Belgian Council of State in respect to the Bill, strongly criticised this choice.

One reason for the exclusion might be that, unlike section 294 of the Dutch Criminal Code, Belgian criminal law does not make suicide a punishable offence. One could then argue that assisting suicide can also not be considered a crime, which would obviate the need for regulation. This line of argument, however, is not entirely convincing. There are some who believe that assisted suicide might indeed be a punishable offence in an indirect way. They invoke section 422 of the Belgian Criminal Code concerning negligence for failing to assist a person in grave danger. The assumption is that a person wishing to commit suicide must be prevented from doing so, since he, or she, is in grave danger. In the absence of any Belgian case law, however, there is no clear way of knowing whether this line of reasoning is sound.

In addition, from the point of view of patient autonomy, assisted suicide is actually preferable to euthanasia. The former offers more safeguards from abuse, since suicide is carried out by the patient him/herself. In any case, respect for patient autonomy is a problem in Flanders since a recent study on medical decisions regarding the end of life, shows that there is a relatively high rate of direct termination of life without an explicit request by the patient. This sort of action occurred almost three times more frequently than euthanasia. Euthanasia is only the tip of the iceberg, constituting 1.1 per cent of the total number of deaths studied, whereas related actions such as assisted suicide and direct termination of life without the patient's request occurred in 0.1 per cent and 3.2 per

cent, respectively, of deaths studied.[9] It seems there is a problem here with freedom of choice and patient autonomy.

In our opinion the most likely explanation for the exclusion of assisted suicide is concerned with the ideological and political context within which the legislative process in Belgium was played out. From the very beginning of the parliamentary process, a hostile atmosphere prevailed between the government and opposition parties. Proponents and opponents of the Bill did not hesitate to portray each other as extremists (conservative or liberal) in the interests of political image formation. In this context, from the very beginning of the debate, the term 'assisted suicide' for a great many members of parliament came to mean literally simply killing someone at their request with no additional conditions. It should be obvious that, in particular the proponents of the Bill, did not want to be accused of supporting something so 'frivolous'. The fact that the distinction between the two Acts lies only in the way the physician goes about his work, was at a certain moment no longer relevant for many of those involved.[10] One of the politicians who intervened on this issue on several occasions in the Belgian Senate noticed this misunderstanding and submitted amendments, but they were all rejected. The time for making choices had passed, and the Bill's approval according to politicians from the political majority would no longer be delayed.

Yet, it is quite possible that in making this distinction between euthanasia and assisted suicide, the Belgian Act is discriminatory in an unconstitutional way. The Belgian constitutional court (the *Arbitragehof*) could accordingly judge this discrimination to be in contravention of sections 10 and 11 of the Belgian constitution, incorporating the principles of non-discrimination and equality respectively. The regular courts might also be able to provide a solution. If a judge is of the opinion that only the letter of the law can be employed in making an interpretation, then a physician who assists a suicide on the same conditions as are applicable for euthanasia, is out of luck: he or she will face criminal charges. However, if the judge applies a more constructive or teleological interpretation of the Belgian Act, seeking inspiration in the Act's preparatory documents, then he or she will quickly discover that there has been a mistake and that the actual intention was not so much to exclude assisted suicide, but rather to exclude totally free euthanasia. In any case, as far as we are concerned, the choice made by the Belgian legislature is not convincing.[11]

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[9] L. Deliens, F. Mortier *et al.*, 'End-Of-Life Decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey' (2000) 356 *The Lancet* 1806–11.

[10] Particularly the Parliamentary Proceedings of the committee discussions in the Belgian Senate is filled with examples of such confusions of language.

[11] Unless the context indicates otherwise, in what follows, we also include assisted suicide when speaking of euthanasia, as far as the Netherlands is concerned.

C. Other End-Of-Life Decisions

Neither the Dutch nor the Belgian Act deals with any other end-of-life decision than euthanasia. This has attracted some criticism: since euthanasia can be camouflaged as pain control, any official supervision of euthanasia is impossible as long as not all end-of-life decisions and actions are regulated.[12] The question is whether such broad supervision is viable in practice, since it would possibly lead to an unmanageable bureaucracy that defeats its purpose. The best way of remedying this would seem to be by guaranteeing patient autonomy through the enactment of legislation on patients' rights.[13]

III. THE PERSONAL SCOPE OF APPLICATION

A. The Physician

According to sections 3 §1 and 4 §2 of the Belgian Act, the physician who performs euthanasia commits no offence when he or she complies with the norms and procedures stipulated in the Act. In the Netherlands, the situation is somewhat different. Section 293 §1 of the Dutch Criminal Code (as amended by section 20 of the Dutch Euthanasia Act), states that ending someone's life at their request remains a criminal offence, but that the physician who respects the criteria laid down in section 2 of the Dutch Euthanasia Act and who reports the death to the municipal coroner in accordance with section 7, second § of the so-called Cremation and Burials Act, may legitimately rely on section 293 §2 of the Dutch Criminal Code. This means that the crime continues to exist, but the physician is not punishable. The result, technically speaking, is that there is in the Netherlands no decriminalisation of euthanasia. As far as the burden of proof is concerned, it makes no difference whether the Belgian or Dutch approach is taken: both in the Netherlands and in Belgium, the public prosecutor bears the burden of proving that, in cases such as this, a criminal offence is committed.

In both Belgium and the Netherlands, only a *physician* can legitimately perform euthanasia. In Belgium, no further requirements are imposed on the physician's competence: the physician performing euthanasia does not have to be the attending physician, nor is any special expertise required, for instance, in palliative care. The latter is not required in the Netherlands either. However, in the Netherlands it is generally accepted that the physician who performs euthanasia should

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[12] See on this extensively, J. Griffiths *et al.*, *op.cit.* at 259–98.

[13] Such an Act recently came into force in Belgium, *i.e.* the Act of 22 August 2002 Concerning the Rights of the Patient.

in principle be the attending physician.[14] In fact, in 70 per cent of cases it is the patient's general practitioner.[15] In this context, Griffiths makes reference to the so-called 'travelling euthanasia doctors'—responsible for a slight fuss in 1994—who became involved with euthanasia via the Dutch Society of Voluntary Euthanasia in cases where the patient's own doctor refused to perform it.[16] Given the fact that, on the one hand, a significant number of Belgian physicians appear not to support the Euthanasia Act[17] and, on the other hand, the capacity of the attending physician is not explicitly required, one can expect that Belgian euthanasia practice is more 'vulnerable' to such 'travelling euthanasia doctors'. Perhaps the 'attending physician' requirement can be derived implicitly from section 3 of the Belgian Act, where it is stipulated that the physician must have a number of conversations with the patient, spread over a reasonable period of time, in order to be certain of the durability of the euthanasia request. In addition, a balanced assessment of the legal requirements demands some familiarity with the patient and his or her symptoms. Against this, however, one can read in the parliamentary documents that a patient should be able to exclude completely his attending physician from the decision-making process. The situation is not, therefore, altogether clear.

It is noteworthy that the Belgian Act, unlike the Dutch Act, does not specify which offence is committed by the physician when he or she fails to comply with the norms and procedures established by the Act. This is all the more striking since the Belgian Act—once again unlike section 293 of the Dutch Criminal Code—has never recognised euthanasia as a separate offence.

The question thus arises: what offence does the physician in Belgium actually commit when not legitimately committing euthanasia? Is it manslaughter,[18] murder[19] or poisoning[20]? This uncertainty is only exasperated by the fact that, until recently, no prosecutions for euthanasia had taken place and there exists no case law on the matter.

The reason for this state of affairs probably has to do with the fact

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[14] Griffiths points out that no specific source *in law* can be found for this generally accepted principle. J. Griffiths *et al.*, *op.cit.* at 103, n. 41. It is, however, a generally accepted guideline of good practice, as found in many reports and documents drafted by advisory bodies and physicians' organisations.

[15] H.J.J. Leenen, 'The Development of Euthanasia in the Netherlands' (2002) *European Journal of Health Law* 128.

[16] J. Griffiths *et al.*, *op.cit.* at 103, n. 41. With the necessary reservations, this practice is nevertheless considered acceptable by some Dutch district courts.

[17] See n. 6, *supra*.

[18] Section 292 Criminal Code.

[19] Section 394 Criminal Code.

[20] *Ibid.*

that the (conditional) decriminalisation of euthanasia in Belgium was not implemented through the Criminal Code but by means of a separate Act, thereby leaving the Criminal Code unaltered. This choice, however, was made only after the legislative process had been underway for some time in parliament. Changing the situation would have meant a considerable delay, which was politically not acceptable to the majority parties in parliament. In any case, with the construction ultimately chosen—namely no alteration to the Criminal Code but the introduction of a separate Act on the matter—it is emphasised by the legislature that the protection of life is and remains a matter of principle, and that killing by request is not a 'normal' affair. But whatever the reason may have been for this choice, unfortunately the question of what provision of the Criminal Code is violated when the conditions of performing euthanasia are not met was left open. In our opinion, this omission represents an infringement of the principle of legality in criminal law.

Continuing along these lines, the Belgian Euthanasia Act also makes no distinction between criminalisation in cases of serious or less serious infringements of the Act. Thus, even bearing in mind the possibility of invoking mitigating circumstances, ignoring a merely formal requirement, such as for example not completing the necessary documents in the proper way, might lead to a sanction being imposed which can scarcely be said to stand in a reasonable proportion to the facts. In this sense, proportionality is lost.

An interesting issue concerns the question regarding the conclusion to be drawn from the fact that only a physician may perform euthanasia. Among healthcare lawyers in the Netherlands, the majority seem to be of the opinion that euthanasia is nevertheless not a 'standard medical act', but a socially regulated act in which physicians happen to be involved. Indeed, if euthanasia were a standard medical act, then refusing to answer a patients' request when the legal requirements are met, would be in conflict with the physician's professional duty.[18] There is more discussion surrounding this in Belgium. Some believe that it is indeed a standard medical act, and the fact that a *physician* must perform euthanasia is cited as proof of this. This argument is unpersuasive: the fact that euthanasia must be performed by a physician does indeed mean that we are dealing with an act carried out by a medical professional, but that does not yet make it a *standard* medical act. Moreover, if it were

[21] In the Netherlands, this debate took place primarily in the context of the question whether the so-called 'medical exception' should be applicable in the case of euthanasia. The concept of the 'medical exception' means that although the Criminal Code does not contain exceptions for medical behaviour, it is nevertheless not criminal as long as it is being done within the margins of normal medical acts. The Dutch Supreme Court rejected the request for the medical exception to be applicable to euthanasia. See its judgment of 21 October 1986, *Nederlandse Jurisprudentie* [1987] nr. 607.

indeed a standard medical act, then the requirement that a physician must perform euthanasia would be superfluous, since in Belgium this requirement would follow anyway from legislation regulating the activities of healthcare professionals. In any event, based on section 14 of the Belgian Euthanasia Act, the physician is not required to consent to a patient's request for euthanasia, which means that there does not exist something like a (subjective) right to euthanasia. Once again, the key to understanding this issue lies in the political context, and ultimately involves specifically the question of whether Catholic hospitals may prohibit physicians working within their walls from performing euthanasia. The answer to this is not merely academic, since about 80 per cent of the hospitals in Flanders are associated with Catholic organisations.

Contrary to what is the case in the Netherlands, in Belgium there is no legal requirement that the physician use 'due medical care' when performing euthanasia.[22] Though there was debate on this point in Parliament, the governing parties considered the requirement to be superfluous since a physician is always required to exercise due medical care. Whether this was an accurate assessment is open to question. In any case, it is apparent from Dutch disciplinary case law that a duty of due medical care in cases of euthanasia imposes a number of specific requirements. For instance, the Medical Disciplinary College of Amsterdam decided on 11 April 1994 that a physician must remain with the patient until such a time as death has been established, or else that he must be available at very short notice in order to intervene if needed. In addition, the physician must administer the necessary lethal medication in the correct dosage, which is perhaps one of the most important aspects of the due care requirement for euthanasia.

Finally, the physician in Belgium does not have to consent to a euthanasia request; he may refuse to perform euthanasia on grounds of conscience or for medical reasons.[23] In such a case, however, he must inform the patient or any person representing the patient (see below), within a reasonable time and explain the reasons for refusal. If the physician's refusal is based on medical grounds, then it must be noted in the patient's medical record. Moreover, at the request of the patient or representative, the physician who refuses to fulfil a request for euthanasia must hand over the patient's medical record to the physician appointed by the patient or the representative. Indeed, the physician may also make his willingness to consent to a request for euthanasia subject to additional conditions, as is provided by sections 3 §2 and 4 §2. The physician in the Netherlands may also refuse to fulfil a request for euthanasia. The Dutch

[22] Section 2 §1(e) of the Dutch Act.
[23] Section 14 of the Belgian Act.

parliamentary proceedings—though not the Dutch Act itself—establish that in such a case a duty exists to refer the patient to another physician.

B. The Patient

The Belgian Act requires that to make a legitimate request for euthanasia an individual must have attained the age of majority (18 or older). In general, minors are excluded from the Belgian Euthanasia Act, which results from the fact that the subject was so controversial that including it would have threatened overall approval of the Act. From this perspective, the Dutch Act is completely different, as can be seen from sections 2, §3 and 4 of the Act. If a minor aged between 16 and 18 is deemed to have a reasonable understanding of his own interests in the matter, then he can submit a legitimate request for euthanasia if, at least, the parent(s) (or the legal guardian) who exercise authority over the minor are included in the decision process. Moreover, if a minor patient aged between 12 and 16 is deemed to have a reasonable understanding of his own interests in the matter, then the physician may consent to the minor patient's request if the parent(s) (or guardian) who exercise authority over the minor are able to reconcile themselves with the request.

IV. THE PATIENT'S REQUEST

An important aspect of both Acts has to do with the patient's request. The Belgian Act draws a distinction between a request in the strict sense (section 3) and a request by means of an advance directive (section 4). The Dutch Act also makes this distinction, but as far as the latter is concerned refers to a 'written declaration'. To facilitate comparison, we will refer to the former type of request as the 'current request' and to the latter as the 'advance directive'.

A. The Current Request

The Belgian Act regulates in detail the formal and material requirements for a current request. Pursuant to section 3 §1, such a request must be 'voluntary', 'considered' and 'repeated'; moreover, it must not be the result of any external pressure. Section 3 §1, 2 further stipulates that the physician must verify that the request is 'durable', ascertaining this by means of several discussions. Note that the Act does not say the request must be *well informed*, though this is perhaps entailed by the requirement that it be 'considered': a request can only be considered when the patient has arrived at the request after weighing up all the elements, including all medical and other information. In principle, the request must also be written by the patient himself, which means drafted, dated and signed by the patient (section 3 §4), and retained in the patient's

medical record (section 3 §5). If the patient is incapable of writing down the request, as a result of a disability for example, then it is to be written down by an adult person who has been chosen by the patient and who has no material interest in the patient's death such as a relative of the patient. This person must record the fact that the patient is not able to formulate the request in writing, and refers to the reasons why. In this case, the drafting of the request must take place in the presence of the physician, and the person must record the name of the physician in the document (these two people do not need to sign the document themselves). The document must be appended to the medical record. The patient may revoke the request at any time, which results in the document being removed from the medical record and returned to the patient (section 3 §4, final sentence).

The Dutch Act, by contrast, speaks only of a 'voluntary and well-considered' request (section 2(1)(a)), with no further formal requirements. In section 293 of the Dutch Criminal Code it is also stated that the request should be 'explicit and serious'. Compared to the Belgian Act, these are rather concise formulations. However, if we examine the due care criteria as they have been established primarily in some authoritative reports on euthanasia as written by advisory bodies and health care organisations, then Dutch euthanasia practice turns out to accept more onerous requirements than the Act would suggest. For instance, the request must in principle be expressed by the requesting party himself; it must be independent, in other words not resulting from any external pressure; it must be well-considered, which means well-informed, following consultations and based on a durable wish for the end of life (which can be demonstrated by the request having been repeated several times over a certain period of time). This latter criterion was expressly omitted as a criterion in the Dutch Act because it was thought that it might cause problems in situations of acute emergency. Finally, the request should preferably be drafted in writing or registered in some other way.

B. The Advance Directive

Section 4 §1 of the Belgian Act regulates in detail the formal requirements imposed on an advance directive in cases where a patient is no longer able to express his will. Interestingly, the material requirements imposed when it is a *current request*, no longer apply here.

The advance directive may be drafted at any time. It must be set down in writing in the presence of two adult witnesses, at least one of whom has no material interest in the patient's death, and it must be dated and signed by the patient making the request, by the witnesses and by the patient's representative, if any. In the advance directive, one or more representatives may be appointed, in order of preference, who will

inform the attending physician of the patient's wishes. In the event of refusal, hindrance, incapacity or death, each representative will be replaced by the person indicated in the advance directive. The patient's attending physician, the physician consulted (see below) and the members of the nursing team are prohibited from acting as persons taken in confidence. The advance directive may be modified or revoked at any time. Delegated legislation, which at the time of writing still has to be issued, determines the way in which the advance directive is best to be drafted, registered, reconfirmed or revoked and, through the office of the Central State Registry, how it is to be communicated to the physicians involved. There is, however, no requirement to utilise the form in the way that will be provided for in that legislation. As a consequence, other forms of advance directive may also be legally valid.

If the patient who wishes to draft an advance directive is permanently physically incapable of doing so, he may appoint an adult who has no material interest in his death to write down his request, in the presence of two adult witnesses, at least one of whom must have no material interest in the patient's death. The advance directive must note that the patient in question is incapable of signing and refers to the reasons why. The advance directive must be dated and signed by the person who writes it down, by the witnesses and by the representatives, if any. A medical certificate must be appended to the advance directive as proof that the patient is permanently physically incapable of writing and signing the advance directive.

The Belgian legislature's objective of limiting the validity of the advance directive to five years following its drafting or confirmation cannot be attained with the Euthanasia Act in its current form, since the third last paragraph of section 4 §1 states: an advance directive is only valid 'if it has been drafted or confirmed less than five years before the moment at which the person in question can no longer express his wishes'. Consider a case where someone drafted such an advance directive on 1 January 1995. On 1 January 2003 the advance directive is then presented to a physician. How can this physician possibly know how long the person in question has been unable to express his wishes? It might be since 1996, but it might also be since 2002. In the former case, the advance directive would be valid since only one year had elapsed between drafting the advance directive and the moment of incapacity; in the latter case, the advance directive would be invalid. This problem could easily have been avoided by correctly formulating the Euthanasia Bill. In determining the advance directive's validity, what is crucial is not the moment at which a patient can no longer express their wishes, but rather the moment at which the advance directive's execution is requested. If more than five years has elapsed between drafting or confirming the advance directive and the moment at which its execution

is requested, it should no longer be considered valid. That would have been an objective, easily verifiable moment. One of the authors of this article (H. Nys) drew attention to this problem during hearings on the Bill at the Belgian House of Representatives on 27 February 2002. The parliamentary representatives were aware of the problem but did not want to modify the text of the Bill, since this would have had constitutional consequences: had there been the slightest alteration to the text, then the Belgian Senate would have had to vote yet again on the modified version of the text. That would have cost too much time, and the government parties did not, for political reasons, want this to occur.

Section 2(2) of the Dutch Act stipulates that in cases of an advance directive, the due care criteria of section 2(1) apply, which means that the patient must have been capable of making a voluntary, well-considered request at the time the advance directive was drafted. As we have just seen, no further legal requirements are imposed on an advance directive in Belgium. The law does not demand that there must be a voluntary, well-considered and repeated request, not resulting from external pressure, as is the case with a current request. This is a significant difference between the Belgian and Dutch legislation. The Dutch Act does not require the advance directive to have any specific formal qualities, apart from being drafted in writing. In any case, euthanasia as a consequence of an advance directive occurs very rarely in the Netherlands, and one reason for this is that before the Act was passed there were already doubts regarding the legal validity in general of such an instrument.[24] This might also explain why very few due care criteria on this issue are to be found in case law and authoritative reports. Even now that there is legislation allowing the use of an advanced directive, few expect that it will frequently be used.

V. THE PATIENT'S SITUATION

Another material requirement deals with the patient's state of health. Once again, we will distinguish between the two situations outlined in the preceding section, namely the situation where the patient submits a current request, and the situation where a request is made by means of an advance directive.

A. In Case of a Current Request

In section 3 §1 the Belgian Act stipulates that the physician must be certain that the patient who submits a current request is in a 'medically

[24] J. Griffiths and A. Klijn, 'Can Doctors' Hands Be Bound? Advance Directives Under Current Dutch Law' (1999) accessible at: www.rechten.rug.nl/mbpsl/milaanpa.htm.

hopeless situation' characterised by 'persistent and unbearable physical or mental suffering which cannot be alleviated and which results from a serious and incurable condition caused by accident or illness'. This definition has provoked copious and confused debates in Parliament.

One can distinguish a more objective and a more subjective element in this. The more objective element has to do with the *serious* and *incurable* nature of the condition caused by an accident or illness. We may assume that, in general, physicians possess the knowledge and expertise to decide about a condition's seriousness and incurability. The Belgian Act makes no distinction between conditions of a physical or a mental nature or origin. Terminal illness is therefore not required by the Belgian Act, nor is it a requirement that has ever been imposed by Dutch case law or the recent Dutch Act. Be that as it may, one of the arguments invoked during the Belgian legislative process for not imposing the requirement of terminal illness, is that it is impossible to define what exactly constitutes a terminal patient. This is, in our opinion, less than convincing: physicians are quite capable of determining what the average life expectancy will be of someone who is in the situation of a patient who submits a euthanasia request. That there can be no absolute certainty and that some patients will in fact live more or less longer than expected, does nothing to diminish this fact. Ultimately, then, this is a matter of reaching an agreement about what terminal means: is it three months, three weeks or three days?

Returning to the issue of a 'medically hopeless situation' characterised by 'persistent and unbearable physical or mental suffering which cannot be alleviated and which results from a serious and incurable condition caused by accident or illness'. Does, for instance, a person suffering from cancer who can be treated temporarily with intensive chemotherapy and thereby living one or two years longer fall within the Act? Maybe not, at least not on the face of it. However, the link with the fact that a medically hopeless situation can involve a purely subjective element—namely whether or not the illness can be alleviated—would seem, in Belgium at least, to render such an interpretation unimportant.

This is a consequence of two interpretative points. First, of the fact that it is the patient, and the patient alone, who determines whether he is suffering from persistent and unbearable physical or mental suffering. The physician's task is simply to be certain that *the patient* finds *himself* in such a situation. If the patient says that this is the case, then the physician can do little else but acknowledge it. There is nothing in the Act about the physician's interpretation or understanding of the concrete symptoms from which the patient is suffering nor about experience with pain and suffering of patients in comparable situations.

Secondly, the Belgian Act does not require a patient to undergo alternative treatment before the physician may agree to a euthanasia request.

Indeed, section 3 §2, 1 stipulates only that the physician must *discuss* with the patient 'his request for euthanasia and any remaining therapeutic options, including that of palliative care . . . '. In our opinion, one *might* conclude from this combination of facts that the patient—for instance the cancer patient mentioned earlier—may refuse a treatment, whereby the patient ends up in a medically hopeless situation. As a consequence, the physician may legitimately agree to such a patient's euthanasia request. The sole objective requirement of the Act—of a serious and incurable condition caused by accident or illness—can as a result perhaps be subjectively fulfilled to a significant or even crucial degree.

Yet at the same time, it may also be the case that the general legal principles of subsidiarity and proportionality apply, despite the suggestion created by the text of the Act. Consenting to a request from a patient for whom there still exists a genuine treatment alternative could then constitute a non-subsidiary or disproportionate action on the part of the physician, since other treatment possibilities would still be open.

Unfortunately, the Belgian Act is not entirely clear on this. In any event, if the 'liberal' interpretation of the Belgian Act is correct, then there is a significant difference with the Dutch Act—or rather with Dutch law. Again, the Dutch Act is much more concise in this regard. In section 2 §1(b), it stipulates that the physician must come to the belief that the patient is suffering hopelessly and unbearably, and that, in addition, *together with the patient*, he must believe that there is no other reasonable solution to the situation in which the patient finds himself. So it is the physician, together with the patient, who must arrive at the belief that there is no other solution for the situation of the patient.

All this is accepted in the Dutch case law,[25] where it is stated that the requirement of 'hopelessness' constitutes an objective element, or at least that its assessment lies with the physician(s) alone. The same is also true, in part, for the requirement of 'unbearability'. As we just saw, this requirement is also not determined by the patient alone. So whereas the requirement of 'unbearability' in the Netherlands constitutes, at least in part, an objective element—it is a matter of medical irreversibility or hopelessness, depending on the professional opinion of a physician—in Belgium it seems that it is conceived as a wholly subjective element.

The Dutch 1994 *Chabot* case provides an illustration of the possible significance of this difference between the law in the Netherlands and Belgium. *Chabot* involved a woman who said she suffered 'hopelessly'

[25] See in particular the 1984 *Schoonheim* decision by the Dutch Supreme Court, *Nederlandse Jurisprudentie* [1985] nr. 106.

and 'unbearably' as a result of psychiatric problems. Although in its judgment the Dutch Supreme Court agreed that, in principle, a psychiatric disorder can be a legitimate reason for assisted suicide, it also stated that:

> In assessing whether there is unbearable and hopeless suffering, such that providing assistance with suicide would be regarded as a justified choice in an emergency situation, it is important to bear in mind that *there can in principle be no question of hopelessness if a real alternative for alleviating that suffering has been freely refused by the person concerned*. (emphasis added)[26]

Shortly after this ruling, the District Court of Haarlem followed the Supreme Court and pronounced judgment in the case of a man who, as a result of three strokes, was disabled on one side and who could not accept being a permanent invalid as a result. The judge ruled that one could not speak of hopeless suffering if a genuine alternative—psychiatric help in this case—for alleviating such suffering had been freely rejected by the patient. In other words, the physician was at fault for having too easily accepted the patient's refusal to explore other alternatives.

In both cases, the judges invoked the principle of subsidiarity (on which the concept of 'hopelessness' depends), and commentators seem to be unanimous in that assisted suicide cannot be justified in the case of a patient who refuses a medically meaningful treatment.[27] Here we are confronted with a possible significant difference between the Belgian Act and Dutch law, a difference that results, provided that the liberal interpretation of the Belgian Act is correct, in the Belgian Act being the more liberal of the two, at least as far as this aspect is concerned.

It should also be noted that assisted suicide, as we saw earlier, does not fall within the Belgian Act. However, all Dutch case law regarding psychiatric patients concerns assisted suicide. This raises questions about comparability, since it leads to the paradoxical situation where euthanasia is applicable to psychiatric patients in Belgium, but assisted suicide is not. The chairman of the Commission of Justice in the Belgian House of Representatives—one of the commissions in which the euthanasia Bill was debated—concluded that euthanasia can never be an option in respect of a psychiatric patient, since mental suffering is irreconcilable with a voluntary and well-considered expression of one's

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[26] Though the *Chabot* judgment pertains to assisted suicide with psychiatric patients, the ruling also applies to patients with purely physical complaints.

[27] J. Gevers and J. Legemaate, 'Physician Assisted Suicide in Psychiatry: An Analysis of Case Law and Professional Options' in D.C. Thomasma *et al.* (eds), *Asking to Die: Inside the Dutch Debate About Euthanasia* (Kluwer Academic 1997) at 77 and 85.

wishes.[28] This opinion is not just in opposition to the Dutch Supreme Court in the *Chabot* case, but more particularly it seems to run counter to any meaningful interpretation of the words (and the intention) of the Belgian Euthanasia Act. In any event, it remains to be seen what the attitude of medical practitioners will be. In view of the Belgian physicians' conservative stance toward the Euthanasia Act, one should not expect any major changes in practice. What remains, in any case, is an absence of legal certainty.

Finally, as we have seen, the text of the Belgian Act explicitly speaks of medical 'hopelessness' as a consequence of 'a serious and incurable condition caused by *accident or illness*' (emphasis added). This means that the legislator apparently wanted to exclude so-called *Brongersma* situations from the Act's applicability. In its judgment of December 2002 the Dutch Supreme Court found, in the *Brongersma* case, that a request for assisted suicide or euthanasia should always be the result of a somatic illness. So although a person's request for assisted suicide or euthanasia can indeed result from a 'hopeless' and 'unbearable' situation, if he is not suffering from a psychiatric or physical *illness* (*i.e.* when there is no direct somatic cause for the wish to die) a physician cannot legitimately answer the request. Of course, the question then remains whether it is possible to clearly define the concept of 'illness' so as to utilise it in practice. This may not be possible, primarily due to the fact that it is usually not clear when a request to die is the result of someone merely being tired of living, or when such a request is also the result of a physical or mental condition. Most physicians seem to agree that in fact some reason can always be found on the basis of which a euthanasia request can be (partly) reduced to a somatic (physical or mental) cause. It could very well be, then, that the requirement contained in the Belgian Act is practically irrelevant.

B. In Case of an Advance Directive

The Belgian Act contains special requirements regarding the patient's state of health when he is no longer conscious where an advance directive exists. Section 4 §1 stipulates that such a patient must be suffering from a serious, incurable condition caused by accident or illness and, moreover, that the state of unconsciousness must be irreversible according to the current state of science. The requirement of unbearable suffering is no longer imposed, since the legislature assumed that such patients are no longer capable of suffering. Had this requirement been imposed,

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[28] Incidentally, the Belgian House of Representatives' Committee on Public Health, which fulfilled an advisory role for the House Committee on Justice in this matter, unanimously recommended that mental suffering alone should never be able to legitimate euthanasia. None of the opinions of the Committee on Public Health was followed.

the fear was that euthanasia in cases of irreversibly unconscious patients would have been impossible. In spite of the Act leaving little room for interpretation as far as this aspect is concerned, most members of Parliament assumed that only patients in a so-called persistent vegetative state (PVS) would meet this criterion. Quite a lot of discussion nevertheless took place on this point in the Belgian Parliament. One of the members of Parliament who had submitted the legislative Bill—the leader of the Dutch-speaking liberal party in the Senate—was of the opinion that, as far as she was concerned, the Act should apply mainly to comatose patients, which is broader than an 'irreversibly unconscious' patient. This gave rise to questions about the applicability of the Act to older people with dementia for instance: are they in irreversibly unconscious situations since they no longer possess any real powers of awareness? While most members of Parliament believed that this ought not be the case, no definitive answer was ever given on this point. As a result, there exists a lack of clarity on this issue.

The Dutch Act, by contrast, states in section 2 §2 that an advance directive can be applied when the patient 'is no longer capable of expressing his wishes'. This requirement is clearly broader than the requirement of the Belgian Act (there is no mention of irreversible unconsciousness). The Act places no special requirements on the patient in cases of an advance directive, but only states, also in section 2 §2, that the 'requirements of due care referred to in the first paragraph apply *mutatis mutandis*'. In view of what has just been said, we might ask ourselves what this could mean with respect to the requirement of unbearable suffering? Can, for example, someone who is unconscious suffer unbearably? Because of this, commentators have raised doubts about the feasibility of this provision in practice.

VI. DUTIES OF THE PHYSICIAN WITH RESPECT TO THE PATIENT'S REQUEST

A. In Case of a Current Request

The Belgian Act goes into great detail as far as this aspect is concerned. In section 3 §1 and §2, the Act stipulates that the physician who performs euthanasia does not commit a crime when he has made certain that the patient's situation is in accordance with the conditions laid down in the Act. In addition, section 3 §2 stipulates that the physician must in every case inform the patient beforehand about his state of health and his life expectancy, discuss with the patient his request for euthanasia, and discuss any remaining therapeutic options including those offered by palliative care, as well as their consequences. He must consult another physician regarding the serious and incurable nature of the condition, and inform him of the reason for such a consultation. The

recommendation of the physician who is consulted is not binding, but such a consultation can of course be authoritative or even incriminating in the event of any later disputes. The physician consulted must be independent both of the patient and of the attending physician, and must be 'competent' to assess the condition in question.[29] He has to inspect the medical record, examine the patient and must make certain of the persistent and unbearable physical or mental suffering that cannot be alleviated. He also has to make a report on his findings. The attending physician must moreover inform the patient of the results of this consultation. In addition, if there is a nursing team in regular contact with the patient, then the patient's request must be discussed with that team as well. Finally, should the patient so desire, the request must also be discussed with family or friends named by the patient. Of course, only the views of the patient himself are decisive; the opinions of the family and friends consulted are not definitive for the legitimacy of the act of euthanasia. Yet this does not preclude the physician from being influenced by the opinions of family and friends in deciding not to agree to a euthanasia request.

In the event that the attending physician believes the patient is not going to die within a foreseeable period of time, there are a number of additional requirements that he must fulfil. In the first place, section 3 §3 stipulates that he must consult a *second* physician, who is a psychiatrist or a specialist in the condition in question and inform him of the reason for such a consultation. This second physician must also inspect the medical record, examine the patient and must make certain of the persistent and unbearable physical or mental suffering which cannot be alleviated, as well as the voluntary, well-considered and repeated nature of the request. This physician must also report on his findings and he must be independent of the patient, of the attending physician and of the first physician consulted. In this case as well, the attending physician is obliged to inform the patient of the results of this consultation. Moreover, in the case of a non-terminally ill patient, at least one month must elapse between the patient's written request and the act of euthanasia.

A general requirement established by section 3 §5 is that all requests formulated by the patient, and all actions performed by the attending physician and their results, including the report(s) of the other physician(s) consulted, must regularly be noted in the patient's medical record.

By comparison, the Dutch Act is very brief. Section 2(1)(a–d) stipulates that the physician must be convinced that there was a voluntary

[29] In principle, every physician is *legally* competent, but the term is also used here in the sense of *professionally* competent. The French version of the Belgian Act uses the term 'compétent', which encompasses both meanings.

and well-considered request by the patient, that there was hopeless and unbearable suffering on the part of the patient, he must have informed the patient about the situation and about his prospects, and must have come to the conclusion, with the patient, that for the particular situation there was no other reasonable solution. Subsection (e) of the same section stipulates that the physician must consult at least one other independent physician who must see the patient and makes a written assessment of the due care requirements indicated in subsections (a) through (d). All these requirements must however be supplemented with the requirements of good medical practice as established by reports and documents from medical and other organisations. Thus, the physician should discuss the matter with the patient's direct family and friends (unless the patient does not desire this, or there exist other good reasons for not doing so), and with the nursing personnel who are in direct contact with the requesting patient.[30] The physician must also maintain a complete medical record that includes details about how he has complied with the legal requirements.

In general, it seems to be a reasonable conclusion that the differences between the Belgian and Dutch Acts regarding this point are, from a material point of view, minor. The important difference lies in the additional requirements imposed by the Belgian Act in the case of a non-terminally ill patient. From a more formal point of view, on the other hand, the differences are indeed of some importance. In the introduction we noted that, in principle, only the legislative requirements are relevant as far as criminal law in the Netherlands is concerned. All additional criteria are primarily, though not exclusively, of importance in disciplinary proceedings. In the Belgian Act, the legislative criteria are, of course, all potentially relevant in criminal proceedings, but these legislative criteria are extremely detailed, unlike the terms of the Dutch Act. One possible explanation for this difference is that Belgian medical disciplinary law differs markedly from its Dutch counterpart. In Belgium the aim is primarily to maintain the honour and dignity of the profession. In practice this means that the disciplinary judge generally does not hear cases, as in the Netherlands, dealing with the professional behaviour of physicians towards their patients, but is more active in the area of behaviour *among* colleagues. Another explanation might be that in Belgium the political debate on euthanasia was not legally pre-structured: there existed no precedents on this issue (as in the Netherlands), and the parliamentary debates had to start from zero. Consequently, the complete results of the debates can be found in the Act, since it is the Act, and the Act only, that provides legal norms. In the Netherlands the case law on this issue is still relevant. Finally, there is also the possibility that the

[30] J. Griffiths *et al*., *op.cit*. at 106.

Belgian legislature did not have a great deal of confidence in the willingness of the Belgian Order of Physicians—which is the main association of physicians in Belgium, and an organisation comparable to the General Medical Council in the United Kingdom—to support the practice of euthanasia in a constructive manner. As far as this is concerned, in the Netherlands, the Royal Dutch Medical Association was in the 1970s and 1980s quick to propagate physicians' openness to euthanasia, which meant that the judiciary was given the opportunity to play a more formative role in the process of creating case law. The Belgian Order of Physicians has however not shown much willingness to influence the political legislative process. The Order was of the opinion that it would be better if the euthanasia question were left entirely up to the profession itself. In the spring of 2000, during the hearings on the Euthanasia Act in the Belgian Senate, the Order's vice-president stated that:

> the National Council [of the Order of Physicians] does not wish to pass judgment either for or against any legislative initiatives in this matter. (. . .) Nevertheless, a pressing question in our minds is whether a legislative initiative will bring us greater legal certainty. Of course it will, some say, because everything will be established in an Act. We, the physicians and lawyers of the National Council, are however not so certain that legal certainty will thereby be assured. (. . .) There is also the question of whether the doctor–patient relationship, to which we attach supreme importance, will not be undermined by the new connotation introduced of the doctor as a bringer of death. As physicians, we feel very uncomfortable in such a role, perhaps because we are not yet used to such a role, but that does nothing to diminish our unease.

In short, whereas the Royal Dutch Medical Association—together with the judiciary—played quite an important role in the Dutch legislative process, the same can certainly not be said of the Belgian Order of Physicians. The Belgian Order has not been advocating for legislation, to say the least, and adopted an attitude of reticence.

B. In Case of an Advance Directive

Due to the fact that the Belgian Act, as we saw above, contains specific provisions in cases where the request is formulated by means of an advance directive, there are also specific provisions with respect to the physician. Broadly speaking, they are the same requirements that are imposed on the physician when confronted with a conscious patient who requests euthanasia.

VII. THE REPORTING PROCEDURE

How can one encourage physicians to subject the practice of euthanasia to external supervision and control? This is the task inevitably facing any government that comes to the conclusion that traditional means of protecting life via a strict criminal prohibition of euthanasia does not in fact fulfil what it promises. Therefore, moving on from legislation regulating euthanasia, commissions have been created in the Netherlands and Belgium whose task it is to supervise the Euthanasia Act. In a sense, these commissions assume the role of what should normally be done by the public prosecutor. As a result, what had previously been an exclusively criminal assessment has been modified to become a more professionally and socially oriented assessment, with the criminal law more in the background. The aim of this is to encourage physicians—who are understandably wary of the criminal justice system—to report their actions. This will yield better insight into the actual practice of euthanasia, thus leading to better social control and hopefully improvements in the practice.

Therefore, section 5 of the Belgian Act stipulates that a physician who has performed euthanasia must complete a registration document[31] and submit it within four working days after the euthanasia had been performed to the 'Federal Control and Evaluation Commission' established by the Act. By virtue of section 8 of the Act, the commission must study the completed registration document, which consists of a non-anonymous and an anonymous part, and determine on the basis of the anonymous section of the registration document whether or not the euthanasia was performed in accordance with the conditions and procedures provided for in the Act. The commission—which is composed of 16 members (eight physicians, four lawyers and four members 'from groups charged with the problem of incurably ill patients')—can, in cases of doubt, decide by simple majority to suspend anonymity. The commission must then inspect the non-anonymous section of the registration document. The commission may request from the attending physician any part of the patient's medical record that concerns the euthanasia. During the parliamentary debates, however, it became apparent that the physician might refuse to provide such information on the basis of professional confidentiality, though of course the physician would then be regarded with suspicion. This point raises the question of the extent of the *nemo tenetur* principle. Although it is not clear how far the right not to incriminate oneself extends—does it also apply to a *potential* suspect such as a physician who performs euthanasia?—this

[31] The document can be accessed in French at www.health.fgov.be/AGP/fr/euthanasie/index.htm

construction creates some tension with the *nemo tenetur* principle. The commission must pronounce judgment on the matter within two months. If the commission holds, in a decision which may be taken by a two-thirds majority, that the conditions provided for in the Act, have not been fulfilled, then it must refer the dossier to the public prosecutor of the jurisdiction in which the patient died.

The Dutch Act established so-called regional assessment commissions, of which five are currently functioning. They were set up in 1998 and comprise three members each (and three substitutes): a physician, an expert in ethical questions, and a lawyer—the latter acting as chair. If euthanasia is performed, the physician in question submits a report to the assessment commission in his region. This commission is tasked with assessing compliance with the due care requirements as provided in the Dutch Act. The commission's judgment, taken by simple majority vote, must be communicated to the physician within six weeks. Either the commission or the physician may request that the judgment to be clarified. In the event of a negative judgment, the commission must notify the public prosecutor as well as the regional health inspectorate.

There are a number of striking similarities between the Belgian and Dutch Acts here. For instance, in both systems reporting is a necessary condition for legitimacy, and only suspicious cases are referred to the public prosecutor. In both systems, the reporting commissions function as a kind of buffer between physician and prosecutor, based on the idea that a physician does not want to be dealt with in an atmosphere of criminality. The intention, of course, is to make the reporting rate as optimal as possible. Finally, in both systems the public prosecutor's office is still empowered to launch an independent investigation, in accordance with that authority's autonomy.

There are, however, also a number of striking differences. The Dutch reporting procedure builds on the physician's duty to report deaths, which existed long before there was any talk of regulating euthanasia.[32] A similar duty to report deaths has never existed in Belgium. Indeed, Belgium is notorious for the high number of exhumations that take place, probably due to the lack of an efficient system for registering deaths. Moreover, whereas it is accepted in the Netherlands that euthanasia is not a natural death, in Belgium the debate on this matter has only just begun. In any event, the Act itself has done nothing to clarify this point. Section 15 of the Belgian Euthanasia Act states that a person who dies as a result of euthanasia performed in accordance with the

[32] J. Griffiths, 'Self-Regulation by the Dutch Medical Profession that Potentially Shortens Life' in H. Krabbendam and H.-M. ten Napel (eds), *Regulating Morality: A Comparison of the Role of the State in Mastering the Mores in the Netherlands and the United States* (Maklu 2000) at 177.

conditions established by the Act, is *deemed* to have died a natural death for the purposes of the execution of any contracts to which he was party, in particular insurance contracts. One might conclude from this that otherwise euthanasia would be seen as an unnatural death.

Finally, the administrative organisation of the Belgian federal commission is not without problems. Can a commission composed of 16 part-time members possibly give serious consideration to all the files, especially now that there will be hundreds, if not thousands per year? At the very least, there will need to be extensive administrative support and assistance.

VIII. CONCLUSION

Belgium and the Netherlands are presently the only two countries in the world that have legislation concerning euthanasia.[33] In this article we attempted a comparison between both Acts, with a focus on the Belgian Act. Although it seems fair to conclude that, from an *ethical* point of view, the general tenure of both Acts is rather liberal, there are also striking differences between them. For example, the exclusion of assisted suicide in the Belgian Act; the procedural steps that have to be followed by physician and patient before euthanasia can be legitimately performed; the status of the advance directive; as well as the possibility to refuse a medically meaningful alternative treatment. More generally, the Dutch Act is more concise than the Belgian Act. This is due to the fact that in the Netherlands before April 2002, when the Dutch Act came into effect, there existed a long established and legally accepted practice concerning euthanasia (and assisted suicide). As a consequence, legal certainty is also attained by, for example, established case law and guidelines of due care. In Belgium, case law was, and still is, non-existent. As a result, the Belgian legislature has opted for detailed and extensive regulation, in order to achieve the maximum legal certainty for physician and patient. As we have seen, it is questionable whether Parliament has succeeded in this, since many aspects of the Act still remain unclear.

[33] Note that assisted suicide is legalised in the US state of Oregon, since the Oregon Death with Dignity Act allows terminally ill Oregon residents to obtain, from their physicians, prescriptions for lethal medications for self-administration. The Act specifically prohibits euthanasia, where a physician or other person directly administers a medication to end another's life.