Federal Commission of Control and Evaluation of Euthanasia

Eighth report to the Legislative Chambers
years 2016 – 2017

Unofficial English translation
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Introduction

This report concerns registration documents submitted during the period from 1 January 2016 to 31 December 2017 examined by the Federal Commission for the Control and Evaluation of Euthanasia.

According to the law on euthanasia, it contains several sections:

Section 1 Statistics based on the information collected in Part II of the registration document that the reporting physicians completed for the period 2016–2017;

Section 2 A description and assessment of the application of the law and its evolution;

Section 3 Recommendations that may lead to legislative initiative and / or other enforcement action.

Section 4 Annexes including the Euthanasia Act and the List of Members of the Commission.

This report has been prepared by

- Members of the Commission
  - W. De Bondt
  - J. De Roeck
  - W. Distelmans
  - J. Herremans
  - L. Proot
  - Mr. Morret-Rauïs

- and the secretaries of the Commission
  - E. De Ville
  - C. Drappier

It was discussed at the plenary sessions of May 15 and 24, 2018 and was unanimously approved on June 12, 2018.

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IMPORTANT: This unofficial English translation should be read in tandem with the official French or Dutch original.

Section 1. Euthanasia in figures 2016–2017

Information gathered from Part II, the "anonymous part", of registration documents received by the Commission in accordance with the Law on euthanasia (article 9).

Number of euthanasia cases practiced and language distribution

	2016	2016 (%)	2017	2017 (%)	TOTAL	% TOTAL
TOTAL	**2028**	**100 %**	**2309**	**100 %**	**4337**	**100 %**
Reported in Dutch	1592	**79**	1792	**78**	**3385**	**78**
Reported in French	436	**21**	517	**22**	**952**	**22**

Distribution of patients by gender

	2016	2016 (%)	2017	2017 (%)	TOTAL	% TOTAL
TOTAL	**2028**	**100 %**	**2309**	**100 %**	**4337**	**100 %**
Male	1033	**50.9**	1175	**50.9**	**2208**	**50.9**
Female	995	**49.1**	1134	**49.1**	**2129**	**49.1**

Distribution of patients by age

	2016	2016 (%)	2017	2017 (%)	TOTAL	% TOTAL
TOTAL	**2028**	**100 %**	**2309**	**100 %**	**4337**	**100 %**
Less than 18	2	**0.1**	1	**0.0**	**3**	**0.1**
18-29	10	**0.5**	15	**0.6**	**19**	**0.4**
30-39	20	**1.0**	17	**0.7**	**37**	**0.9**
40-49	77	**3.8**	56	**2.4**	**133**	**3.1**
50-59	190	**9.4**	228	**9.9**	**418**	**9.6**
60-69	442	**21.8**	479	**20.7**	**920**	**21.2**
70-79	534	**26.3**	604	**26.2**	**1138**	**26.2**
80-89	573	**28.3**	664	**28.8**	**1237**	**28.5**
90-99	176	**8.7**	237	**10.3**	**414**	**9.5**
100 and over	4	**0.2**	8	**0.3**	**18**	**0.4**

Place of euthanasia

	2016	2016 (%)	2017	2017 (%)	TOTAL	% TOTAL
TOTAL	**2028**	**100 %**	**2309**	**100 %**	**4337**	**100 %**
Home	908	**44.8**	1046	**45.3**	**1954**	**45.1**
Hospital	821	**40.5**	865	**37.5**	**1686**	**38.9**
Rest home – nursing home	256	**12.6**	348	**15.1**	**604**	**13.9**
Other	43	**2.1**	50	**2.2**	**93**	**2.1**

Basis of written request

	2016	2016 (%)	2017	2017 (%)	TOTAL	% TOTAL
TOTAL	**2028**	**100 %**	**2309**	**100 %**	**4337**	**100 %**
Current request	2000	**98.6**	2276	**98.6**	**4279**	**98.7**
Advance declaration	28	**1.4**	33	**1.4**	**58**	**1.3**

Foreseeable future death

	2016	2016 (%)	2017	2017 (%)	TOTAL	% TOTAL
TOTAL	**2028**	**100 %**	**2309**	**100 %**	**4337**	**100 %**
Expected in the near future (brief)	1749	**86,2**	1934	**83,8**	**3683**	**84,9**
Not expected in the near future (not brief)	279	**13,8**	375	**16,2**	**654**	**15,1**

Conditions underlying the request for euthanasia

	2016	2016 (%)	2017	2017 (%)	TOTAL	% TOTAL
Breakdown for each year as a % of all conditions combined						
TOTAL	**2028**	**100 %**	**2309**	**100 %**	**4337**	**100 %**
Tumours (cancers)	1364	**67.3**	1417	**61.4**	**2781**	**64.1**
Poly-pathologies	268	**13.2**	442	**19.1**	**710**	**16.4**
Diseases of the nervous system	121	**6.0**	179	**7.8**	**301**	**6.9**
Diseases of the circulatory system	90	**4.4**	79	**3.4**	**169**	**3.9**
Diseases of the respiratory system	67	**3.3**	70	**3.0**	**137**	**3.2**
Mental and behavioural disorders	37	**1.8**	40	**1.7**	**77**	**1.8**
Diseases of the musculoskeletal system, muscles and connective tissues	20	**1.0**	23	**1.0**	**43**	**1.0**
Traumatic injuries, poisonings and other consequences of external causes	17	**0.8**	18	**0.8**	**35**	**0.8**

	2016	2016 (%)	2017	2017 (%)	TOTAL	% TOTAL
Breakdown for each year as a % of all conditions combined						
TOTAL	**2028**	**100 %**	**2309**	**100 %**	**4337**	**100 %**
Diseases of the digestive system	10	**0.5**	11	**0.5**	**21**	**0.5**
Diseases of the genitourinary system	8	**0.4**	8	**0.3**	**16**	**0.4**
Some infectious and parasitic diseases	6	**0.3**	7	**0.3**	**12**	**0.3**
Symptoms, signs and abnormal results of clinical and laboratory examinations, not elsewhere classified	4	**0.2**	8	**0.3**	**12**	**0.3**
Diseases of the eye and associated structures	8	**0.4**	0	**0.0**	**8**	**0.2**
Diseases of the blood and haemopoietic organs and certain disorders of the immune system	1	**0.0**	2	**0.1**	**5**	**0.1**
Endocrine, nutrition and metabolic diseases	3	**0.1**	2	**0.1**	**3**	**0.1**
Diseases of the skin and subcutaneous tissues	2	**0.1**	1	**0.0**	**3**	**0.1**
Diseases of the ear and mastoid process	0	**0.0**	1	**0.0**	**2**	**0.0**
Congenital malformations and chromosomal abnormalities	1	**0.0**	1	**0.0**	**1**	**0.0**
Some diseases whose origin is in the perinatal period	1	**0.0**	0	**0.0**	**1**	**0.0**

	Brief 2016	Not brief 2016	Brief 2017	Not brief 2017	TOTAL Brief	TOTAL Not brief	% TOTAL Brief	% TOTAL Not brief
Breakdown for each year as a % of all conditions combined and according to the foreseeable nature of the death								
TOTAL	**1749**	**279**	**1934**	**375**	**3683**	**654**	**% /4337**	**% /4337**
Tumours (cancers)	1348	16	1401	16	**2749**	**32**	**63.4**	**0.7**
Poly-pathologies	158	110	261	181	**419**	**291**	**9.7**	**6.7**
Diseases of the nervous system	77	45	96	83	**173**	**128**	**4.0**	**3.0**
Diseases of the respiratory system	61	6	67	3	**128**	**9**	**3.0**	**0.2**
Diseases of the circulatory system	64	26	61	18	**125**	**44**	**2.9**	**1.0**
Diseases of the digestive system	10	0	11	0	**21**	**0**	**0.5**	**0.0**
Traumatic injuries. poisonings and other consequences of external causes	9	8	10	8	**19**	**16**	**0.4**	**0.4**
Diseases of the genitourinary system	8	0	8	0	**16**	**0**	**0.4**	**0.0**
Diseases of the musculoskeletal system, muscles and connective tissues	3	17	6	17	**9**	**34**	**0.2**	**0.8**
Some infectious and parasitic diseases	2	3	4	3	**6**	**6**	**0.1**	**0.1**

	Brief 2016	Not brief 2016	Brief 2017	Not brief 2017	TOTAL Brief	TOTAL Not brief	% TOTAL Brief	% TOTAL Not brief
Breakdown for each year as a % of all conditions combined and according to the foreseeable nature of the death								
TOTAL	**1749**	**279**	**1934**	**375**	**3683**	**654**	**% /4337**	**% /4337**
Endocrine, nutrition and metabolic diseases	2	1	2	0	**4**	**1**	**0.1**	**0.0**
Symptoms, signs and abnormal results of clinical and laboratory examinations, not elsewhere classified	2	2	2	6	**4**	**8**	**0.1**	**0.2**
Mental and behavioural disorders	2	35	1	39	**3**	**74**	**0.1**	**1.7**
Diseases of the blood and haemopoietic organs and certain disorders of the immune system	1	0	2	0	**3**	**0**	**0.1**	**0.0**
Congenital malformations and chromosomal abnormalities	1	0	1	0	**2**	**0**	**0.0**	**0.0**
Diseases of the eye and associated structures	1	7	0	0	**1**	**7**	**0.0**	**0.2**
Diseases of the skin and subcutaneous tissues	0	2	1	0	**1**	**2**	**0.0**	**0.0**
Diseases of the ear and mastoid process	0	0	0	1	**0**	**1**	**0.0**	**0.0**
Some diseases whose origin is in the perinatal period	0	1	0	0	**0**	**1**	**0.0**	**0.0**

Forms of suffering mentioned

	2016	2016 (%)	2017	2017 (%)	TOTAL	% TOTAL
TOTAL	**2028**	**100 %**	**2309**	**100 %**	**4337**	**100 %**
Physical and psychological suffering reported together	1240	**61.1**	1472	**63.8**	**2712**	**62.5**
Physical suffering only	702	**34.6**	750	**32.5**	**1452**	**33.5**
Psychological suffering only	86	**4.2**	87	**3.8**	**173**	**4.0**

Qualifications of physicians consulted compulsorily

	2016	2016 (%)	2017	2017 (%)	TOTAL	% TOTAL
Qualification of the 1st physician consulted compulsorily						
TOTAL	**2028**	**100 %**	**2309**	**100 %**	**4337**	**100 %**
GP	758	**37.4**	823	**35.6**	**1581**	**36.5**
Specialist	759	**37.4**	792	**34.3**	**1551**	**35.8**
LEIF/EOL	375	**18.5**	510	**22.1**	**885**	**20.4**
Trained in palliative care	136	**6.7**	184	**8.0**	**320**	**7.4**
Qualification of the 2nd physician consulted compulsorily						
TOTAL	**278**	**100 %**	**375**	**100 %**	**653**	**100 %**
Psychiatrist	160	**57.6**	197	**52.5**	**357**	**54.7**
Specialist	118	**42.4**	178	**47.5**	**296**	**45.3**

Method and products used

	2016	2016 (%)	2017	2017 (%)	TOTAL	% TOTAL
TOTAL	**2028**	**100 %**	**2309**	**100 %**	**4337**	**100 %**
Thiopental + muscle relaxant intravenous	1425	**70.3**	1615	**69.94**	**3040**	**70.1**
Thiopental only intravenous	485	**23.9**	516	**22.35**	**1001**	**23.1**
Propofol + muscle relaxant intravenous	82	**4.0**	127	**5.50**	**209**	**4.8**
Morphine and/or anxiolytic + muscle relaxant intravenous	22	**1.1**	32	**1.39**	**54**	**1.2**
Oral barbiturates	12	**0.6**	11	**0.48**	**23**	**0.5**
Others	2	**0.1**	8	**0.35**	**10**	**0.2**

Decisions by the Commission

	2016	2016 (%)	2017	2017 (%)	TOTAL	% TOTAL
TOTAL	**2028**	**100 %**	**2309**	**100 %**	**4337**	**100 %**
Simple acceptance	1544	**76.1**	1763	**76.4**	**3307**	**76.3**
Opening of Part I for details of the procedure followed or compliance with the conditions	230	**11.3**	160	**6.9**	**390**	**9.0**
Opening of Part I for administrative reasons	123	**6.1**	217	**9.4**	**340**	**7.8**
Opening of Part I for simple remarks	131	**6.5**	169	**7.3**	**300**	**6.9**

Referral to the public prosecutor: no file was transmitted in 2016 and 2017.

Section 2. Description and Assessment of Law Enforcement for the period 2014-2017

A. Functioning of the Federal Commission for the Control and Evaluation of Euthanasia

The law on euthanasia of 28 May 2002 provides in Article 5 that a physician who performs euthanasia must complete a registration document and transmit it within four working days to the Federal Commission of Control and Assessment of Euthanasia (hereinafter referred to as the Commission). This document is divided into two parts. Part I is the confidential part which includes personal data about the patient, the physicians involved and any other persons consulted, such as nursing staff, family members or close carers. This part may only be consulted after a decision by the Commission. Part II is the anonymous part and includes all the data on the basis of which the physician concerned practiced euthanasia.

Chapter V of the Euthanasia Act specifies the composition, working method and mission of the Commission.

a. The composition of the Commission

The Commission is composed of sixteen full members and sixteen alternate members appointed by Royal Decree, distributed as follows:

- Eight members are medical physicians, at least four of whom are lecturers, professors or professors emeritus at a Belgian university.
- Four members are lecturers, professors or emeritus professors of law at a Belgian university, or lawyers.
- Four members come from the circles responsible for the problem of patients suffering from an incurable disease.

When composing the Commission, linguistic parity and pluralistic character must be respected. In addition, each linguistic group must have at least three members of each sex.

Members are appointed for a four-year term on the basis of a dual list presented for voting in the House of Representatives. The Commission is chaired by two Presidents: a French-speaking President and a Dutch-speaking President, elected by their respective linguistic group.

b. The mission of the Commission

In accordance with Article 8 of the Law, the Commission processes the registration documents sent to it. It verifies, on the basis of Part II (the anonymous part), whether euthanasia was carried out in accordance with the essential conditions and procedure laid down by law. In case of doubt, the Commission may, by a simple majority, open the confidential part (part I). On the basis of the data in this one, it is possible - if necessary - to request additional information from the reporting physician. The physician may be heard by the Commission. If two thirds of the members of the Commission decide that the euthanasia practiced is not in conformity with the law, the file is transmitted to the public prosecutor.

The Commission also has the legal task of drafting a biennial report which is sent to the House of Representatives.

This report must include the following:

- A statistical report containing all the information found in Part II of the registration document.
- A report containing a description and assessment of the application of the law.
- Where appropriate, recommendations that may lead to legislative initiative or other measures to refine the enforcement of the law.

c. The practical functioning of the Commission

The evaluation of registration documents - approximately 190 to 200 per month - is carried out in two stages: firstly and individually and then during the monthly meeting. This working method ensures that they are all thoroughly evaluated.

1. Prior and individual assessment

All members of the Commission, both staff and alternates, receive electronically (SharePoint) or by post at regular intervals during the month preceding the meeting, Parts II of the registration documents sent by the physicians. They have the opportunity to study and evaluate the files before the monthly meeting. In this way, each member may identify the documents that do not, he/she thinks, have enough information or may not be in accordance with the law. In addition, each member can note and send remarks to the secretariat. In this way, members (staff or alternates) who are absent from the meeting may also comment. An overview of all comments made on certain files is attached to the invitation to the meeting.

2. The monthly meeting of the Commission

At this monthly meeting, members mainly discuss registration documents that require special attention. Indeed, some are no problem and can be approved without any discussion (76%). This method of work allows all documents to be properly processed.

The cases that are discussed in detail are, on the one hand, registration documents that contain inaccurate or insufficient information, for which it must be ensured that they comply with the law and, on the other hand, special cases such as organ donation after euthanasia, euthanasia of patients domiciled abroad or cases of euthanasia that have encountered barriers in care institutions in a problematic way within a care institution. The meeting begins with the approval of the report of the last meeting of the Commission and the evaluation of the answers of the physicians to whom additional information was requested. If this information is sufficient, the document is approved. Then the new documents are discussed. During the meeting, the members present can provide details or make comments in order to correctly evaluate the file. In case of doubt or inaccuracy, the Commission may open Part I for further information. If necessary, details may be requested from the reporting physician. If the answers provided are still not sufficient, the physician concerned may be invited to give details at a meeting of the Commission. If it considers that the conditions provided for by law have not been respected, the file is subject to a vote for a possible transmission to the public prosecutor. At least two-thirds of the voting members must agree to this referral.

It should be emphasized that the members of the Commission are subject to the duty of confidentiality. This means that the data entrusted to them in the exercise of their mission and related to it cannot be made public.

In 2016 - 2017, the Commission met monthly, except for three months. In March 2016, following the attacks in Zaventem and Brussels and the ensuing lockout, the meeting had to be postponed. In addition, there was only one meeting during the summer holidays.

B. Evaluation of the practice of euthanasia

Remarks

- The Commission has limited itself in section I of this report to its statutory mission of providing statistics on reported euthanasia in the last two years. In section II, the Commission proposes a four-year evaluation (2014-2017), taking into account the codification introduced in 2014.
- As in the previous report, the classification of conditions causing euthanasia is carried out according to ICD-10-CM, "International Statistical Classification of Diseases and Related Health Problems". The ICD-10-CM is a closed classification system that provides a single ranking for each condition. This makes it possible to compare the data for 2016 and 2017 with those for 2014 and 2015.

  At first, the conditions are grouped by category, then by subgroup and finally by diagnosis.

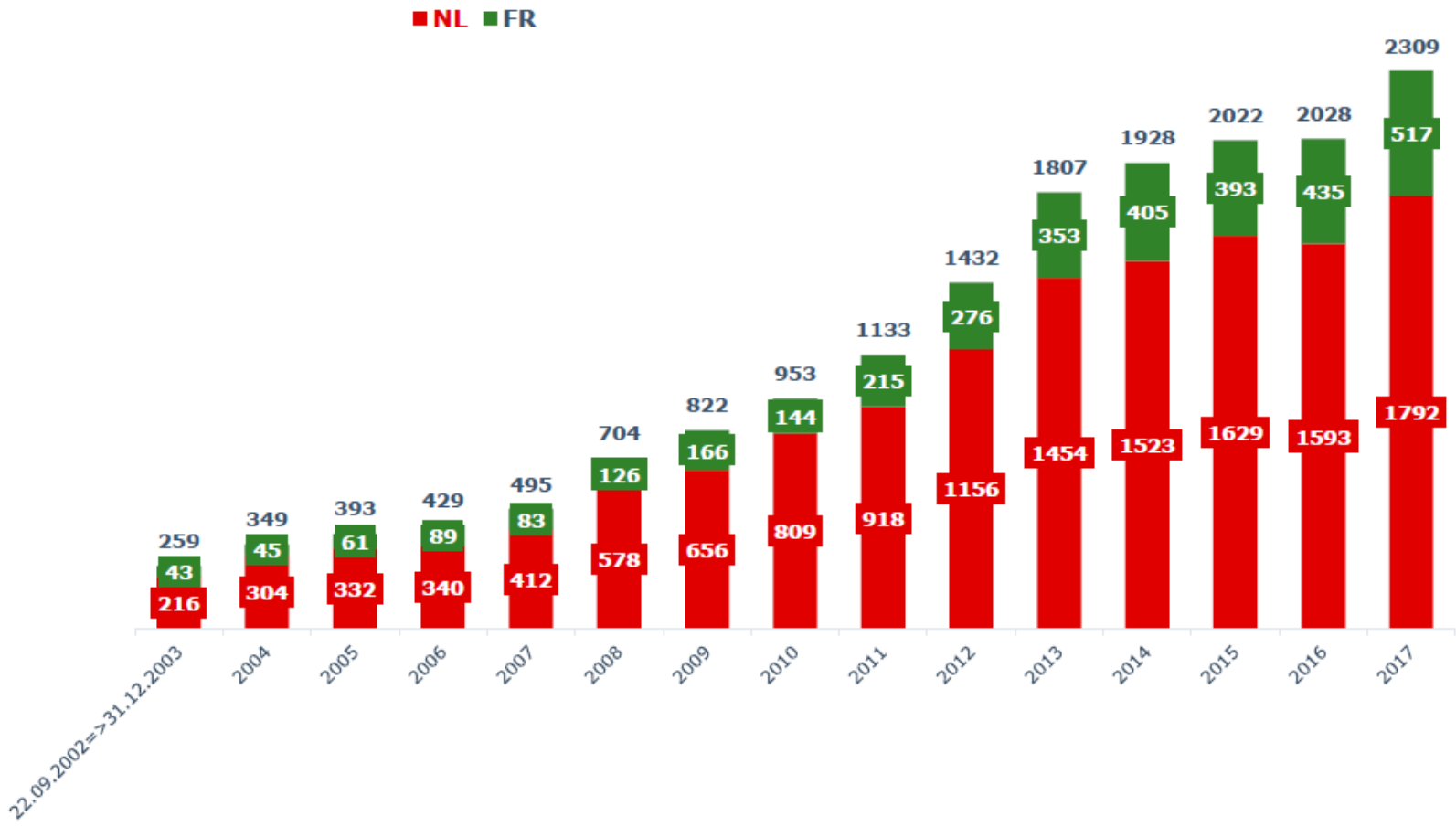
  Examples:
  - Stroke diagnosis (stroke) is classified as Circulatory Disease since the condition is caused by a disruption of blood flow to the brain. In this category of diseases, stroke is part of the subgroup of ischemic cerebrovascular diseases.
  - Pulmonary fibrosis is a condition that causes respiratory failure and falls under the category Respiratory Diseases. Pulmonary fibrosis belongs to the subgroup of interstitial lung diseases.
  - The diagnosis of lung cancer falls under the category of Tumors (cancers) and does not fall under the category of lung diseases. In this category, lung cancer is a subgroup of malignant neoplasms of the respiratory and intrathoracic organs.
  - Heart failure, a condition in which cardiac pump function is severely impaired, is of course in the category of circulatory diseases and the subcategory of other heart conditions.

- In case of multiple conditions, each disease should be classified separately. Prior to 2014, patients with multiple conditions were often classified in the predominant category. Since only one code per registration document is required, the Commission has decided to always classify these patients as "polypathologies".
- To ensure a better follow-up of the evolution of the data over the years, the graphs were expressed in absolute figures and not in percentages, contrary to the previous report.

a. The number of declarations

Over the years, the evolution of the number of euthanasia has been constant. After an apparent stagnation during the period 2014 - 2016, however, in 2017 we note a significant increase of 13% in the number of documents transmitted compared to 2016.

Figure 1. Number of euthanasia cases practiced and language distribution



b. The language of writing the registration documents

The proportion of Dutch / French registration documents remains around 80/20%, despite the increase in the number of euthanasia recorded in these two languages.

In absolute figures, the difference between Dutch and French registration documents remains important, even though the number of registration documents in French is increasing; it has indeed gone from 435 in 2016 to 517 in 2017.

Linguistic distribution of conditions, all deadlines combined

	2014 NL	2014 FR	2015 NL	2015 FR	2016 NL	2016 FR	2017 NL	2017 FR
TOTAL	**1523**	**405**	**1629**	**393**	**1593**	**435**	**1792**	**517**
Tumours (cancers)	1022	282	1115	256	1067	297	1113	304
Poly-pathologies	151	25	178	31	216	52	350	92
Diseases of the nervous system	90	43	103	37	95	27	127	52
Diseases of the circulatory system	86	19	75	26	71	19	56	23
Diseases of the respiratory system	58	12	41	13	50	17	48	22
Mental and behavioural disorders	57	4	56	7	32	5	39	1
Diseases of the osteo-articular system, muscles and connective tissue	15	8	14	1	19	1	17	6
Traumatic injuries, poisonings and some other consequences of external causes	13	5	9	8	12	5	16	2
Diseases of the digestive system	6	1	10	3	9	1	8	3
Symptoms, signs and abnormal results of clinical and laboratory examinations, not elsewhere classified	5	1	9	0	2	2	7	1
Diseases of the genitourinary system	3	2	7	5	7	1	4	4
Some infectious and parasitic diseases	4	1	5	4	3	2	3	4
Diseases of the blood and hematopoietic organs and certain disorders of the immune system	1	0	0	0	1	0	2	0
Endocrine, nutrition and metabolic diseases	4	0	3		1	2	1	1
Congenital malformations and chromosomal abnormalities	2	0	1	1	1	0	1	0
Diseases of the eye and related structures	5	1	1	1	6	2	0	0
Diseases of the ear and mastoid process	0	0	0	0	0	0	0	1
Diseases of the skin and subcutaneous tissue	1	1	2		0	2	0	1
Some diseases whose origin is in the perinatal period	0	0	0	0	1	0	0	0

This table does not show any significant differences between the statements written in Dutch and those in French.

Patients with a malignant tumour (cancer) remain the majority in both language groups. In terms of percentages, there is a decrease, but not in absolute numbers.

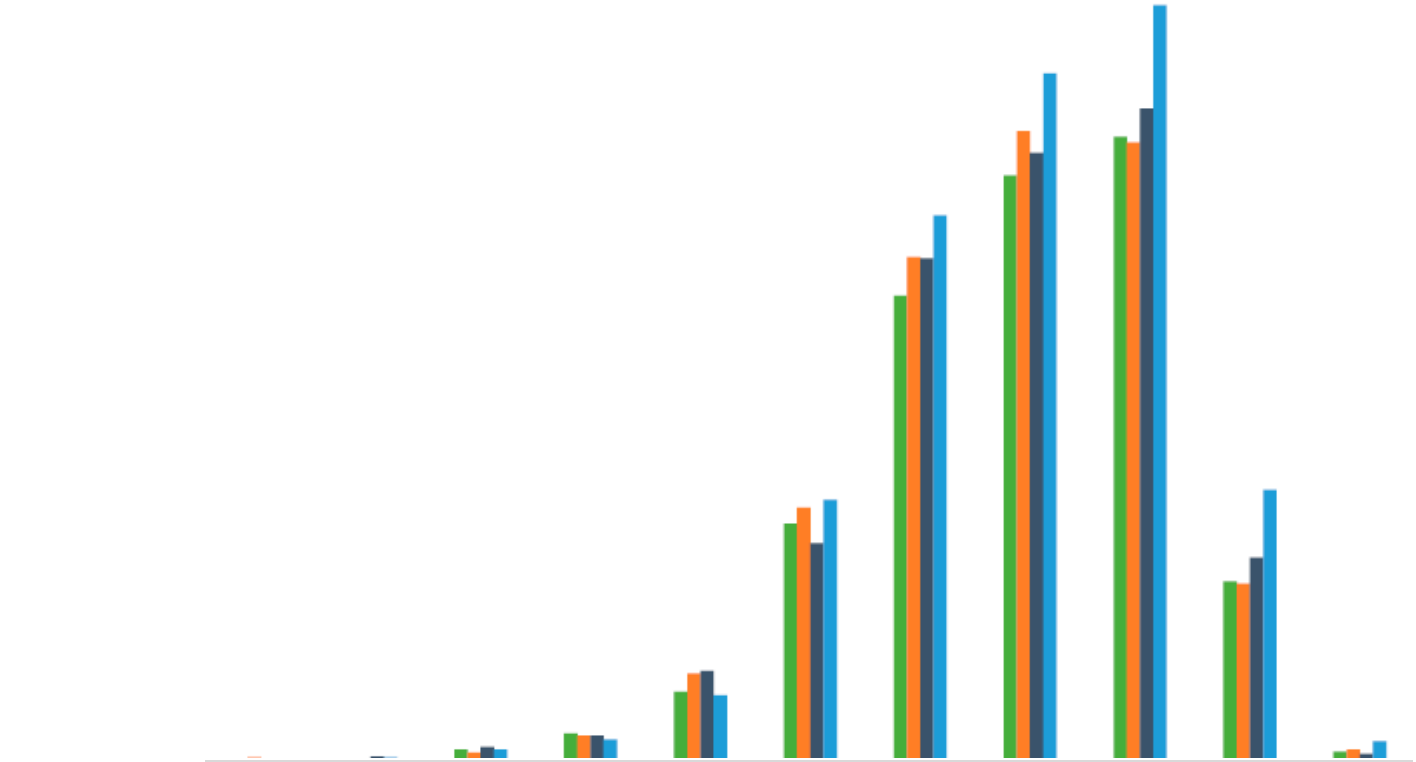
The group of patients with poly-pathologies is increasing. Over four years, the number of documents written in Dutch concerning poly-pathologies has almost doubled and the number of documents written in French concerning poly-pathologies has almost tripled. In this respect, it should be recalled that before the new coding, many patients with poly-pathologies were coded under another category.

The number of euthanasia cases due to mental disorders and behavior (psychiatric conditions) fell in both language groups.

c. The age of the patients

Euthanasia in patients under 40 remains very limited. It is mostly patients in the 60, 70 and 80 age groups who are asking for euthanasia. The most important group is patients over the age of 80 years.

Figure 2. Age of patients



	?	< 18	18–29	30–39	40–49	50–59	60–69	70–79	80–89	90–99	100+
2014	0	0	8	22	59	207	408	514	548	156	6
2015	1	0	5	20	75	221	442	553	543	154	8
2016	0	2	10	20	77	190	441	534	573	177	4
2017	0	1	8	17	56	228	479	604	664	237	15
Total (N = 8287)	1	3	31	79	267	846	1770	2205	2628	724	33

Heading "?": A reporting document in 2015 was sent to the Commission without Part I.
Since Part I contains the name and address of the reporting physician, the Commission was not able to write to the physician, who remained unknown.

Euthanasia in patients who are minors

During the two-year period covered by this report, the Commission received three declarations concerning the euthanasia of minors (9, 11 and 17 years old - two registration documents in Dutch and one in French). The latter each time suffered from incurable and particularly serious conditions that led to their death in the short term. The conditions were classified in the following categories:

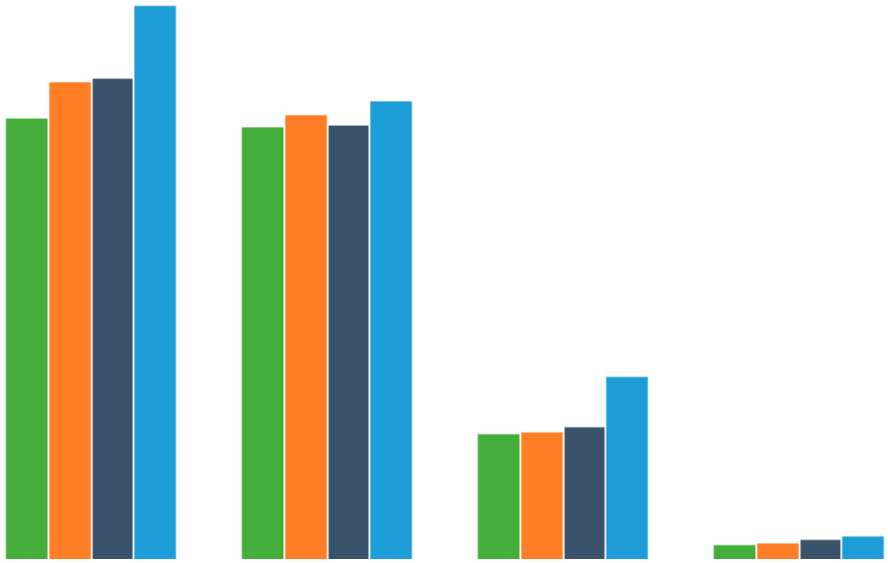
- muscular and neuromuscular disorders: severe Duchenne muscular dystrophy;
- malignant tumor of the eye, brain and other parts of the central nervous system: glioblastomas;
- abnormal metabolism: cystic fibrosis.

All three statements were written in great detail. The Commission was thus able to ensure that the minor's ability to discern was explicitly confirmed by a child psychiatrist or psychologist. Many other physicians and care providers were consulted in addition to the mandatory notices to be collected. The Commission unanimously approved these three files. Although, luckily, few children are involved, extending the law to discerning minors makes sense, as it aims to allow them free choice and the flow of speech with respect to childrens' end of life.

d. The place of euthanasia

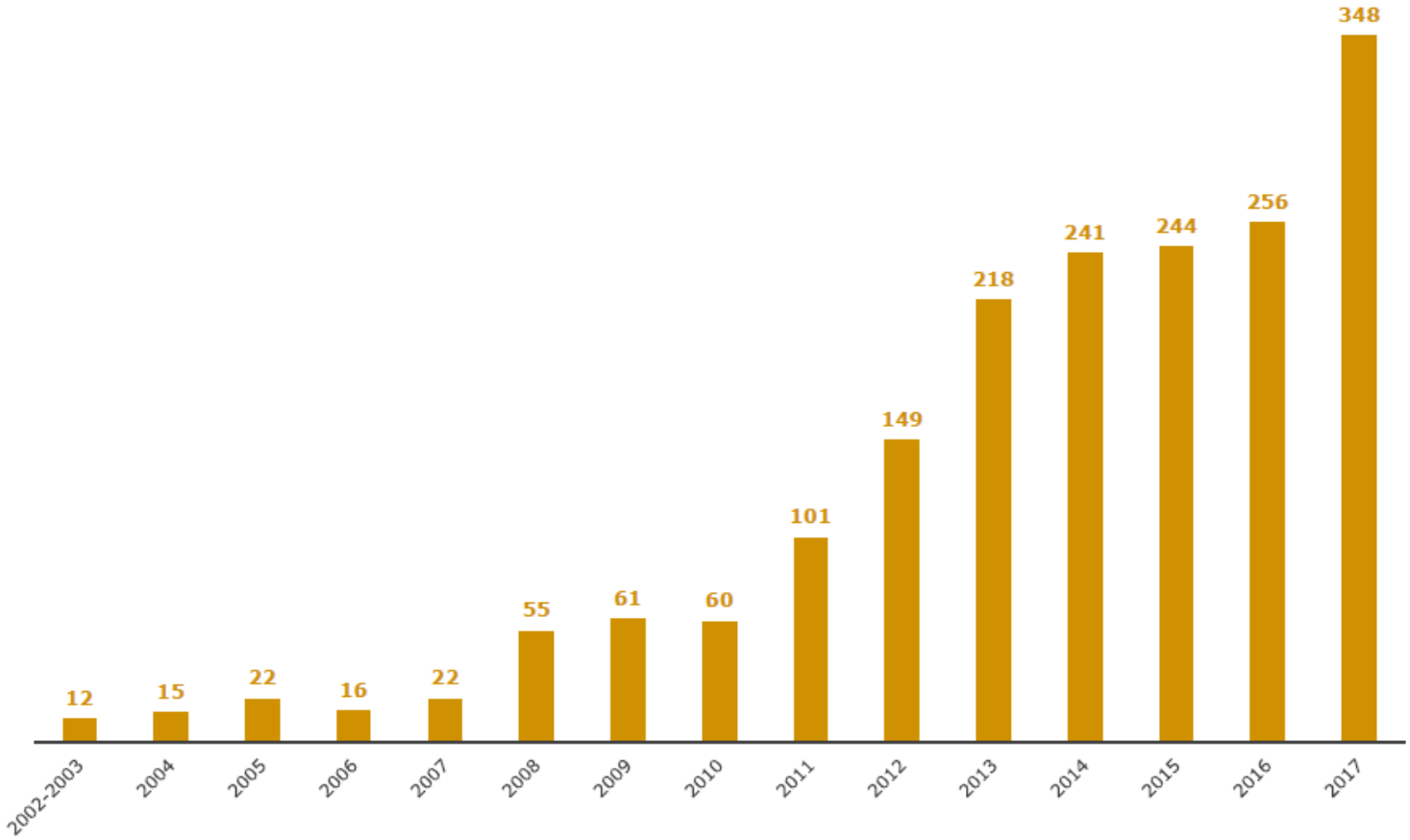
The number of euthanasia cases in homes has tended to increase while those in hospitals has decreased. This corresponds to the patient's wish to end his life at home. This explains why the general practitioner occupies a prominent place both for the examination of the request for euthanasia and for the act itself. In addition, the number of euthanasia cases in nursing homes and nursing homes continues to increase. Compared with 2002-2003, the number expressed as a percentage has tripled.

Figure 3. Location of euthanasia



	Home	Hospital	Care or Nursing Home	Other
2014	835	817	241	35
2015	901	840	244	37
2016	908	821	256	43
2017	1046	865	348	50
Total (N = 8287)	3690	3343	1089	165

Figure 4. Evolution of euthanasia in a rest home or nursing home (N = 1820)



e. Euthanasia on the basis of an advance directive

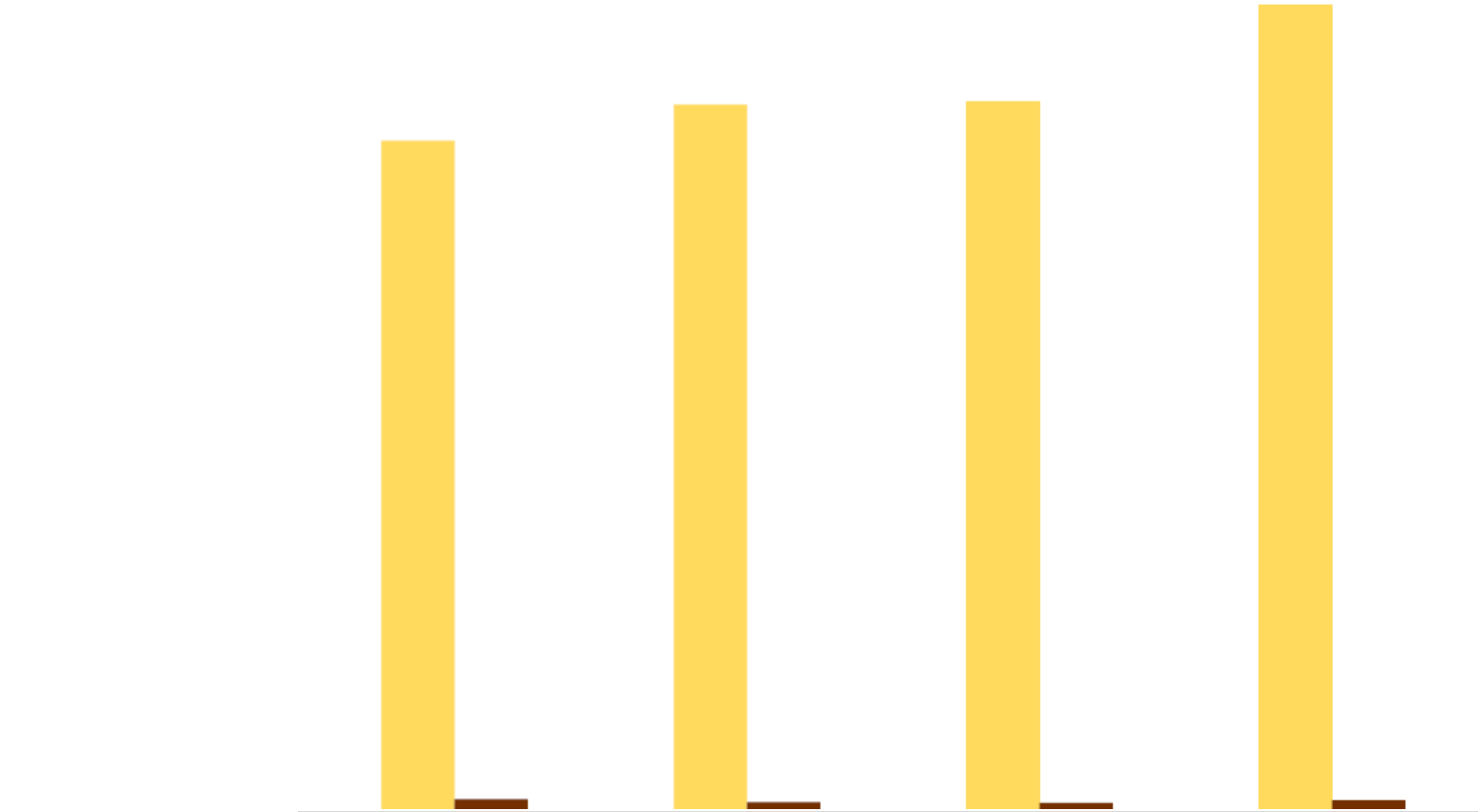
To practice euthanasia on the basis of an advance directive of euthanasia, the physician must ensure, in accordance with Article 4 §1 of the Euthanasia Act, that the patient:

- has a serious or incurable injury or pathological condition;
- is unconscious;
- and that this situation is irreversible according to the current state of science.

Some conditions will lead more than others to an irreversible state of unconsciousness, such as primary or metastatic brain malignancies, thrombosis or haemorrhage stroke, post-traumatic brain hemorrhages, a vegetative state, etc.

In 2014 – 2017, the Commission received 122 declarations of euthanasia on the basis of an advance directive, which corresponds to approximately 1.5% of euthanasia reported during this period.

Figure 5. Basis of euthanasia

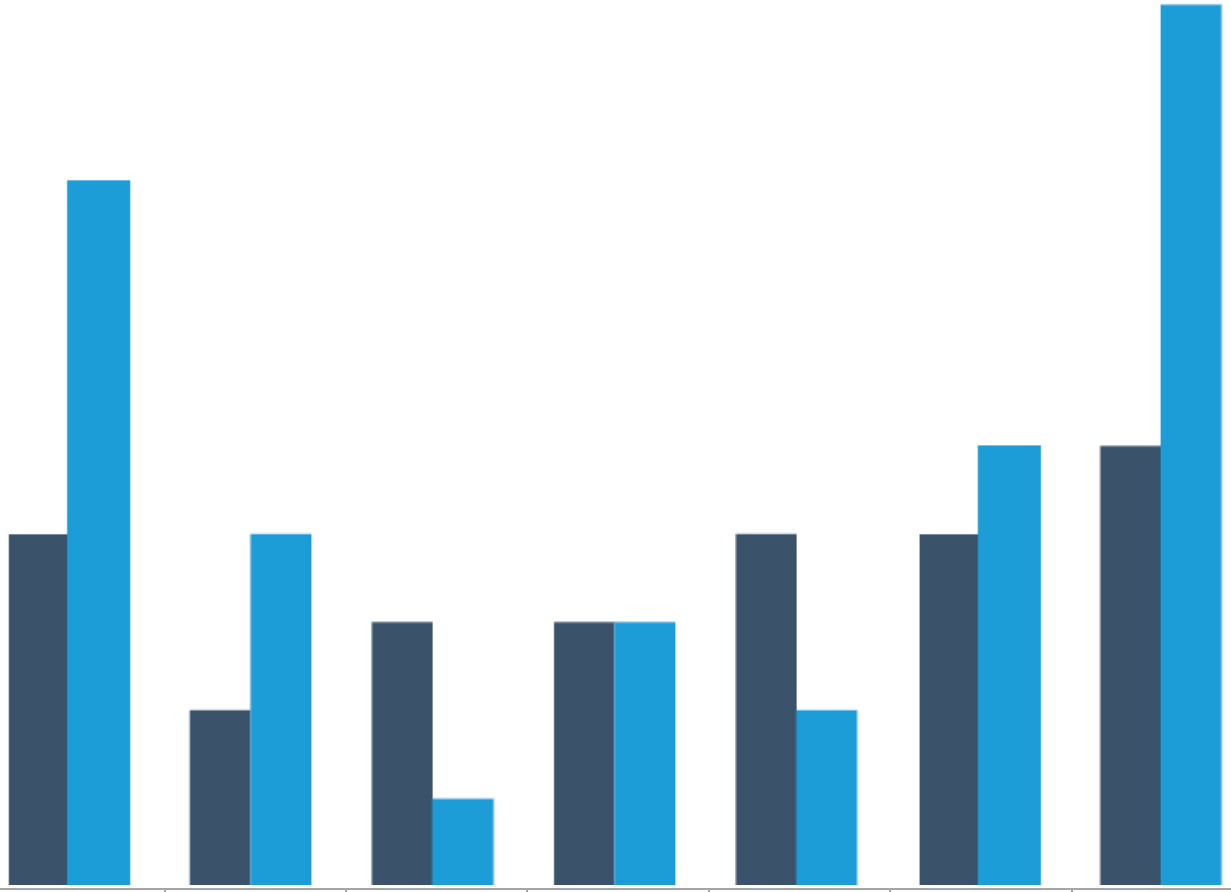


	2014	2015	2016	2017
Current request	1892	1994	2003	2276
Advance directive	36	28	25	33
Total (N = 8287)	1928	2022	2028	2309

Of the 12 patients who had made an advance directive of euthanasia less than one month previously, two had malignant brain tumors or brain metastases. Two patients who were in an irreversible coma after a suicide attempt had drafted an advance declaration of 5 and 35 months respectively.

For the other patients, the advance declaration was written one to 58 months before euthanasia.

Figure 6. Time between advance directive and euthanasia



	<1 m	1 m	2–3 m	4–6 m	7–12 m	13–24 m	>24 m
2016	4	2	3	3	4	4	5
2017	8	4	1	3	2	5	10
TOTAL (N = 58)	12	6	4	6	6	9	15

Note: The dates of the advance declarations are only collected from 2016

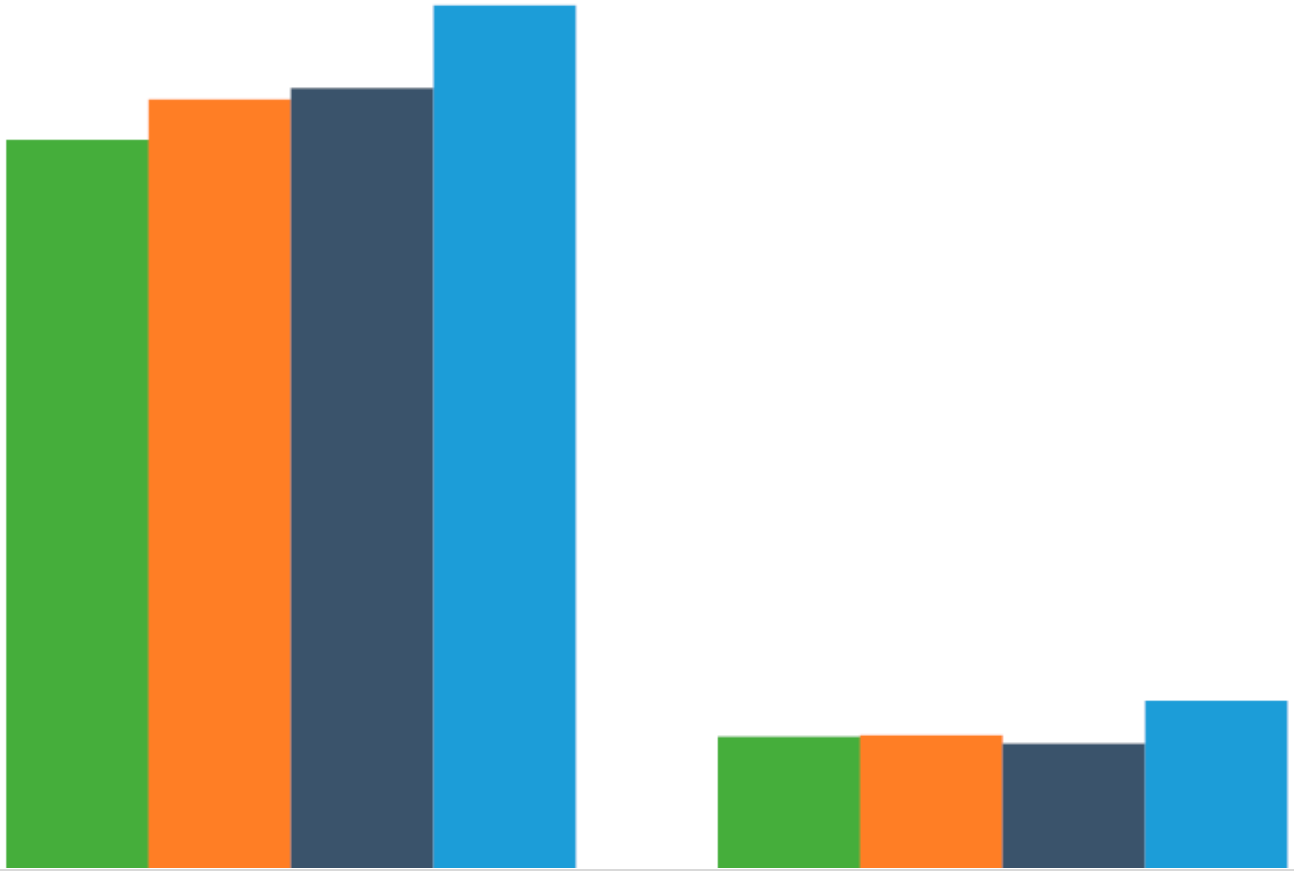
f. The foreseeable term of death

The law on euthanasia foresees, if the death will not obviously intervene in the short term, an enhanced procedure namely the additional consultation of a physician who will have to be either specialist of the condition concerned, or psychiatrist, as well as respecting a minimum waiting period of one month between the written request and the euthanasia. The time until death can be estimated as non-brief when death is not expected in the weeks or months ahead.

Determining whether the patient will die in the short or long term is not always easy. During the discussions held in the Commission concerning the physician's estimate of the foreseeability of death, it became apparent that apart from obvious cases, the physician in charge of the patient is the only one able to judge the more or less close date of death (see the brochure for the medical profession at www.commissioneuthanasie.be).

When euthanasia was performed in an irreversibly unconscious patient on the basis of an advance declaration, the death date was placed in the statistical category of expected deaths in the near future.

Figure 7. Predicted death timeframe



	Brief	Not brief
2014	1633	295
2015	1723	298
2016	1749	279
2017	1934	375
Total (N = 8287)	7039	1247

g. The distinction between waiting time and reflection time

The euthanasia law provides that, if the death of the patient will not be evident in the near future, the physician must wait a minimum of one month between the written request and the euthanasia. In the Netherlands, this obligation does not exist.

This one-month delay has sometimes been criticized: it would be too short to conclude with certainty that the patient really wants euthanasia, and that a mature and thoughtful decision would require a longer period of reflection and consultation with the patient.

This criticism is unfounded because it starts from the hypothesis - erroneous - that the patient makes his decision during this month. In reality, the decision process (and thus the time for reflection) begins well before the realization of the demand for euthanasia in writing. First of all, the patient matures his reflection and then only confirms it in writing: the mandatory "written request", also called the "current request". After this explicit writing, a minimum waiting period of one month must be respected in the event that the death of the patient is not expected in the short term. The term "waiting time" thus gives a better understanding of "thinking time".

It should be noted that the legislature has also surrounded the decision-making process — which is the period before the writing of the application — with essential conditions, form and procedure. First of all, the law requires the patient to make a "thoughtful" request, for which writing is required. The preparatory work of the law on euthanasia and the doctrine shows that "reflected" implies among other things that the patient is able or unable to express his will. In other words, a possible mental illness should not be an obstacle to making a decision on the basis of rational reasoning. The physician will have to actually note that the patient is certainly able to make a decision or to express his will, and that a thoughtful request can be formulated.

Then, the term "reflected" also requires the reality of demand. After weighing all the elements, the patient must come to the conclusion that euthanasia is the only solution for him. In this respect, various obligations of information weigh on the physician. The physician must enlighten the patient on his state of health and life expectancy, confer with the patient on his request for euthanasia and discuss with him the therapeutic possibilities still possible, as well as the possibilities offered by palliative care and their consequences. Together with the patient, the physician must reach the conviction that there is no reasonable alternative to the patient's situation and that the request of the patient is entirely voluntary (Section 3, §2, 1°, of the Euthanasia Act).

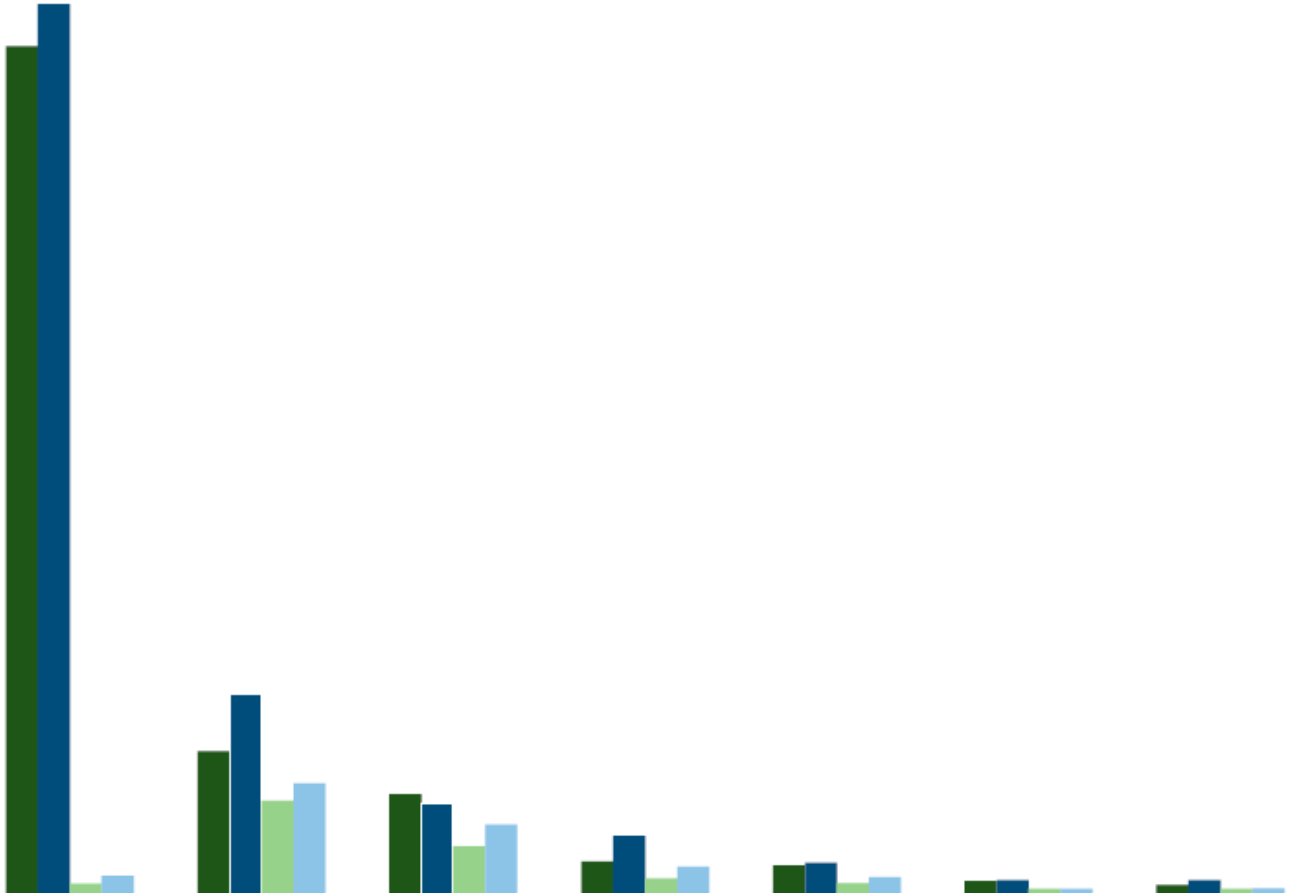
Lastly, the request for euthanasia must also be "repeated", "repeated" (section 3 (1) and section 3 (2) (2) of the Euthanasia Act). A "repeated" request implies that the patient must make a request several times, either orally or in writing. A "repeated" request, in Dutch "duurzaam", means that the request persists, even between repetitions. To this end, the physician conducts several interviews with the patient over a reasonable period of time, taking into account the patient's state of health.

All of this is part of the patient's decision process. It is only after the patient has determined what he wants, that the request is made in writing and that, for the patient whose death is not expected in the short term, is when the 'month' waiting period begins.

The registration document does not include a question about the reflection time. However, many physicians have made comments in section 6 (where the physician should indicate the elements "which made it possible to ensure that the request was formulated voluntarily, thoughtfully and repeatedly") concerning the fact that the patient had long discussed with his physician about his wish for euthanasia before writing his written request.

Since 2016, the waiting time has been automatically calculated for all patients, the objective being to be able to evaluate the process for different groups of patients.

Figure 8. Waiting time by anticipation of death (brief/not brief)



	< 1 m	1 m or more	2–3 m	4–6 m	7–12 m	13–24 m	> 24 m
Brief 2016	1266	213	149	48	42	19	13
Brief 2017	1329	298	135	86	46	20	20
Not brief 2016	15	139	71	23	16	7	7
Not brief 2017	27	165	103	40	25	7	8
TOTAL (N=4337)	2637	815	458	197	129	53	48

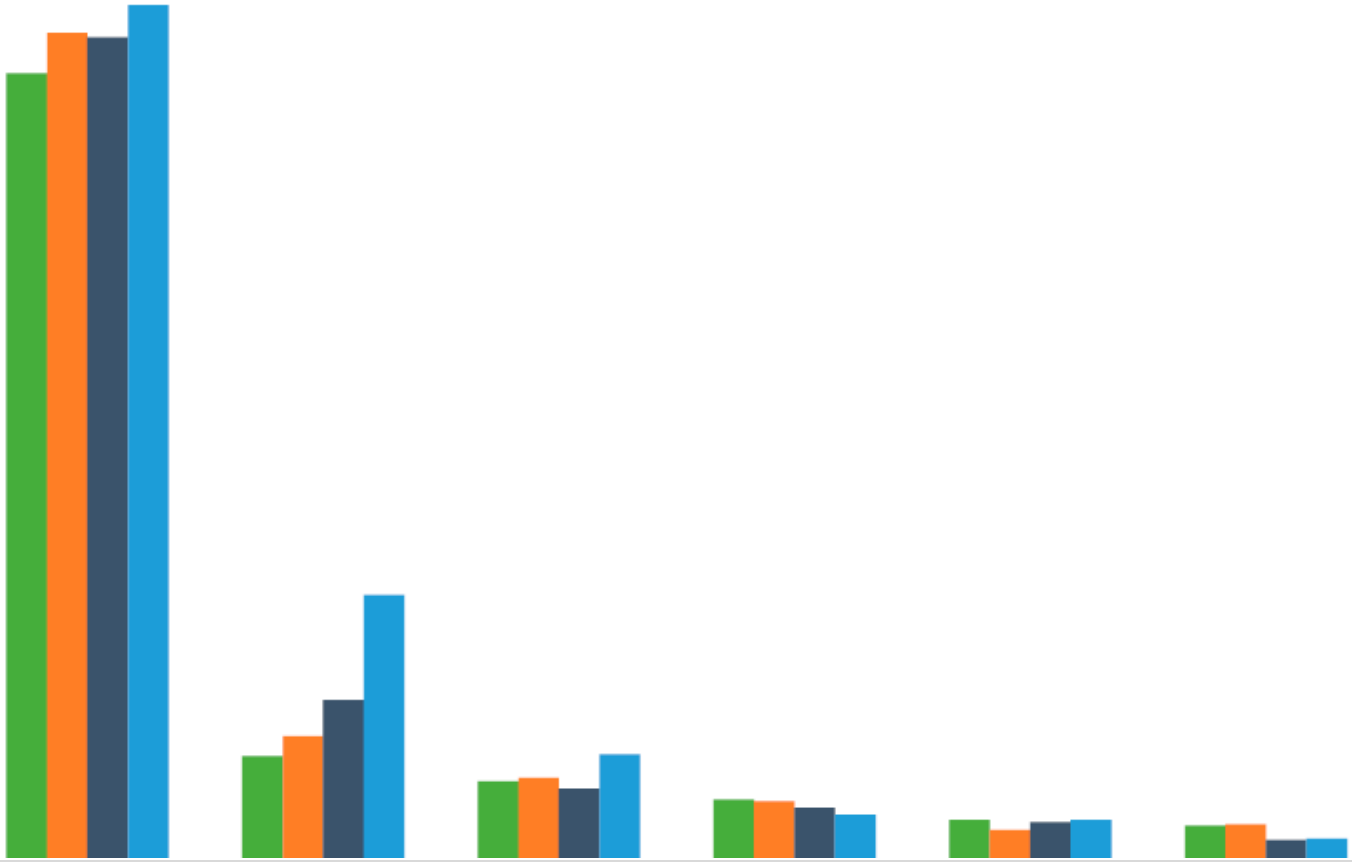
Records of patients whose death was not expected in the near future and where the one-month waiting period was not respected were systematically discussed. In such a case, an instructional letter was systematically sent to remind the physician of the procedure to be followed in case of unexpected death in the short term.

The other information provided (diagnosis, consultation dates of the physicians consulted, elements indicated in section 6 of the registration document), however, allowed the Commission to accept these statements.

h. The conditions that underly euthanasia

Categorization identifies trends, such as continuing to increase or decrease the number of euthanasia in a patient category. The division into subgroups makes it possible to verify, within the same category, which conditions more frequently underlie euthanasia cases. The distribution according to the foreseeable date of death makes it possible to evaluate medical hopelessness by patient group.

Figure 9. Distribution of conditions, all times to expected death

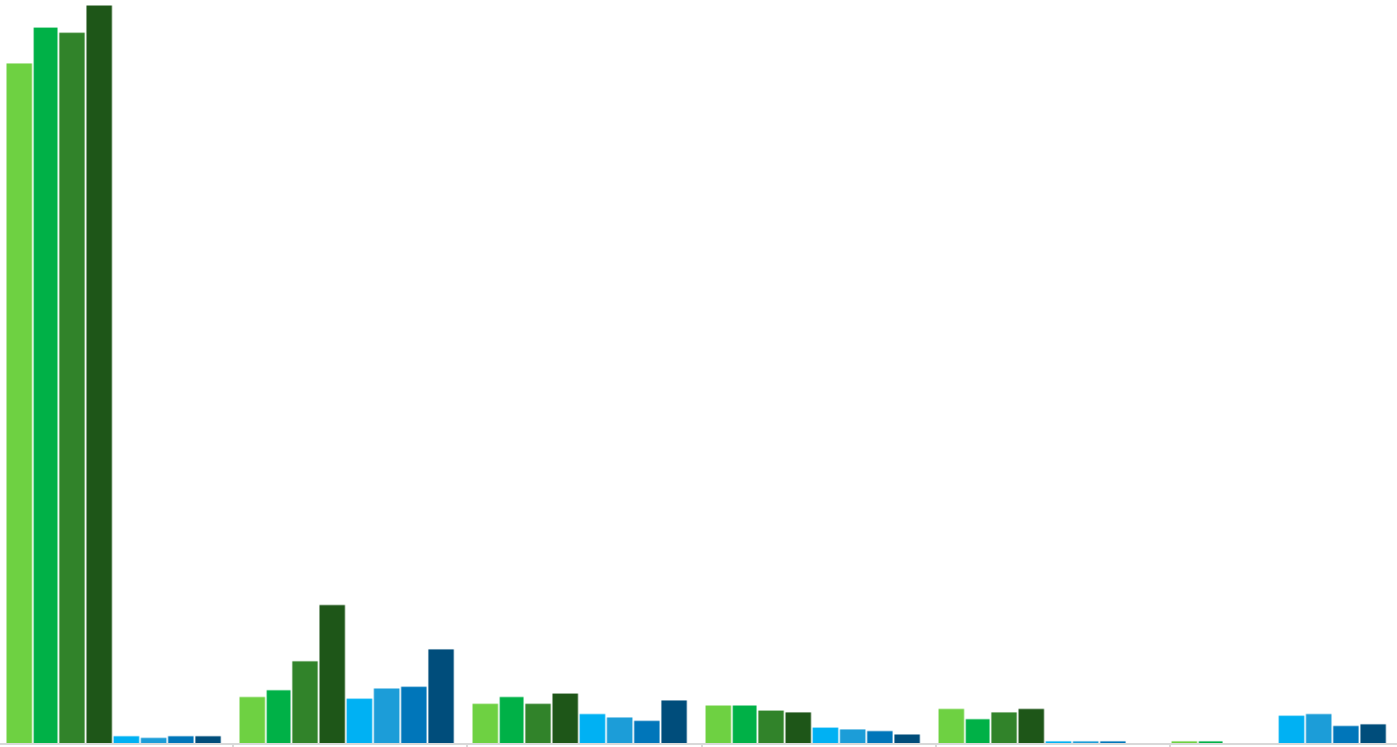


	Tumours	Poly-pathologies	Diseases of the nervous system	Diseases of the circulatory system	Diseases of the respiratory system	Mental and behavioural disorders
2014	1304	176	134	104	70	61
2015	1371	209	140	101	54	63
2016	1364	268	122	90	67	37
2017	1417	442	179	79	70	40
Total (N = 8287)	5456	1095	575	374	261	201

Note: only the most frequent conditions have been included in this figure

In the group of patients whose death is clearly not expected in the short term, patients suffering from poly-pathologies are the most widely represented, while the death of cancer patients is rarely considered such.

Figure 10. Distribution of conditions by expected death



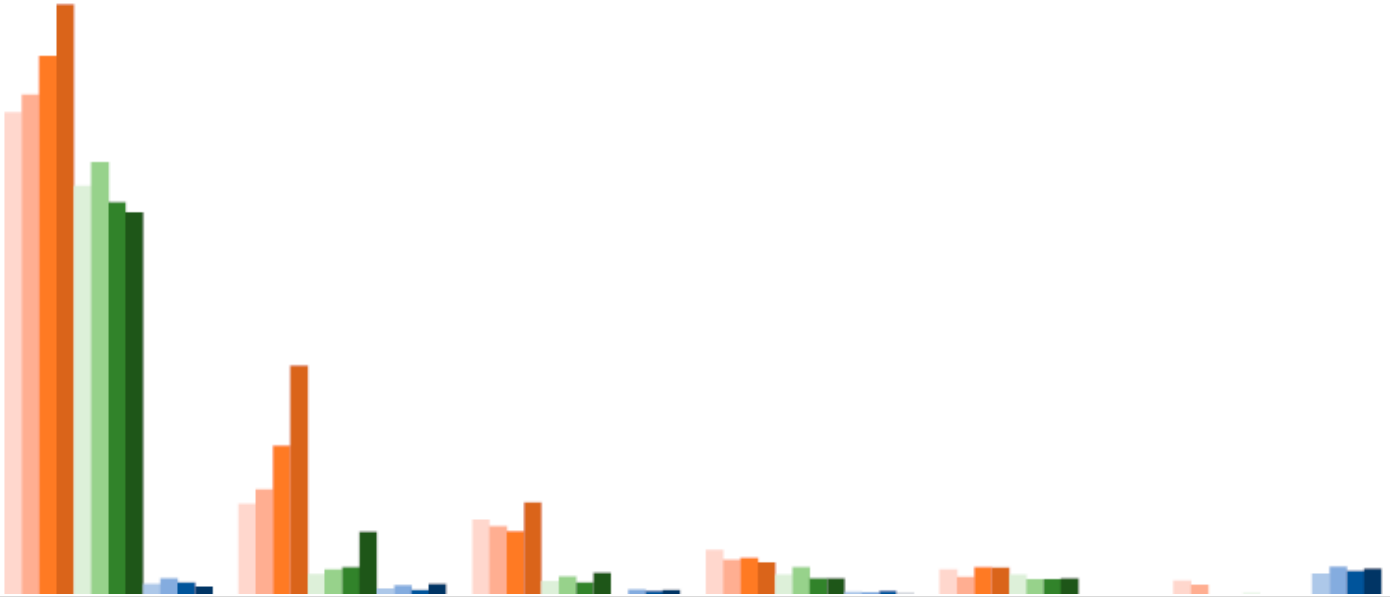
	Tumours	Poly-pathologies	Diseases of the nervous system	Diseases of the circulatory system	Diseases of the respiratory system	Mental and behavioural disorders
Brief 2014	1290	90	76	73	66	5
Brief 2015	1358	102	88	73	48	6
Brief 2016	1349	158	77	64	61	2
Brief 2017	1401	262	96	61	66	1
Not brief 2014	14	86	57	32	4	55
Not brief 2015	13	107	52	28	6	57
Not brief 2016	15	110	45	26	6	35
Not brief 2017	16	181	82	18	3	39

i. The suffering mentioned

Examples of suffering:

- physical: pain, dyspnea, dysphagia, exhaustion, haemorrhage, digestive obstruction, paralysis, wounds, repeated transfusions, etc.
- psychological (not to be confused with psychiatric affections): addiction, loss of autonomy, loneliness, despair, loss of dignity, despair at the idea of losing one's ability to maintain social contacts, etc.

Figure 11. Types of suffering by condition



	Tumours	Poly-pathologies	Diseases of the nervous system	Diseases of the circulatory system	Diseases of the respiratory system	Mental and behavioural disorders
2014 Both	696	133	110	67	39	23
2015 Both	721	154	101	53	28	17
2016 Both	777	217	94	56	42	0
2017 Both	851	332	135	49	41	0
2014 Physical	590	32	22	31	31	5
2015 Physical	624	39	29	42	25	3
2016 Physical	567	42	20	26	25	0
2017 Physical	552	93	34	26	26	0
2014 Psychic	18	11	1	7	0	33
2015 Psychic	26	16	10	6	1	43
2016 Psychic	20	9	8	8	0	37
2017 Psychic	14	18	9	4	2	40

For the majority of patients, several types of physical and mental suffering have been observed simultaneously. This confirms the observation that physical suffering leads to significant psychic suffering, which is considered by the physician as an additional element to be taken into account regarding the unbearable, constant and unappeasable nature of suffering. It should be emphasized that the suffering as mentioned in the registration documents was always the result of one or more serious and incurable conditions.

The Commission considers that certain objective factors may actually indicate an unbearable suffering, but that this is largely subjective and depends on the individual's personality, conceptions and values.

Regarding the question of whether or not the suffering is unappeasable, the patient's right to refuse treatment, even palliative, should be taken into account, for example when the treatment involves side effects or methods of application that the patient considers unbearable. The Commission considers that in such a case the patient and the physician must consult each other.

j. The multidisciplinary approach of the euthanasia process

Beside the obligatory consultation of one or two independent physician(s), other care providers (generalist(s) and / or specialist(s) depending on the patient, palliative team, nurses and psychologists) are involved in the process of euthanasia (in 62% of the statements). This shows that a request for euthanasia is being discussed within the medical teams. In the decision-making process, the opinions provided by the other members of the team can indeed be very important.

A multidisciplinary approach of this type is a method of work very widely applied in health care. This demonstrates transparency in the decision process. However, additional consultations should not result in creating conditions not provided for by law, to the detriment of patient compliance. We must not forget that the two people who must ultimately make the decision are the physician and the patient.

Even if the reporting physician is not obliged to notify the involvement of other care providers and the multidisciplinary consultation related thereto, however, there are indications in this respect in sections 6, 10 and 12 of section II of the recording document. This means that the figures mentioned below are an underestimate of the involvement of other care providers.

In the figures of this report, a distinction is drawn between, on the one hand, generalists, specialists and, on the other hand LEIF-EOL physicians[1] and/or palliative care physicians for whom it is not mentioned if they are general practitioners or specialists. The reporting physician is not required to indicate whether the physician consulted is a LEIF-EOL physician and/or a palliative care physician. In other words, the role of the latter is perhaps more important than what is mentioned here.

Remarks

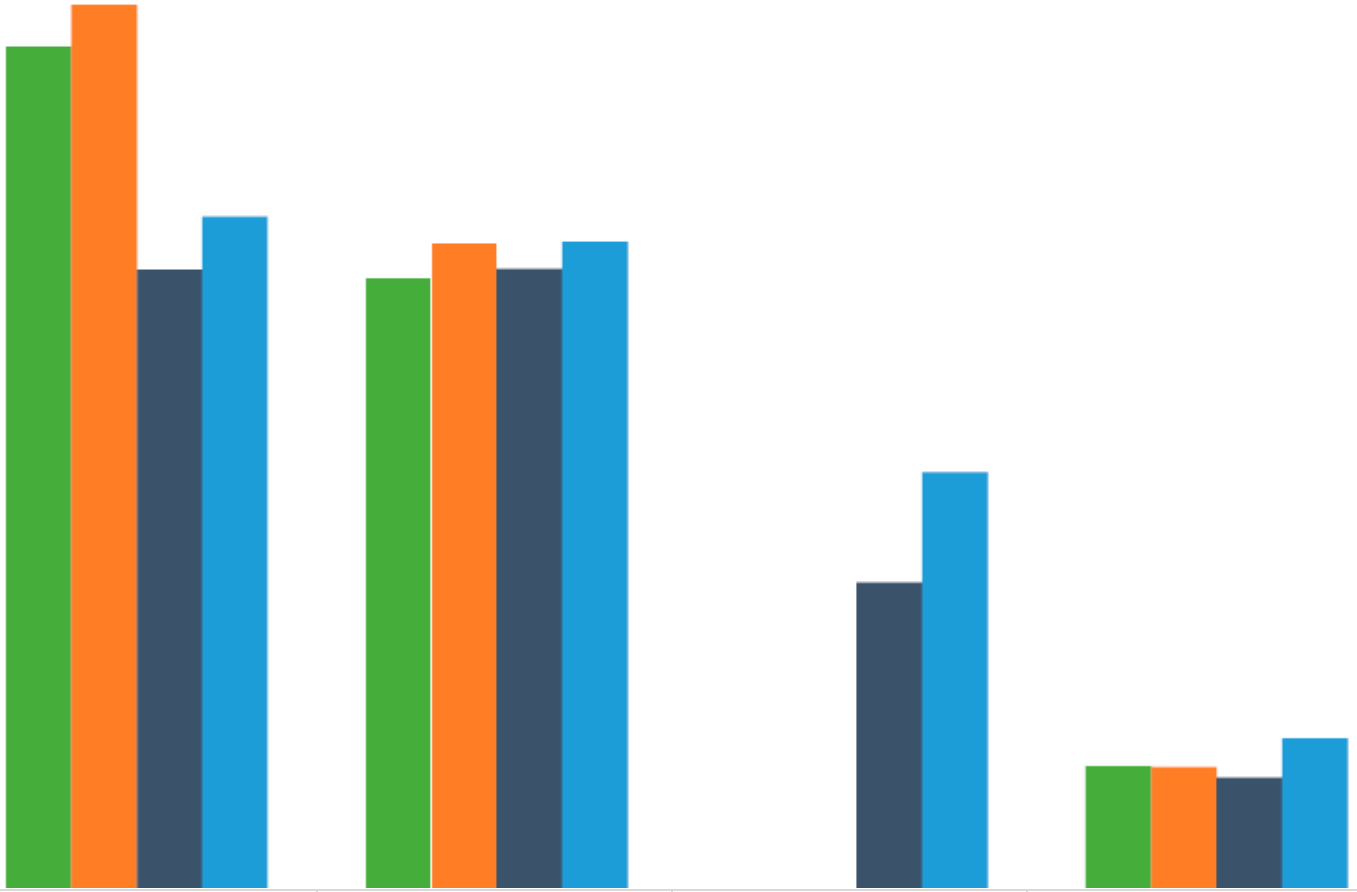
- A physician trained in palliative care is a medical specialist or a general practitioner who has completed additional training in the field of palliative care.
- Hospital physicians and specialists in training are designated as specialists.
- LEIF-EOL physicians are general practitioners or specialists who have received additional training on the issue of decision-making at the end of life and who are part of the LEIF-EOL Consortium. *Attention:* in previous reports, unless otherwise stated, LEIF-EOL physicians were classified as general practitioners. In this report they are classified in a separate category.
- In case of poly-pathologies, the Commission considers generalists as specialists on the basis of their experience, and therefore that the second physician compulsorily consulted in case of unexpected death in the short term may be a generalist.

1. https://www.leif-eol.net/

1. The first physician consulted compulsorily

In the case of a patient whose death is expected shortly, only one opinion is sufficient. Any physician may, whatever his specialty, render an opinion as the first physician consulted.

Figure 12. Qualification of the 1st physician consulted compulsorily



	GP	Specialist	LEIF/EOL	Trained in palliative care
2014	1031	747	0	150
2015	1082	791	0	149
2016	758	759	375	136
2017	823	792	510	184
Total (N = 8287)	3694	3089	885	619

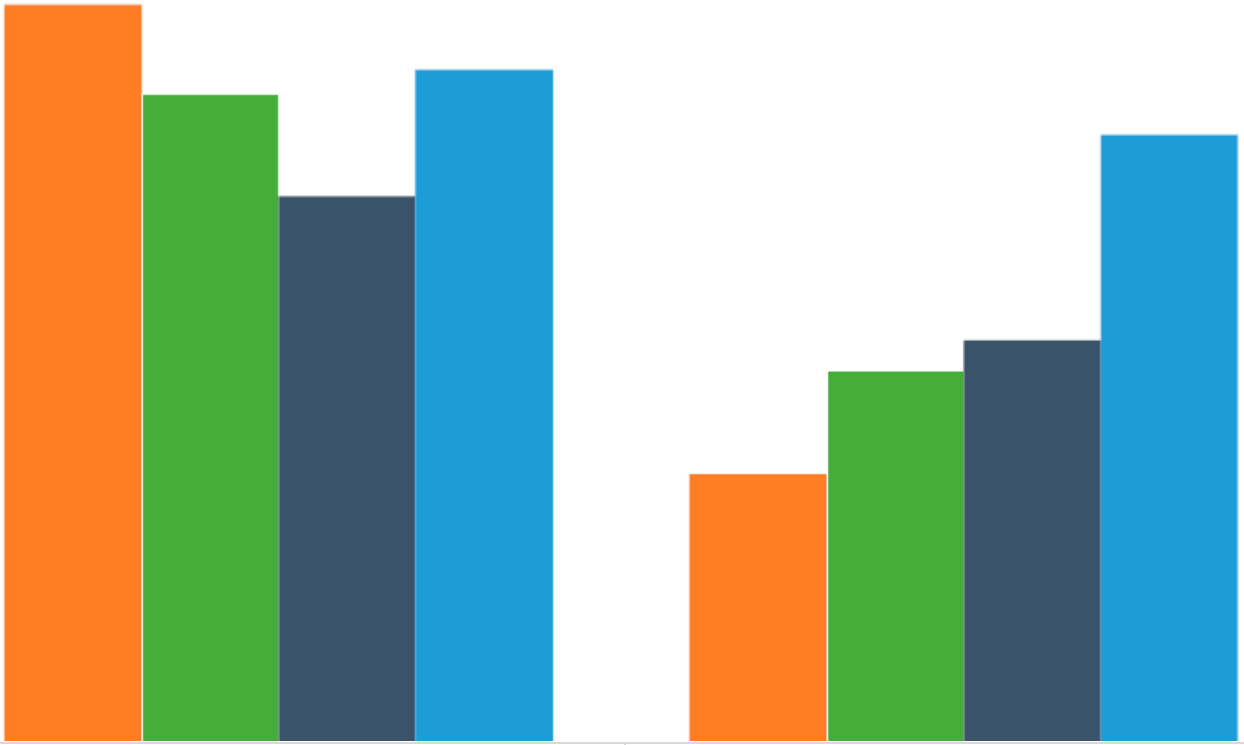
Note: prior to 2016, unless otherwise stated, LEIF / EOL physicians were classified as general practitioners.

In addition to the GP, specialists have a role to play and, rarely here, psychiatrists. In about 1/5 of cases, it is only mentioned that the first physician consulted is a physician who has received additional training in end-of-life care, either a LEIF-EOL physician or a palliative care physician, without specifying it is a generalist or a specialist.

2. Second independent physician consulted (in case of death not expected in the short term)

In the event that the death of the patient is not expected in the short term, a second independent physician, specialist in the condition in question, or psychiatrist, must be consulted.

Figure 13. Qualification of the second physician consulted compulsorily (death not expected in the short term)



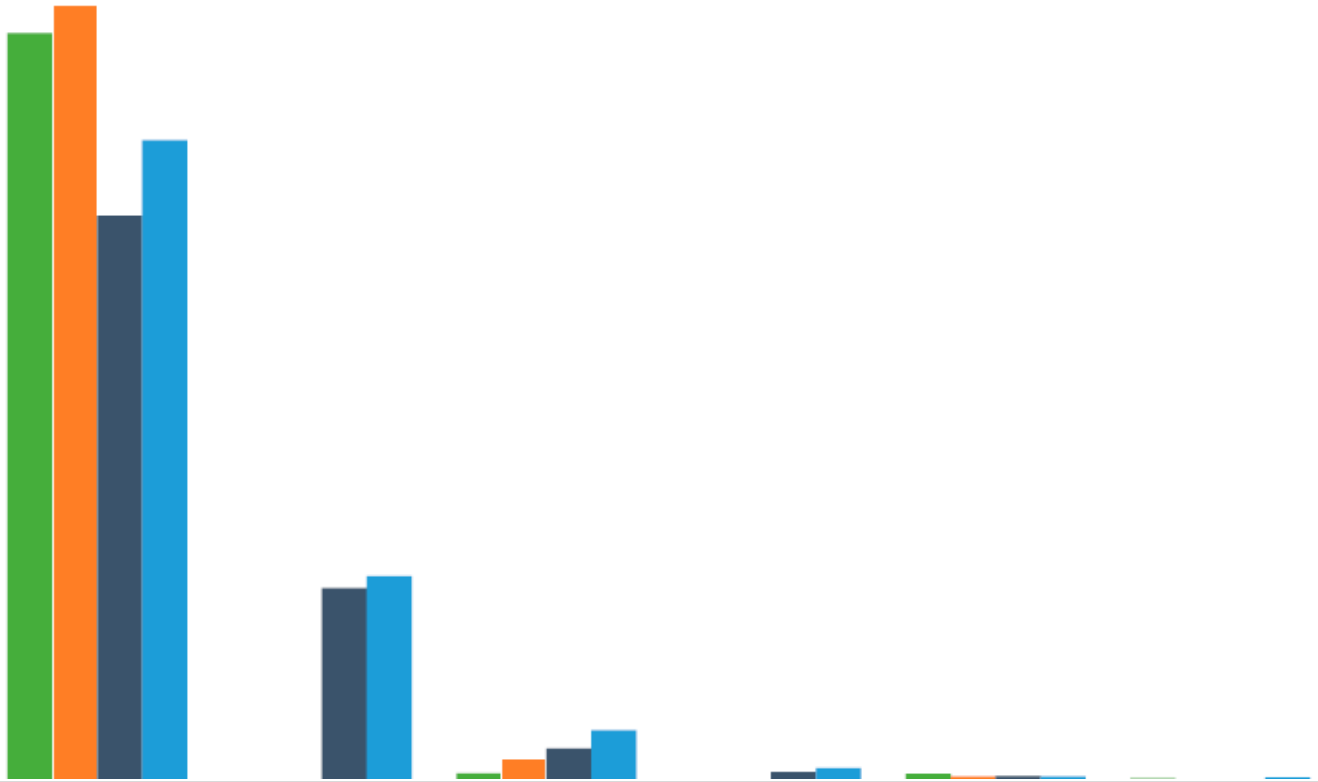
	Psychiatrist	Specialist
2014	216	79
2015	190	109
2016	160	118
2017	197	178
Total (N = 1247)	763	484

During the period 2014 — 2017, 1247 patients were considered as patients whose death was not expected in the short term. However, for a larger number of patients, two opinions were mentioned in the registration document. This means that physicians sometimes asked for the advice of a second physician, even when death was expected in the short term. In this respect, both psychiatrists and specialists in the condition in question were consulted.

k. The manner in which euthanasia and the products used were practiced

Euthanasia usually takes place in several stages. The induction of coma most often by a barbiturate is regularly followed by the administration of a neuromuscular paralyzer; cardiorespiratory arrest follows. This can possibly be preceded by the administration of a sleep inducer.

Figure 14. Means and products used



	Intravenous Thiopental + muscle relaxant	Intravenous Thiopental alone	Intravenous Propofol + muscle relaxant	Intravenous morphine +/- anxiolytic alone + muscle relaxant	Oral barbiturates	Other
2014	1885	0	19	0	18	6
2015	1955	0	54	0	11	2
2016	1425	485	82	22	12	2
2017	1615	516	127	32	11	8
Total (N = 8287)	6880	1001	282	54	52	18

Note: the categories "Thiopental alone" (repeated in 2014–2015 in "Thiopental + muscle relaxant") and "Morphine and / or anxiolytic alone + muscle relaxant" (included in 2014-–2015 in "Others") have only been accounted for since 2016*

The most commonly used drugs for coma induction are thiopental (IV or bone) or propofol. Ketamine is rarely used. The muscle relaxants generally used are cisatracurium, rocurium, atracurium, mivacurium and vecuronium.

The use of morphine, diazepam and potassium chloride is not a good clinical practice.

Induction of unconsciousness by oral barbiturate administration was used for 54 euthanasia (less than 1% of euthanasia).
Several registration documents indicated that the technique used for euthanasia was the administration of a lethal dose of a barbiturate potion that the patient swallowed himself. In the majority of these cases, the death occurred quickly without further intervention; in some cases, a neuromuscular paralyzer was injected after the loss of consciousness. Such a way of acting can be described as "medically assisted suicide".
The Commission considers that this way of proceeding is authorized by law, provided that the legal conditions and procedures for euthanasia to be authorized have been respected and that the act has been carried out under the constant responsibility of the physician, who is present. uninterrupted and ready to intervene until the end of the process. Indeed, the law does not impose the manner in which euthanasia is to be practiced.
This interpretation is consistent with that of the National Council of the Order of Physicians in its opinion of March 22, 2003.

I. Decisions of the Commission

Remarks

- *Simple acceptance* means that, according to all present members of the Commission, the registration document was fully completed, all conditions were met and the procedure was correctly followed.
- *Opening of Part I for administrative reasons* means that for example the date and/or place of death, the qualification of the physicians consulted and/or the products used for euthanasia were not mentioned in the registration, but all conditions have been met and the procedure has been followed correctly.
- *Opening of Part I to clarify compliance with the conditions and the procedure followed*. These details concern, for example, the diagnosis, the voluntary, thoughtful and repeated nature of the request, the date of the written request in the event of an unexpected death in the short term or the conclusions of the physicians consulted compulsorily.
- *Opening Part I for simple remark* means for example that anonymity in Part II of the registration document has not been respected.
- *Transmission to the Public Prosecutor* means that the Commission considers, after having examined the file thoroughly and after having heard the physician concerned, that the conditions of the law were not fulfilled and this, after a two-thirds majority vote.

In 2016–17, 76.3% of the returns were correctly completed, complied with legal requirements and were therefore accepted from the outset.

In 23.7% of the cases, the Commission decided to lift anonymity and to open Part I, in order to request additional information from the reporting physician.

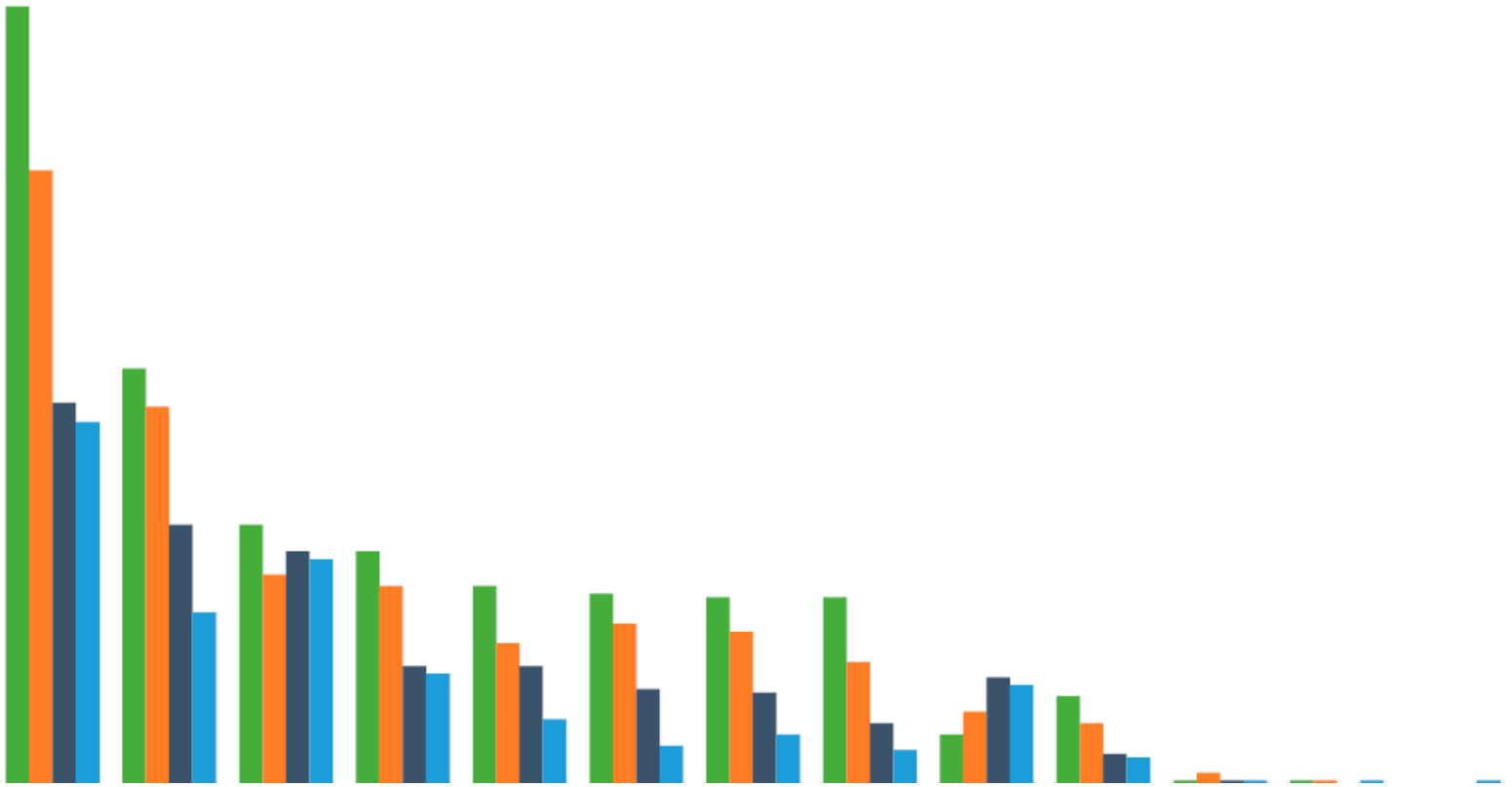
This opening was, in 6.9% of the statements, solely justified by the Commission's desire to point out to the physician, mainly for the purpose of information and pedagogy, shortcomings in his answers or errors of interpretation concerning the procedures followed. The latter, however, did not question the respect of legal conditions. In these cases, no response from the physician was sought.

In 16.8% of the declarations, the opening of Part I was intended to obtain from the physician additional information desired by the Commission concerning one or more points of the document that were poorly, inadequately or incompletely completed. Most of these points concerned missing administrative information or procedural details. The answers given each time provided the useful information and the declarations could be accepted.

In rare cases, the statements were accepted by the Commission, although one or the other procedural point had not been followed to the letter, but each time ensuring absolute respect for the essential conditions of the procedure. the law (conscious and capable patient, written request, medical situation without end and constant suffering, unbearable and unappeasable, resulting from a serious and incurable condition). The information brochure drawn up by the Commission has been systematically attached to all the letters sent to the physicians concerned.

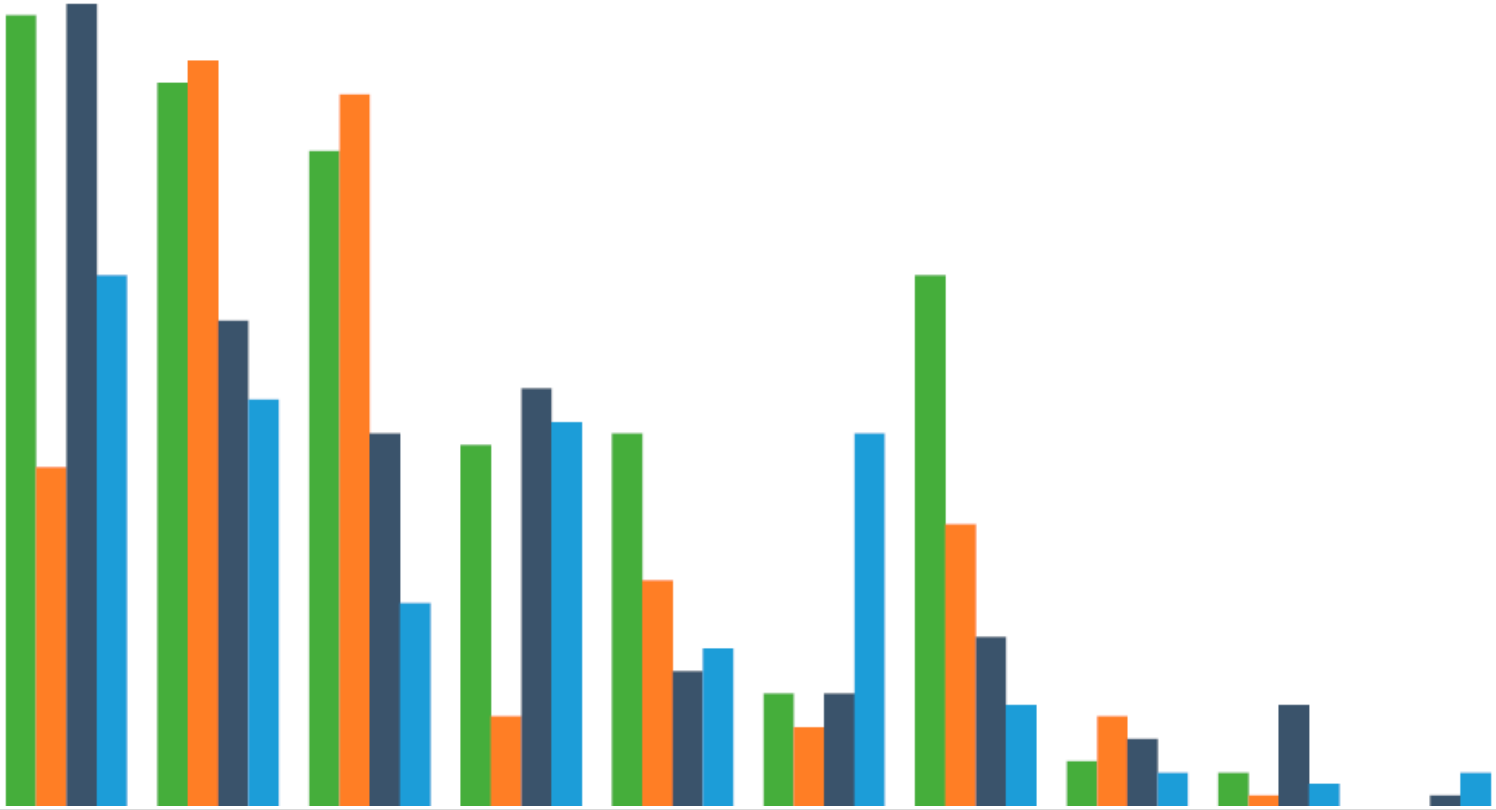
According to the evolution of statistics (2014–2017), it is clear that physicians are filling out registration documents more and more comprehensively, and therefore less additional information is required regarding conditions provided for in the law (see 2014: 20.2% versus 2017: 16.8%). This may be due to the exchange of instructional correspondence during all these years between the Commission and the medical profession.

Figure 15. Breakdown of opening reasons for details of compliance and the procedure followed



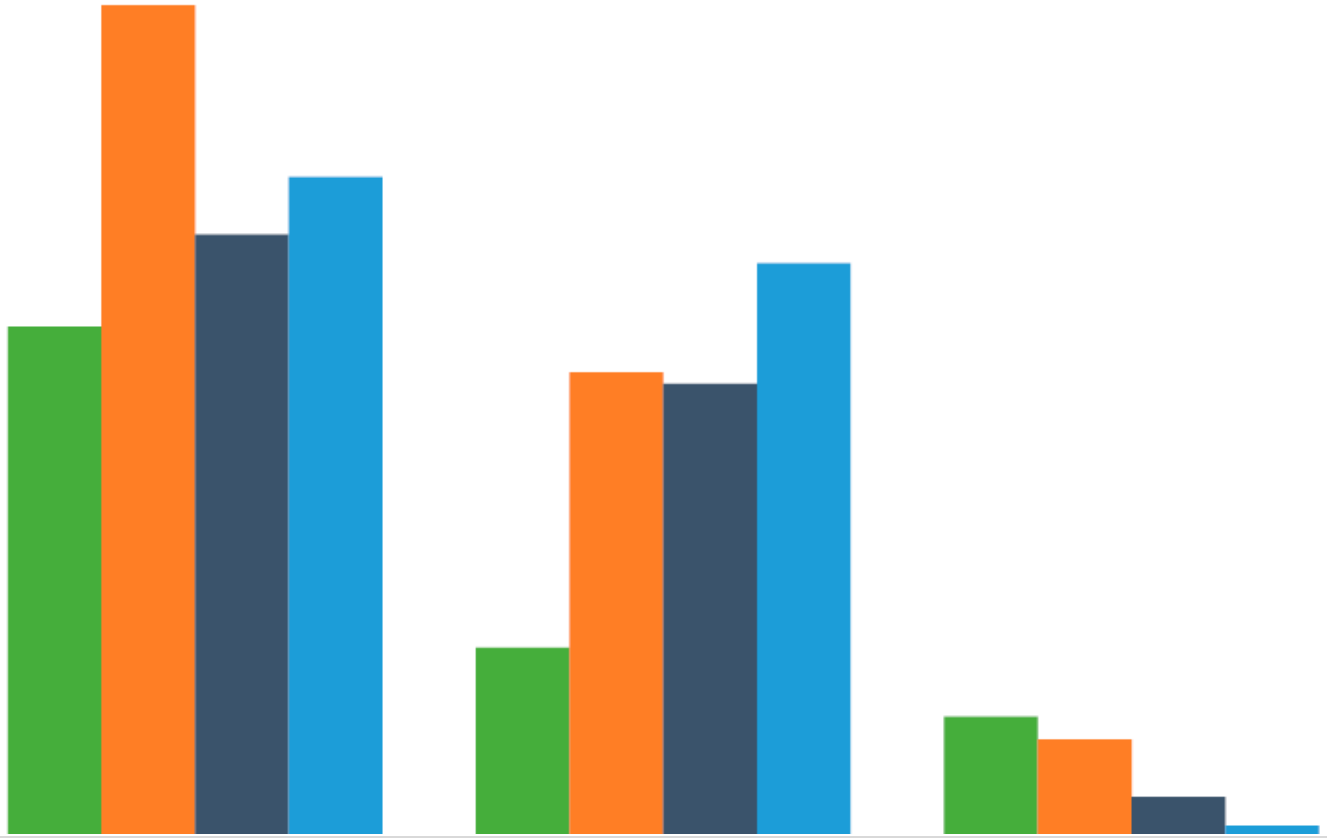
	Date written request	1st physician's opinion	Procedure followed	Voluntary, repeated + thoughtful request	Approaching death	Unappeas-able aspect of suffering	Nature of suffering	Written request exists	Diagnosis	2nd physician's opinion	Date of anticipatory declaration	Advance declaration – physician's advice consulted	Irreversible unsconsious-ness?
2014	204	109	68	61	52	50	49	49	13	23	1	1	0
2015	161	99	55	52	37	42	40	32	19	16	3	1	0
2016	100	68	61	31	31	25	24	16	28	8	1	0	0
2017	95	45	59	29	17	10	13	9	26	7	1	1	1
Total (N = 1943)	560	321	243	173	137	127	126	106	86	54	6	3	1

Figure 16. Distribution of reasons for opening for administrative reasons



	1st physician's qualifications	Products used	Technique used	Date of death	Date of birth	2nd physician's qualifications	1st physician consultation date	Place of euthanasia	Sex	2nd physician consultation date
2014	70	64	58	32	33	10	47	4	3	0
2015	30	66	63	8	20	7	25	8	1	0
2016	71	43	33	37	12	10	15	6	9	1
2017	47	36	18	34	14	33	9	3	2	3
Total (N = 985)	218	209	172	111	79	60	96	21	15	4

Figure 17. Distribution of opening reasons for simple remark



	Anonymity	Instructional letter (everything in the form, ...)	Confusion in current and anticipated application form
2014	89	33	21
2015	145	81	17
2016	105	79	7
2017	115	100	2
Total (N = 794)	454	293	47

The study of the reasons for the opening of part I re-emphasizes the absolute necessity of an electronic registration document that can be sent via a secure link to the Commission's secretariat. Such an electronic document would reduce by at least 5% the number of documents for which Part I must be opened. An electronic document could be sent digitally only when all the compulsory sections are actually completed. This would be a significant time-saver for the secretariat and would increase the number of documents that can be approved immediately. Therefore, it is important for the authorities to allocate a budget.

Special cases

Two cases that have not been identified as euthanasia are explained in this report. These cases were examined, as required by Article 8 of the Euthanasia Act, and the Commission decided - for the second case, after a vote - not to repeat them in statistics of euthanasia performed.

- **The first case was a case of palliative sedation**
  It was not euthanasia in the sense that it is defined by the Euthanasia Act. Moreover, there is no legal obligation to record palliative sedation with the Commission, not even when such palliative sedation is likely to result in or precipitate death. Since the Commission assessed this case as "palliative sedation", it considered that it should not be included in the statistics. This decision was part of a decision (in this respect, see the 2004-2005 report) concerning the non-integration of a similar case, as it was not a case of euthanasia.
- **The second case concerned an act interrupting life without request from the patient**
  In this complex case where the patient had not made an explicit request, some members of the Commission considered that the law on euthanasia had been violated and that the file should be sent to the public prosecutor. Indeed, demand is one of the essential legal conditions. However, other members considered that a referral to the prosecution was not appropriate. Two arguments have supported this position. On the one hand, the fact that the means used in such a situation of agony did not necessarily indicate the practice of euthanasia. On the other hand, several members of the Commission pointed out that in this case, the physician was faced with an emergency situation characterized by an extremely painful agony suffered by the patient for 24 hours, while her expectation of life was at most 2 to 3 days. Moreover, this patient was likely to choke. In addition, the patient's behavior and non-verbal communication were interpreted by the physician, the nursing staff, and the family members of the patient as a request for euthanasia. A two-thirds majority, legally required for removal to the public prosecutor (see article 8 of the law) was not reached (9 for referral to the public prosecutor, 7 against).

C. Specific evaluation of certain categories of patients

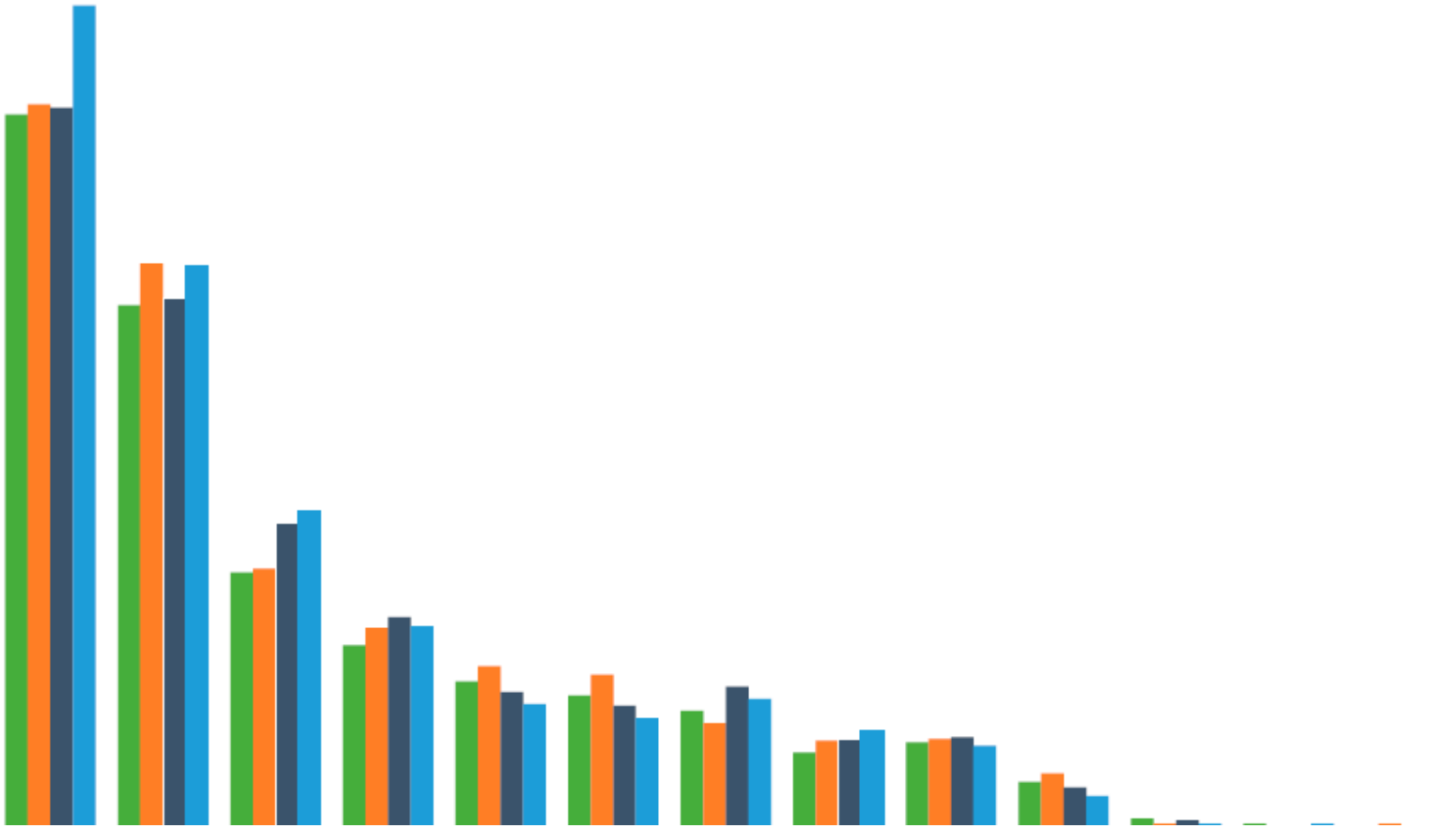
a. Patients suffering from oncological diseases (tumours/cancers)

In 2016 – 2017, oncology conditions were still the main category for which patients requested euthanasia.

Although the absolute number of patients euthanized due to an oncological condition has increased over the past four years, the percentage of the annual total has decreased.

However, the number of oncological patients requesting euthanasia is likely to increase over the next few years. According to the '"Belgian Cancer Registry", in the publication "*Cancer incidence projections in Belgium 2015–202*", the number of new cancer patients will increase during this period from 67820 to 79140, or by 17%. The potential increase within each subcategory depends, on the one hand, on the opportunities for early cancer detection and community collaboration in this regard and, on the other hand, on the increased opportunities of treatment of the cancers in question in this subcategory.

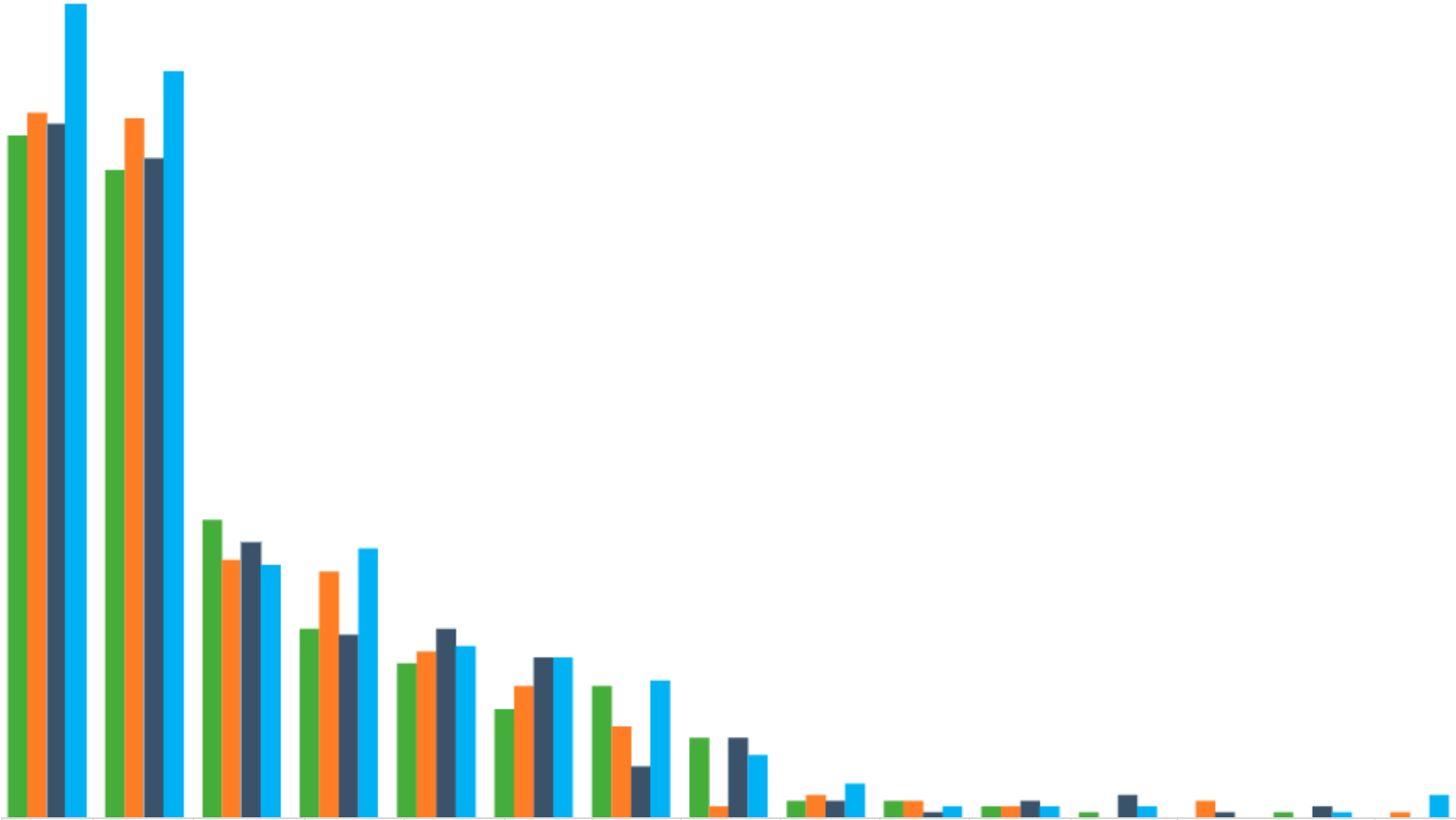
Figure 18. Oncological conditions: subgroups



	Digestive organs	Respiratory organs	Rare	Breast	Female genitals	Kidney and urinary tract	Male genitals	Lip, oral cavity and pharynx	Eye, brain and central nervous system	Melanoma and skin	Location not specified	Bone and cartilage	Uncertain or unknown behaviour
2014	410	300	146	104	83	75	66	42	48	25	4	1	
2015	416	324	148	114	92	87	59	49	50	30	1		1
2016	414	304	174	120	77	69	80	50	51	22	3		
2017	473	323	181	115	70	62	73	55	46	17	1	1	
Total (N = 5456)	1713	1251	649	453	322	293	278	196	195	94	9	2	1

In 2014 - 2017, 5456 patients were euthanized in relation to malignant tumor. On the basis of the subcategories, these are mainly malignant tumors of the digestive organs, respiratory organs and a group of rare malignancies.

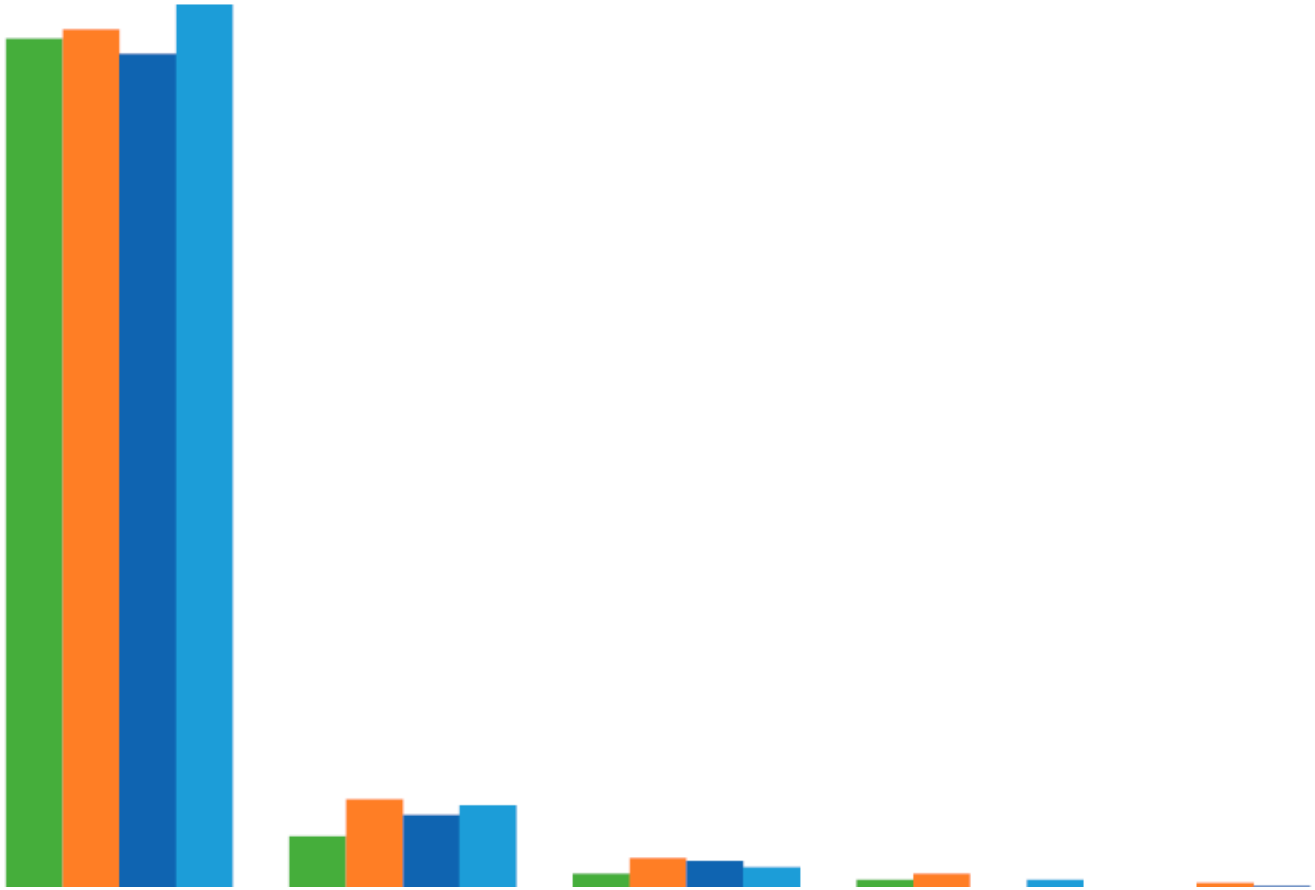
Figure 19. Oncological conditions: malignant tumors of the digestive system



	Colon	Pancreas	Oesophagus	Stomach	Rectum	Bile duct	Liver	Intestine	Small intestine	Anus	Gastro Intestinal Stromal Tumour (GIST)	Duodenum	Gall bladder	Appendix	Other
2014	119	113	52	33	27	19	23	14	3	3	2	1		1	
2015	123	122	45	43	29	23	16	2	4	3	2		3		1
2016	121	115	48	32	33	28	9	14	3	1	3	4	1	2	0
2017	142	130	44	47	30	28	24	11	6	2	2	2		1	4
Total (N = 1713)	505	480	189	155	119	98	72	41	16	9	9	7	4	4	5

For malignant tumors of the digestive tract, these are mainly patients with cancer of the colon, pancreas, esophagus and stomach. In the future, it is assumed that the number of these cancers will increase, despite early detection campaigns and new therapeutic possibilities. Currently, cancers of the pancreas and esophagus cannot yet be detected in time, which greatly reduces curative probabilities.

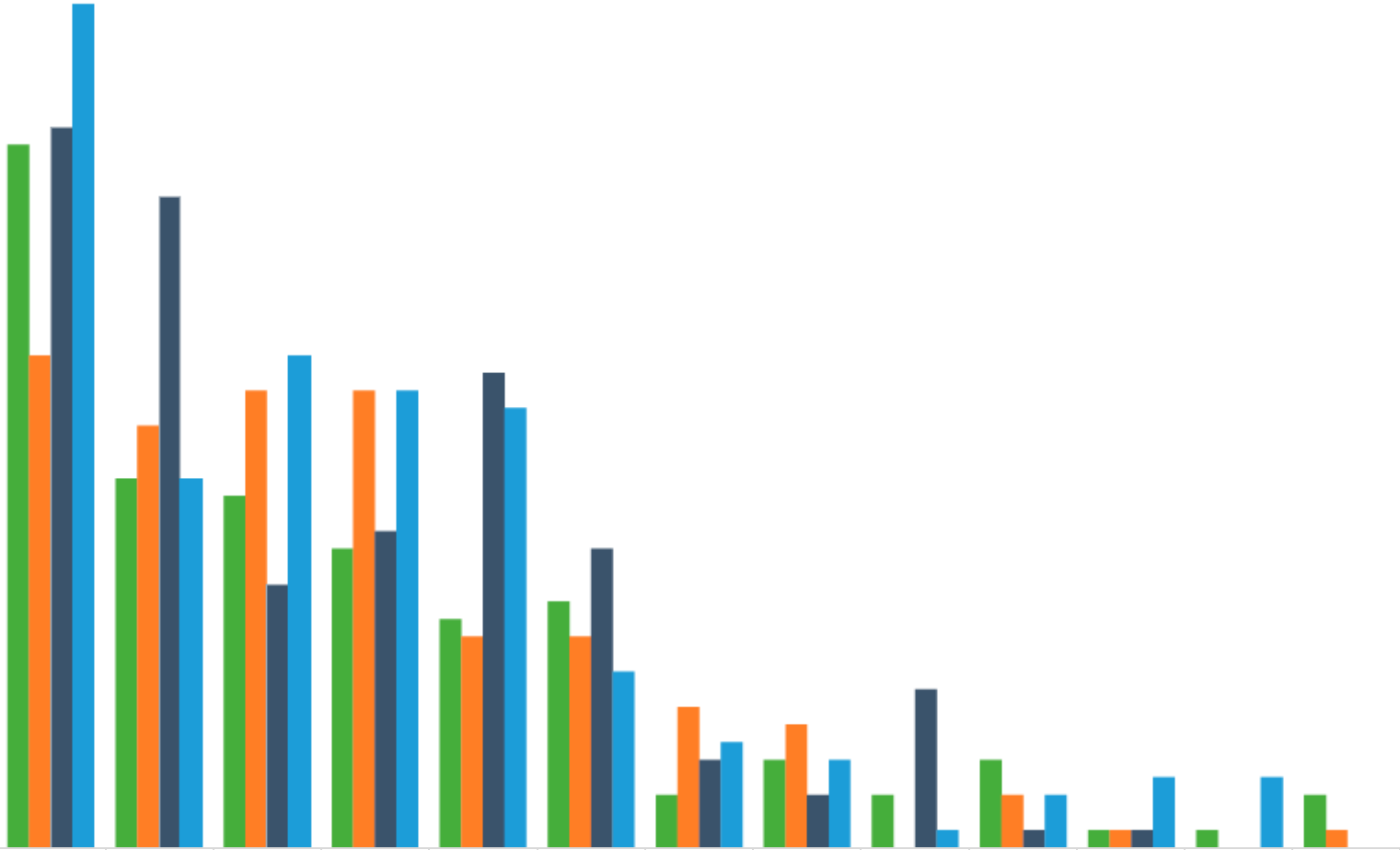
Figure 20. Oncological disorders: malignant tumors of the respiratory organs



	Lung	Mesothelioma	Larynx	Hypopharynx	Thymoma
2014	275	17	5	3	0
2015	278	29	10	5	2
2016	270	24	9	0	1
2017	286	27	7	3	0
Total (N = 1251)	1109	97	31	11	3

For malignant tumors of the respiratory organs, lung cancer is the most common form. Bone metastases cause many pains, and brain metastases can cause irreversible disturbances of consciousness.

Figure 21. Oncological conditions: rare malignant tumors

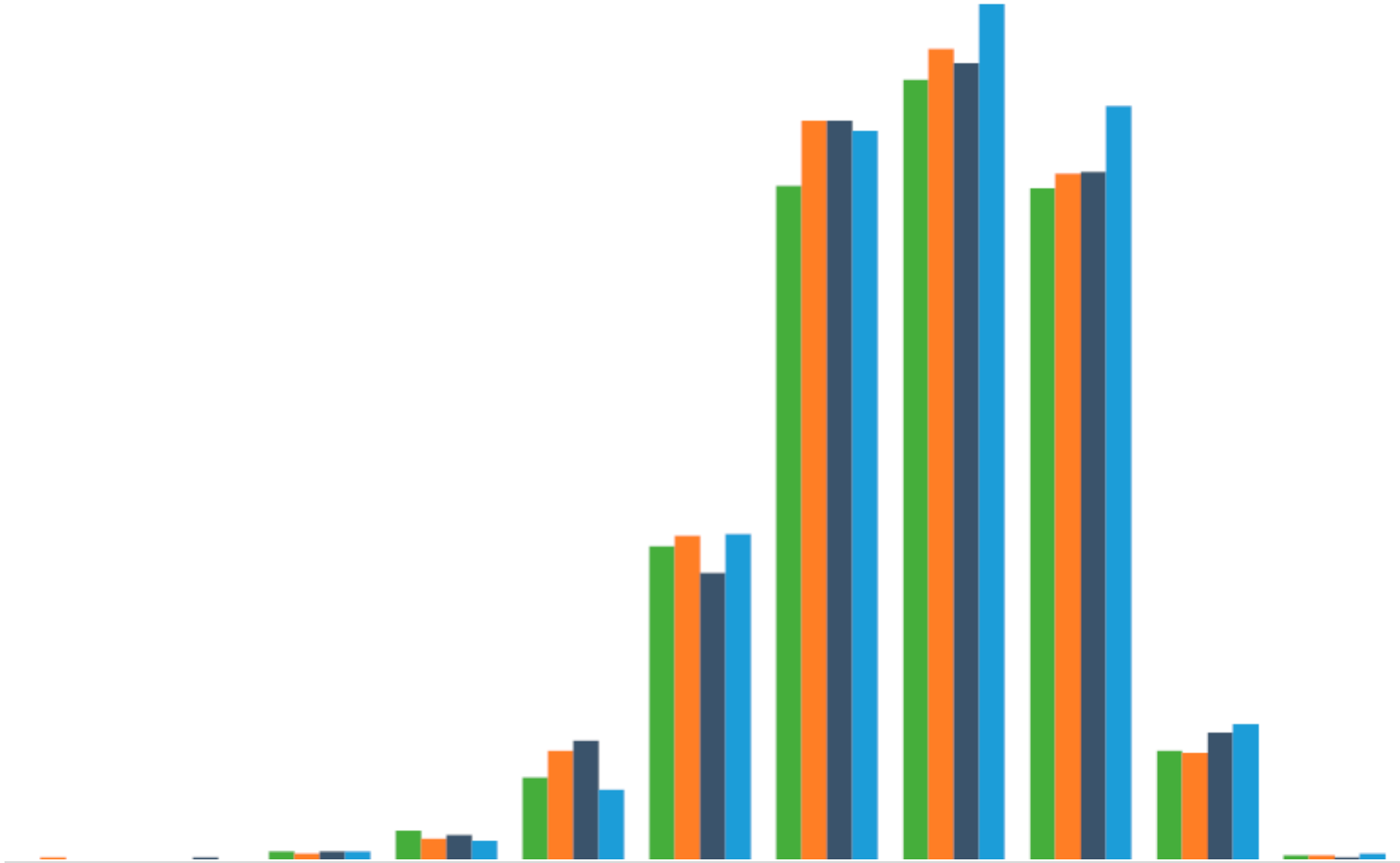


	Double carcinoma	Leukemia	Lymphoma	Sarcoma	Unknown origin	Multiple myeloma	Myelo-dysplasia	Thyroid	Neuro-endocrine tumour	Other category	Myelo-fibrosis	Walden-strom	Unspec-ified
2014	40	21	20	17	13	14	3	5	3	5	1	1	3
2015	28	24	26	26	12	12	8	7	0	3	1	0	1
2016	41	37	15	18	27	17	5	3	9	1	1	0	0
2017	48	21	28	26	25	10	6	5	1	3	4	4	0
Total (N = 649)	157	103	89	87	77	53	22	20	13	12	7	5	4

The group of rare malignant tumors includes double carcinomas, that is, patients with two types of cancer, and cancers of unknown origin. The prognosis for these two cancer groups is often poor. Malignant tumors of lymphoid and hematopoietic tissues (lymphoma, leukemia and myeloma) are also common.

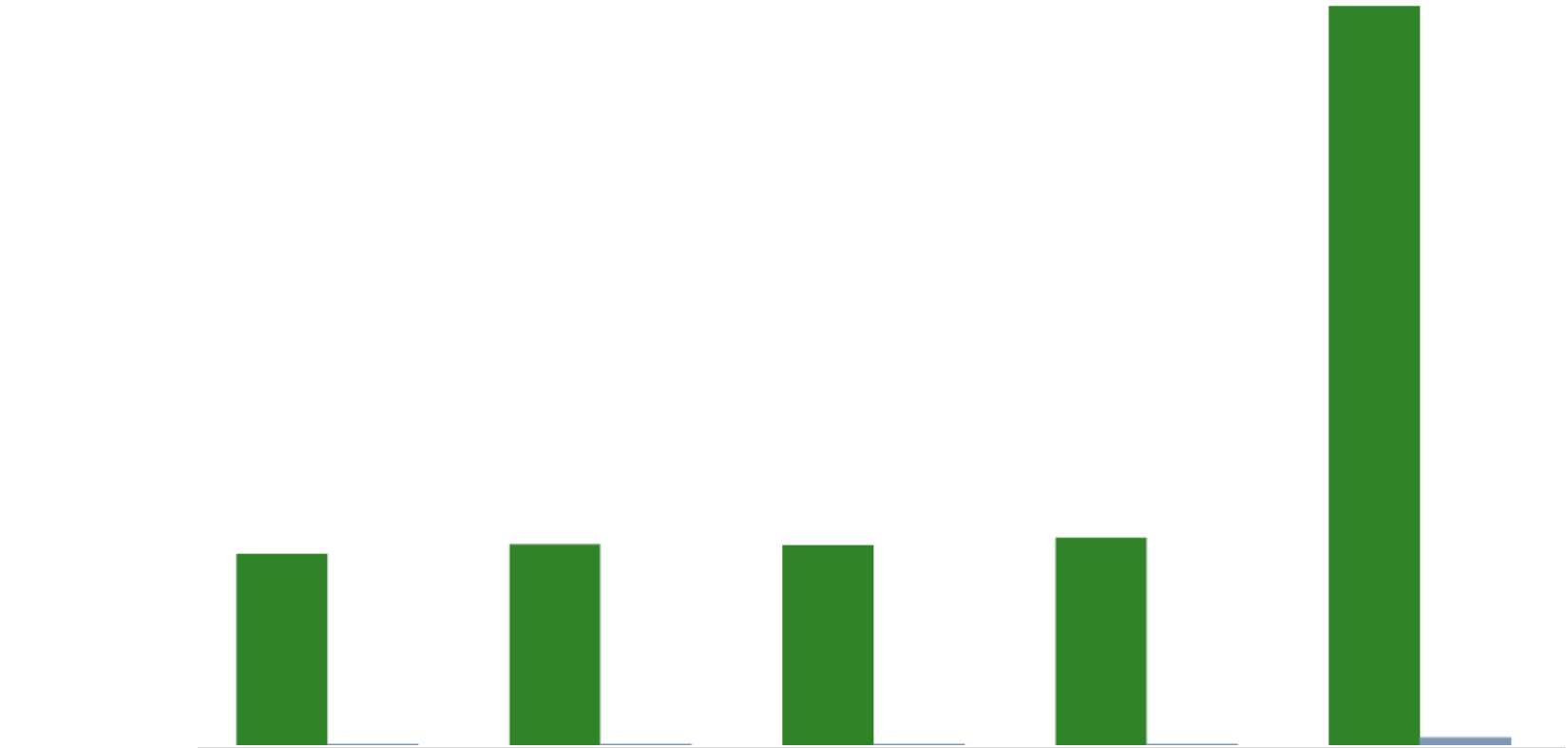
According to the *Belgian Cancer Registry*, in Belgium, cancer mainly affects people of a certain age. 67% of women and 78% of men are over 60 at the time of diagnosis. In the following graph, it can be seen that the largest group of euthanasia patients suffering from oncological diseases concerns patients over 60 years of age.

Figure 22. Oncological conditions: age of patients



	?	< 18	18–29	30–39	40–49	50–59	60–69	70–79	80–89	90–99	100+
2014	0	0	4	14	40	153	329	381	328	53	2
2015	1	0	3	10	53	158	361	396	335	52	2
2016	0	1	4	12	58	140	361	389	336	62	1
2017	0	0	4	9	34	159	356	418	368	66	3
Total (N = 5456)	1	1	15	45	185	610	1407	1584	1367	233	8

Figure 23. Oncology conditions: prediction of end-of-life



	2014	2015	2016	2017	TOTAL (N = 5456)
Brief	1290	1358	1349	1401	5398
Not brief	14	13	15	16	58

As expected, the death of almost all oncology patients was expected in the near future with the exception of 58 patients (1.06%).

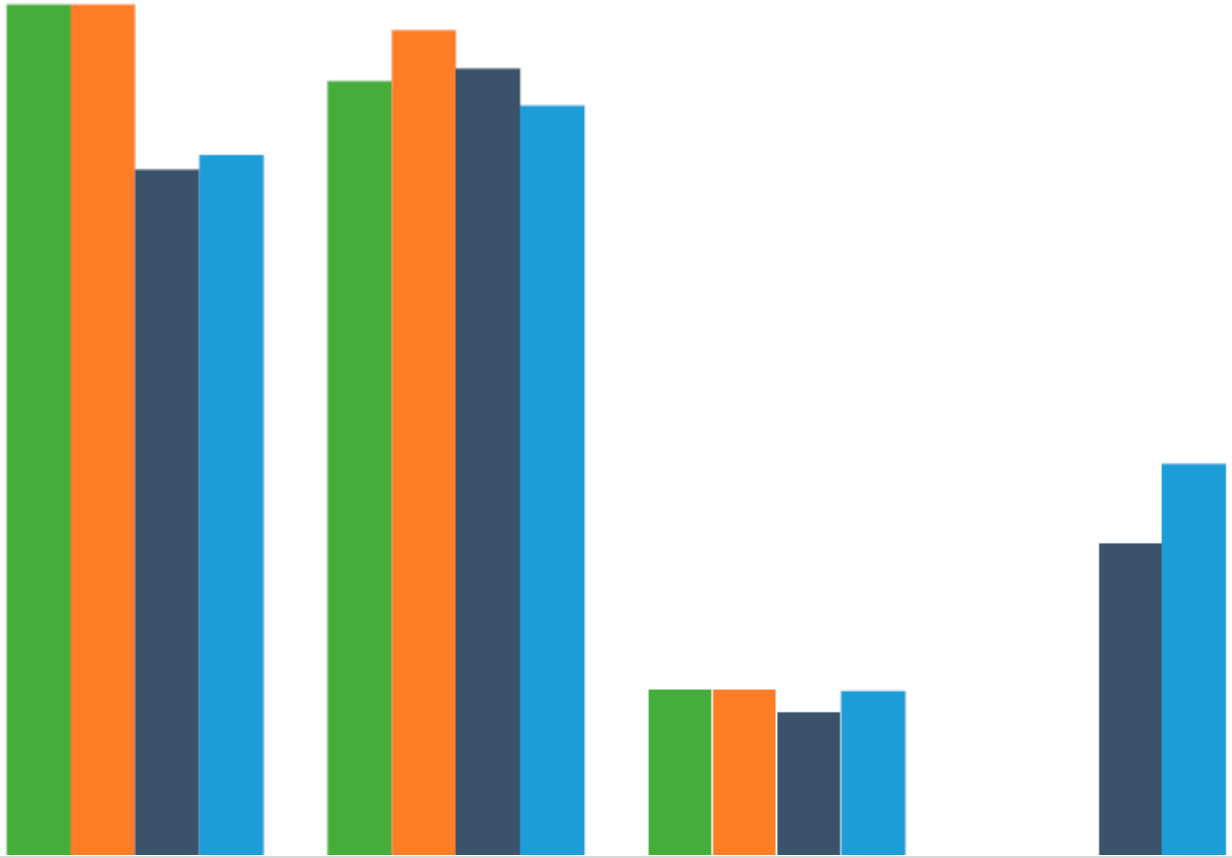
The reasons why oncological patients request euthanasia are many:

- symptomatic metastases, e.g. in the bones, liver and brain,
- the exhaustion of therapeutic possibilities,
- extensive recurrence of cancer that was no longer treatable (tumors of the head and neck, ovarian, cerebral, etc.),
- medical contraindications to treatment such as heart disease, terminal lung disease and kidney failure.

In, so to speak, all the statements, the physician indicated that there was, besides the physical suffering expressed and intractable, also a serious psychic suffering. Although this is not explicitly requested, the reporting physician has frequently indicated that conventional palliative treatments do not control this suffering in a manner acceptable to the person concerned. In addition, it is frequently mentioned that the patient prefers euthanasia to palliative sedation.

GPs, like specialists, have a crucial role to play in the process of euthanasia in this group of patients. Since the vast majority of these patients' deaths are expected in the near future, only one opinion of an independent physician is needed, regardless of specialization.

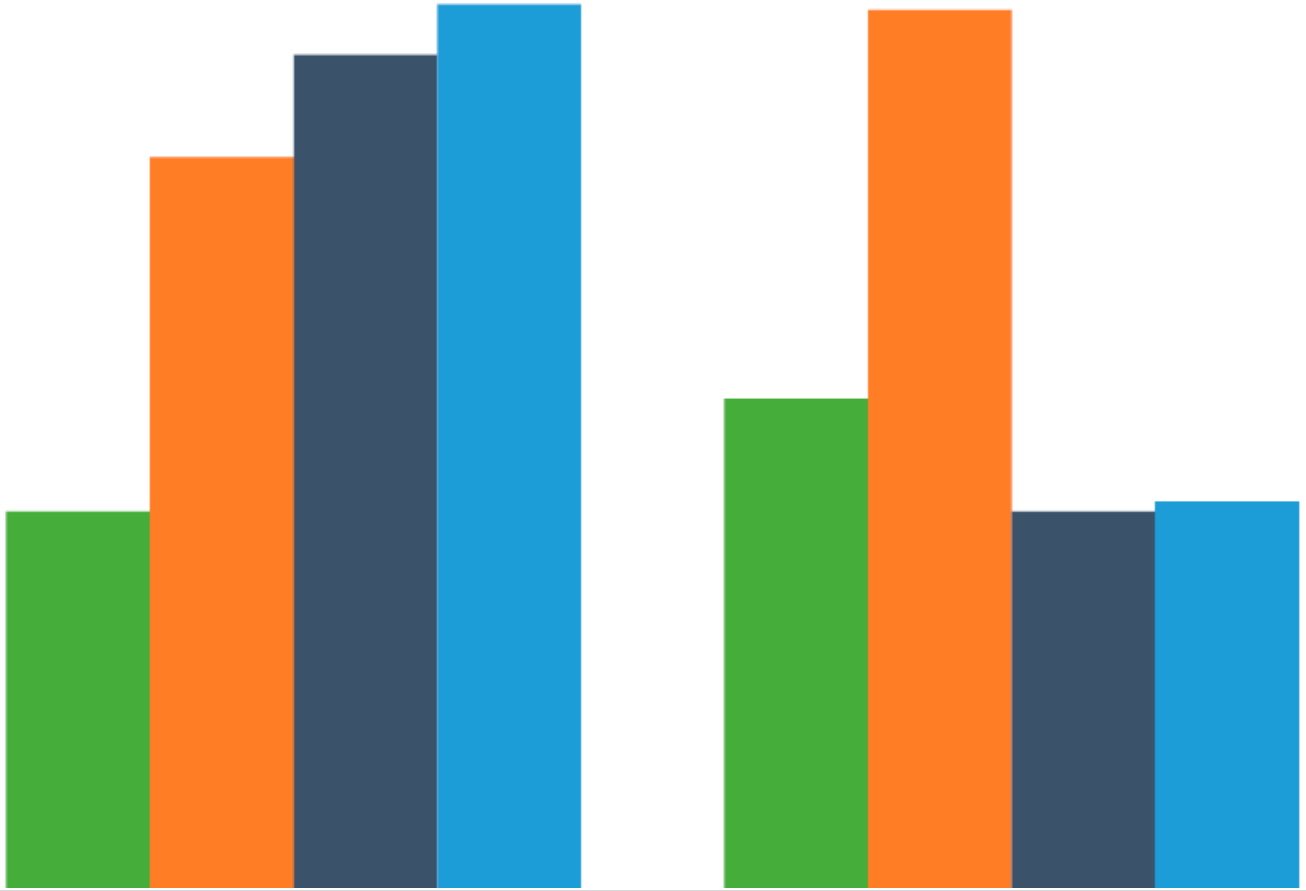
Figure 24. Oncological conditions: qualification of the first physician consulted



	GP	Specialist	Trained in palliative care	LEIF/EOL
2014	639	546	119	
2015	670	582	119	
2016	484	555	103	222
2017	494	529	117	277
Total (N = 5456)	2287	2212	458	499

In addition to the mandatory consultation of independent physicians, other care providers (consulted outside legal obligations) are involved in the euthanasia process. However, reporting physicians are not required to report the involvement of other health care providers and the associated multidisciplinary approach. Again, this means that the numbers are an underestimate of the involvement of other care providers.

Figure 25. Oncological conditions: other physicians, palliative team or psychologists consulted outside legal obligations (Total number of reports concerned: 2678 out of 5456 oncological patients)



	Other physicians or psychologists	Palliative teams
2014	322	418
2015	624	749
2016	711	322
2017	754	331
Total (N = 4231)	2411	1820

Timeout

Since 99% of these cancer patients are expected to die early, it makes sense that, when euthanasia is performed, the waiting time for most of these patients is less than a month. Although physicians are not required to, 22% of them report that patients, in the weeks or months before euthanasia, have discussed with their physician about euthanasia in case their suffering would have become unbearable.

b. Patients suffering from poly-pathologies

The Commission's 7th biennial report mentions that, in Belgium, poly-pathologies constitute, after oncological conditions, the major reason for requests for euthanasia. This was confirmed in 2016 – 2017.

The selection of registration documents relating to euthanasia due to poly-pathologies was carried out on the basis of Van den Akker's 1996 definition of multimorbidity (= poly-pathologies), namely: "*the co-occurrence of multiple chronic or acute diseases and medical conditions within one person*"[2]. As mentioned above, many patients suffering from poly-pathologies were, before ICD coding 10, previously encoded under another category.

For these patients, the severity of their condition was not the result of a single condition but of a combination of several conditions which were not likely to improve and which caused more and more serious handicaps of up to organ failure:

- *tumours (cancers)* are, in case of poly-pathologies, difficult to treat or even intractable,
- *gait and mobility disorders* due to polyarthrosis, vertebral fracture, fall, etc. and which are accompanied by pain, expressed or not, and a significant limitation of the possibilities of movement of the patient, resulting in a loss of autonomy,
- *vision problems*, going as far as a bilateral blindness, with the result that the patient is no longer able to read a newspaper or a book or watch television, he becomes more and more dependent on the care and that has the effect of isolating him from his social contacts,
- *diseases of the nervous system* such as Parkinson's disease or the sequelae of thrombosis (CVA) worsening the dependence on care and social isolation of the patients concerned,
- *hearing problems*, including complete hearing loss, which prevent the patient from having contact,
- *advanced to terminal heart diseases and chronic lung diseases* (classified as "GOLD" 3 to 4) that limit the physical capabilities of the patient and reduce the living space to one room. Social life is reduced to such a point that loneliness sets in,
- *urinary and faecal incontinence*, which many feel is an attack on their dignity,
- *the onset of dementia* that causes the older person to fear a long mental and cognitive decline with, ultimately, loss of personality,
- *cachexia and marked physical wasting*, irreversible and intractable, resulting in continuous bed rest.

The combination of these conditions explains that the death of 60% of these patients is considered to be expected in the short term and that their suffering is unappeasable. On the other hand, extreme physical suffering leads to psychic suffering, which is indicated by some patients to be a fatigue of living, but which is secondary to the physical suffering expressed. However, without a legal medical context, fatigue is never accepted by the Commission as a justification for euthanasia.

It is difficult to ascertain whether such a request meets the requirements of the Euthanasia Act, since in addition to physical suffering, mental suffering also plays an important role. This is why a study was conducted last year from the registration documents of patients who were euthanized because of poly-pathologies during the 2013–2016 period. There were 870 files. This publication discusses in detail how to examine a request for euthanasia based on poly-pathologies[3].

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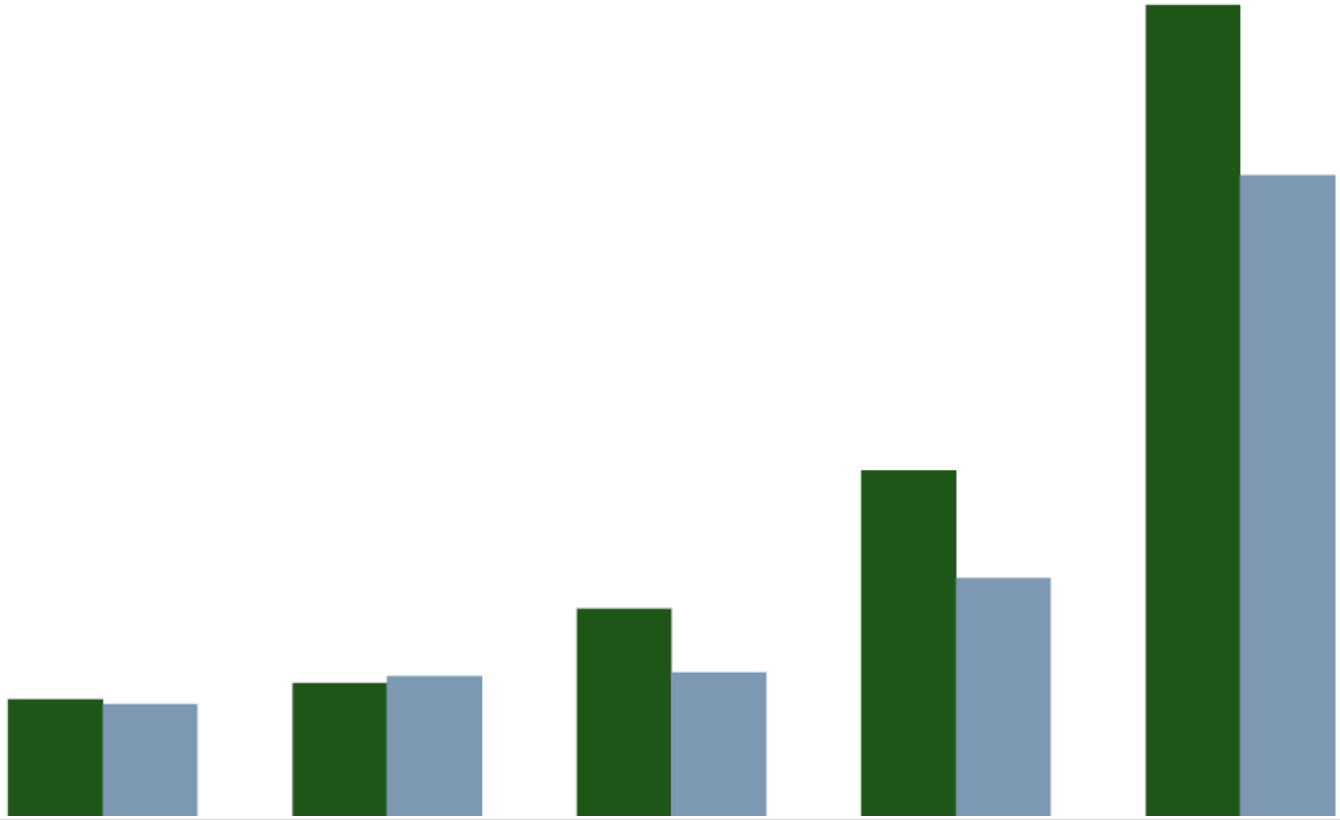
2 Van den Akker M, Buntinx F, Knottnerus JA, Comorbidity or multimorbidity: what's in a name? A review of literature, Eur J Gen Pract 1996;2:65-70.

3 Proot L, Distelmans W, Polypathologies en de Belgische euthanasiewet. Analyse registratiedocumenten euthanasie 2013 – 2016, Tijdschrift voor Geneeskunde, 2018 (sous presse).

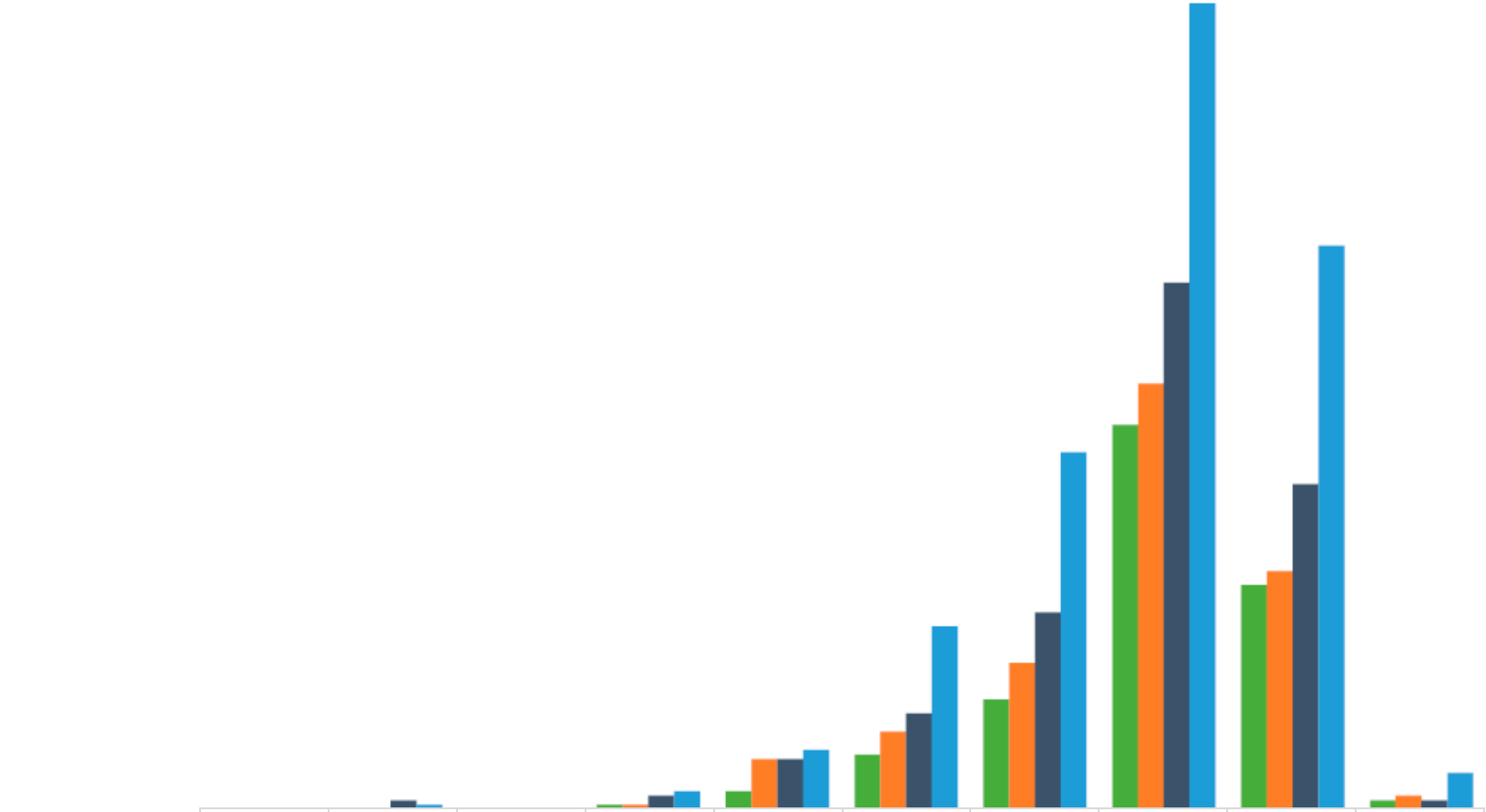
Figure 26. Poly-pathologies according to the foreseeable term of death



	2014	2015	2016	2017	TOTAL (N = 1096)
Brief	90	102	158	262	612
Not brief	86	107	110	181	484

During the period 2014–2017, the number of registration documents for patients suffering from poly-pathologies has doubled. Given the growing aging of the population and the mechanism of occurrence of poly-pathologies, this group is likely to continue to increase.

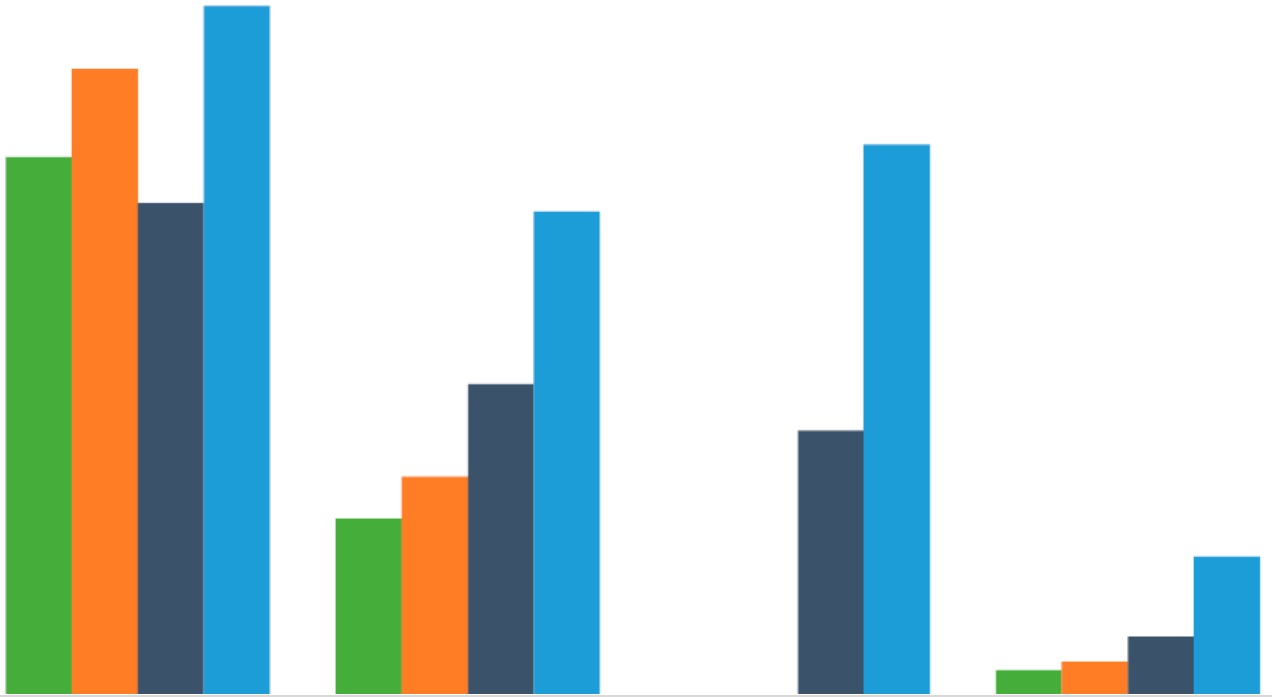
Figure 27. Poly-pathologies: age of patients



	< 18	18–29	30–39	40–49	50–59	60–69	70–79	80–89	90–99	100+
2014				1	4	12	24	84	49	2
2015				1	11	17	32	93	52	3
2016		2		3	11	21	43	115	71	2
2017		1		4	13	40	78	176	123	8
Total (N = 1096)	0	3	0	9	39	90	177	468	295	15

In comparison with oncological patients, the peak age slipped 10 years, and rose to more than 80 years and 90 years. In exceptional cases, poly-pathologies occur at a young age or at a very young age.

Figure 28. Poly-pathologies: qualification of the first physician consulted



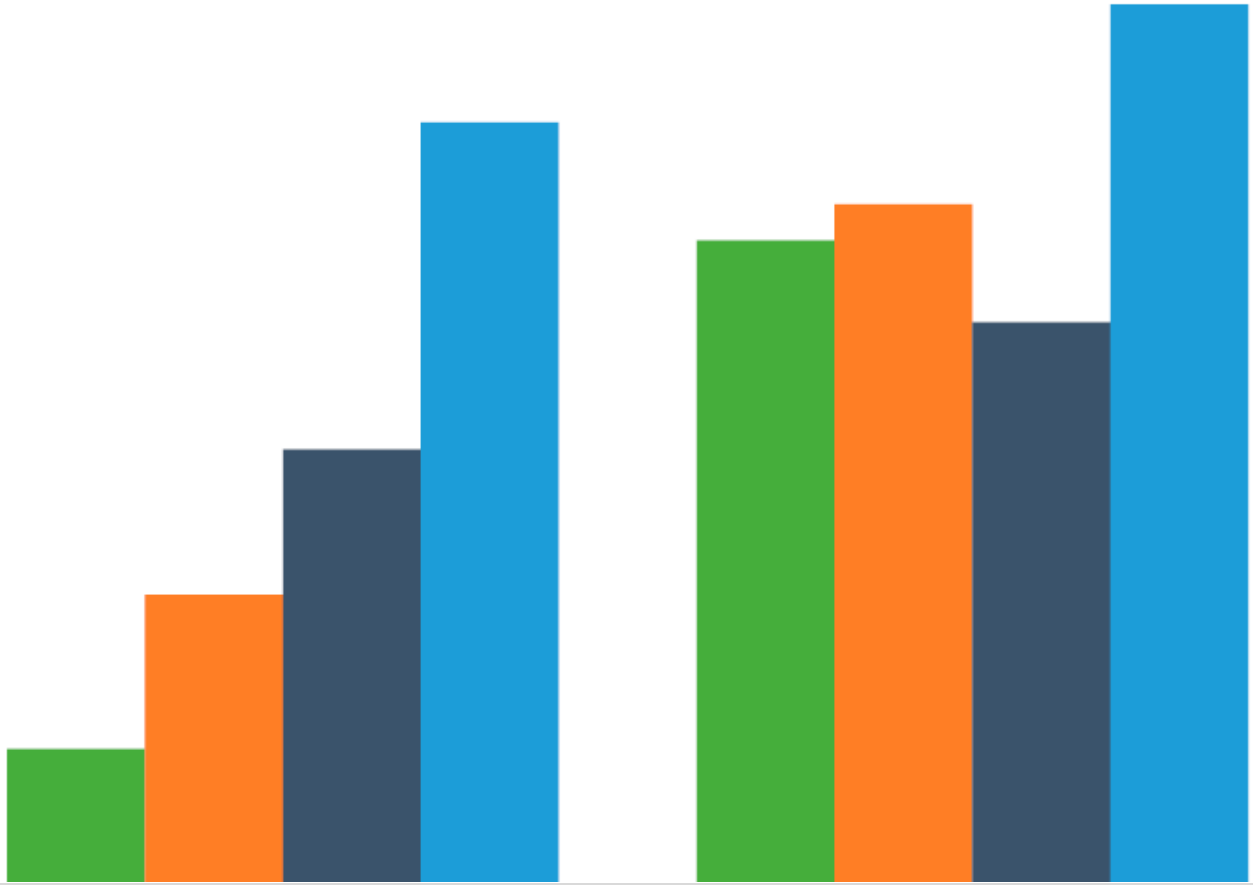
	GP	Specialist	LEIF/EOL	Trained in palliative care
2014	128	42		6
2015	149	52		8
2016	117	74	63	14
2017	164	115	131	33
Total (N = 1096)	558	283	194	61

In case of poly-pathologies, the Commission considers the general practitioner to be a specialist. In other words, a general practitioner can also act as a second physician consulted when it is expected that the patient suffering from poly-pathologies will not die soon.

A general practitioner usually comes in as the first physician consulted and, to a lesser extent, a specialist or psychiatrist. In more than 40% of cases, a physician with special expertise in end-of-life care is called upon.

In 2014–2017, the death of 484 patients suffering from poly-pathologies was not considered as expected in the short term. A second opinion was requested for these patients.

Figure 29. Poly-pathologies: qualification of the second physician consulted compulsorily (death not expected in the short term)



	Specialist	Psychiatrist
2014	15	71
2015	32	75
2016	48	62
2017	84	97
Total (N = 484)	179	305

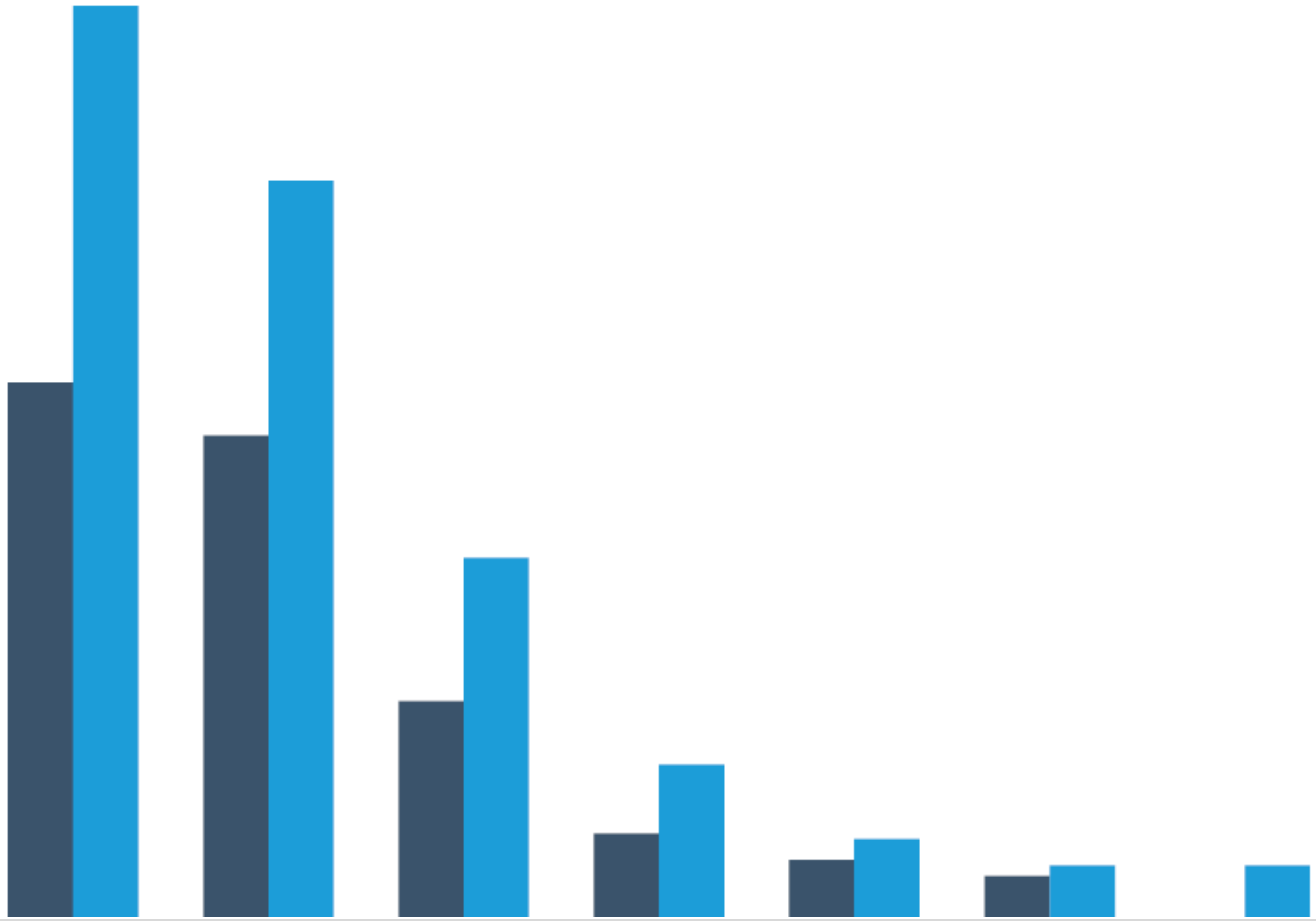
The psychiatrist was most often called upon to obtain this second opinion. General practitioners, considered specialists in poly-pathologies, were less often consulted as second physicians. In 1/5 of the requested opinions, a LEIF-EOL physician and/or a physician trained in palliative care were again called upon, without mentioning his specialization.

Figure 30. Poly-pathologies: other physicians, palliative team or psychologists consulted outside legal obligations (Total number of reports concerned: 527 out of 1096 poly-pathological patients)

	Other physicians or psychologists	Palliative teams
2014	61	38
2015	115	71
2016	156	43
2017	276	61
Total (N = 821)	608	213

For patients suffering from poly-pathologies as well, physicians spontaneously mention the multidisciplinary approach with other care providers (consulted outside legal obligations). As mentioned above, this figure is an underestimate.

Figure 31. Poly-pathologies: Timeout



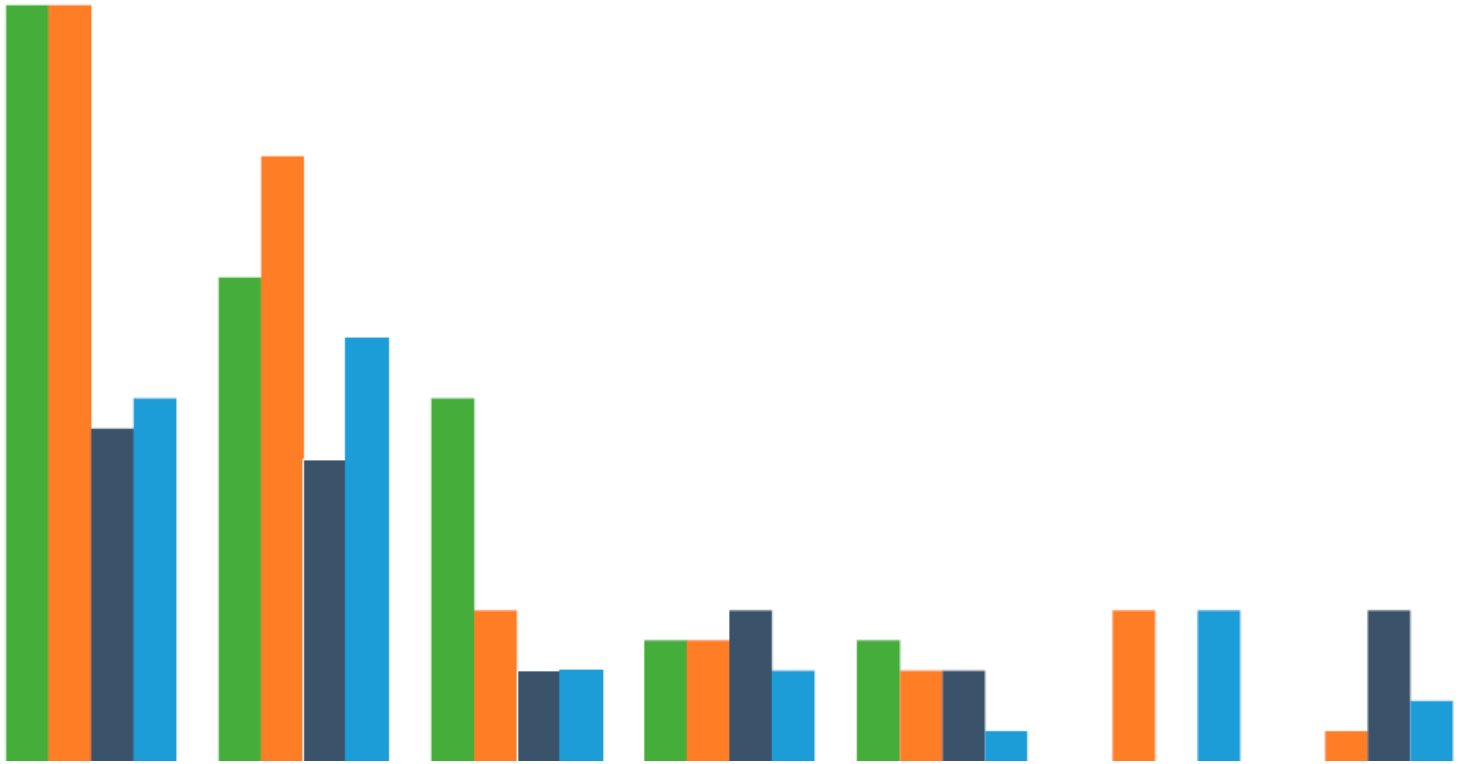
	<1 m	1 m	2–3 m	4–6 m	7–12 m	13–24 m	>24 m
2016	101	91	41	16	11	8	0
2017	172	139	68	29	15	10	10
Total (N = 711)	273	230	109	45	26	18	10

As expected, the waiting time for many patients with multiple pathologies is less than one month. In the vast majority of cases, it is less than two months. This is not surprising given that for nearly 55% of these patients, death is considered to be expected in the near future and many are very old.

c. Patients with psychiatric conditions (mental and behavioural disorders)

During the 2014–2017 period, 201 registration documents were coded under category ICD-10 "Mental and Behavioral Disorders" (psychiatric conditions).

Figure 32. Psychiatric disorders: subgroups



	Mood disorders (depression, bipolarity, …)	Organic mental disorders, including symptomatic disorders (dementia, Alzheimer's ...)	Personality and behavioural disorders in adults (personality disorder, ...)	Neurotic disorders, disorders related to stressors and somatoform disorders (posttraumatic stress disorder, ...)	Schizophrenia, schizotypal disorder and delusional disorders (schizophrenia, ...)	Organic mental disorders, including symptomatic disorders (autism, ...)	Complex (combination of several categories)
2014	25	16	12	4	4		
2015	25	20	5	4	3	5	1
2016	11	10	3	5	3		5
2017	12	14	3	3	1	5	2
Total (N = 201)	73	60	23	16	11	10	8

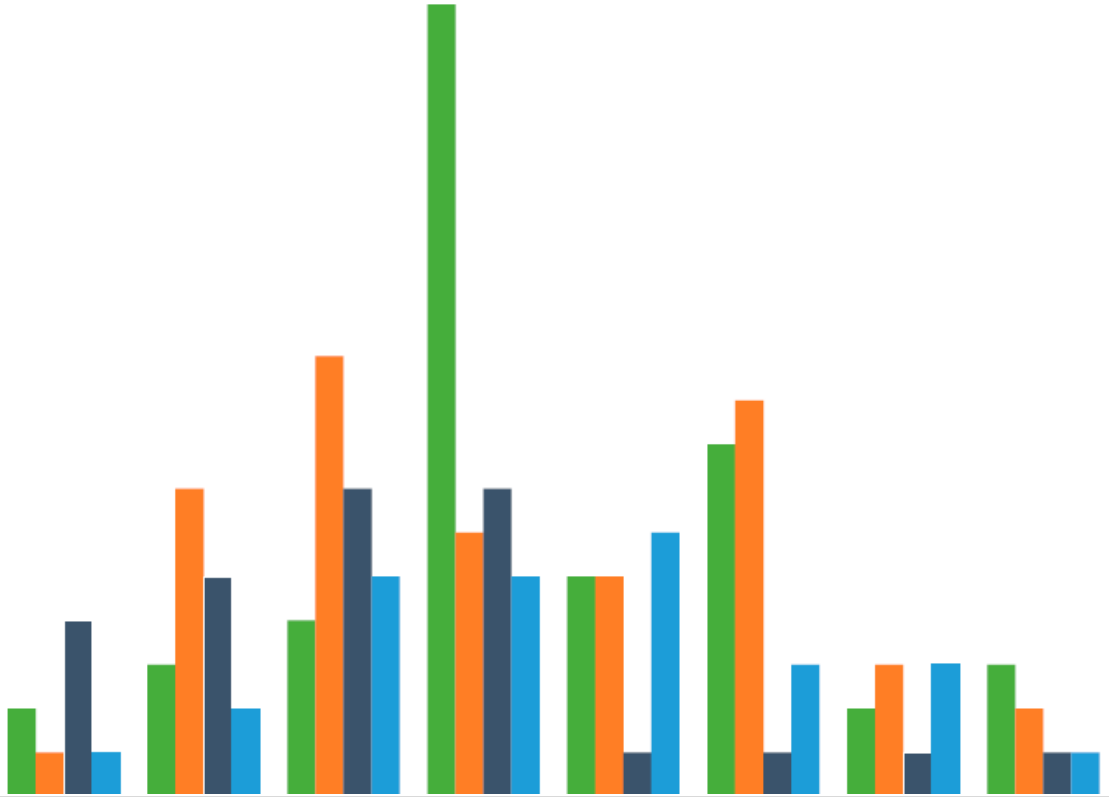
Complex Topic: ICD-10 psychiatric code coding does not permit the coding of complex psychiatric disorders that include different psychiatric syndromes. To classify these disorders one has to rely on the DSM or "Diagnostic and Statistical Manual of Mental Disorders". These two classification systems are however linked. The DSM methodology is mainly used to identify the best corresponding diagnosis(es), which is (are) then transposed into an ICD-10 code. However, the use of DSM codes is only possible if the patient's complete medical file is available.

Compared with the years 2014-2015, the Commission received fewer reports of euthanasia in 2016-2017 for patients suffering from psychiatric illness, with the exception of patients suffering from Alzheimer's disease.

In the following analysis, the group of patients suffering from organic mental disorders (such as Alzheimer's or dementia) is considered separately.

1. Psychiatric disorders excluding dementia

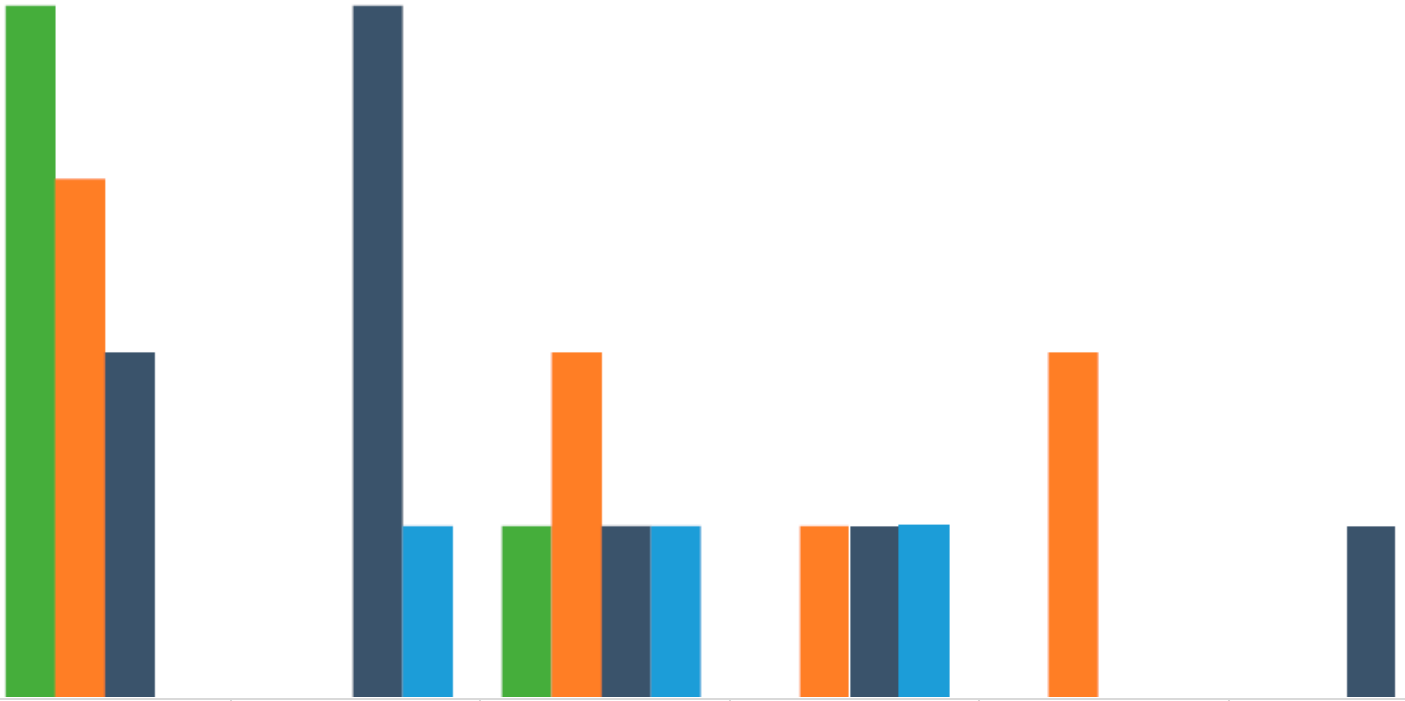
Figure 33. Psychiatric disorders (excluding dementia): Age of patients



	< 18	18–29	30–39	40–49	50–59	60–69	70–79	80–89	90–99	100+
2014		2	3	4	18	5	8	2	3	
2015		1	7	10	6	5	9	3	2	
2016	0	7	5	7	7	1	1	1	1	0
2017	0	1	2	5	5	6	3	3	1	0
Total (N = 141)	0	8	17	26	36	17	21	9	7	0

79 psychiatric patients, 56%, were between 40 and 69 years old; 25 patients were under 40 years old and 16 patients were over 80 years of age, 7 of whom were over 90 years old. In this group, it is almost exclusively mood disorders, namely depression and neurosis anxiety in patients with known psychiatric history.

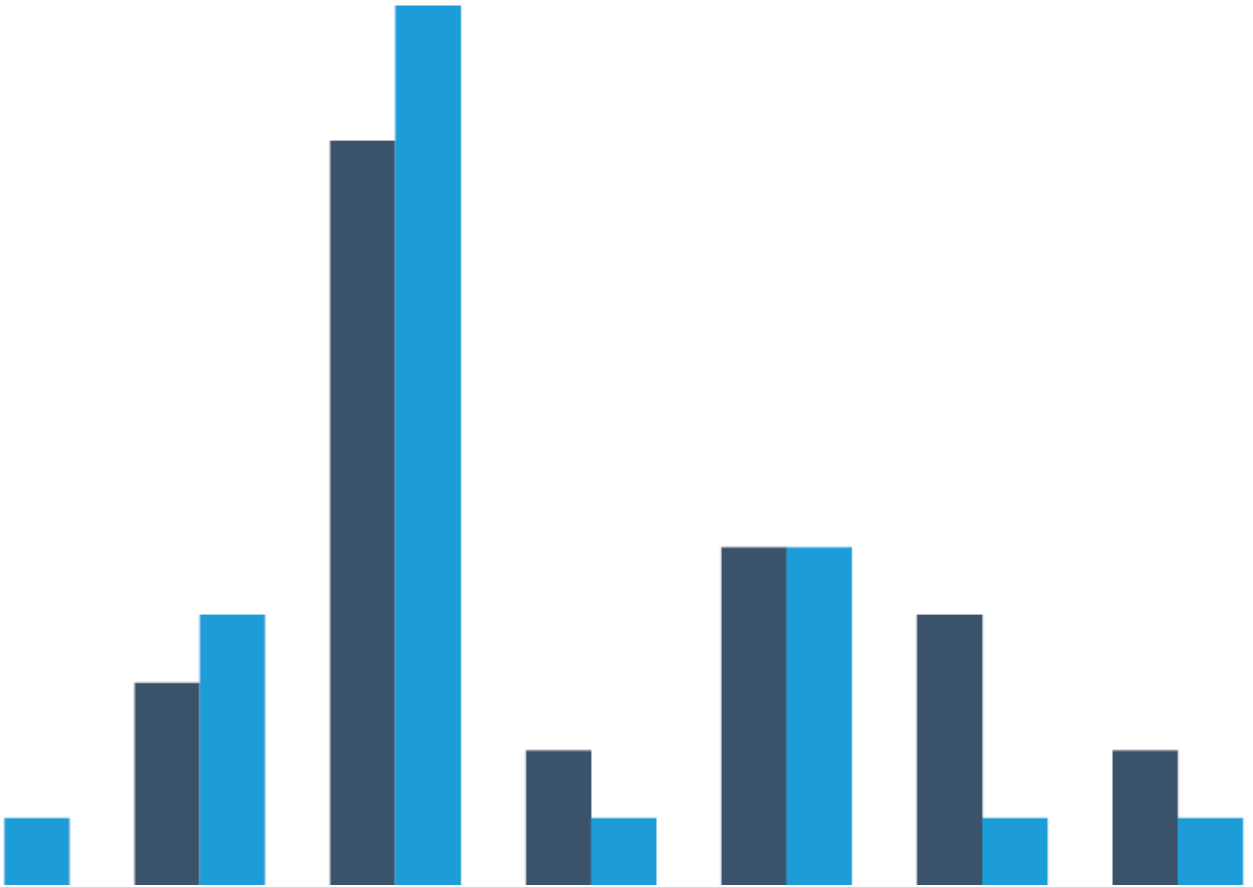
Figure 34. Psychiatric disorders (excluding dementia): subgroups of patients under 40



	Personality and behavioural disorders in adults (personality disorder, ...)	Complex (combination of several categories)	Mood disorders (depression, bipolarity, ...)	Neurotic disorders, disorders related to stressors and somatoform disorders (posttraumatic stress disorder, ...)	Organic mental disorders, including symptomatic disorders (autism, ...)	Schizophrenia, schizotypal disorder and delusional disorders (schizophrenia, ...)
2014	4	0	1	0	0	0
2015	3	0	2	1	2	0
2016	2	4	1	1	0	1
2017	0	1	1	1	0	0
Total (N = 25)	9	5	5	3	2	1

In the group of patients under 40, it is mainly personality and behavioral disorders. All these patients have been treated for many years, both outpatient and residential. There has always been talk of intractable suffering. For this type of disorder, serious mental trauma at a very young age has been mentioned several times, such as domestic violence, psychological neglect or sexual abuse.

Figure 35. Psychiatric disorders (excluding dementia): waiting period

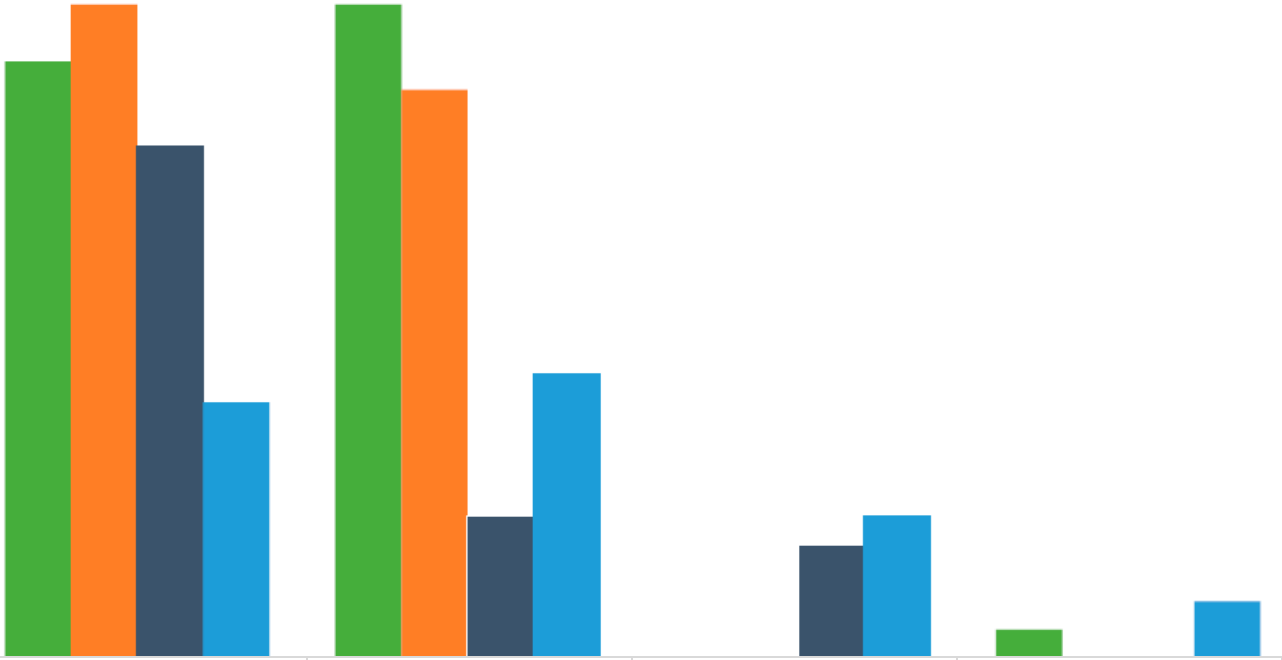


	<1 m	1 m	2–3 m	4–6 m	7–12 m	13–24 m	>24 m
2016		3	11	2	5	4	2
2017	1	4	13	1	5	1	1
Total (N = 53)	1	7	24	3	10	5	3

It is reasonable to assume that the death of a patient with a psychiatric disorder is not expected in the short term. The only patient for whom the waiting time was less than one month was 92 years old. He had a unipolar mood disorder. He refused any treatment, given the rapid deterioration of his general condition. He had already spoken orally several months ago.

For 18 patients, the waiting time was 7 months or more and for 8 patients, the waiting time was one year or more. Among the 3 patients for whom the waiting time was more than 24 months, the longest waiting time was 48 months.

Figure 36. Psychiatric disorders (excluding dementia): qualification of the 1st physician consulted



	Specialist	GP	LEIF/EOL	Trained in palliative care
2014	21	23		1
2015	23	20		0
2016	18	5	4	0
2017	9	10	5	2
Total (N = 141)	71	58	9	3

With regard to the examination of a request for euthanasia of a patient suffering from a psychiatric disorder, the first physician consulted may be any physician, whatever his specialization. However, one does not have to mention his specialization. Therefore, it was not possible to verify whether the LEIF-EOL physician and/or the trained palliative care physician was a GP or specialist.

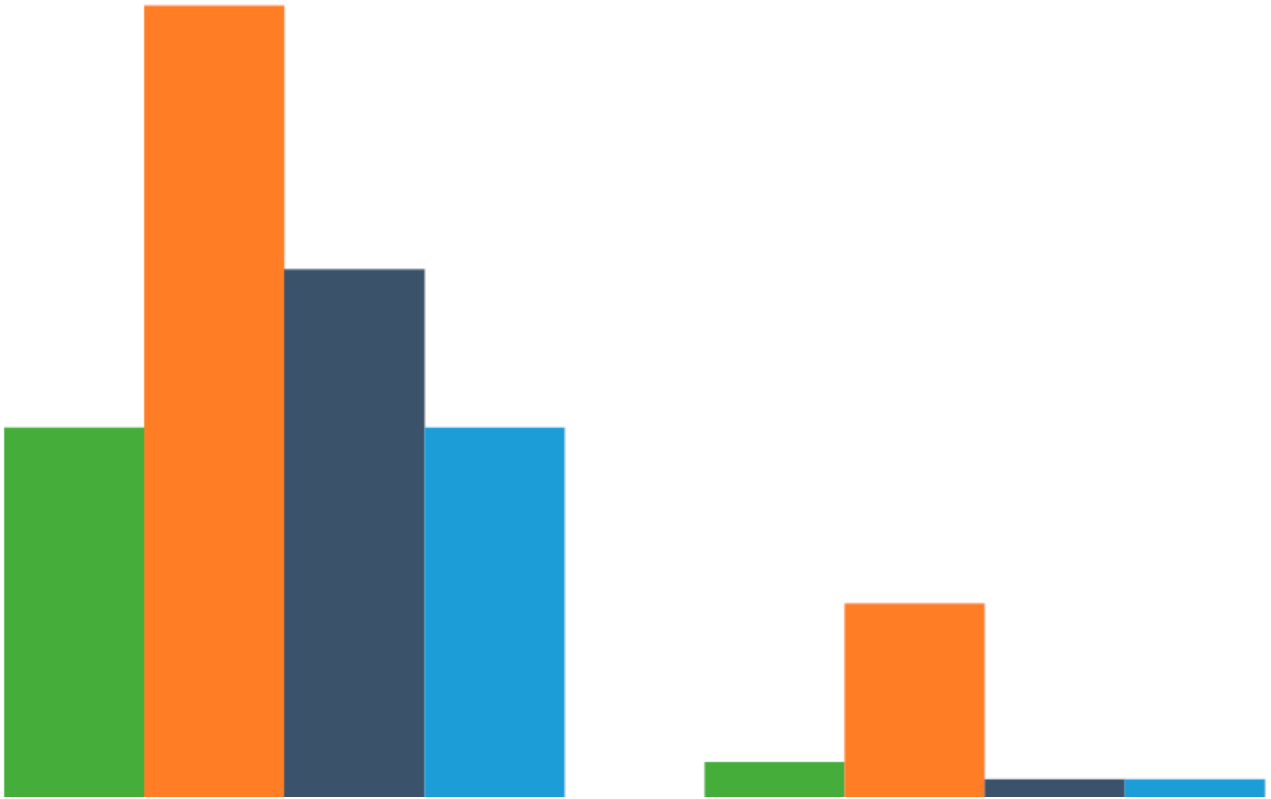
It should be noted that for almost half of the patients, the first physician consulted was already a psychiatrist. In addition, the first opinion came frequently from a physician (general practitioner, psychiatrist or specialist) who received additional training in the problem of decision-making at the end of life.

Figure 37. Psychiatric disorders (excluding dementia): qualification of the second physician consulted compulsorily (death not expected in the short term)

	Psychiatrist	Specialist
2014	40	2
2015	36	5
2016	23	3
2017	25	1
Total (N = 135)	124	11

In 98% of cases, the second physician consulted was a psychiatrist. In 17% of cases, the psychiatrist had also received additional training in the issue of decision making at the end of life.

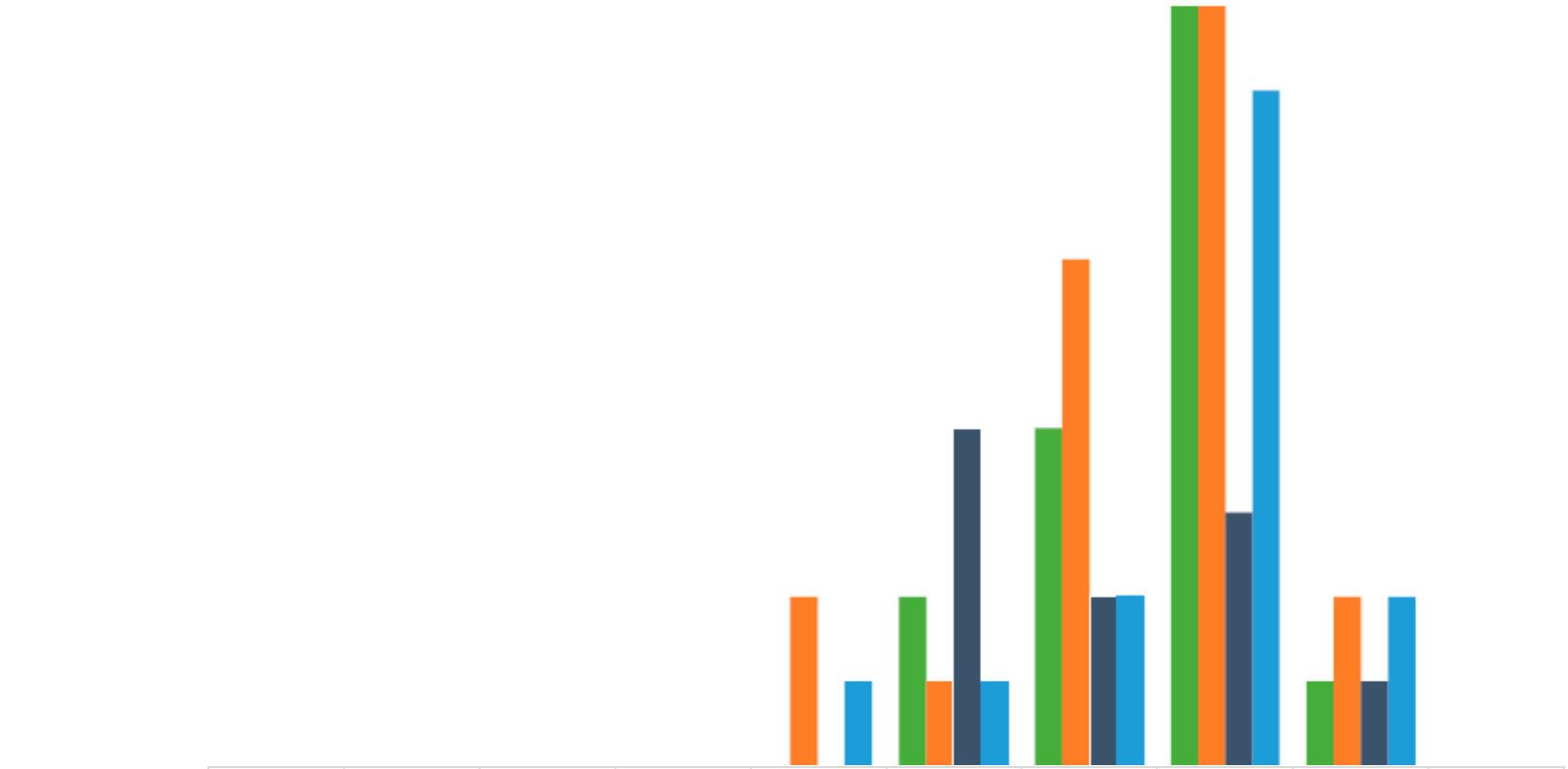
Figure 38. Psychiatric disorders (excluding dementia): other physicians, palliative team or psychologists consulted outside legal obligations (Total number of reports concerned: 74 out of 141 patients with psychiatric conditions)



	Other physicians or psychologists	Palliative teams
2014	21	2
2015	45	11
2016	30	1
2017	21	1
Total (N = 132)	117	15

The reporting physician is not required to mention which other providers were consulted. It is assumed that other providers are consulted much more often than is mentioned. However, it is worth emphasizing the multidisciplinary approach to clarification of euthanasia demand for this group of patients. Despite the absence of obligation, we know that a multidisciplinary consultation took place for at least 40% of these cases.

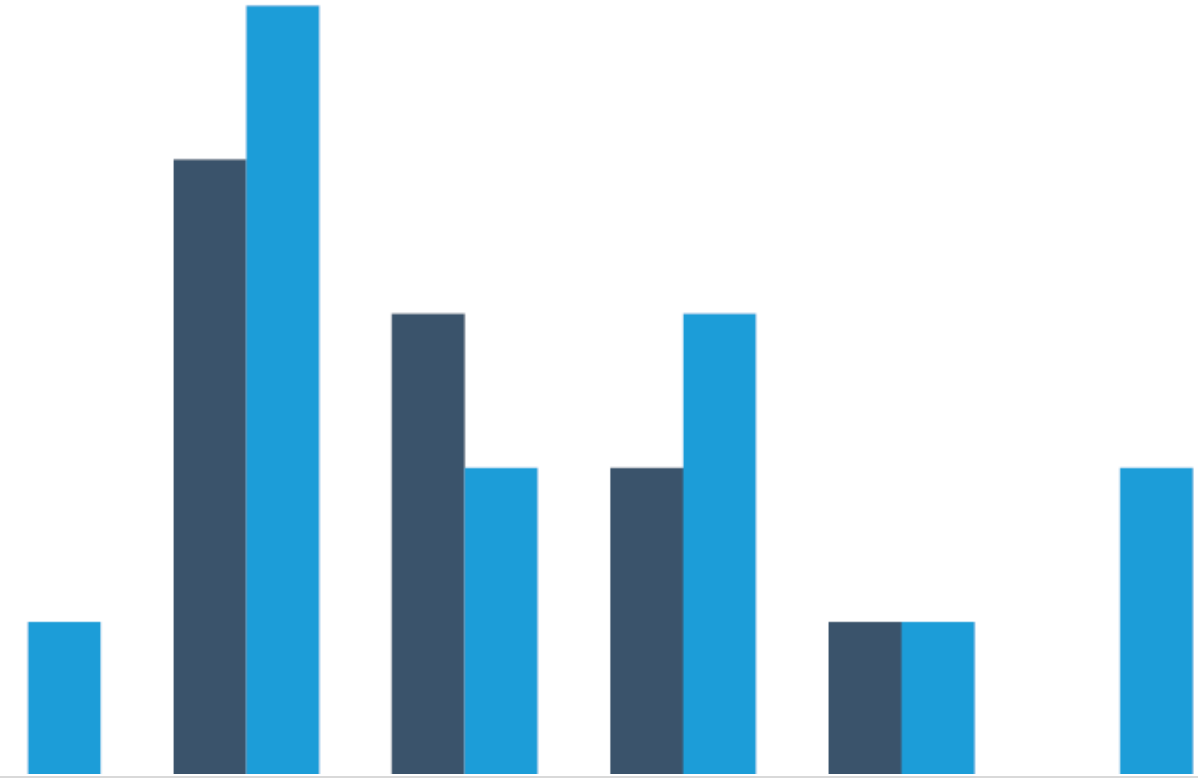
Figure 39. Psychiatric disorders (dementias): Age of patients



	< 18	18–29	30–39	40–49	50–59	60–69	70–79	80–89	90–99	100+
2014	0	0	0	0	0	2	4	9	1	0
2015	0	0	0	0	2	1	6	9	2	0
2016	0	0	0	0	0	4	2	3	1	0
2017	0	0	0	0	1	1	2	8	2	0
Total (N = 60)	0	0	0	0	3	8	14	29	6	0

During the 2014-2017 period, 60 patients requested euthanasia because of a dementia process. As expected, the vast majority of these patients were over 70 years old. Out of a total of 60 patients, 9 deaths were considered as expected in the short term by the physician who performed the act.

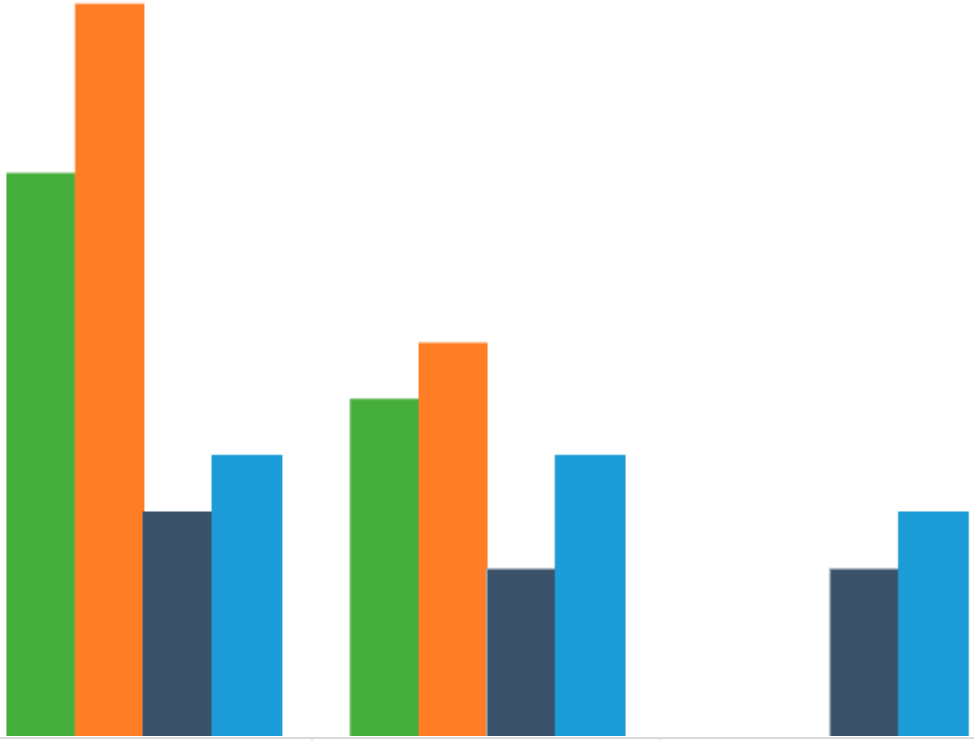
Figure 40. Psychiatric disorders (dementias): Waiting time



	<1 m	1 m	2–3 m	4–6 m	7–12 m	>24 m
2016	0	4	3	2	1	0
2017	1	5	2	3	1	2
Total (N = 24)	1	9	5	5	2	2

In the group of demented patients, the waiting time was not respected in one case. The death of this one patient with a waiting time of less than one month was not expected in the short term. However, there were two opinions (older than one month) from independent physicians, as required by the Euthanasia Act.

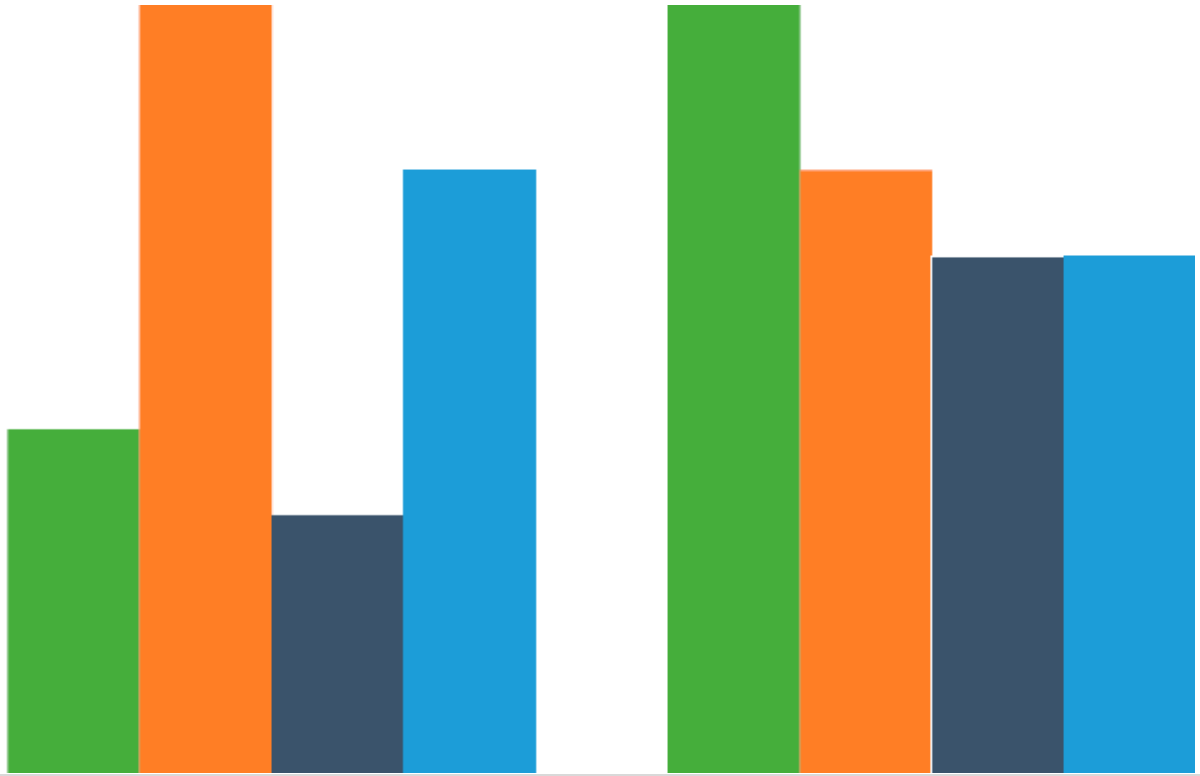
Figure 41. Psychiatric disorders (dementias): qualification of the first physician consulted



	GP	Specialist	LEIF/EOL	Trained in palliative care
2014	10	6		
2015	13	7		0
2016	4	3	3	0
2017	5	5	4	0
Total (N = 60)	32	21	7	0

The first physician consulted does not have to be a specialist of the condition in question. In this respect, a GP has a very important role to play, since he is the one who makes the first opinion for more than 70% of these patients. For 7 patients, the opinion was given by a physician who received additional training in decision making at the end of life. For this group also, the above information applies.

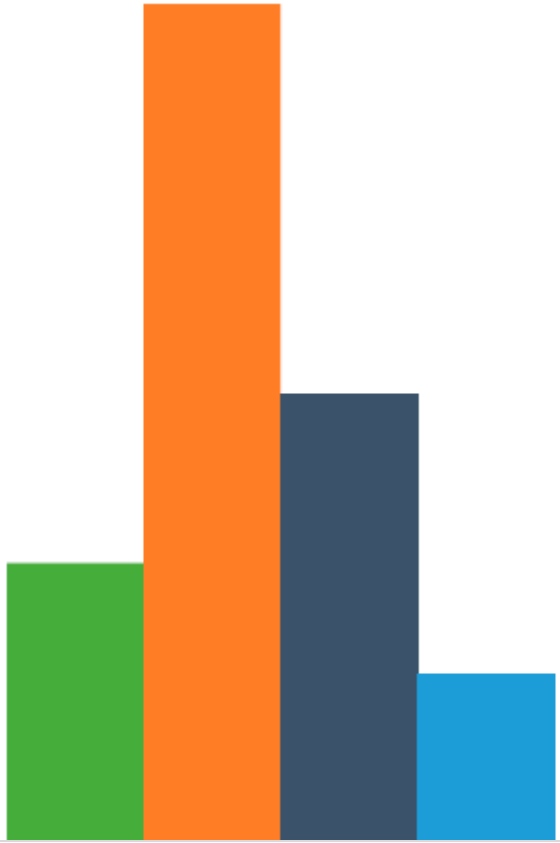
Figure 42. Psychiatric disorders (dementias): qualification of the second physician consulted compulsorily (death not expected in the short term)



	Specialist	Psychiatrist
2014	4	9
2015	9	7
2016	3	6
2017	7	6
Total (N = 51)	23	28

Unlike the first group of patients suffering from a psychiatric condition, the second opinion can also be given by a specialist such as a neurologist, a geriatrician or an internist.

Graph 43. Psychiatric disorders (dementias): other physicians, palliative team or psychologists consulted outside legal obligations (Total number of reports concerned: 25 out of 60 patients with psychiatric conditions)



	Other physicians or psychologists	Palliative teams
2014	5	2
2015	15	6
2016	8	0
2017	3	0
Total (N = 39)	31	8

For dementia patients who have made a request for euthanasia, several opinions have also been requested from other health care providers in addition to the mandatory notices.

d. Patients residing abroad

In Part II, which is the part of the registration document available to the members of the Commission, only the place of birth is requested. The home is requested in Part I, the part that can only be opened when additional information is requested from the reporting physician. However, some physicians mention in Part II that this is a foreign patient. According to component II of the declarations, in 2016 and 2017, 23 patients residing abroad came to Belgium to obtain a favorable response to their request for euthanasia.

These patients mainly had disseminated cancer (e.g. breast or prostate cancer) or severe incurable neurologic disease (e.g. multiple sclerosis, Parkinson's disease, amyotrophic lateral sclerosis, ALS, or of Charcot). More than half of the deaths were expected in the near future. The patients were mainly aged 40 to 59 or 70 to 89 years old. These euthanasias were conducted both in the Dutch-speaking and the French-speaking parts of the country.

e. Patients who donated organs

Some patients wish to donate their organs and help others in this way. Physicians are not required to mention organ donation in the registration document. Organ donation has been reported in 8 patients for the years 2016 - 2017.

Patients had either a nervous system disorder or a mental and behavioral disorder. The majority of them were Dutch-speaking women aged 50 to 69, and the death was not expected in the near future.

D. Conclusion

The purpose of this biennial report is to discuss in a detailed and transparent manner the results and trends observed in recent years as reflected in the registration documents.

a. The number of euthanasia cases

Between 2014 and 2016, the number of recorded euthanasia remained stable. In contrast, the year 2017 was characterized by an increase of 13%.

As already reported in previous reports, the Commission does not have the possibility to assess the proportion of reported euthanasia in relation to the number of euthanasia actually performed. It must be remembered that only acts that intentionally terminate life at the request of a patient (section 2 of the Euthanasia Act) meet the legal definition of euthanasia. The end-of-life use of various non-lethal drugs or the lethal nature of which is questionable (especially morphine drugs), in order to combat suffering, is therefore not, by definition, a euthanasia, although it may hasten death.

b. The conditions that underly euthanasia

The oncology patient group remains the largest group of patients requesting euthanasia. The last four years have seen a slow but steady increase in these cases. As a percentage, the proportion decreases slowly. It should be noted that the death of 99% of oncological patients was expected in the near future at the time of euthanasia.

The largest increase was found in the group of patients suffering from poly-pathologies. Over a four-year period, it almost doubled, from 232 to 444 patients (note that before 2014, this group of patients was often classified under another category, especially in oncology, cardiovascular or respiratory conditions). More than 70% of these patients were over 80 years old.

The detailed study of the documents of euthanasia of these patients suffering from poly-pathologies shows that in Belgium each patient is a combination of several serious and incurable conditions and whose death is, in half of the cases, expected in the near future. As a reminder, without a medical context in accordance with the law, ‘fatigue of living’ is never accepted by the Commission as a justification for euthanasia.

In the past two years, the number of patients with psychiatric conditions (excluding dementia such as Alzheimer's disease) was less than 30 per year. Since 2014, out of a total of 141 patients, 16 were over the age of 80 and 7 were over 90 years of age and mostly suffered untreatable unipolar mood disorders (depression).

25 out of 141 patients were younger than 40 years old. In this particular group, we find mostly long-standing complex personality disorders and some patients with autistic syndrome. All were considered by reporting physicians to be untreatable.

Requests for euthanasia have been examined in a multidisciplinary way with counselors and treatment psychiatrists, psychologists, nurses, etc. The waiting period ranged from 6 to more than 24 months.

In 2017, the Flemish Association of Psychiatry (VVP) published an opinion on the proper review of a request for euthanasia of a psychiatric patient.[4]

c. Healthcare providers consulted beyond legal obligations

In 2016 and 2017, special attention was given to notifications of the different providers involved in the euthanasia process. This is, in this case, data that the physician is not required to communicate. Today, a multidisciplinary approach is planned in all medical disciplines. It is a characteristic of quality medicine. Physicians consult with other physicians and other relevant providers before making a decision about a possible diagnosis, before further examinations and treatment. The registration documents indicate that such consultation is also taking place in the context of a euthanasia. Physicians want to evaluate the important issue of end-of-life at the patient's request based on the opinion of other providers. However, additional medical consultations should not lead to the creation of conditions not provided for by law, to the detriment of the respect of the patient's wishes, which must remain the central parameter to be taken into consideration.

4 http://vvp-online.be/

Section 3. Commission recommendations regarding law enforcement

A. With regard to the conduct of national scientific studies on all medical decisions in end of life

So far, there are no national studies on different medical decisions at the end of life (euthanasia, sedation, massive doses of opiates, discontinuation of treatment, voluntary interruption of life without demand, ...).

B. With regard to the need to inform citizens and train care providers

The Commission considers that, in order to ensure the correct legal application of euthanasia, both citizens and physicians and, by extension, all healthcare providers must be adequately informed. This is not yet the case despite various non-governmental initiatives. It is important that authorities take initiatives or subsidize third party initiatives.

The faculties and universities responsible for training all health professionals should include in their curriculum training in end-of-life care.

The Commission reiterates the importance of an informative brochure for the public. This booklet should focus on the application of the law on euthanasia, but also on the application of the Patients' Rights Act and the Palliative Care Act.

The information leaflet drawn up by the Commission for the medical profession is always sent to the declaring physician when Part I of a registration form has to be opened, either to make comments or to request additional information. This information leaflet is also available on the Commission's website www.commissioneuthanasie.be, in the publications section, which also contains the registration document.

C. With regard to possible amendments to the law of 28 May 2002 on euthanasia

The Commission confirms, as it was previously the case, that the application of the law did not lead to major problems or abuses that would require legal initiatives. Only one file was sent (in 2015), after extensive discussions, to the prosecutor of the King for further investigation.

In recent years, much attention has been paid to the issue of waiting time, the time between the date of the written application and the date of euthanasia. This has been calculated for all patients in the last two years. It was found that the waiting time was not only dependent on the expected due date of death, but also on the nature of the pathology underlying the euthanasia demand. In case of euthanasia of a patient whose death is not expected in the short term, the waiting time can be 6 to 12 months or more, depending on the nature of the condition. This is why the distinction between thinking time and waiting time is reiterated in Part II of this report, as was the case in the previous report.

The Commission regrets that no solution has been found to the complexity of the drafting of the advance declaration of euthanasia and the registration and renewal procedures. The renewal of the declaration remains an obstacle for citizens.

D. With regard to the functioning of the Commission

In order to properly evaluate a file, during joint discussions, some members of the Commission often give clarifications specific to their expertise (legal or medical information). Several discussions within the Commission have also been summarized here. In doing so, the Commission wishes to contribute to the transparency of the evaluation methodology and demonstrate that the law is correctly applied. The Commission insists that the most important and time-consuming part of its work is carried out beforehand and individually. It is the mission that is accepted by each member of the Commission at the time of designation.

The current functioning of the Commission is hampered by an growing budget shortage. A much larger budget is needed to expand the secretariat team so that the growing number of registration documents and the ever-increasing statistical work can be handled.

Moreover, given the large number of euthanasia cases, it is urgent to have an electronic registration system for reporting physicians. This will greatly reduce the workload of the members of the Commission and the secretariat, and facilitate the electronic processing of data. Much of the work done by the Commission is done on a voluntary basis, unlike in the Netherlands where regional control commissions — *Regional Review Committees* have a budget adapted to their workload.

Section 4. Annexes

Annex 1: 28 MAY 2002, Law on Euthanasia

Article 1

This law governs a matter provided in article 78 of the Constitution.

Chapter I: General provisions

Article 2

For the purposes of this Act, euthanasia is defined as intentionally terminating life by someone other than the person concerned, at the latter's request.

Chapter II: Conditions and procedure

Article 3

§1. A physician who practices euthanasia does not commit an offense if he/she has ensured that:

- the patient is an adult or emancipated minor, capable or still a minor with the capacity for discernment, and is conscious at the time of his/her request;
- the request is formulated voluntarily, thoughtfully and repeatedly, and does not result from external pressure;
- the patient, adult or emancipated minor, finds himself in a medically futile situation and reports a constant and unbearable physical or psychological suffering that cannot be alleviated and that results from a serious and incurable accidental or pathological affliction;
- the minor patient with capacity for discernment is in a medically futile situation with constant and unbearable physical suffering which cannot be alleviated and which causes death in the short term, and which results from a serious or incurable accidental or pathological affliction;
- the conditions and procedures prescribed by this Act have been met.

§2 Without prejudice to the additional conditions that the physician wishes to include in his/her intervention, he/she must, in advance and in all cases:

1. inform the patient of his/her state of health and life expectancy, to consult with the patient on his/her request for euthanasia and to discuss with him/her the therapeutic possibilities still conceivable as well as the possibilities offered by palliative care and their consequences. It must come to the patient's conviction that there is no other reasonable solution in his/her situation and that the patient's request is entirely voluntary;
2. be certain of the persistence of the physical or psychic suffering of the patient and his/her durable will. To this end, the physician conducts several interviews with the patient, spaced a reasonable amount of time apart with regard to the patient's state of health;
3. consult another physician about the serious and incurable nature of the condition, specifying the reasons for the consultation. The consuling physician takes note of the medical file, examines the patient and makes sure of the constant, unbearable and unappeasable nature of the physical or psychic suffering. He/she writes a report concerning his/her findings.

   The consulting physician must be independent, both with regard to the patient and the attending physician and be competent in the pathology concerned. The attending physician informs the patient about the results of this consultation;
4. if there is a health care team in regular contact with the patient, discuss the patient's request with the team or members of the team;
5. if the patient so desires, discuss his/her request with relatives that the patient designates;
6. ensure that the patient has had the opportunity to discuss his/her request with the people he or she wishes to meet.
7. in addition, when the patient is an unemancipated minor, consult a child psychiatrist or psychologist, specifying the reasons for this consultation. The consulted specialist takes note of the medical file, examines the patient, ensures the capacity of discernment of the minor, and certifies it in writing. The attending physician informs the patient and his legal representatives of the result of this consultation.

   The attending physician shall discuss with the legal representatives of the minor, providing them with all the information referred to in §2.1, and ensure that they agree on the minor patient's request.

§3 If the physician is of the opinion that the death of the adult or emancipated minor patient will clearly not occur in the short term, he/she must, in addition:

1. consult a second physician, psychiatrist or specialist of the pathology concerned, specifying the reasons for the consultation. The consulting physician takes note of the medical file, examines the patient, ensures the constant, unbearable and unappeasable nature of the physical or mental suffering and the voluntary, thoughtful and repeated nature of the request. He/she writes a report concerning his/her findings. This consulting physician must be independent with regard to the patient as well as to the attending physician and the first consulting physician. The attending physician informs the patient about the results of this consultation;
2. allow at least a month to pass between the patient's written request and euthanasia.

§4 The patient's request, as well as the agreement of the legal representatives if the patient is a minor, are recorded in writing. The document is written, dated and signed by the patient him/herself. If he/she is not in a position to do so, his/her application shall be recorded in writing by an adult of his/her choice who cannot have any material interest in the death of the patient.

This person mentions the fact that the patient is not able to formulate his/her request in writing and indicates the reasons. In this case, the application is recorded in writing in the presence of the physician, and said person mentions the name of the physician in the document. This document must be placed in the medical file.

The patient may revoke his/her request at any time, in which case the document is removed from the medical record and returned to the patient.

§4/1 After the patient's request has been enacted by the physician, the possibility of counseling is offered to those affected.

§5 All requests made by the patient, as well as the steps taken by the attending physician and their results, including the report(s) of the physician(s) consulted, are regularly recorded in the patient's medical record.

Article 3bis.

A pharmacist who delivers a euthanizing substance does not commit an offense when he does so on the basis of a prescription in which the physician explicitly mentions that it is in accordance with this Act.

The pharmacist provides the prescribed euthanizing substance in person to the physician. The King lays down the criteria of prudence and the conditions to which the prescription and the delivery of drugs which will be used as a euthanizing substance that must be adhered to.

The King takes the necessary measures to ensure the availability of euthanizing substances, including pharmacies that are accessible to the public.

Chapter III: The advance directive

Article 4

§1 For cases where one is no longer able to express one's will, every legally competent person of age, or emancipated minor, may draw up an advance directive instructing a physician to perform euthanasia if the physician ensures that:

- the patient suffers from a serious and incurable disorder, caused by illness or accident;
- the patient is no longer conscious;
- this condition is irreversible given the current state of medical science.

In the advance directive, one or more person(s) taken in confidence may be designated in order of preference, who inform(s) the attending physician about the patient's will. Each person taken in confidence replaces his or her predecessor as mentioned in the advance directive, in the case of refusal, hindrance, incompetence or death. The patient's attending physician, the consulting physician and the members of the nursing team may not act as persons taken in confidence.

The advance directive may be drafted at any moment. It must be composed in writing in the presence of two witnesses, at least one of whom has no material interest in the death of the patient and it must be dated and signed by the drafter, the witnesses and by the person(s) taken in confidence, if applicable.

If a person who wishes to draft an advance directive is permanently physically incapable of writing and signing an advance directive, he/she may designate a person who has attained the age of majority, and who has no material interest in the death of the person in question, to draft the request in writing, in the presence of two witnesses who have attained the age of majority and at least one of whom has no material interest in the patient's death. The advance directive indicates that the person in question is incapable of signing and why. The advance directive must be dated and signed by the drafter, by the witnesses and by the person(s) taken in confidence, if applicable.

A medical certificate must be annexed to the advance directive proving that the person in question is permanently physically incapable of drafting and signing the advance directive.

An advance directive is only valid if it is drafted or confirmed no more than five years prior to the person's loss of the ability to express his/her wishes.

The advance directive may be amended or revoked at any time.

The King determines the manner in which the advance directive is drafted, registered and confirmed or revoked, and the manner in which it is communicated to the physicians involved via the offices of the National Register.

§2 The physician who performs euthanasia, in consequence of an advance directive as referred to in §1, commits no criminal offence when he/she ensures that:

- the patient suffers from a serious and incurable disorder, caused by illness or accident;
- the patient is unconscious;
- and this condition is irreversible given the current state of medical science;
- when he/she has adhered to the conditions and procedures as provided in this Act.

Without prejudice to any additional conditions imposed by the physician on his/her own action, before carrying out euthanasia he/she must:

1) consult another physician about the irreversibility of the patient's medical condition and inform him/her about the reasons for this consultation. The consulting physician consults the medical record and examines the patient. He/she reports on his/her findings.

   When the advance directive names a person taken in confidence, the latter will be informed about the results of this consultation by the attending physician.

2) The consulting physician must be independent of the patient as well as of the attending physician and must be competent to give an opinion about the disorder in question;

3) if there is a health care team that has regular contact with the patient, discuss the content of the advance directive with that team or its members;

4) if a person taken in confidence is designated in the advance directive, discuss the request with that person;

5) if a person taken into confidence is designated in the advance directive, discuss the content of the advance directive with the relatives of the patient designated by the person taken in confidence.

The advance directive, as well as all actions by the attending physician and their results, including the report of the consulting physician, are regularly noted in the patient's medical record.

Chapter IV: Notification

Article 5

Any physician who has performed euthanasia is required to fill in a registration form, drawn up by the Federal Control and Evaluation Commission established by Article 6 of this Act, and to deliver this document to the Commission within four working days.

Chapter V: The Federal Control and Evaluation Commission

Article 6

§1 There is hereby established a Federal Commission for the Control and Evaluation of the Application of this Law, hereinafter referred to as "the Commission".

§2 The Commission shall consist of sixteen members, appointed on the basis of their knowledge and experience in matters falling within the competence of the Commission. Eight members are medical physicians, at least four of whom are lecturers, professors or professors emeritus at a Belgian university. Four members are lecturers, professors or emeritus professors of law at a Belgian university, or lawyers. Four members come from the circles responsible for the problem of patients suffering from an incurable disease.

Membership in the Commission is incompatible with the membership of a legislature or membership of the federal government or a community or regional government.

The members of the Commission are appointed, in accordance with linguistic parity — each linguistic group having at least three candidates of each sex — and ensuring a pluralist representation, by royal decree deliberated in the Council of Ministers, from a double list of candidates presented by the House of Representatives, for a renewable term of four years. The term of office expires automatically when the member loses the capacity in which he/she sits. Candidates who have not been nominated as full members are appointed as alternate members, according to a list determining the order in which they will be called upon as replacement. The Commission is chaired by a French-speaking president and a Dutch-speaking president. Presidents are elected by the members of the Commission belonging to their respective linguistic group.

The Commission may deliberate validly only if two-thirds of its members are present.

§3 The Commission establishes its own internal regulations.

Article 7

The Commission establishes a registration document that must be completed by the physician each time he/she practices euthanasia.

This document is composed of two parts. The first part must be sealed by the physician. It contains the following data:

1. the surname, first names and home address of the patient;
2. surname, first names, registration number at the INAMI and home address of the attending physician;
3. surname, first names, registration number at INAMI and home address of physician(s) who have been consulted about the request for euthanasia;
4. the surname, first names, home address and qualification of all persons consulted by the attending physician, and the dates of these consultations;
5. if there was an advance declaration and it designated one or more people of trust, the name and surname of the person(s) of trust who intervened.
6. the surname, first names, registration number at the INAMI and the address of the pharmacist who delivered the euthanizing substance, the name of the products delivered and their quantity and, if applicable, the surplus that was returned to the pharmacist.

This first part is confidential. It is transmitted by the physician to the Commission. It may only be consulted after a decision of the Commission, and may under no circumstances serve as a basis for the Commission's evaluation mission.

The second part is also confidential and contains the following information:

1. the sex and date and place of birth of the patient and, in the case of the minor patient, whether he/she was emancipated;
2. the date, place and time of death;
3. mention of the serious or incurable injury or pathological condition suffered by the patient;
4. the nature of the suffering that was constant and unbearable;
5. the reasons why this suffering was described as unable to be alleviated;
6. the elements that made it possible to ensure that the request was formulated voluntarily, thoughtfully and repeatedly and without outside pressure;
7. if it could be estimated that the death would occur in the near future;
8. if there is an advance directive;
9. the procedure followed by the physician;
10. the qualification of the physician(s) consulted, the opinion and the dates of these consultations;
11. the qualification of the persons consulted by the physician, and the dates of these consultations;
12. the manner in which euthanasia was performed and the means used.

Article 8

The Commission studies the completed registration form submitted to it by the attending physician. On the basis of the second part of the registration form, the Commission determines whether the euthanasia was performed in accordance with the conditions and the procedure stipulated in this Act. In cases of doubt, the Commission may decide by simple majority to revoke anonymity and examine the first part of the registration form. The Commission then becomes aware of the first part of the registration document. The Commission may request the attending physician to provide any information from the medical record relating to the euthanasia.

The Commission hands down a verdict within two months.

When, by a two-thirds majority decision, the committee considers that the conditions laid down in this law have not been complied with, it sends the file to the public prosecutor in the jurisdiction where the patient died.

If, after anonymity has been revoked, facts or circumstances come to light which would compromise the independence or impartiality of one of the Commission members, this member will have an opportunity to explain or to be challenged during the discussion of this matter in the Commission.

Article 9

For the benefit of the legislative chambers, the Commission will draft the following reports, the first time within two years of this Act's coming into force and every two years thereafter:

a) a statistical report processing the information from the second part of the completed registration forms submitted by physicians pursuant to Article 8;

b) a report in which the implementation of the law is indicated and evaluated;

c) if required, recommendations that could lead to new legislation or other measures concerning the execution of this Act.

For the purpose of carrying out this task, the Commission may seek additional information from various public services and institutions. The information thus gathered is confidential. None of these reports may reveal the identities of any persons named in the documents submitted to the Commission for the purposes of the review as determined in Article 8.

The Commission may decide to supply statistical and purely technical data, purged of any personal information, to university research teams that submit a reasoned request for such data.

The Commission may grant hearings to experts.

Article 10

The King places an administration at the Commission's disposal for the fulfillment of its legal missions. The staff and the linguistic framework of the administrative staff are fixed by royal decree deliberated in the Council of Ministers, on the proposal of the Ministers of Health and the Minister of Justice.

Article 11

The Commission's operating costs and personnel costs, including remuneration for its members, are divided equally between the budget of the Minister of Health and the budget of the Minister of Justice.

Article 12

Any person who is involved, in whatever capacity, in implementing this Act is required to maintain confidentiality regarding the information provided to him/her in the exercise of his/her function. He/she is subject to Article 458 of the Penal Code.

Article 13

Within six months of the tabling of the first report and, where appropriate, the recommendations of the committee referred to in Article 9, the House of Representatives shall hold a debate on this subject. This period of six months is suspended during the time that the House of Representatives is dissolved and/or during which there is no government having the confidence of the House of Representatives.

Chapter VI: Special Provisions

Article 14

The request and the advance directive referred to in Articles 3 and 4 of this Act are not compulsory in nature.

No physician may be compelled to perform euthanasia.

No other person may be compelled to assist in performing euthanasia.

Should the physician consulted refuse to perform euthanasia, then he/she must inform the patient and the persons taken in confidence, if any, of this fact in a timely manner, and explain his/her reasons for such refusal. If the refusal is based on medical reasons, then these reasons are noted in the patient's medical record.

At the request of the patient or the person taken in confidence, the physician who refuses to perform euthanasia must communicate the patient's medical record to the physician designated by the patient or person taken in confidence.

Article 15

Any person who dies as a result of euthanasia performed in accordance with the conditions established by this Act is deemed to have died of natural causes for the purposes of contracts he/she had entered into, in particular insurance contracts.

The provisions of Article 909 of the Civil Code apply to members of the health care team referred to in Article 3 of this Act.

Article 16

This Act shall enter into force no later than three months after its publication in the Official Belgian Gazette.

We promulgate this Act, and order that it be sealed with the seal of the State and published by the Official Belgian Gazette.

Brussels, 28 May 2002.

ALBERT
By the King:
The Minister of Justice,
Mr VERWILGHEN
Sealed with the seal of state:
The Minister of Justice,
Mr VERWILGHEN.
Modifications:

- Law of 16-06-2016 published on 30-06-2016 (amended Article: 6)
- Law of 28-02-2014 published on 12-03-2014 (amended Articles: 3; 7)
- Law of 06-01-2014 published on 31-01-2014 (amended Articles: 6; 13)
- Law of 10-11-2005 published on 13-12-2005 (amended Articles: 3bis; 7)

[*Note: This unofficial English translation of the Euthanasia Act is based in part on a translation by Dale Kidd published in 2002 (see* 'Ethical Perspectives*, vol 9, no. 2–3, pp182–8*'*), with later amendments and modifications incorporated into this text*.]

Appendix 2: List of the members of the Commission

Full member	Corresponding substitutes
As medical physicians, at least four of whom are lecturers, professors or professors emeritus at a Belgian university:	
1. M. Chris Verslype (NL)	1. M. Maurice Sosnowski (FR)
2. M. Didier Giet (FR)	2. M. Dominique Lossignol (FR)
3. M. Etienne De Groot (NL)	3. Mme Marie-Élisabeth Faymonville (FR)
4. M. Wim Distelmans (NL) — Dutch Chair	4. M. Marco Schetgen (FR)
5. M. Philippe Boxho (FR)	5. M. Luc Proot (NL)
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Commission fédérale de Contrôle et d'Évaluation de l'Euthanasie

Secrétariat de la Commission.
Place Victor Horta 40/10
1060 Bruxelles – Belgique
Tel: +32 (0)2 524 92 63

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Ed. Resp.: Tom Auwers, Chairman of the Executive Committee, FPS Public Health, Food Chain Safety and Environment
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