LAW AND ETHICS. THE BELGIAN LAW ON EUTHANASIA AND MINORS … A BRIDGE TOO FAR FOR THE CURRENT DECADE?

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Abstract

The Belgian Parliamentary Act on Euthanasia of May 28, 2002, provides a clear example in the context of a conference dedicated to the efficiency of legal norms and challenges of the current decade. The legislation entails a vibrant and sensitive subject in society. Currently only a minority of countries worldwide have legislation covering euthanasia. When the law was made, an explicit provision was decided that ensured its workings would be subject to a parliamentary evaluation. Vast and detailed hearings have taken place in the Belgian Senate to make this legislative evaluation concrete.

The changes to the Belgian law on euthanasia have taken place after a long and vast process in Belgian parliament. It provides a clear example of legislative evaluation, its mechanisms and its impact on the parliamentary assembly and society as a whole. This process has given way to multiple proposals of law to alter, expand or limit the scope and mechanisms enshrined in it. This year, these have led to a parliamentary majority agreeing to significantly enlarge the population eligible to make use of its provisions. From now, minors also fall under the scope of the legislation. Given the international attention that has been given to the current widening of the scope of the Belgian law on euthanasia, the authors consider it to be a very relevant topic for an international setting. Finally, since the new law is being voted for as this research takes place, and has yet to be finalized between now and the date of the conference, the topic can hardly be more relevant.

This paper analyses the 2002 Act, the applied process of evaluation, how it has led to an agreement on the—even more sensitive—subject of opening up its scope to children, and the concrete changes and mechanisms in the renewed 2014 legislation.

Key Words: *medicine law, penal law, euthanasia, life-ending decisions, status underage persons.*

1. Introduction

1.1 Very few countries in the world have an explicit regulation under which euthanasia is possible one way or another. Among those countries can be listed the Netherlands (2001),[1] Belgium (2002)[2] and Luxembourg (2008).[3]

In Australia the Parliament of Australia's Northern Territory passed a Bill on

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[1] Act of April 12, 2001, concerning the review of euthanasia and assisted suicide and amendment of the Penal Code and the Burial and Cremation Act, went into force on April 1, 2002. More on this legislation, see R. Cohen-Almagor, *Euthanasia in the Netherlands. The Policy and Practice of Mercy Killing*, Dordrecht, Kluwer Academic Press, 2005, 205 pp.

[2] Act of May 28, 2002 on Euthanasia went into effect on September 20, 2002.

[3] Act of March 16, 2008 on Euthanasia and Assisted Suicide.

Euthanasia (1995)[4], but the final Act was repealed by the Australian Senate on March 25, 1997.

However, while the vast majority of countries have no laws permitting active euthanasia or assisted suicide, it cannot be ignored that in the medical field in other countries doctors, nurses, friends and family members practice "euthanasia" illegally on seriously ill patients. Although euthanasia is illegal in the United States, four states have a legal basis on physician-assisted suicide. In 1994 the population of the state of Oregon approved the Death with Dignity Act[5] which permitted physician-assisted suicide; a more or less similar regulation was adopted by the State of Vermont by the Patients' Choice at End of Life Bill.[6] The state of Washington's ballot on November 4, 2008—Initiative 1000—achieved a vote of 58 percent and therefore the Death with Dignity Act went into effect. Recently, September 2015, also the Senate in California has passed a law allowing assisted suicide; before California will become the fifth state in the US allowing a form of "euthanasia", the law must still be ratified by the Catholic Democratic governor.

The Montana Supreme Court on December 31, 2009 ruled in *Baxter vs. Montana* that suicide—even when a physician plays a role—is not a crime; Montana was therefore the third state in the US to legalize physician-assisted suicide.

In 1997 the Constitutional Court of the Republic of Colombia approved medical voluntary euthanasia for terminally ill persons who have clearly given their consent; however, the Colombian Congress has never approved this judgment and therefore euthanasia remains a crime in the country. Under Article 114 Swiss Penal Code any person who—for commendable motives, and in particular out of compassion for the victim—causes the death of a person at that person's own genuine and insistent request, is liable to a custodial sentence not exceeding three years, or to a monetary penalty. Article 115 of the same Code states that a person who, for selfish reasons, incites someone to commit suicide or who assists that person in doing so, will—if the suicide was carried out or attempted—be sentenced to a term of imprisonment of up to five years[7]. Although at first sight assisted suicide remains a criminal offence, in legal practice it can be determined that indirect, active and passive euthanasia—in the case of an absence of selfish motives and under strict conditions—is not punishable by law and is therefore "legal".

1.2. Belgium is now going one step further. Following the example of the Netherlands—where minors from the age of 12 years may request euthanasia—the

[4] Rights of the Terminally Ill Act of May 25, 1995 and went into effect on July 1, 1996; for an analysis of this Act, see Ch. Ryan, *Euthanasia in Australia*, New England Journal of Medicine 1996/5, 1-5.

[5] Death with Dignity Act of October 27, 1997. See M. Lee, "The Oregon Death With Dignity Act: Implementation Issues", *Western Journal of Medicine* 1997, 398-401; M. HARTMAN, "The Oregon Death With Dignity Act: Review and Proposals for Improvement", 30p to consult on http://www.ethesis.net/cohen/Oregon. See also US Supreme Court, January 17, 2006, *Gonzales vs. State of Oregon*, http://euthanasia.procon.org/files/GonzvOR.

[6] About this inter alia M. Eijckholt, *Physician Assisted Suicide, Vermont and Euthanasia on Clear Terms*, www.amc.edu/BioethicsBlog/post.cfm/physician-assisted-suicide-vermont-and-euthanasia-onclear-terms.

[7] Ch. Schwarzenegger and S. Summer, *Criminal Law and Assisted Suicide in Switzerland*, 2005, pp. 1-5, www.rwi.uzh.ch/lehreforschung/alphabetisch/schwarzenegger/publikationen/assisted-suicide Switzerland; also R. Cohen-Almagor, *Euthanasia in the Netherlands, o.c.*, pp. 11-12.

Belgian legislator extends the existing Euthanasia Act to "judgment skilled" minors without imposing any age limit: a "world first"!

The following contribution focuses on the Belgian euthanasia legislation for minors, beginning with the existing Euthanasia Act. To avoid any ambiguity when reading this article, first the concept of "euthanasia", as it should be understood in the Belgian law, is briefly discussed in relation to other forms of non-natural termination of life. It will then be examined as to how euthanasia fits within the context of Articles 2 and 8 of the ECHR, in particular relating to the right to life. Finally, the article will handle some possible problem areas and consider potential next steps in the expansion of the Euthanasia Act.

2. The Notion of "Euthanasia" in Belgian Legislation

2.1 *Termination of life on request by a third party.* Under Article Two of the Euthanasia Act 2002, euthanasia is defined as *"the intentional termination of life by another than the person on his request*". This definition is based on the advice given at the time by the Advisory Committee on Bioethics[8] and is vital for distinguishing "euthanasia" from other life-ending actions[9] that do not fall within the scope of the Euthanasia Act. Thought in this respect includes not starting or stopping a (pointless) medical treatment (prevention of therapeutic tenacity), and the administration and/or increasing dosage of anaesthetics to combat pain (lethal dosing), with the possibility of a life-shortening effect. Both acts fall within regular medical practice. Although not prohibited in the Belgian legal context, physician-assisted suicide is not covered by the above definition.

The legal doctrine emphasizes that in this respect a *general* and *neutral* definition be used in legislation;[10] *general* as the Act does not stipulate who may, or can, carry out the life-ending treatment and *neutral* because the life-ending treatment—although it thus often associated—is not connected to length of life, i.e., the terminal nature of the disease or the nature of suffering.

2.2 The legal definition used in Article 2 Euthanasia Act is therefore based on three cumulative aspects, namely an intentional termination of life, on request of a person, and carried out by another person.[11]

In order for euthanasia—in the context of the Belgian legislation—to exist, an explicit action is required; an abstention is not enough. An active goal-oriented

[8] Advice n° 1 of May 12, 1997 on the desirability of legislation of euthanasia, paragraph I. (see www.health.belgium.be/bioeth), *RW* 1997-98, p. 269.

[9] More extensive Y.H. Leleu and G. Genicot, *L'euthanasie en Belgique et Pays-Bas*, Revue Trimestrielle droits d'homme, 2004/57, pp. 10-15.

[10] See T. Vansweevelt, *De Euthanasiewet: De ultieme bevestiging van het zelfbeschikkingsrecht of een gecontroleerde keuzevrijheid?*, Tijdschrift Gezondheidsrecht 2003, n° 22, pp. 223-224.

[11] The following articles clarify that the third person to be a doctor; cf. with a similar requirement in the Dutch euthanasia law (see also Court Almelo May 29, 2009 Nederlands Juristenblad 2009, 483 with annotation T.M. Schalken in which a man - not a doctor - was convicted to ten months in prison for assisted suicide of his wife for providing her the means used; Court Almelo May 29, 2009, http://jure.nl/ecli:nl:rbalm:2009:bi5891 with respect to a "foundation"; Court Amsterdam January 22, 2007: providing general information regarding termination of life without instructions and concrete actions or skills to be helpful, is not assisted suicide).

action, with death as intended result, is paramount. Then, it is required that the person concerned requests euthanasia; a request from the patient is necessary at any time. If not, termination of life without request is equivalent to murder or manslaughter. The core of the Belgian Euthanasia Act is the self-determination of the patient,[12] and the legislator aims to avoid a scenario whereby the termination of life is made beyond the patient's control. Finally, euthanasia assumes that the life-ending operation is carried out by a third party. A physician who only delivers the medical means that the patient may self-administer is defined as performing (physician-) assisted suicide but not euthanasia.

2.3 *A conditional decriminalization*. An important legal issue arose with the adoption of the Euthanasia Act:[13] Should articles in the Criminal
Code be adjusted in relation to the possibility of euthanasia, or should the crimes "murder" and "manslaughter" be retained without change?[14]

A change would have had the advantage of clarity; such an adaptation of the penal code would then *de facto* give euthanasia the same status as other medical procedures. However, the legislator considered that there are reasonable grounds not to take this path. Several MPs decided that, for rather symbolic reasons, it would be inappropriate to amend the Criminal Code. Consequently, the criminal law under the current euthanasia regulation, even after the extension of euthanasia to minors, remains unchanged, and life-terminating treatment under certain conditions[15] is no longer considered a crime; a report, to be drawn up in advance by the physician, should still allow an *a posteriori* monitoring by the Federal Control and Evaluation Commission.[16] Performing euthanasia thus has no concrete consequences for the doctor as long as the statutory requirements have been respected. In such a case, the doctor commits no offence and will not be prosecuted.

A later inserted article 3*bis* [17] also depenalizes the intervention of a pharmacist; those who personally deliver a prescribed euthanaticum commit no offence if they act on the basis of a provision in which the physician explicitly states that he is acting in accordance with the Euthanasia Act.

3. Euthanasia and the Right to Life

3.1. Article 2 of the ECHR protects the right to life: In this context, the question may be raised as to a law that permits euthanasia under strict conditions,

[12] The Belgian Constitutional Court considered the Euthanasia Act contains sufficient safeguards to ensure that the patient who expresses his will in accordance with the provisions of the Act, does this in full freedom, see Const. Court nr. 43/2004 of January 14, 2004.

[13] For the discussions in the Belgian Senate, consult *Parliamentary Documents* Senate, 1999-2000, n° 1-244/22. More extensive T. Vansweevelt, *De Euthanasiewet: De ultieme bevestiging van het zelfbeschikkingsrecht of een gecontroleerde keuzevrijheid?, l.c.*, n° 41-44, 230.

[14] Zo bepaalt o.m. artikel 5 van de Wet van 9 december 2003 betreffende het Europees aanhoudingsmandaat uitdrukkelijk dat euthanasie — zoals abortus — niet met "moord" is gelijk te stellen, cf. Grondwettelijk Hof nr. 128/2007 van 10 oktober 2007.

[15] See *infra*, n° 13.

[16] More on this Commission, *infra*, n° 30-32.

[17] Art. 2 Parliamentary Act of November 10, 2005 supplementing the Act of May 28, 2002 concerning <euthanasia> with provisions on the role of the pharmacist and the use and availability of euthanatica (*Belgian Government Gazette* December 23, 2005).

whether or not it is in conflict with the aforementioned treaty provision. On the question of whether the legal possibility of euthanasia constitutes an infringement on the right to life, the European Court for the Protection of Human Rights in the case of Pretty v. the United Kingdom provides no direct answer; however, the Court has emphasized that the right to life is one of the most basic fundamental rights and therefore cannot be interpreted in such a way that it might entail a right to die.

With regard to medical treatment that would lead to the death of the patient, the same Court states that it is not the function of the Court to gainsay the doctors' assessment of the patient's condition; every state has adequate provisions for securing high standards among health professionals and for the protection of lives, so a possible error of medical judgment—i.e., lethal dosing—even if established, is not sufficient to engage state responsibility under Article 2 ECHR.

Above all, however, the Court examines euthanasia issues especially within the scope of Article 8 ECHR. In the aforementioned Glass ruling the Court held that, if necessary, a medical "do not resuscitate" notice be made by the treating physicians against the will of the family, and this would be examined under Article 8; however, to do so, the complaint was manifestly ill-founded.

The starting point here is, again, the Pretty case. In this judgment, the ECHR ruled that a legal euthanasia regime would fall within the margin of appreciation of each state party. Thus, each state must assess "the danger and the possibility of abuse in cases of relaxation of the penal legislation on assisted suicide"; as euthanasia in one state may remain punishable while another state could incorporate measures within the legislation to prevent abuses of assisted suicide. In Koch v. Germany's assisted suicide case Article 8 is relevant; the competent German authorities refuse the complainant's request to receive the lethal dose of medication because it would conflict with the objectives of the German Act on Narcotics. Eventually the patient—the wife of the plaintiff—dies by assisted suicide provided by Dignitas in Switzerland. The Court does not rule a decision about the right to suicide under Article 8, but considers that the rights of Koch are violated where no appeal against the decision of the Federal Institute for Medications and Medical Supplies—which had refused to provide the lethal medication—was open for the plaintiff. In a recent case, Gross v. Switzerland, the Court judged that the right of an individual to decide how and at what point his life ends, on condition that he or she is able to freely decide and act accordingly, constitutes an element of the right to respect for private life. However, in the current state of legislation, the Swiss Penal Act is too unclear on the matter and applies an obligation to clear guidelines concerning assisted suicide.

3.2. During discussion of the initial Euthanasia Act, the question relating to compliance with the treaty law of a guaranteed "right to life" obviously came forward. Both the Council of State—in its advice on the draft law on euthanasia—and the Constitutional Court, in annulment proceedings against the Euthanasia Act 2002, circumvent the question relating to compliance with the "right to life". Roughly the opinion states that the introduction of euthanasia legislation, as with other bioethical issues, presupposes a political and policy choice, and in such cases it is not up to the courts to decide on this subject. In the annulment appeal the Constitutional Court ruled that the assumption that a person who no longer wants to live still has his free will and is able to judge—moreover taking into account that the Euthanasia Act

contains numerous safeguards to ensure that an applicant's demand for euthanasia is beyond his free will—determined there to be no legal reason to overrule the Act on euthanasia.

4. The Belgian Euthanasia Act

4.1 The personal scope of application

4.1.1. *The principle of the legally competent adult.* The initial Article 3, §1, first indent Euthanasia Act determined that the patient is a legally competent adult or emancipated minor, who must be aware at the time of his request. Under Belgian law this relates to any person who has reached the age of eighteen years or who is emancipated below that age, for example by marriage or at the request of (one of) the parents. It is important to stress that the state of nationality legislation is important because the Euthanasia Act presupposes neither a nationality nor a residence requirement. Consequently, with regard to foreign nationals in Belgium, their national (civil) law should be ascertained whether they are construed as an adult or emancipated and legally competent.

The legal requirement of "legal capacity" therefore meant that certain categories of persons were not covered by the scope of the Euthanasia Act. This could include non-emancipated minors, judicially-declared incompetent adults[18] and minors capable of extended minority.[19]

4.1.2. At the time of the approval of the Euthanasia Act the legal position of minors in euthanasia caused a major disagreement. All amendments submitted which intended to broaden the scope to non-emancipated minors[20] over a certain age were rejected.[21] From the adoption of the initial Euthanasia Act bills were filed in each parliamentary term to extend decriminalization of active assistance with the termination of life, to the possibility euthanasia for minors, those with brain pathology, and so on.

At the beginning of the 2010-2014 parliamentary term new bills were also submitted. The traditional supporters and opponents of extending the euthanasia legislation once again fought each other from their known objectives; a point of difference with previous legislatures was the presence of a significantly lower number of ethical-ideological coloured MPs. In this manner, there was a sufficient basis to

[18] Art. 489 Belgian Civil Code. It concerns people in a persistent state of insanity or silliness. A translation of the civil code in English: J. Crabb, *The Constitution of Belgium and the Belgian Civil Code*, Colorado, Rothmann, 1982.

[19] Art. 487*bis* Belgian Civil Code. For a more detailed analysis of disability under Belgian law, see E. Strubbe, "Naar een wettelijke erkenning van levensbeëindiging bij wilsonbekwamen, *RW* 1999-2000, 318; Y.H. Leleu and G. Genicot, *L'euthanasie en Belgique et aux Pays Bas, l.c.*, 24-25; Th. Vansweevelt, *De Euthanasiewet: De ultieme bevestiging van het zelfbeschikkingsrecht of een gecontroleerde keuzevrijheid?, l.c.*, n° 50-56, p. 233.

[20] It fits in this context to point out that the inclusion of the emancipated minors within the scope of the original Euthanasia Act already had led confusion in other countries about the scope of the regulation. Foreign authors, not familiar with this legal concept, who for linguistic reasons could not consult the original Dutch or French legal text believed that euthanasia in Belgium was already possible for "judicious" minors.

[21] More in detail by H. Nys, *Euthanasie bij kinderen naar Belgisch recht*, *TJK* 2009/4, pp 277-278.

begin new parliamentary discussions on the extension of euthanasia to minors.[22]

4.1.3. ... *to judgment skilled non-emancipated minors*. The Act of February 28, 2014[23] opens the door to euthanasia requests for the aforementioned first category.

Unlike the Dutch Euthanasia Act—where minors may request euthanasia from the age of 12 years—the comprehensive Belgian legislation states no age limit. During the parliamentary hearings organized as part of the legislative process, some experts[24] pointed out that children often do not understand the finality of death. Proponents of the Extension Act emphasized different inferences from the hearings, in particular that age is not a decisive factor for youngsters to be able to formulate a full request for euthanasia. That latter vision evolved to the majority opinion; besides, the legal doctrine[25] had already argued likewise that the introduction of a minimum age, as in the Netherlands, would be too arbitrary.

It was thereby assumed that age is generally not a medical but a legal reality, so in the medical context of the voluntary termination of life, "judgment skilled" is a better criterion.[26] The central premise of the Euthanasia Act 2002—in particular the obligation that patient's request of euthanasia is free, voluntary and considered, and is recurrently expressed[27]—applies also to minor applicants. Concerning this category a criterion must apply that corresponds the most with the central premise, but that still makes the distinction between minors who are themselves capable of making a considered and autonomous deliberation,[28] and others. Thus Article 3, §1, first clause, of the Euthanasia Act makes mention of *"a judgment skilled minor [who] at the time is aware of his request"*.

4.1.4. *Judgment skilled: a concept hard to define?* Obviously, the interpretation of the notion of "judgment skilled" will be the crucial legal issue in the application of euthanasia for non-emancipated minors.

In this respect it does not need to be stressed that diametrically opposite visions between Members of Parliament remain relevant.[29] In this regard a dispute[30]

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[22] For a more extensive analysis, see L.M. Veny en P. Goes, "Een wereldprimeur: de uitbreiding van de Euthanasiewet naar niet-ontvoogde minderjarigen", *Rechtskundig Weekblad*, 2013-14, te verschijnen.

[23] Act of February 28th, 2014 amending the Act of 28 May 2002 concerning euthanasia, in order to allow euthanasia for minors, hereinafter referred to as extension law (not yet published in the Belgian Government Gazette).

[24] Cf. *Parliamentary Documents* Senate, 2013-14, n° 5-2170/4, 20.

[25] Read, inter alia, C. Rommelaere, "Euthanasie des "enfants" et des "déments"… Réflexions sur les propositions de loi", *Tijdschrift Gezondheidsrecht (Health Law Journal)* 2013/2, 82.

[26] *Parliamentary Documents* Senate, 2013-14, n° 5-2170/4, 21.

[27] Also *infra*, n° 18.

[28] C. Rommelaere, *Euthanasie des "enfants" et des "déments"... Réflexions sur les propositions de loi, l.c.*, 83.

[29] On the basis of the interventions of the pediatricians the report of the Parliamentary Commission (Parliamentary Documents Senate, 2013-14, n° 5-2170/4, 75) maintains that "*just by their disease* [*youngsters]* can better assess their medical condition; *they are more mature"*.

[30] Cf. the statements that children "due to their disease are more susceptible to influence by parents because they are weaker and more vulnerable" and "we do not yet know what the impact of a prolonged illness on young children, on the development of their ability to make independent choices, will be", thus the Working Group Meta forum Catholic University Leuven "Vision text: euthanasia and human vulnerability", to consult on www.kuleuven.be/metaforum/page.php?FILE=w-g&LAN=N&ID=9.

arises as to the impact of a long-term illness and/or suffering on the judgment of a minor, and as to an increased susceptibility to interference from authority figures—for example parents and other family members, and others within the close circles of the minor.

According to some experts, children who suffer often develop a real maturity. The disease awareness of a minor within his or her own experience evolves considerably. What the child experiences influences his or her maturity and thus also the way he thinks about death and thus of the significance of the request he formulates.[31] For some other speakers, society must be vigilant of the fact that severely sick children absorb the psychological and emotional suffering of their relatives much like a "sponge"; they would thus take on the tacit request of their relatives, for whom it is difficult to face the end of life of a child. In the same vein, it is noted that it should be borne in mind that unwell minors remain vulnerable people sensitive to a particular moral pressure.[32] Specifically, this aspect of the protection of ill young people should be interpreted as a fundamental value that legislation consequently has to imbue.

In an early commentary on the Euthanasia Act it was emphasized that this discussion exposes the fault line between two different visions of life: The absolute respect and the sanctity of life, versus the right of man to self-determination.[33] In the treatment of the Extension Act the first vision was no longer discussed, but rather a dialogue between the absolute right to self-determination of man and the protection of vulnerable people was approached.

4.1.5. It will therefore follow, firstly, that the notion "judgment skilled" will gradually be interpreted and elaborated upon[34] and, secondly, it will be necessary to identify those requests made as a result of the suffering of the parents of minors.[35] However, it is necessary to ensure that assessment of the judgment competence of a minor by a third party should not mean that the decision is left to a third person; yet implicitly an age limit in the application of the Euthanasia Act infers as such.

4.2 Application conditions

4.2.1 *General conditions*. In order that termination of life be under the jurisdiction of the Euthanasia Act, the patient must be in a medically unmitigable situation of constant and unbearable physical or psychological suffering that cannot be alleviated, and that it must be the result of a serious and incurable disorder caused by accident or illness,. The three substantive requirements—formulated in the previous definition—apply equally to adults, emancipated and non-emancipated minor euthanasia applicants.

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[31] *Parliamentary Documents* Senate, 2013-14, n° 5-2170/4, 26.

[32] Thus *Parliamentary Documents* Senate, 2013-14, n° 5-2170/4, pp 17.

[33] T. Vansweevelt, *De euthanasiewet. Toepassingsgebied en krachtlijnen, l.c.*, p 444.

[34] One suggestion here is the interpretation "*capable* of making a reasonable assessment of his interests", as referred to in article 12 of the Patients' Rights Act of August 22, 2002, cf. *Parliamentary Documents* Senate, 2013-14, n° 5-2170/1, 2-3 and n° 5-2170/4, 72.

[35] *Parliamentary Documents* Senate, 2013-14, n° 5-2170/4, 58 and 59; also Working Group Meta forum Catholic University Leuven "Vision text: euthanasia and human vulnerability", to consult on http://www.kuleuven.be/metaforum/page.php?FILE=w-g&LAN=N&ID=9.

The section above[36] has already emphasized that the Belgian Euthanasia Act does not require the disease or illness in question to be terminal. However, it is required that the patient is in a *medically hopeless condition*; meaning that the doctor cannot alleviate the suffering of the patient, that his suffering can no longer be treated adequately, and that nothing the doctor suggests can provide adequate relief to the patient or provide curative treatment. When a real alternative medical treatment exists, the counselling physician must refuse euthanasia even if the patient desires that he no longer wants to undergo any alternative treatment. This relates to an objective medical condition to be determined by the physician.[37] In addition, there must be *constant and unbearable physical or mental suffering*; unlike the previous requirement, this concerns a subjective condition. It is obvious that neither those in the patient's immediate environment, nor the physician, but only the patient, can pass judgment on this condition. In the context of a euthanasia request, the physician is largely dependent on the personal perception of this suffering by the patient;[38] as to that the idea of self-determination in the Belgian Euthanasia Act has very clearly moved forward. This condition also assumes that the suffering is permanent, in other words not a temporary or transient pain perception. Moreover, it can mean *physical* as well as mental suffering.[39] Yet in this context it is important to stress that this right to self-determination is subject to supervision by the treating physician, through implementation of Article 7 Euthanasia Act where the latter has the obligation to send the prescribed registration document to the Audit and Evaluation Committee. Finally, the suffering must be a result of a *serious and incurable disease, caused by accident or illness*, as the first requirement here applies once more an objective condition to be determined by the physician. The terms "serious" and "incurable" are cumulative in their application; a serious disease that is curable now, e.g., some cancers, or an incurable disease that the medical world does not perceive as serious, such as psoriasis, cannot be given as a reason for life-ending treatment. It is clear that only a medical cause is at the basis of euthanasia; in the case of termination-of-life requests based on social, relational—important for the purpose of minor applicants—and financial reasons, the doctor is obliged to refuse the application of the life-ending act.

4.2.2. *The terminal character as an additional condition for non-emancipated minors*. During the parliamentary discussion of the initial Euthanasia Act, and in numerous bills, aspects associated with the terminal character of a medical condition for adult applicants was a tricky point of discussion.[40] The question arose, however, as to whether or not such a requirement should make a—hard to justify—distinction between terminal and non-terminal patients, since the experience of persistent and unbearable suffering does not necessarily depend on the end of a person's life. For a

[36] *Supra*, n° 3; see also *infra*, n° 14.

[37] *Parliamentary Documents* Senate, 2000-2001, n° 2-244/22, 765.

[38] Th. Vansweevelt, *De Euthanasiewet: De ultieme bevestiging van het zelfbeschikkingsrecht of een gecontroleerde keuzevrijheid?, l.c.*, n° 74, 240.

[39] It is noteworthy that purely psychological suffering is rather rare, but the physical suffering is frequently associated with a psychological perception.

[40] See also W. D Bondt, "De eerste evaluatie van de toepassing van de euthanasiewet: capita selecta en kanttekeningen", *Rechtskundig Weekblad* 2005-06, 86.

given legal doctrine this would create, in any case, discrimination between people who experience a similar "unbearable and irreversible suffering".[41]

In many cases, it is also almost impossible for doctors to precisely determine the end of life; moreover, is this to be assessed in terms in days, weeks or months? Ultimately the reason that the qualification "terminally" is not included in the Euthanasia Act is linked to the subjectivity of the concept. The insertion of the words *"within a foreseeable future have to result in death"*, would likewise provide problems of interpretation when implementing the law. On the grounds that a terminal diagnosis as a requirement for euthanasia would trigger the greatest legal uncertainty, the legislator in 2002 did not make it obligatory as a condition.

The inclusion of the possibility of euthanasia for non-emancipated minors in the original Act of May 28, 2002 would have resulted in exactly the same conditions being applicable; so once again raising the question of the need for a terminal diagnosis at the point of request. At the last moment, and with amendment,[42] a further restriction was added that the minor applicant must be terminally ill, expressed as follows: *"that within the foreseeable future death has resulted."*[43] This addition was intended to avoid any misunderstanding that, in the case of minor applicants, euthanasia would only be possible in the case of a terminal illness or disorder.

4.3 Procedural aspects

4.3.1. In the context of, and in relation to, the core element of this contribution, it would lead too far to describe all of the procedural aspects in detail. The following discussion focuses, therefore, on those elements where specific rules apply for non-emancipated minors.

4.3.2. *Obligation to provide information and consultation*.[44] Notwithstanding the aforementioned substantive requirements the physician must, in advance of the life-ending act and in all cases: 1°, inform the patient as to his health and his life expectancy, and consult with the patient as to his request for euthanasia, discussing any remaining therapeutic options—as well as those of palliative care—and their implications[45]; 2°, ensure himself of the persistent physical or psychological suffering of the patient and the sustainable nature of his request to the extent of having multiple discussions with the patient over a reasonable period of time; 3°, contact another independent physician about the serious and incurable nature of the disease, inform him of the reasons for the consultation[46] and then inform the patient in this regard; 4°, where appropriate, discuss the case—on patient's request—with those members of the

[41] W.D. Bondt, *De eerste evaluatie van de toepassing van de euthanasiewet: capita selecta en kanttekeningen, l.c.*, 89-90; Th. Vansweevelt, *De Euthanasiewet: De ultieme bevestiging van het zelfbeschikkingsrecht of een gecontroleerde keuzevrijheid?, l.c.*, n° 81-84, 243-244.

[42] See amendment Mahoux, n° 12, *Parliamentary Documents* Senate, 2013-14, n° 5-2170/3, 10 en n° 5-2170/4, 86.

[43] Art. 3, §1, third indent, Act Euthanasia.

[44] See art. 3, §2, Act Euthanasia.

[45] The objective is to reach in consultation with the patient to the conclusion that there exists no more reasonable alternative for his medical situation and to ensure that the patient's request is based on full voluntary.

[46] The physician will inspect the medical file, will examines the patient, will verify if the constant and unbearable physical or mental suffering cannot be alleviated, and then will draw up a report with reference to its findings.

nursing team who are in regular contact with the patient; 5°, at the entreaty of the patient discuss his euthanasia request with designated fellow-men and; 6°, ensure that the patient has had the opportunity to speak about his request with those whom he wishes.

In the event that the adult or emancipated minor patient will apparently not die in the foreseeable future, the treating physician should—in accordance with Article 3, §3, under the same conditions and obligations as described point three above— also consult a second physician who will ensure himself of the voluntary, well-considered and repeated nature of the patient's request. Between the patient's written request and the implementation of euthanasia at least one month must have elapsed.

All requests of the patient, the physician's actions and reports by the consulted physician(s) are registered in the personal medical record of the patient.

4.3.3 In the case of non-emancipated minor patients, there is an additional requirement.

According to Article 3, §2, 7° Euthanasia Act, if a request for euthanasia is made by a non-emancipated minor, the treating doctor in addition consults a child and adolescent psychiatrist or psychologist and informs him of the reasons for this consultation. The consulted specialist notes the medical file, examines the patient, verifies the judgment ability of the minor and certifies his findings in writing. The treating physician informs the minor applicant and his legal representatives of the outcomes of that consultation. During an interview with the legal representatives of the minor, the doctor gives them the necessary information and assures that they alone give their consent to the request for euthanasia of the minor patient.

4.3.4. *The request*. The patient presents his request in writing, and this document is dated and signed by the patient. If the patient is unable to do so, the written request is made by an adult chosen by the patient; the latter may have no material interest in his death. The selected person reports that the patient is unable to formulate a request in writing, stating the reasons; the notice is made by a chosen person in front of the doctor whose name is recorded on the document. This document shall be attached to the medical record.

In the case of a non-emancipated minor patient's request, the consent of the legal representatives is also required.[47]

4.3.5. Each patient may at any time revoke the request, after which the document is removed from the medical file and returned to the patient.

4.3.6. *The living will concerning euthanasia*. In the event that the patient—in the future—can no longer express his will, any legally competent adult or emancipated minor may express in a written living will concerning euthanasia that a physician—who has assured them that the patient is suffering from a serious and incurable disorder caused by accident or illness, is no longer conscious and that his medical condition according to the scientific medical knowledge is irreversible—performs a life-ending act.[48]

[47] On the role of the parents in a euthanasia request of a non-emancipated minor, see *infra*, n° 23.
[48] Art. 4, §1, Act Euthanasia.

The written living will concerning euthanasia may be drawn up at any time vis-à-vis two adult witnesses, of whom at least one has no material interest in the death of the patient; the document shall be dated and shall be signed by the person making the statement, by the witnesses and, where appropriate, by the confidant(s).[49]

The living will concerning euthanasia shall be recorded in the medical file of the patient. According to Article 14 Euthanasia Act the living will concerning euthanasia—as well as the request referred to in Article 3 of the same statute—has no compelling value.

4.3.7. The living will concerning euthanasia can only be taken into account if this has been drawn up fewer than five years before the date on which the person can no longer express himself.[50]

4.3.8. Non-emancipated minors are excluded from the scope of Chapter III "The Living Will" of the Euthanasia Act; therefore, they cannot draft, in advance, a living will relating to the termination of their life—at least not concerning euthanasia—in the event that they would no longer be able to express their wishes.

This ruling was considered "not desirable"[51] by the legislator, taking into account also the fundamental legal incapacity of minors in general. In particular, legal doctrine[52] responded to the proposals at an earlier stage, raising the point that an explanation or a well-founded justification to circumvent these problems would have been in place. Others[53] consider it logical that, if "judgment skilled" minors are permitted euthanasia, they equally must be able to draw up such a living will concerning euthanasia in advance.

4.3.9. *Role of parents and their consent as legal representatives of a minor*. The initiators of the Extension Act have not ignored that underage patients, in their request for euthanasia, are legally incapable; the non-emancipated minor patient possesses—pertaining to civil law—no capacity to bind themselves legally and will need someone to act on his behalf. While the starting point is the minor's application, it is also necessarily opted to require the consent of the parents or legal representatives before such a request may be granted.[54]

The question arises as to how, in the case of parental refusal—or even worse refusal by just one parent—the treating physician and associated medical team must proceed. In this context, it can be repeated that the request for euthanasia is not to be perceived as an enforceable individual right—least of all in respect of a minor—but implies an auxiliary decriminalization of suicide.[55] It is therefore obvious that in this case euthanasia in a legal manner will not be carried out and the legislator indicates that a conflict will occur. Neither the modified Euthanasia Act, nor the parliamentary documents or activities, provide a comprehensive solution to resolve such a conflict.

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[49] The confidant informs the treating physician of the wishes of the patient in case of this latter's inability; there is a sequence in which each confidant replaces its predecessor in case of refusal, foreclosure, disability or death. The physician treating the patient, the consulted physician and the consulted members of the nursing team cannot occur as a confidant (art. 4, §1, third intend).

[50] Art. 4, §1, six intend, Euthanasia Act.

[51] *Parliamentary Documents* Senate, 2013-14, n° 5-2170/4, 78.

[52] H. Nys, *Euthanasie bij kinderen naar Belgisch recht, l.c.*, 281.

[53] Cf. *Parliamentary Documents* Senate, 2013-14, n° 5-2170/4, 29 en 31.

[54] Consult *Parliamentary Documents* Senate, 2013-14, n° 5-2170/4, 29 en 31.

[55] *Parliamentary Documents* Senate, 2013-14, n° 5-2170/4, 30.

A number of suggestions are formulated to elaborate a procedure that would make it possible for the final decision to be taken by consensus; a decision-making process would meet this objective. That path is not maintained in the final legal text.[56] In our view, a judicial solution should be avoided by all means; following a recent court case in France, where the Administrative Tribunal in Châlons-en-Champagne[57] had to bite the bullet on euthanasia, many reactions came from the medical world. A judge should not, however, play the role of the treating physician(s) by deciding in his (or their) place the termination-of-life request of a patient.

4.3.10. The approved text remains a clear compromise in all areas. While, on one hand, its approval was rejected on the grounds that the scheme would provide too few safeguards against inconsiderate, injudicious or improper actions, others were of the opinion of the requirement of legal representatives' consent to be a far-reaching and excessive restriction on the right to self-determination of the non-emancipated minor patient, particularly since he must already be considered to possess "judgment ability" by a paediatrician. For the latter group, the logic followed incoherently by the legislator;[58] a combination of an inquiry with respect to the judgment ability of the minor, on the one hand, and the consent of the parents on the other involves two conditions that are contrary to each other. Certain Members of Parliament[59] therefore advocate limiting the condition of the consent of the legal representatives to cases where the minor does not have judgment ability. However, the amendment has not yet been adopted.

With the chosen course of action the legislator demonstrates pragmatism; it is alleged against on the premise that, although such situations can be discussed in theory, in practice it is hard to imagine that a doctor would carry out euthanasia on a minor contrary to the will of the parents.

4.3.11. *Psychological assistance*. Finally, pursuant to Article 3, §4/1, Euthanasia Act, after the doctor has addressed the request of the patient the possibility of psychological assistance is provided to those involved. While the bill only gives the certainty that the parents would be offered psychological assistance after the doctor "accepts" the request of the patient, in the final legal text this opportunity is extended to all cases where the doctor has addressed the request. The legislator ruled that there was no reason to foresee assistance only if the request for euthanasia was accepted; after all, in the case of refusal the need for psychological assistance may also exist among those involved.

4.3.12. *Role of the physician in a euthanasia request*. Pursuant to Article 14 Euthanasia Act physicians—or any other person[60]—cannot be forced to contribute to the application of euthanasia.

If the consulted physician refuses the application of euthanasia, he must inform the patient or any possible confidant in reasonable time about the reasons for his refusal. In the event of a refusal on medical grounds, this will be recorded in the

[56] See *Parliamentary Documents* Senate, 2013-14, n° 5-2170/4, 30, 34-35 en 76.

[57] *Le Monde* January 18, 2014.

[58] *Parliamentary Documents* Senate, 2013-14, n° 5-2170/4, 49.

[59] Cf. Amendment Thibeaux, n° 2, *Parliamentary Documents* Senate, 2013-14, n° 5-2170/2, 1-2.

[60] Private (catholic) hospitals, as well as (religious) doctors and other staff may refuse to cooperate to euthanasia.

medical file of the patient. A physician who refuses to respond to a request for euthanasia, must, at the request of the patient or the confidant, notify another physician—designated by the patient or confidant—of the medical file detailing the patient's state; the designated doctor can grant the request and fulfil the living will of the patient.

Any person who—in any capacity whatsoever—is involved in the implementation of the law, is obliged to maintain the confidentiality of the related information entrusted to him in the performance of his duties. Article 458 of the Criminal Code[61] relating to professional confidentiality is applicable.

4.3.13. Physicians and staff of the medical team involved in the euthanasia actions cannot—in the application of Article 15, second clause, Euthanasia Act—profit from donations inter vivos or testamentary who bear the patient in the course of the disease may have made for their benefit.

4.3.14. *A natural death!* Article 15 Euthanasia Act expressly stipulates that a person who dies as a result of euthanasia in application of the conditions set by the aforementioned Act, shall be deemed to have died a natural death. This means that implementation of the agreements to which he was a party, and in particular the insurance contracts, should be respected in good faith and at all times by the contractor.

4.4 An a posteriori control

4.4.1 *Declaration*. Within four working days, the euthanasia-treating physician delivers—according to Article 5 Euthanasia Act—a completed registration document to the federal Audit and Evaluation Commission.

This document consists of two parts[62]: A *general part* with the coordinates of the applicant, the treating physician, the consulted physician(s), other persons consulted and, if applicable, the confidants in case of a living will concerning euthanasia. The second confidential part contains: 1°, the gender, date and place of birth of the patient and, with respect to the minor patient, their possible emancipation; 2°, the date, place and hour of death; 3°, the nature of the serious and incurable disorder, caused by accident or illness, from which the patient was suffering; 4°, the nature of the persistent and unbearable pain; 5°, the reasons why this suffering could not be alleviated; 6°, on the basis of what elements one is satisfied that the request is considered voluntary and repeated, and is not the result of any external pressure; 7°, if it could be assumed that the patient would die in the near future; 8°, if a living will concerning euthanasia has been formulated; 9°, the procedure that the physician has followed; 10°, the capacity of the physician or physicians, the dates of consultations, and advice given; 11°, the capacity of the persons consulted by the physician and the dates of these consultations, and; 12°, the manner in which euthanasia was applied, and the means used.

[61] That provision reads as follows: medical practitioners, physicians, surgeons, health officers, pharmacists, midwives and all other persons who by virtue of their status or profession have knowledge of secrets entrusted to them, and which they disclose outside the case that they are called upon in court or before a parliamentary inquiry commission to give testimony, and outside the case where the law requires them to disclose those secrets, be liable to of eight days to six months and a fine of one hundred euros to five hundred euros.

[62] Art. 7 Euthanasia Act.

4.4.2. *The Federal Audit and Evaluation Commission*.[63] The Commission consists of sixteen members where multiple parities and quotas must be observed. There exists a French and a Dutch-speaking language group consisting of eight members each; amongst the candidates of each language group at least three members of each gender must be recommended. The Commission is composed of eight doctors and eight lawyers, of which a maximum of four members in each section can be professor at a university;[64] four members from the lawyer section belong to circles responsible for the problems experienced by terminally ill patients.

All members are appointed based on their knowledge and experience in matters within the competence of the Commission; there is an incompatibility with a parliamentary mandate and minister of State secretary in the federal or federated government.

The Commissioners are appointed by Royal Decree from a double list proposed by the House of Representatives for a renewable period of four years; the non-elected candidates are ranked as successors chronologically. The mandate comes to an end after the nomination term—unless prolonged—and ends automatically if the member loses the professional capacity through which he serves.

4.4.3. The Commission edits the registration document that is to be filled in by the doctor, whenever he practices a euthanasia request.[65]

It examines the fully-completed registration documents and checks—on the basis of the second part of the document—if the euthanasia is executed under the conditions of, and in accordance with, the procedure stipulated by the law.

In case of doubt as to the correct application of the law, the Commission may decide by simple majority to lift anonymity by taking note of the general part of the registration document.[66] The Commission may also ask the treating physician for details of each element in the medical file relating to the euthanasia.

The Commission will give her opinion within two months.

If the Commission decides, with a majority of two-thirds, that the provisions of the legal requirements have not been complied with, it will then pass the file to the public prosecutor.

4.4.4. For the benefit of the federal parliamentary assemblies, the Commission writes a biennial statistical report in which, firstly, the information of the second part of the fully completed registration document is processed; secondly, the application of the law is indicated and evaluated, and; thirdly, where appropriate, recommendations are made that could lead to legislative initiatives and/or other measures relating to implementation of the law.

In order to fulfil its tasks, the Commission may gather any additional information—confidentially and anonymously—at the various government departments and institutions, and receive expert opinions.

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[63] Chapter V Euthanasia Act, hereinafter cited as "The Commission".

[64] Or practicing barristers or solicitors.

[65] Hereabout *supra*, n° 29.

[66] In case after the lifting of anonymity it is established that a member cannot act independently or impartially, the member has the possibility to stand down or it can be challenged for the further handling of the case, cf. art. 8, third intend, Euthanasia Act.

The Commission may decide, upon reasonable request, to communicate statistical and technical data to university research teams, to the exclusion of all personal data.

5. Conclusion

5.1. The extension of the decriminalization of euthanasia to non-emancipated minors marks a further step—from an international point of view—in already progressive legislation. At a time during which almost all countries still lack any euthanasia legislation, such an extension of the Belgian euthanasia rules may be seen as significant. Henceforth youngsters of that target group, who are in a situation of persistent and unbearable physical suffering, which within the foreseeable future must result in death, can request for euthanasia provided they are deemed "judgment skilled".

The current amendment is, of course, an obvious compromise; the current text of the Extension Act is remarkable, alongside its implementation through the position of an opposition party that was responsible for an alternative majority. Particularly remarkable is the legislation of euthanasia for non-emancipated minors, but within tighter conditions and contours than is the case for adults and emancipated minors; the target in this case is the "judgment skilled", non-emancipated minor, under the double condition that their suffering must be of a physical and terminal nature. There is, therefore, no mere extension of the existing scheme for adults for non-emancipated minors.

Advantageously, a more limited regulation was preferred so that a parliamentary majority could support the non-government bill; this at the expense of a more elaborate—but parliamentary unsupported—extension law. Yet—and this was clearly stated in the discussion of the different bills—each step beyond serves just an intermediate stage, i.e., a stepping stone or a springboard for future extension or liberalization. Therefore, discussions as to access to euthanasia by patients with dementia, and a weakening of the conditions related to the living will concerning euthanasia, are the two main contenders to appear on the parliamentary agenda in the relatively near future.