

Euthanasia in Belgium: Shortcomings of the Law and Its Application and of the Monitoring of Practice

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In 2002 with the passing of the Euthanasia Law, Belgium became one of the few countries worldwide to legalize euthanasia. In the 18 years since the passing of the law, much has changed. We argue that in Belgium a widening of the use of euthanasia is occurring and that this can be ethically and legally problematic. This is in part related to the fact that several legal requirements intended to operate as safeguards and procedural guarantees in reality often fail to operate as such. We focus on three kinds of safeguards or procedural guarantees: (1) the legally defined due care criteria for eligibility for euthanasia; (2) the consultation of a second (and sometimes third) physician; and (3) the reporting of euthanasia cases to the Federal Control and Evaluation Commission for Euthanasia. We will show how each of these three safeguards can exhibit shortcomings in theory and practice.

Keywords: *Belgium, euthanasia, law, ethical analysis, shortcomings*

I. INTRODUCTION

Euthanasia was decriminalized in Belgium in 2002, making it one of only a handful of countries where this practice is allowed under certain conditions¹ ([Law of 28 May 2002 on Euthanasia](#)). Although the passing of the Euthanasia

Law in 2002 was the result of significant parliamentary debate, it was in no way an end point; societal and political debate continues, for example, on whether or not to widen the scope of this law (Van den Broek and Eeckhaut, 2017). The interpretation and application of the Belgian Euthanasia Law are far from settled.

Witness to this is the fact that in the 18-year period that has passed since the enactment of the Euthanasia Law, there have been many political attempts to amend it. Proposals, for example, have been submitted to legally oblige physicians who receive a euthanasia request but are unwilling to perform euthanasia themselves to refer the patient to another (more willing) physician. A number of legislative proposals have also been filed to allow euthanasia for patients with advanced dementia and for minors who are unable to consent (e.g., neonates). All but two proposed amendments were voted down. The Euthanasia Law was first amended in 2005 to provide legal protection for pharmacists dispensing the lethal medication for the performance of euthanasia (Law of 10 November 2005). In 2014, the Euthanasia Law was amended again, this time to allow euthanasia for minors who are judged to have “capacity for discernment,” without setting an age limit (Law of 28 February 2014).

Apart from the political and legal debate, there have also been many notable changes in the performance of euthanasia since 2002. A first trend is the continuing rise in the number of euthanasia cases. This trend is clear from both the official reports and anonymous empirical surveys. According to the latest official report, 2359 cases of euthanasia were reported in 2018 and 2656 cases in 2019 (Federal Control and Evaluation Commission for Euthanasia [FCECE], 2020). Given that 108,745 people died in Belgium in 2019, reported euthanasia accounts for 2.4 percent of all deaths. By contrast, the most recent anonymous physician survey study suggests that, for Flanders (the Dutch-speaking part of Belgium) in 2013, the number was 4.6 percent of all deaths (Chambaere et al., 2015). A follow-up study looking more closely into the euthanasia cases reported in the anonymous survey showed that only around 60 percent of them were reported to the FCECE (Dierickx et al., 2018). There is thus a significant extent of underreporting.

Moreover, notable changes are occurring with regard to the characteristics of the persons who receive euthanasia. A 2015 study by Dierickx et al. compared the granting rate of euthanasia requests in 2007 with the rate in 2013. They found that:

There are increasing numbers of requests and granted requests in patients with diseases other than cancer, those who die after 80 years of age, and those who reside in nursing homes. (Dierickx et al., 2015, 1705–6)

The official reports of the FCECE likewise show a shift in euthanasia characteristics. The latest report (covering 2018 and 2019) shows an increase of

reported euthanasia cases not only for unbearable psychological suffering, but also for so-called “polypathology,” which accounts for 17.4 percent of all euthanasia cases reported in 2019 and represents the second most common indication for receiving euthanasia (after cancer, which accounts for around 62 percent of all reported euthanasia cases) (FCECE, 2020). For defining polypathology, the FCECE relies on a definition given by Van den Akker, Buntinx, and Knottnerus (1996): “the co-occurrence of multiple chronic or acute diseases and medical conditions within one person” (FCECE, 2020, 36). We discuss this in more detail below.

In general, it seems hard to deny that in Belgium a trend exists toward a broader use of euthanasia for an ever wider variety of indications. Although changes in the practice and a broader use of euthanasia do not *automatically* imply an ethical problem, they are worth analyzing. We argue that these changes are in part related to the fact that several legal requirements of the euthanasia law that are intended to operate as safeguards and procedural guarantees in reality often fail to operate as such. We believe this is ethically and legally problematic and should be of concern to everyone, regardless of their stance on the ethical justifiability of euthanasia in general. Hence, in our analysis of these safeguards and procedural guarantees, we make abstraction of the more general ethical debate on the justifiability of euthanasia. We focus on three kinds of safeguards or procedural guarantees: (1) the legally defined due care criteria for eligibility for euthanasia; (2) the consultation of a second (and sometimes third) physician; and (3) the reporting of euthanasia cases to the FCECE.

One might wonder whether the issues raised in this article are limited to the Belgian euthanasia law or whether they are inherent to any legalization of euthanasia, as is suggested by some commentators (e.g., Keown, 2018). However, in this article, we focus solely on the Belgian context and we believe that research into the situation in only one jurisdiction cannot support either a confirmation or a refutation of the claim that legalization must *inherently* be problematic. We would note, however, that several studies do indicate that a trend towards a broader use of euthanasia can also be shown in The Netherlands (Van der Heide, van Delden, and Onwuteaka-Philipsen, 2017; Snijdewind et al., 2018). This has led some commentators to conclude that the legal boundaries in The Netherlands are being extended or even stretched (Florijn, 2018; Quill, 2018). A study in The Netherlands looked at the cases brought before the Regional Euthanasia Review Commissions and found that “in some cases, physicians knowingly pushed the limits of EAS law” (Miller and Kim, 2017, 1). This being said, fully exploring the differences and similarities between the Belgian and Dutch situations would require much more research and merit one or more separate in-depth publication(s). In the remainder of this article, we focus

on the shortcomings of the Belgian euthanasia law and euthanasia practice, as well as the monitoring of the latter.

II. THE LEGALLY DEFINED CRITERIA FOR ELIGIBILITY FOR EUTHANASIA

The Belgian Euthanasia Law contains a set of specific criteria that must all be met in order for euthanasia to be legal. Some pertain to the characteristics that make a patient eligible for euthanasia (e.g., conscious request, unbearable suffering, etc.), whereas others pertain to the process of assessing the fulfillment of the due care criteria, to the performance of euthanasia (e.g., consultation of a second and, sometimes, third physician) or to the legally required reporting of euthanasia cases to the FCECE. These criteria have been discussed in detail elsewhere (Vansweevelt, 2003; Delbeke, 2012; Nys, 2017).

For this section, we only focus on the legally defined criteria that must *all* be met for a patient to be eligible for euthanasia. Schematically, these are:

1	The patient has to be an adult, an emancipated minor, or a minor with capacity for discernment.
2	The patient has to make a voluntary, well-considered, repeated request that is not the result of external pressure.
3	The patient has to be in a medical condition without prospect of improvement.
4	The patient has to (a) experience constant <i>and</i> unbearable physical or psychological suffering (b) that cannot be alleviated.
5	The patient's suffering should result from (a) a serious <i>and</i> incurable disorder (b) caused by illness or accident.

Criteria 1 and 2

The first criterion stipulates that for a patient to be eligible for euthanasia, she has to be an adult, an emancipated minor, or a minor with “capacity for discernment.” It could be argued that, since the extension of the Euthanasia Law to minors in 2014, this criterion is redundant because it collapses into the second criterion. Patients who meet the second criterion (i.e., make a voluntary, well-considered, repeated request) arguably always meet the first criterion since they are either an adult, an emancipated minor, or a nonemancipated minor with capacity for discernment. By contrast, a nonemancipated minor without capacity for discernment is not able to make such a voluntary request.

How the voluntariness and well-considered nature of the request should be assessed is not stipulated in the Euthanasia Law, and no standardized tool is provided either by professional medical organizations or by the FCECE. This has given rise to the criticism that it is unclear how reliable the

physician's assessment of voluntariness can be in the absence of standardized assessment tools (Kim, De Vries, and Peteet, 2016).

Criterion 3

The third criterion requires that the patient is “in a medical condition, without prospect of improvement” (Law of 28 May 2002 on Euthanasia; authors' translation). It is relevant to note that the prospect of improvement in this condition does not refer to the suffering experienced, but rather to the existence of a medical condition and the absence of possible curative interventions. Thus, whether this criterion is fulfilled is best judged by a physician, and arguably even by a physician with expertise in and up-to-date knowledge of the specific medical condition the patient is suffering from.

Criterion 4

The fourth criterion stipulates that the patient has to experience “constant and unbearable physical or psychological suffering that cannot be alleviated” (Law of 28 May 2002 on Euthanasia). This criterion comprises different elements. It requires (1) that patients are suffering unbearably when making the euthanasia request and (2) that this suffering cannot be alleviated in the future. The first concerns the presence and severity of *present* suffering, which is primarily subject to an assessment by the patient herself. Although physicians can establish the presence of a particular medical condition, they generally cannot accurately diagnose the presence of suffering. Moreover, even if in certain instances they would be able to do so (e.g., via fMRI scans; Wager et al., 2013), it would be inappropriate to bypass the most straightforward route for assessing suffering: asking the patient herself. It could be remarked that relying on self-reporting entails the risk of patients not honestly reporting the degree and form of suffering they are experiencing.² Although this is true, two points should be made in this regard.

First, the presence of constant and unbearable suffering is only one of the criteria for being legally eligible to receive euthanasia. The other criteria are clinical, and patients need to meet these as well.

Second, although patient involvement and assessment are required, physician involvement in assessing the patient's suffering may also be important. By means of validated pain assessment tools, physicians can help to translate the patient's phenomenological experience of suffering into reliable information (Gordon, 2015). Moreover, physician involvement has also been argued to be relevant for assessing psychological suffering; for example, by the Flemish and the Dutch associations for psychiatry in their guidelines for euthanasia in the context of psychiatric suffering (Berghmans et al., 2009; Vandenberghe et al., 2017). When discussing the criterion of unbearable suffering of psychiatric patients, both guidelines stress that unbearableness should be assessed by the patient herself, but they equally emphasize that

the intersubjective nature of the suffering should also be evaluated by the physician/psychiatrist through “repeated conversations, thorough observation and examination” (Berghmans et al., 2009; authors’ translation).

Who should judge whether suffering can be alleviated in the future, for example, by use of medical intervention, is a point of discussion (Belgisch Raadgevend Comité voor Bioethiek, 2017). One could argue that since it is up to the patient to determine whether her suffering is constant and unbearable, it should by extension be up to the patient to decide whether her suffering can be alleviated. On the other hand, physicians should possess the knowledge and expertise required to judge the effects of particular therapies and/or medication. In this line of reasoning, if a patient refuses a particular treatment that the attending physician reasonably assumes will help alleviate the suffering, the patient can be said to experience suffering, but cannot be said to experience suffering *that cannot be alleviated*.

Criterion 5

The fifth eligibility criterion for euthanasia is that the suffering that patients experience must result from a serious and incurable disorder caused by illness or accident. This criterion harbors various elements. First, it requires that the suffering experienced *must result from the disorder* and not from another cause, which implies the presence of a *causal link*. Hence, for euthanasia to be a legally valid option, the presence of both suffering and an incurable disorder is not sufficient. Indeed, a causal link between the two must be established.

Second, the criterion requires that the disorder is incurable and serious. Establishing whether or not this is the case requires medical expertise, and hence must be assessed by a physician. In some respects, the *incurability* criterion can be said to overlap with the criterion, discussed above, that patients requesting euthanasia must be in a medical condition without prospect of improvement. The “without prospect of improvement” criterion is stricter than the incurability criterion, for medical conditions are conceivable that are incurable but where there is nevertheless a prospect of improvement. Determining who should assess whether the disorder is *serious* is clearly up for debate.

Finally, the disorder causing the suffering must be caused by *illness or accident*. Provided that all the other criteria are met, this allows euthanasia for diagnosed psychiatric disorders, for example, but disallows euthanasia for patients who do not have a disorder but are tired of life (Van Tol, Rietjens, and van der Heide, 2010; van Wijngaarden, 2016).

How broadly or narrowly one should understand the concept of illness as mentioned in the Belgian euthanasia law is unclear. However, the FCECE seems to apply a broad definition of illness, since it mentions having approved several cases of euthanasia for “congenital abnormalities,” and also

for what it enigmatically describes as “symptoms, unusual clinical findings and lab results not otherwise classified” (FCECE, 2020, 5; authors’ translation).

III. ILLUSTRATIONS OF POTENTIAL OVERSTRETCHING

We argue that since the decriminalization of euthanasia in 2002 there have been significant changes in how the abovementioned criteria for eligibility are interpreted. Although this does not automatically imply a problematic practice, we provide three illustrations of domains in which the criteria are potentially overstretched and therefore at least indicate that these practices, in our opinion, are problematic. The first illustration pertains to the criterion of incurability, the second concerns the legal requirements for patients experiencing psychological suffering, and the final illustration is that of so-called polyopathy.

Incurability

As mentioned above, for a patient to be able to legally receive euthanasia, she has to experience suffering that results from a serious and incurable disorder caused by illness or accident. Determining whether or not a disorder is incurable requires medical expertise and should therefore be a responsibility of the attending physician (as well as of the second consulted physician whose role we discuss later in this article).

With regard to this condition, some debate has arisen over the question whether patients who request euthanasia but refuse particular treatments can still legally receive euthanasia (FCECE, 2020). In other words, the key question here is whether the incurability criterion refers to the *mere existence* of possibly effective treatments or to the existence of possible effective treatments *acceptable to the patient*. The FCECE has dealt with this issue in its latest report and argued that:

When considering whether suffering can or cannot be alleviated, one has to take into account the patient’s right to refuse treatment or even palliative care, for example when this treatment has side effects or involves methods of administration he/she considers unbearable. (FCECE, 2020, 20; authors’ translation)

Although this quote mentions the criterion of alleviability of suffering, it also has significant implications for another of the legal criteria, namely, the criterion of incurability and the related question as to when a patient’s medical condition can be deemed incurable. In the view of the FCECE, patients can refuse curative treatments and thereby still legally qualify for euthanasia if the side effects of those curative treatments are deemed unbearable by the patient. Such a statement is authoritative, since the FCECE is the official instance charged with checking all euthanasia cases. A shift in their interpretation of the legal criteria most likely results in a shift in euthanasia practice.

This issue is also crucial because if patients are the only reference for judging the acceptability of side effects or administration methods of treatments, the *medical* criteria of nonalleviability of suffering and of incurability, explicitly mentioned in the Euthanasia Law, could stealthily be turned into the *patient-subjective* criterion of unbearable, that is, the former could easily collapse into the latter. Patients could then be deemed to be experiencing suffering that cannot be alleviated, or they could be considered to be incurable, despite there being treatments which could provide improvement or alleviation, simply because they refused such treatments on the ground that they consider them to be unbearable. Although this might correspond to the increasing focus on patient self-determination, we believe that there are good reasons for resisting this patient-subjective interpretation of incurability. Physicians are involved in euthanasia as both medical experts and moral agents. Their role, in our view, should not be reduced to merely meeting patients' demands because this would result in a pure instrumentalization of physicians.³

Of course, we are not arguing that it would be permissible to interfere with patients' rights to refuse treatment, which is a fundamental moral right (and is also enshrined in the [Belgian Law on Patients' Rights, 2002](#)). Patients always maintain the possibility to refuse treatment, without having to justify this decision. However, such refusal should never *automatically* make a patient qualify for receiving euthanasia.

Psychological Suffering Caused by a Psychiatric Condition

Another point of controversy is the fact that the Belgian Euthanasia Law allows euthanasia for both physical and psychological suffering, but does not specify how the difference between the two should be conceived. The absence of any consensus or legal guidance on how to define psychological suffering makes it possible to use the concept in an increasingly broad way. Available empirical evidence and reports show that euthanasia is performed increasingly frequently in cases of psychological suffering (e.g., for schizophrenia, borderline disorder, or depression) ([FCECE, 2020](#)).

A challenge for cases of psychological suffering is the fact that, as mentioned above, the law requires that the patient suffers from a medical condition without prospect of improvement and that her suffering cannot be alleviated. It has been argued that this is difficult if not impossible for psychiatric disorders ([Kelly and McLoughlin, 2002](#)). The Dutch Association of Psychiatry has recognized this problem and issued a guideline in 2009 for psychiatrists faced with a request for euthanasia or assisted suicide from a patient with a psychiatric disorder. The Association acknowledged that patients with a psychiatric disorder can qualify for euthanasia, but argued that:

A patient can, according to the commission, only be considered "incurable" when the following interventions have been tried:

- All indicated regular biological treatments
- All indicated psychotherapeutic treatments
- Social interventions that could make suffering more bearable. (Berghmans et al., 2009, 37; authors' translation)

In 2017, the Flemish Association for Psychiatry likewise issued a guideline that quotes and supports the abovementioned Dutch guideline's list of interventions to be tried before patients can be considered incurable (Vandenberghe et al., 2017). Both guidelines, moreover, require that all indicated treatments must have been *tried* rather than merely having been considered. The guideline recommends a period of at least 1 year between the written request and the actual performance of euthanasia, since it considers such a period to be crucial for ascertaining that the psychiatric condition is indeed incurable and suffering cannot be alleviated. Moreover, the Flemish guideline states that patients obviously have an absolute right to refuse treatment, but that "as a consequence of that, normally, in such cases the criteria for incurability cannot be shown to obtain and euthanasia is, therefore, impossible" (Vandenberghe et al., 2017, 3; authors' translation). As noted above, the FCECE, by contrast, considers that patients who refuse curative treatments still qualify for euthanasia.

Since the Flemish guideline is rather recent, its effect cannot yet be evaluated. It will be interesting to see whether and how this guideline will be used in practice, since there is evidence that in the past much less strict criteria for euthanasia were used. First, we can refer to a Belgian study that reported on 100 cases of patients with a psychiatric condition who requested euthanasia. In order for these patients to qualify for euthanasia, the psychiatrist required that: "All therapeutic options that could alleviate suffering, including palliative care, must be discussed with the patients and their practitioners" (Thienpont et al., 2015, 4). This is different from both the Dutch and Flemish guidelines, as both require that the available options must have been tried and found to be ineffective rather than merely having been discussed with the patient. Second, while the Flemish guideline recommends a period of at least one year between the written request and the performance, this was only the case for about 15 percent of the reported cases of euthanasia for psychiatric conditions in 2016 and 2017. In about 60 percent of cases, the period between the request and the performance in cases of psychiatric conditions (not including dementia) was three months or less (FCECE, 2018). In the latest FCECE report covering 2018 and 2019, the waiting period is no longer reported (FCECE, 2020).

Polypathology

The conditions specified in the Euthanasia Law are increasingly argued to also cover so-called "polypathology," that is, a combination of various conditions. Although there is nothing inherently problematic about polypathology, we would argue that problems arise if the concept is interpreted too broadly.

As mentioned above, in its latest report the FCECE indicates that for its statistics on poly pathology it relies on a definition given by [Van den Akker, Buntinx, and Knottnerus \(1996\)](#), who define multimorbidity as: “the co-occurrence of multiple chronic or acute diseases and medical conditions within one person.” The FCECE uses this definition, but opts for “poly pathology” instead of “multimorbidity,” the term used by Van den Akker et al.

Euthanasia following poly pathology is becoming increasingly common, and the vast majority of such cases (71 percent) involves patients over the age of 80 ([FCECE, 2020](#)). By comparison, when one considers euthanasia cases in general, only about 37 percent of cases concern patients over the age of 80. However, this strong representation of elderly patients in poly pathology cases is no surprise in view of the examples given by the FCECE of conditions that can give rise to poly pathology. These include reduced eyesight which could result in increased social isolation, poly arthritis, reduced hearing to complete deafness that inhibits the person’s ability for human contact, early stage dementia, and incontinence ([FCECE, 2020](#)). Several of these examples are conditions that affect most elderly patients to at least some degree ([Raus and Sterckx, 2015](#)). In this line of thinking, a significant number of elderly patients would in fact qualify for euthanasia based on “poly pathology.” Indeed, a survey looking into the cases of euthanasia for poly pathology reported between 2013–2016 shows that in 88.1 percent of all poly pathology euthanasia cases, the patient was over the age of 70 ([Proot and Distelmans, 2018](#)).⁴

Based on a broad understanding of poly pathology, some commentators argue that the concept can also cover tiredness of life. In an interview with a Belgian newspaper, health law Professor Herman Nys argued that persons who are tired of life are able to receive euthanasia under the current Euthanasia Law because, due to their older age, they are likely to have several age-related conditions. In that same interview, the president of the FCECE admitted that such cases of euthanasia for tiredness of life are indeed already being reported to the Commission ([Beel, 2011](#)). This is problematic because these cases are likely not to meet the legal criteria. There are two possibilities. First, the Commission is aware that the reported cases were cases of euthanasia for tiredness of life and the Commission may or may not regard this as problematic. If tiredness of life cases do not meet the legal criteria, the FCECE may in this case fail to fulfill its role of checking whether all criteria of due care are met. Second, perhaps the Commission was unable to deduce unambiguously from the reports whether or not it concerned a case of euthanasia for tiredness of life. However, if this is the case, there is a structural problem with the way in which these cases are reported because the Commission would then be unable to fulfill its role.

IV. A PRIORI CONTROL: CONSULTATION OF ONE OR TWO INDEPENDENT PHYSICIANS

Apart from the specific criteria that need to be met in order for a patient to qualify for euthanasia, the Euthanasia Law contains various procedural requirements intended as safeguards. Several of these are a priori, meaning that they are aimed at guaranteeing that the due care criteria are fulfilled before euthanasia is performed, whereas others are a posteriori, which means that they come into play after the euthanasia has been performed. In this section, we first discuss the a priori control mechanism provided by the Law: the obligatory consultation of one or two independent physicians.

Legal Requirements

The Euthanasia Law requires that, following a euthanasia request, the attending physician must consult a second, independent physician. This consulted physician should examine the patient and “must ascertain the patient’s constant and unbearable physical suffering that cannot be alleviated” ([Law of 28 May 2002 on Euthanasia](#); authors’ translation). She should also draft a report of her findings.

In two particular cases, an additional independent physician must be consulted. First, in cases where the patient requesting euthanasia is not expected to die in the foreseeable future, consultation of an independent physician must occur. Here, the additionally consulted physician should ascertain the presence of suffering that cannot be alleviated (like the first consulted physician), but also “the voluntary, well-considered and repeated nature of the euthanasia request” ([Law of 28 May 2002 on Euthanasia](#); authors’ translation). The Euthanasia Law requires this second consulted physician to be either a psychiatrist or an expert in the patient’s particular condition.

The second case in which two rather than one independent physician need to be consulted by the patient’s attending physician concerns euthanasia for nonemancipated minors. In these cases, the attending physician must consult a child and adolescent psychiatrist or a psychologist (in addition to the first consulted physician). This expert should certify in writing that the minor indeed possesses “capacity for discernment.”

These consultations have been argued to provide a strong safeguard that those who receive euthanasia fulfill all legally required due care criteria ([Constitutional Court of Belgium, 2015](#)). However, as we argue, there are some grounds for concern.

Concerns

Expertise of the second consulted physician

As mentioned above, in cases where the patient is not expected to die in the foreseeable future, the attending physician must consult an additional

(second) independent physician, who must be either a psychiatrist or a specialist in the patient's condition. In its 2018 report, the FCECE states that for polypathology, it considers any GP to be a specialist (FCECE, 2018). This has far-reaching implications. In 2019, polypathology represented 17.4 percent of all reported euthanasia cases and a staggering 47 percent of all reported *nonterminal* euthanasia cases (FCECE, 2020). If the second consulted physician is also allowed to be a GP, it is possible that all physicians involved in the assessment are GPs. We would submit that the second consulted physician should possess a complementary or more *specific* expertise.

By way of example, we can refer to cases of euthanasia for psychiatric disorders. Because most patients suffering from psychiatric disorders are not imminently dying, two physicians will have to be consulted in such cases. The Euthanasia Law requires that the second consulted physician must be either a specialist in the condition the patient is suffering from, or a psychiatrist. In the case of euthanasia for psychiatric suffering, this frequently boils down to the same, as a specialist in the psychiatric condition will likely be a psychiatrist. However, if a patient with psychiatric suffering is diagnosed with another condition, the case can be reframed as a polypathology case; hence according to the FCECE, any GP can be the second consulted physician. Under these circumstances, euthanasia could thus be performed without any involvement of a psychiatrist; some research suggests that this is indeed occurring. A recent study by Dierickx et al. into the reported cases of euthanasia for psychiatric disorders found that: "Although it is a legal requirement to do so, a psychiatrist was not consulted in all cases with a diagnosis of psychiatric disorder" (Dierickx et al., 2017, 7). They argued that:

A possible explanation for this is that physicians may have only mentioned the diagnosis that was the main cause of the unbearable suffering; it may be that in these cases the person suffered from multiple pathologies, in which cases the Committee agreed that the legally required third physician could be a general practitioner. (Dierickx et al., 2017, 7)

Put differently, whereas euthanasia for nonterminal conditions requires the consultation of a psychiatrist or a physician with expertise in the particular condition, this legal requirement is dropped by the FCECE when the case is labeled as a polypathology case. This means that for patients who are also being treated by a psychiatrist, euthanasia can, in theory, be performed for polypathology without this psychiatrist being informed or involved. The extent to which this happens is unclear. When reporting on the characteristics of the *first* consulted physician, the FCECE report distinguishes between GPs and specialists. However, when reporting on the characteristics of the *second* consulted physician, as required for nonterminal patients, it groups together all physicians under the single heading of "specialist." This results in a lack of transparency which, if the steep rise of euthanasia for "polypathology" continues, will become even more problematic than is already the case.

The nonbinding nature of the advice of the consulted physicians

The obligatory consultations have as their main function to remove possible doubts on the part of the patient's attending physician and, in that way, to contribute to the objectivity of the latter's assessment and decision. Additionally, they can be regarded as built-in checks against ill-considered and rushed decisions and as a welcome instrument to share some of the psychological burdens involved in the decision-making (Report of [Laloy and Van Riet, 2001](#)).

However, it was recently confirmed by a judgment of the Constitutional Court of Belgium that the opinions given by the consulted physicians are not binding ([Constitutional Court of Belgium, 2015](#)). The only exception is the advice of the child and adolescent psychiatrist or psychologist who must be consulted in the case of euthanasia for minors; this advice is binding. This means that a patient's attending physician can legally perform euthanasia on the patient even where the consulted physicians have issued negative advice.

This may raise two ethical concerns. First, it raises the question to what degree the consultation of an independent physician indeed serves as a safeguard, given that the consulted physician is only solicited to give an *opinion* on the medical situation of the patient. Ultimately, the verification of the (non-)fulfillment of the due care criteria is left to the patient's attending physician. That the consulted physicians are not allowed to intervene in the therapeutic relationship between the patient and the attending physician is evidenced by the fact that it will be the latter who communicates the outcome of the consultation to the patient. Making the advice of the consulted physician(s) binding, as was proposed in two of the early legislative proposals submitted by majority parties, was finally considered to be too intrusive in that respect ([Adams and Geudens, 2000](#)). To what extent this would operate as a fail proof safeguard can, of course, be questioned. One could argue that in the case of binding negative advice one can always consult another physician, repeating this process until a physician is found who provides positive advice.

Taking into account that the mechanism of a priori control turns out to be aimed at providing support for rather than oversight of the attending physician's decision-making process, it is doubtful whether this mechanism will in practice function as a *guarantee* that euthanasia will be performed in conformity with the legal requirements.⁵ One of the most frequently heard criticisms of the Euthanasia Law is that it is largely predicated on trust in the attending physician, which is said to leave too much power to the subjective appreciation of one individual. Indeed, the fact that a physician could perform euthanasia and be in conformity with the legal requirements even when the consulted physicians report that in their opinion the patient blatantly is *not* suffering continuously and unbearably without prospect of improvement or clearly does *not* have a serious and incurable condition, has

raised concern (Report of [Giet et al., 2002](#); Report of [Khattabi and Van Hoof, 2014](#); Report of [Smeyers, 2014](#)).

Second, issues of moral complicity arise. The advice of a consulted physician who finds that the legal criteria have *not* been met in a particular case could actually be used to fulfill the legal requirements to perform euthanasia in this case. This may incentivize consulted physicians who disagree with euthanasia in a particular case not to provide any advice, since this is the only guarantee that they will not support the performance. Moreover, if they consider that a particular case does not fulfill the legal criteria, they have no legal means to report this or to prevent the euthanasia from occurring.

In this regard, it should be noted that studies indicate that the performance of euthanasia in spite of negative advice is more than just a hypothetical scenario. For instance, [Van Wesemael et al. \(2011\)](#) found that in 4 of 363 studied cases of euthanasia involving adults, euthanasia was performed in spite of negative advice from the consulted physician ([Van Wesemael et al., 2011](#)). Moreover, the same study found that in 20 of these 363 cases, euthanasia was even performed without any consultation of an independent physician. The occurrence of a lack of consultation of an independent physician is also confirmed by the most recent empirical study on the frequency of euthanasia. In a supplementary appendix to their article, [Chambaere et al. \(2015\)](#) report that in 2013 no independent physician was consulted in 7.4 percent of all cases under study (which amounts to 26 cases of a total of 349) ([Chambaere et al., 2015](#)).⁶ These cases were not reported to the FCECE because it claims that a second and third physician was consulted in every reported euthanasia case ([FCECE, 2018](#)).

V. A POSTERIORI CONTROL: REPORTING TO THE FEDERAL CONTROL AND EVALUATION COMMISSION FOR EUTHANASIA

In establishing an a posteriori control mechanism that would be fit for the purpose, the legislature aimed to find a balance between societal control on the one hand and legal certainty for physicians on the other hand. Taking into account that euthanasia concerns the intentional termination of someone's life, from a legal perspective it would be perfectly logical to require a systematic notification of euthanasia cases to the medical examiner and the Public Prosecutor. This had, in fact, been the approach followed in The Netherlands from the early 1980s. However, when at the end of the 1990s initiatives were taken in The Netherlands and Belgium to draft a legal framework that would decriminalize euthanasia, that particular approach was considered too problematic. Practice in The Netherlands had shown that less than half of the estimated total number of cases of euthanasia were reported. It turned out that physicians dreaded the administrative burden and the high risk of prosecution ([Gevers, 1996](#)). Physicians signaled that they did

not want to be dragged into the criminal justice system because of helping their patients with unbearable suffering die a dignified death (van der Wal and van der Maas, 1996).

Drawing on that experience, the Belgian legislator, like the Dutch legislator in 2001, chose to not implement a system of notification of the medical examiner and the Public Prosecutor. Several legislative proposals that would make such reporting obligatory were rejected (Adams and Geudens, 2000). It was argued that the automatic involvement of the Public Prosecutor would make physicians too hesitant to collaborate and to report. According to the critics, such a monitoring system would fail to increase the transparency, uniformity, and legal compliance of the performance of euthanasia. Moreover, it was deemed inappropriate to expect from physicians that, by voluntarily reporting their cases of euthanasia, they would expose themselves to the risk of criminal prosecution (Vansweevelt, 2003).

Instead, both in The Netherlands and in Belgium a *sui generis* monitoring body was established that was intended to function as a filter between the physicians and the Public Prosecutor (Adams and Geudens, 2000). In Belgium, the Euthanasia Law requires that all euthanasia cases be reported to the FCEC. This Commission, which is neither a court nor an administrative body, is supposed to check for each reported case whether the legal criteria were met (Dierickx, 2003). It is composed of 16 members: eight physicians, four legal experts and four experts in the care for incurably ill patients.⁷ The requirement to report cases of euthanasia to a Commission of which half the members are physicians and which will not result in an automatic notification of the Public Prosecutor was considered essential to elicit the collaboration of physicians who perform euthanasia (Vansweevelt, 2003; Balthazar, 2003).

The report that needs to be submitted to the FCECE consists of an anonymous part and a part with the identifying data of the persons involved (Article 7). Normally, the members of the FCECE only access the anonymous part which includes information on (1) the nature of the serious and incurable condition from which the patient suffered; (2) the nature of the constant and unbearable suffering; (3) the reasons why the suffering could not be alleviated; (4) the elements that assured the physician that the patient's request was voluntary, well-considered, and repeated; (5) whether the patient was expected to die within the foreseeable future; and (6) the capacity of the persons consulted and, with regard to the consulted physician(s), their qualifications and opinions. If on examining these elements doubt arises as to whether the legal criteria were met, the Commission can, if a majority of the members wishes to do so, open the envelope which contains the names and addresses of the patient, the reporting physician, the consulted physicians and the other consulted persons. In 2018–2019, the nonanonymous part was opened in 24.8 percent of reported cases, mostly because particular information was missing from the reporting form or because the form was poorly completed (FCECE, 2020). Accessing this part allows the Commission

to request the reporting physician to provide any information from the medical record that relates to the euthanasia. If, following this examination, the Commission decides with a two-thirds majority that the legal criteria have not been met, it must refer the case to the Public Prosecutor, who can then decide to initiate an official investigation (Article 8). In the 18 years since the law entered into force, only one case has been referred (FCECE, 2020). Important to note is that this euthanasia case was televised as an episode of the Australian show *Dateline*; hence, the specifics of this case came to public attention. Since the TV show made clear that at least one of the legal criteria for euthanasia had not been met, it would seem that the FCECE was left with no alternative but to refer the case to the Public Prosecutor.

Some concerns exist regarding the functioning of the Commission. We discuss the lack of initiatives to address the underreporting; shortcomings of the reporting form; and the composition of the commission and its view on its role and powers.

The Lack of Initiatives to Address the Underreporting

The FCECE's functioning is undermined to a significant extent by underreporting of euthanasia cases. Obviously, the FCECE cannot be held responsible for the unwillingness of some physicians to report. However, we find it regrettable that the Commission fails to problematize the issue of underreporting and does not take a clear stance. In their 2018 report, for example, they repeat their claim that they are unable to compare the number of reported cases to the number of actually performed cases.

This statement ignores the vast amount of available empirical research that provides insights into the incidences of euthanasia (as well as into other end-of-life practices). Recent research suggests, for example, that roughly one in three cases of euthanasia is not reported (Dierickx et al., 2018). Moreover, comparisons of reported cases of euthanasia with unreported cases have found that "Unreported cases were generally dealt with less carefully than reported cases" (Smets et al., 2010, 4). The FCECE should be aware of this empirical research. One could wonder whether the FCECE or the Belgian Parliament should not acknowledge this as a problem that should be addressed.

Shortcomings of the Reporting Form

When reporting a case of euthanasia to the FCECE, the attending physician has to fill out a standard form (in two parts), the basic content of which has been explained above. This reporting form is of crucial importance; hence, we discuss it in more detail. It is this document that allows for any possibility of societal control of euthanasia and for the FCECE to do its job properly. Indeed, if the reporting form is inadequate (as we argue below), then the system of monitoring euthanasia practice via the FCECE is problematic. We look at three specific shortcomings of the reporting form.

The anonymous nature of the reports

First, in Belgium, reporting euthanasia cases happens anonymously. The nonanonymous part may only be opened when a majority of the Commission expresses doubts as to whether the legal criteria are met. This is in stark contrast with The Netherlands where reporting happens nonanonymously. The reason for the anonymous reporting appears to be that it was expected that this would make physicians more likely to report. However, it should be noted that 16 years after the legalization of euthanasia, reporting in Belgium is still significantly lower than in The Netherlands where there is nonanonymous reporting. Studies suggest that in The Netherlands about 80 percent of all euthanasia cases are reported (Van der Heide et al., 2017).

There are several disadvantages to anonymous reporting. For one, an important legal condition is that the consulted physicians should be independent from both the patient and the attending physician. Anonymous reporting makes this virtually impossible to check by the Commission. The FCECE understands independence as meaning that there should be no family tie or hierarchical relation between the attending and the consulted physician(s) and that the patient should not have a regular therapeutic relationship with the consulted physician. In its latest report, the FCECE stipulates that “independence” does not necessarily mean that the consulted physician should never have met the patient or shouldn’t know his or her medical history. The FCECE also argues that “the demand for a strict and full independence of the consulted physician is already very difficult and in reality unattainable” (FCECE, 2020, 45; authors’ translation). Such a position makes things even more difficult to check, especially nonanonymously. When the attending and consulted physician share a last name, the familial tie could perhaps be suspected, but in other cases (no therapeutic relation and no hierarchical link), checking their dependence or independence is much less evident.

Moreover, since the Commission largely consists of practicing physicians with expertise in the field, it could be expected that some of the members of the Commission will on occasion be expected to monitor their own cases. The Euthanasia Law stipulates that, if the envelope containing identifying data were to be opened and it would come to light that one of the Commission members was involved as either the attending or a consulted physician, that member must recuse him/herself during the discussion of the case (Article 8). However, this provision fails to prevent a possible conflict of interests on the part of a member of the Commission in the usual cases where only the anonymous part is accessed and the identity of the physicians involved is not clear. Moreover, the procedure to be followed when the physician concerned does not want to recuse him/herself is not clear (Balthazar, 2003).

The reports are overly concise

The task of the FCECE is to check whether all legal criteria have been fulfilled. To check whether the condition of, for example, incurability is met,

the Commission would arguably require a lot of information. However, the reporting form is remarkably concise, especially when compared to the form used in The Netherlands.

To determine the presence of a serious condition and unbearable suffering that cannot be alleviated, the reporting form contains three boxes to fill out. In one box, physicians have to report the exact diagnosis, in a second box they have to report the “nature and description of the continuous and unbearable suffering,” and, finally, in a third box they have to provide “reasons why this suffering could not be alleviated.” The form does not specify which type of information is required or the level of detail that is required. We have little information about how these forms are filled out since, unlike the Dutch Regional Commissions, the FCECE does not report about particular cases. In its 2016 report, the FCECE does provide some examples of filled-out forms, and these confirm that the information provided can be very concise or scarce.⁸ In one example, the attending physician reported only the following as a reason why the suffering could not be alleviated: “*Illness was unsusceptible to further treatment. Further deterioration and decline were to be expected*” (FCECE, 2016, 25; authors’ translation). However, such an answer amounts to a mere declaration that the suffering could not be alleviated and does not therefore provide a *reason why* the suffering could not be alleviated. The answer to the question “why could the suffering not be alleviated?” cannot simply be “because the suffering could not be alleviated.”

In the Dutch form, by contrast, the reporting physicians are required to describe which therapeutic and palliative options were discussed with the patient, which therapeutic options were tried (including method, means, and dosage) and which palliative options were tried (including method, means, and dosage). Furthermore, the Dutch form also requires the physicians to answer the following question: “why were you convinced that, in accordance with the latest medico-scientific insights, suffering was impossible to alleviate?”

While filling out a more detailed form takes more time, there seem to be important reasons to prefer it. If the FCECE is indeed to serve as a safeguard by checking whether all legal criteria have been met, it needs to be provided with the information necessary to carry out this task. Currently, the Commission is not in a position to monitor all legal due care criteria on the basis of the registration forms it receives. More specifically, elements that cannot be directly checked include whether or not the patient was conscious at the time of the request, whether, for adult euthanized patients, the person was not legally incompetent, and whether or not the result of the consultation of the consulted physician(s) was communicated to the patient (Delbeke, 2012; Nys, 2016). Furthermore, since the name, address, and capacity of the consulted physician(s) are not included in the anonymous part, the independence of the consulted physician(s) cannot be controlled unless the Commission decides to open the part with identifying data.

The advice of the consulted physicians does not need to be included

A third matter of concern regarding the reporting form is that it does not require for the report of the consulted physician(s) to be included. The *reporting physician* merely summarizes the report of the consulted physician(s). The Commission is thus obliged to rely on the reporting physician to truthfully represent the advice of the consulted physician(s) (Balthazar, 2003). This, again, contrasts with The Netherlands where the official report of the consulted physician(s) must be included with the reporting form. In our view, there are strong reasons for preferring the Dutch model. In the Belgian system, there is no guarantee whatsoever that the summary provided by the reporting physician provides an accurate representation of the consulted physicians' reports.

Of course, the original report of the consulted physician(s) must be included in the patient's medical file. Theoretically, if the Commission would, by a majority vote, decide to open the envelope with identifying data, it could ask the reporting physician to provide the original reports of the consulted physician(s). However, how often this will happen is unclear, since the Commission would only ask for the original report if it doubted whether all legal criteria were met. This judgment will in turn be partly based on the reporting physicians' summary of the consulted physicians' advice. If their advice is not truthfully represented, it is unlikely that the Commission will express doubt about the legality of the case.

The Composition, Role, and Powers of the Commission

Failure to provide transparency

As the only a posteriori monitoring body, we believe that the FCECE has an important obligation of transparency. Currently, the Commission limits itself to issuing a report every two years that contains some of the relevant statistics and points of discussion.

By contrast, in The Netherlands, the Regional Euthanasia Review Committees publish numerous anonymized cases that provide insight into the Committees' decision-making. These anonymous summaries are made publicly available. We believe that such an approach might help to improve decision-making and to inform public debate.

The composition of the Commission

The Euthanasia Law stipulates that at least eight of the Commission's 16 members must be physicians. This is highly relevant since in Belgium the FCECE can only refer cases to the Public Prosecutor if a two-thirds majority is reached (Leleu and Genicot, 2004; Delbeke, 2012). The Belgian legislator did not consider it desirable that, within the Commission, the group of physicians or the two groups of experts who are not physicians would be able

to decide to refer a case to the Public Prosecutor against the wishes of the other group. It was deemed essential for the Commission's buffer function that a case would only be referred if at least some members of each of both groups would agree (Report of [Giet et al., 2002](#)).

It was apparently assumed by the legislature that physicians would be more likely to report cases of euthanasia if they were assured that they would be monitored by peers (other physicians), rather than by outsiders from another discipline. However, as noted earlier, reporting rates continue to be low, so it is arguable that this requirement did not have the desired effect. It has unfortunately produced other effects, though. As a result of the current procedure, physicians sitting on the Commission can de facto block *any* attempt to refer euthanasia cases to the judicial authorities ([Adams and Geudens, 2000](#)).⁹ We believe this can indeed happen. In its 2018 report, the FCECE describes a controversial case where life was terminated without the patient's request. According to the FCECE, this case was heavily debated, with nine members in favor of referring the case to the Public Prosecutor and seven members against referral. As the two-thirds majority required for referral was not reached, the case was approved by the [FCECE \(2018\)](#). Hence, the question arises as to whether, instead of operating as a mechanism for societal monitoring, the Commission could operate as a control device of physicians, by physicians, for physicians, or perhaps even as a protection device?

In this regard, several commentators have observed that the Commission does not seem to act as a filter between physicians who perform euthanasia and the Public Prosecutor, but instead as a shield that prevents potentially problematic cases from being referred (Report of [Khatabi and Van Hoof, 2014](#); Report of [Smeyers, 2014](#)). From the enactment of the Euthanasia Law to the end of 2019, 21,126 cases were reported to the Commission,¹⁰ yet the first time a case was ever referred to the Public Prosecutor was on 27 October 2015 ([Nys, 2017](#)). In The Netherlands, the five Regional Euthanasia Review Committees (the official instances to which all Dutch euthanasia cases have to be reported) find that the legal requirements may not have been met in, on average, 0.16 percent of all reported euthanasia cases ([Regional Euthanasia Review Committees, 2017](#)). In absolute numbers, this amounts to 44 cases, the details of which have all been published on the Regional Committees' website.

The fear that the FCECE operates as a shield that prevents problematic cases from being referred was fueled by the recent resignation of neurologist Dr. Ludo [Vanopdenbosch \(2018\)](#). In this letter of resignation, Dr. Vanopdenbosch, who stressed that he has no principled objections to euthanasia and that he has performed it several times, doubted both the FCECE's objectivity and its independence. He explained in his letter that this could be illustrated with a striking example of a euthanasia case involving a patient suffering from advanced dementia and Parkinson disease. This case

was reported to the FCECE and was discussed there on 5 September 2017. According to Dr. Vanopdenbosch, not a single legal criterion was met (e.g., there had not even been a request from the patient). After several hours of debate, the two-thirds majority required to send the case to the Public Prosecutor could not be found. This, Vanopdenbosch argues, proves that the Commission is obsolete. On a more general level, Vanopdenbosch also explained that he was not given the opportunity to speak up during the FCECE meetings and that he was effectively muzzled. Finally, Vandenopbosch argued that the reporting form does not allow the Commission to check whether the legal criteria were met. The President of the FCECE, Dr. Wim Distelmans, responded that Dr. Vanopdenbosch was given the opportunity to speak up and that the case he mentioned had been incorrectly classified by the reporting physician as a euthanasia case, whereas it should have been classified as a palliative sedation, and hence not reported to the FCECE (Cheng, 2018). However, it should be noted that in its information brochure, the FCECE specifically mentions that if there is an intention on behalf of the physician to shorten the patient's life, administering high doses of morphine or analgesics is considered to be euthanasia and should be reported (FCECE, 2015). In the case at issue, nobody disputes the fact that the physician indeed intentionally ended the patient's life and, moreover, that this was done at the request of the patient's relatives. However, as far as we know, the judicial authorities have not taken any action against the physician in question.

The Commission's (view on its) role and powers

Another element of concern is the powerful role that has been allotted to the FCEC. Clearly, as a result of the requirement that a two-thirds majority is needed to refer cases to the Public Prosecutor, the Commission has strong sovereignty in deciding whether or not to refer. The choice to entrust the a posteriori control to such a Commission implies that a body other than a judicial authority may take decisions that will keep euthanasia reports out of the hands of the judiciary. In two very recent cases, however, the authority of the Commission is being put to the test.

First, it should be noted that the Commission's task of monitoring euthanasia cases in no way detracts from the Public Prosecutor's independent authority to investigate and prosecute cases of euthanasia (Report of Giet et al., 2002). Anyone who can demonstrate a personal interest can file a complaint with the Public Prosecutor who has the prerogative to initiate investigations, even into cases that have been approved by the FCECE. If considered useful, the Public Prosecutor can request or even seize the report submitted to the Commission (Dierickx, 2003). This happened for the first and currently only time in 2018 when a woman filed a legal complaint following her sister's euthanasia for psychiatric suffering. She claimed that her sister's euthanasia case was not handled professionally and that several legal criteria were not

met. An official investigation ensued which concluded that, even though the FCECE had approved the case, there were indeed reasons to believe that one or more legal criteria were not met in this case. This resulted in a highly mediated Court of Assizes case where all three physicians (the treating physician and both consulted physicians) were tried for unlawfully poisoning a patient. Eventually all three doctors were acquitted, although the treating physician will now face trial again as the Belgian Court of Cassation has ruled that the decision to acquit provided by the Court of Assizes was insufficiently substantiated as regards the attending physician.

Second, in 2017 a Belgian citizen, Tom Mortier, filed a petition with the European Court of Human Rights following the euthanasia of his mother. Mortier was not informed of his mother having requested and received euthanasia which, he petitions, is a violation of Article 2 (Right to life) and Article 8 (Right to respect for private and family life) of the European Convention on Human Rights. In December 2018, the Court officially agreed to look into the case.

Our concern is that the Commission's current level of discretion in assessing the legitimacy of euthanasia cases in practice leaves it with considerable powers that would normally be the prerogative of the legislature or the judiciary. For instance, although the Euthanasia Law lays down clear criteria of due care that must be met for euthanasia to be legal, the body entrusted with the control of this legality has the authority to approve cases that fail to meet these criteria. The Commission in fact confirms that it does this. In the 2018 FCECE report, one can read that: "Although in some rare cases one or more procedural requirements were not followed correctly, the euthanasia reports were nevertheless approved by the Commission after, every time, having assured itself that all the 'essential conditions' of the law were fulfilled: a competent patient, a written request, a medical condition without prospect of improvement, constant and unbearable suffering that cannot be alleviated and is caused by a serious and incurable condition" (FCECE, 2018, 26; authors' translation). It should be noted that this claim is odd in view of the fact that, as mentioned above, in the same report the FCECE describes a case in which there was no written request.

The many other legal requirements are, apparently, deemed "non-essential" by the FCECE. Take, for example, the requirement that in cases of non-imminently dying patients there should be a period of at least one month between the patient's request and the performance of euthanasia. In its most recent report, the FCECE lists no less than 42 cases where the legally required one-month waiting period was not adhered to. The Commission notes that these cases "were systematically the topic of discussion. In these cases a didactic letter was systematically sent to the physicians to remind them of the procedure that needs to be followed in [such cases]" (FCECE, 2018).

Indeed, even when several legal criteria are not met, cases are still approved. In this way, the Commission's sovereignty in interpreting the legal criteria and in communicating its viewpoint to physicians who perform euthanasia

may lead to a reinterpretation of what constitutes legitimate euthanasia practice. There does not seem to be any legal ground for making a distinction between “essential” and “non-essential” conditions. If such a distinction is considered desirable, it is up to the Belgian Parliament to make this clear. To the extent that the FCECE’s interpretation of the scope and importance of the legal criteria goes beyond the one offered in the parliamentary proceedings and in case law, the Commission may steer euthanasia practice in a way that lacks transparency and escapes societal, parliamentary, and judicial control. In our view, this should give rise to significant concern. Yet to the extent that concerns are raised, these are largely ignored by policy makers and hardly result in any serious debate in Belgium.

VI. CONCLUDING REMARKS

Euthanasia, which involves the deliberate ending of a patient’s life, is a far-reaching and irreversible act that should be closely monitored. In this article, we have argued that there are shortcomings in the Belgian euthanasia law, the application of that law, and the monitoring of euthanasia practice. This leads us to conclude that several of these shortcomings are structural and thus require more than simply increased oversight.

The Euthanasia Law has specified several safeguards which, at the time of the enactment of the law, were considered to be fundamental. However, as we have explained in this article, there are various reasons to conclude that many of these (alleged) safeguards actually fail to operate as such. First, the scope of the Euthanasia Law has been stretched from being used for serious and incurable illnesses to being used to cover tiredness of life. Second, the obligatory consultation of one or two independent physicians may fail to provide a real safeguard. Their tasks are quite limited, and, more importantly, their advice is not binding anyway. The final authority to perform euthanasia lies with the attending physician who can perform it even against the (negative) advice of the consulted physicians. Third, the a posteriori control by the FCECE also raises concerns. The Commission is unable to check the fulfillment of various legal criteria, and it has substantial authority to (re) interpret the Euthanasia Law as it sees fit.

Due to the anonymity and the concise nature of the reporting form, the Commission is unable to check whether particular legal criteria are in fact met, even though that is its main task. Furthermore, due to the Commission’s composition and the authority it has taken upon itself, it might actually function as a shield, rather than a monitoring body. We have expressed the concern that the FCECE de facto has the power to change the interpretation of the Euthanasia Law unhindered by parliamentary, judicial, and societal control.

Furthermore, the observation that up until now the FCECE has only referred one case to the Public Prosecutor despite various indications that

the legal criteria are not always met may lead one to question whether the a posteriori control mechanism is adequate. Tellingly, the Coordinating President of the Dutch Regional Euthanasia Review Committees has recently pointed out that, contrary to the purpose of the Dutch *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, “the filter between physicians who perform euthanasia and the judiciary system has proven to be completely impenetrable” and “the boundaries of acceptable euthanasia are not determined by the judiciary but by the Committees themselves” (Nieuwsuur, 2017). The Coordinating President therefore calls for a change in the procedure of referring cases of euthanasia that do not seem to be in conformity with the legal requirements or that are especially controversial, so as to allow greater involvement of the judiciary. For Belgium, such remarks are even more pertinent, yet whether anyone will take them seriously remains to be seen.

NOTES

1. Other countries include, amongst others, The Netherlands (2001), Luxemburg (2009), Canada (2016), and Colombia, where euthanasia was decriminalized by decisions of the Constitutional Court in 1997 and 2014, but no legislation has been adopted on the issue. In 2017, the Australian state Victoria passed a Voluntary Assisted Dying Bill that took effect in 2019. It is important to distinguish euthanasia from physician-assisted suicide which is the act whereby a physician intentionally provides the means by which a person herself can end her life (e.g., by swallowing a deadly dose of medication). In some jurisdictions, for example, in The Netherlands, both physician-assisted suicide and euthanasia have been decriminalized. In Belgium, however, the euthanasia law defines euthanasia as “intentionally terminating life by someone other than the person concerned, at the latter’s request.” This means that only euthanasia, where a physician performs the final act, is legally allowed. This article will only focus on euthanasia.

2. We thank one of the anonymous reviewers for pointing this out.

3. This taps into the heated debate concerning the limits of conscientious objection by physicians to controversial acts such as abortion and euthanasia (see, e.g., [Wicclair \(2000\)](#) in favor of allowing conscientious objection and [Savulescu \(2006\)](#) who, on the contrary, pleads against recognizing conscientious objection in medicine). This issue is not the topic of our article. We would simply like to note that the Belgian euthanasia law provides that no one can be required to be involved in euthanasia, giving everyone (physicians, nurses, pharmacists, etc.) a right to object on any ground (e.g., conscientious or medical). The right to conscientious objection is thus legally settled in Belgium, although of course the ethical debate continues.

4. This study by Proot and Distelmans looked at the registration forms of the euthanasia cases for polyopathy reported to the FCECE between 2013 and 2016. The authors investigated the severity of the reported polyopathy cases using severity scales on the basis of the information provided in the registration forms. They concluded that in most cases of euthanasia for polyopathy, patients experience severe suffering without prospect of improvement. However, we question whether such an analysis is possible on the basis of the registration forms. The 2016 report of the [FCECE \(2016\)](#) provided several examples of filled-out registration forms; these seem to be very succinct. Moreover, as a member and, in the case of Dr. Distelmans, president of the FCECE, the authors might have an interest in showing that the cases they have approved in the Commission did indeed meet the legal requirements. In this respect, it is notable that although both authors mentioned their membership in the FCECE, they claimed to have no conflict of interest.

5. Note that alternative proposals for a mechanism of a priori control (e.g., approval by an ethics committee, a court, or a medical team) may raise more important concerns because they may be more difficult to reconcile with considerations regarding urgency, neutrality, dignity of the patient, and willingness to comply on the part of physicians, and might therefore de facto block the access to euthanasia for patients who should be eligible to receive it.

6. Note that the FCECE has the complete discretion to find that not consulting another physician (or the failure to examine the patient on the part of a consulted physician) does not necessarily amount to an inadmissible breach of the legal requirements, if these procedural requirements could not possibly be fulfilled (i.e., in the light of considerations of urgency), but the “material” due care criteria are still satisfied (Delbeke, 2014). The role of the FCECE and its far-reaching authority are discussed in the following section.

7. See Article 6 of the Euthanasia Law.

8. Interestingly, the 2016 report is the only FCECE report that provides any examples. The most recent report again includes only statistical information.

9. Note that the Commission can only take valid decisions if two-thirds of the 16 members are present (i.e., 11 members) and that cases may only be referred if at least eight members are convinced that the legal requirements have not been met. Since 8 of the 16 members are physicians and since physicians may also be found among the four members who need to have a background in the care of incurably ill patients, their voice will be decisive (Nys, 2017).

10. The reports of the FCECE indicate the following figures: 2002–03: 259; 2004: 349; 2005: 393; 2006: 429; 2007: 495; 2008: 704; 2009: 822; 2010: 953; 2011: 1133; 2012: 1432; 2013: 1807; 2014: 1928; 2015: 2022; 2016: 1592; 2017: 1792; 2018: 2359; and 2019: 2656.

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