A Call For Autonomy And Compassion

*Insights from the Belgium Law on Euthanasia and propositions for future regulations of assisted death in Canada*

by

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CIHR Fellow in Health Law, Ethics and Policy (2010-2011)

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Abstract

The current blanket prohibition of assisted death in Canada continues to be the subject of much debate. This thesis examines the shortcomings and strengths of the Belgium Law on Euthanasia of 2002 and discusses whether similar legislation could be implemented in Canada. More particularly, the thesis looks at the spirit and intent of the law, the conditions under which assisted death is permitted, and the control mechanism present in the Belgian law. The analysis of Belgium’s ten years of experience with assisted death allows us to argue that the risks inherent in assisted death regime can be controlled in a system where an exception is made for competent people in a situation of unbearable suffering. Important safeguards to prevent abuse and protect people from vulnerable groups are identified in the Belgian statute. This thesis recommends in its conclusion to regulate assisted death as an expression of compassion for suffering patients, in line with Canada’s longstanding commitment to respect for patient autonomy.
Pour papa
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Introduction

About six months ago, Pierre was 55 years old and was diagnosed with terminal pancreatic cancer. His life expectancy was anywhere between one month to a year, depending on the growth and spread of the cancer. Pierre was faced with making difficult end-of-life decisions. After exploring the different alternatives with his oncologist, and learning that the chances of success were extremely low, Pierre decided to reject chemotherapy or any treatments that would attempt to treat the cancer. He chose to receive palliative care. Pierre was not afraid of dying but he was afraid of pain and suffering. He is received morphine as pain control medication. Pierre experienced the unusual symptom of being thirsty to the point he believed he was going to die of thirst. But when he tried to relieve himself by drinking anything including water, his body reacted violently with vomiting and major pain. Pierre’s wish was to die at home with his family but the severe and unbearable thirst came as an unexpected twist of his terminal illness that forced him to check into an hospital to receive hydration through IV, something that is not possible to get at home in his rural town.

Upon admission to the hospital, the medical team increased Pierre’s morphine and although the thirst come and went, he was never totally at peace and he also experienced hallucinations and confusion from the morphine. Pierre, like many others, was a proud man, who always liked to be independent, autonomous and have control over his life, as much as possible. After his admission to the hospital, Pierre did not last very long. He died about two weeks later. But those two weeks were nothing like what he would have wanted. Pierre was confused from the medication, but had parcels of lucidity just enough to realize the state he was in and be frustrated by it. Although he was spiritually at peace with the imminence of his death, he was not restful. Pierre was agitated. He suffered from the side effects from the medications and he was still thirsty. His family could not bear to see him suffering so much and they begged the palliative care physician to end his life as quick as possible (also knowing it was Pierre’s wish). The physician offered to give Pierre just enough medication to keep him asleep and calm if that’s what he wanted. Pierre agreed and those were his last words. He passed away three days later.

This story is just one of many similar stories that happen every day, some a lot worse, some a lot better. Through these stories the question arises: How does a nation like Canada want
to respond to end-of-life suffering and people’s last choices? When everything else fails and someone believes it is time to drop the grand curtain, their last wish is not legally granted in Canada except by suicide or starvation. How does a society deal with the sufferings of its citizens? How important is the value of self-determination versus the sanctity of life? While Canadians have the right to let themselves die they are not allowed to receive assistance to safely and actively induce death. If they do, their helper will violate section 241(b) of the Canadian Criminal Code. At best, medical assistance to end one’s life is done behind closed doors and in unknown conditions. Is that what we want as a society?

In the fast speed race of life, we rarely stop and think of how we want our lives to end but when one really thinks about it, what is more important than your last breath? Are we ready to let someone else dictate the way that final breath is going to take place? Of course, there are serious limits to our powers over the details of the end of our lives. But if we could have more control over when and how, that would certainly allow some people to experience a better death.

This is not to say that Canada has not begun the discussions about end of life decisions. Issues around assisted death have periodically surfaced in Canadian current affairs from the Law Reform Commission of Canada’s reflections and recommendations on the topic in 1983 up to the most recent constitutional challenge in British Columbia in 2012. In between, approximately 11 attempts at reforming the Canadian Criminal Code one way or the other to deal with assisted death have failed and a number of court decisions have been rendered on the matter. The Criminal Code prohibition of assisted suicide hit Canada’s highest court in 1994 with the infamous Rodriguez case, Sur Rodriguez suffered from amyotrophic lateral sclerosis and wanted to be allowed to get assistance to die at the time of her choosing, i.e. when she stopped enjoying life. Because of her condition she would be unable to commit suicide by herself at that point, which was why she was seeking the court’s intervention. In a 5:4 split decision, the majority of the judges refused to declare Section 241(b) of the Criminal Code unconstitutional based on the principle of the sanctity of life. But our law evolves constantly and 18 years later,

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1 Criminal Code, R.S.C., 185, c. C-46, s. 241(b) [Criminal Code].
2 Canada, Law Reform Commission of Canada, Euthanasia, Aiding Suicide and Cessation of Treatment, Report #20 (Ottawa: Department of Supply and Services, 1983).
3 Carter v. Canada (AG), 2012 BCSC 886 [Carter].
4 Criminal Code, supra note 1 at s. 241(b).
on June 15th 2012 Justice Smith of the Supreme Court of British Columbia declared the prohibition against physician assisted suicide unconstitutional partly on grounds held by dissenting justice in the Rodriguez case, and partly applying the most recent legal development of Canadian law to the issue.  

Assisted death has always remained in the background for Canadian culture and we can expect it will not go away anytime soon. The media is now presenting special series about end-of-life and in March 2012, Québec’s Commission sur le droit de mourir dans la dignité submitted its report in favour of medical assistance to die contextualized in a continuum of care philosophy. The topic does not leave anyone indifferent. A number of organizations have and continue to take a stand either in favour of or against the regulation of assisted death. Considering that 25% of Canadians will be over 65 years old by 2031 and the literature on point suggest that Canadian end of life care is poor and disparate, we can expect that our baby boomers becoming elders will want more and better choices. Current polls show significant public support for assisted death. In 2011, a survey found that 67% of Canadians supported legalizing physician assisted suicide. Most recently, a 2012 Angus Reid survey showed that 80% of Canadians were in favour of legalizing physician assisted death under certain conditions.

The complexity of this topic cannot be overstated, but I believe that the Canadian population is ripe to take the next step: going from prohibition to regulation. While the Carter

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6 Carter, supra note 3.
7 Quebec, Commission Spéciale mourir dans la dignité: Rapport (Québec: Assemblée Nationale, Mars 2012) [Québec, Special Commission ].
12 Angus Reid, “Support was for competent, fully informed and terminally ill patients” (26 July 2012) online: Angus Reid Public Opinion <http://www.angus-reid.com>. 
decision has less legal authority than *Rodriguez*, it is an extremely valuable thorough and thoughtful decision that explains, describes and analyses the current state of Canadian law and the issue of assisted death. Justice Smith rightfully reminds us that the main argument against permitting assisted death and the rationale behind the failure of most Canadian attempts at regulating is the belief that the risks inherent to assisted death cannot be adequately addressed by any means or safeguards. This is not a paper that discusses what constitutes a good death or makes the case for assisted death but aims to contribute to the development of best practices when Canada decides to allow people more control over the nature and time of their death.

Assisted death is a divisive issue. It is an issue that invokes intense passion on both sides of the debate. Nevertheless, just like Canadians have dealt with other sensitive topics such as abortion a few years ago, we as a society have important decisions to make in the end of life spectrum. In a pluralistic society, making policy that is acceptable to everyone is a challenge but I believe it is not unattainable. I share the opinion of Sumner who says that according to the principle of respect, no one should impose their view on their opponent.\(^\text{13}\) Prohibition clearly violates the principle of respect because it imposes one side’s view on the other. Certainly, we live in a society that sets limits and accepts prohibitions even if some people disagree and feel disrespected on the basis that other interests are harmed. But this is not the case for assisted death. Moreover, the values and morals of societies evolve and polls are clearly indicating a large number of the Canadian public willing to entertain some form of tightly regulated assisted death. To regulate the practice of assisted death does not impose or compel anyone to do what they do not want. Opponents’ argument that we must keep the practice illegal because nothing short of prohibition is in order to protect the vulnerable of our society.\(^\text{14}\) However, this speculative argument can be refuted with the help of a credible body of literature and most importantly the experience of Belgium over the last 10 years. Rather than close the door to assisted death for all Canadians, a carefully regulated and monitored regime of exception like the Belgian model can accommodate the end-of-life wishes of some Canadians while respecting the wishes of others.


\(^{14}\) *Carter, supra* note 3 at para 1230.
Unlike Canada, Belgium not only had the parliamentary discussion, but believed it was time to act and let some of its suffering people die if they wanted to. In 2002, the tensed political climate seems to have caused the recently elected government rushed the adoption of the *Belgium Law on Euthanasia*, albeit imperfect. The debate became ideologically polarized and critical and fundamental amendments and clarifications to the legislation were not included. This situation left a number of uncertainties in the legal regime that needed and still need to be clarified by parliament and courts. I believe Canada must learn from the Belgian experience. We can draw not only from the best practices of the euthanasia regime they have put in place, but also from its deficiencies.

Using the Belgium experience and wisdom, I propose to the reader an ethically acceptable, safe and practicable regulatory regime for assisted death in Canada. This thesis is a discussion of what parameters Canada should consider if it allowed assisted death to be decriminalized based on the values of autonomy and compassion.

I believe the introduction of a strictly regulated regime would provide well-informed, competent Canadians with unbearable suffering welcomed access to assistance in dying. Inspired by Wayne Sumner’s recent book on assisted death and the brilliant analysis made in *Carter*, the regime I see fit for Canada is one that respects patient autonomy, and is based on compassion. Autonomy is a fundamental principle of Canadian democracy. But it should be limited when faced with major considerations of “public safety, order, health, or morals or the fundamental rights and freedom of others.”

Opening the gate to aid for dying is not without its risks. But the risks are identifiable and the right policy should include the highest standards of safeguards to prevent abuse and slippage. Access to assisted death must be I carefully

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16 At the beginning of the legal change process, parties were hoping for cooperation and coalition work towards regulation of euthanasia. But ideological divisions rapidly surfaced and polarized the debate. Many amendment proposals from the opposition parties were systematically rejected, whether they were necessary or not. At the end of the day, despite the consociational democracy system of Belgium, the legislation was basically bullied in. The whole context surrounding the enactment of the Belgium legislation is worth a discussion on its own, one could be critical of the whole process but it is outside the scope of this paper. For an interesting and informative reflection about the context, see John Griffiths, Heleen Weyers & Maurice Adams, *Euthanasia and Law in Europe* (Hart Publishing, 2007) at 275.
17 Sumner, *supra* note 15.
18 *Carter supra* note 3.
circumscribed and monitored circumstances\textsuperscript{20} to protect the vulnerable groups of our society and maintain public confidence in the system. Studying the Belgium model will help us to verify if such a policy is conceivable. Like in Belgium before the enactment of the \textit{Belgium Law on Euthanasia},\textsuperscript{21} Canada knows assisted death is happening but it is very difficult to obtain overall information about the practices.\textsuperscript{22} Therefore, regulating the practice would offer much more control and oversight against abuse, an improvement from the status quo.

I propose to begin with some clarification of the language and the legal definitions to contextualize the discussion. Afterwards I will then discuss with four major components of the \textit{Belgium Law on Euthanasia},\textsuperscript{23} which will be divided in the following chapters; The Spirit and Intent of the Law; The Provider; The Patient; and The Control Mechanism. I will end my thesis with a chapter discussing palliative care as I believe it constitutes an important component of the debate and is often intertwined in the discussion of assisted death. For each of these components, I will describe its application in the Belgian context and provide a critique. Drawing on the 10 years Belgian experience, I will propose the fundamental principles Canada may consider in a regulatory regime of assisted death in respect to Canadian’s visage.

\textsuperscript{20} Carter, \textit{supra} note 3 at par 295.
\textsuperscript{21} \textit{Belgium Law on Euthanasia, supra} note 15.
\textsuperscript{22} Canada, Senate of Canada, \textit{Of life and death}, \textit{Special Senate Committee Report on Euthanasia and Assisted-suicide} (Ottawa: Minister of Supply and Services Canada, 1995) at 22. \textit{[Of life and Death]} (First words of the practice in Canada were part of testimonies during the hearings of this Special Senate Committee).
\textsuperscript{23} \textit{Belgium Law on Euthanasia, supra} note 15.
Chapter 1

Terminology

Before entering in the heart of the subject matter, it is necessary to clarify the various terms and language used when discussing assisted death.

In Belgium, euthanasia is defined in section two of the *Belgium Law on Euthanasia* as

“intentional life-termination action by someone other than the person concerned, at the request of the latter.”

The definition was borrowed from the Netherlands who used it specifically in 1985 in the Dutch State Commission on Euthanasia’s report. The word *action* “thus requires a positive act; an omission (e.g. withdrawing treatment on which the patient’s life depends) is not euthanasia.”

The word *intentional* is meant to differentiate cases of withdrawing or withholding or treatment that have significant risks of hastening death but that are used for other therapeutic purposes such as the relief of suffering. The intentions of the person committing the action have to be clearly understood to end life. Those cases of “indirect” intentions to shorten life are usually covered under the principle of “double effect” (i.e., pain-relief with life-shortening effects), which constitutes accepted medical practice in Belgium and also falls outside the scope of the *Belgium Law on Euthanasia*. It is an accepted practice as well in Canada and therefore the proposed policy of this thesis only includes cases for which termination of life is the clear intent.

That the act had to be requested by the person is particularly important. It refers to the volition aspect of the act and makes the distinction between voluntary and non-voluntary
An end-of-life decision is voluntary only when it is the result of an informed choice by a competent patient. It is important to note that the Belgian statute only mentions euthanasia and not assisted suicide. Other jurisdictions tend to go the other way around, allowing the lesser and not the greater. Oregon, Washington and Switzerland have regulated policies of assisted suicide while euthanasia is prohibited. One explanation is that these policies are strongly grounded on the principle of self-determination/patient autonomy. This is not the case in Belgium. We will discuss this in more details in the second chapter (Spirit and Intent of the Law). Speculations around why assisted suicide was left out of the Belgian legislation range from ideological differences to the speedy legislative process. However, as the law develops over time, assisted suicide is now considered to be an accepted practice. Indeed, the Belgium Euthanasia Federal Control and Evaluation Commission (Federal Commission), in its first and second reports, addressed specifically this issue and concluded that it did not matter if it was the patient or the physician administering the lethal drug. The Federal Commission stated that as long as the conditions laid out in the statute were respected, and the physician is present to accompany the patient towards death, the law is respected. The legislation does not go into details as to what means should be used by the physician to hasten death. The Federal Commission concluded that if the physician deemed it acceptable to let the patient self-administer the lethal substance, there was no breach of the law.

Whether or not the term assisted suicide is included in the legislation, and whether it is the patient who drinks a lethal cocktail or a physician who injects a drug, the activity falls within the scope of the Belgium Law on Euthanasia. The important element as we will see below is that the physician remains present throughout and remains ready to intervene in case of distress.

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30 Sumner, supra note 13 at 17.
31 Ibid.
34 Belgium, First report, supra note 33 at 17.
While the Federal Commission offered such an interpretation, the question has not been tested in front of the court. At any point in time, a court challenge could be launched and the end result would depend on which legal interpretation the judge favours. In effect, as mentioned by Adams and Nys, the letter of the law would dictate the judge to apply criminal charges to a physician who assists a suicide. Conversely, a judge employing the teleological interpretation would quickly discover that the law was not well written and the intention of parliament was not to exclude medically assisted suicide. In any case, it is advisable for Canada and other jurisdictions to clarify the distinction of agency that separates assisted suicide from euthanasia when regulating assisted death.

In Quebec, the Special Commission on Dying with Dignity recently argued that assisted suicide should not be permitted because it does not constitute a treatment per se. I disagree and find this position surprising since “it is generally accepted that the differences between euthanasia on the one hand and assisted suicide on the other, are ethically and legally minimal.” Indeed the Quebec Special Commission’s position differs from most of the jurisdictions that currently allow assisted death. In contrast, jurisdictions such as Oregon allow the lesser (assisted suicide) and exclude euthanasia, not the opposite. The Commission’s argument to reject one and accept the other is that they are sensitive to the implications of the acceptance of suicide in our society, the risk of sending the wrong message to society and the negative impact on anti-suicide campaigns. It is an argument that is often brought up in the literature by the opponents of assisted death. I strongly agree with the sensitivity of this consideration and recommend staying away from the term suicide in any regulatory regime. It is part because of the Quebec Commission’s reasoning and in part to avoid confusion that I will use the terminology of assisted death throughout this paper.

The Québec Commission’s opposition to assisted suicide goes further than words and attacks the practice itself. It claims assisted suicide is not permitted mainly because it is contrary to the spirit behind their work. They came to accept some cases of medical aid to die only in a

35 Adams & Nys, supra note 32 at 357.
36 Sumner, supra note 13 at 18.
37 Quebec, Special Commission, supra note 7, at 81.
38 Griffiths, Weyers & Adams, supra note 16 at 310.
39 Quebec, Special Commission, supra note 7 at 81.
40 For example see José Pereira, “Legalizing euthanasia or assisted-suicide: illusion of safeguards and controls” (2011) 18:2 Current Oncology at 6; and see also Rodríguez, supra note 5.
context of continuum of care. This seems like a different approach than what we have seen in other jurisdictions. The discussion should be about allowing a person to die and the assistance necessary to ensure it is done safely. If the goal is to accompany the patient, I would strongly suggest that we do not concentrate on who is administering the lethal medication but rather on how to protect people from non-voluntary death. I believe that requiring the physician be present at all times, as does Belgian legislation\textsuperscript{41}, serves exactly this purpose. The focus should not be on who does it but on how it is done. The Commission’s intention has some merit in that they are attempting to keep the role of the physician central and involved so as to create a tight safeguard. But one does not exclude the other. The practice of assisted suicide should be included in what the Commission calls “medical aid to die”.

Both self and physician administered forms of assisted death should be made available and the law must be clear about this. It would be discriminatory, Sumner rightfully suggests, to not make assisted death available to patients whose condition prevents them from self-administering the lethal cocktail.\textsuperscript{42} The Royal Society of Canada Expert Panel on End-of-Life Decision-Making agrees and finds no morally significant difference between the two activities.\textsuperscript{43}

For the purpose of this thesis, I accept and will go by the Belgium definition of euthanasia but will employ the term \textit{assisted death} as it includes both euthanasia and assisted-suicide. Working with this definition means I will set aside from the debate practices of euthanasia that are non-intentional and non-voluntary as they are outside the scope of the \textit{Belgium Law on Euthanasia} and outside this thesis.

\textsuperscript{41} Belgium, \textit{First report, supra} note 33 at 17 (Position of the Belgium Federal Commission to the effect that a physician should be ready to intervene in any case).

\textsuperscript{42} Sumner, \textit{supra} note 13 at 174.

Chapter 2
Spirit of the Law

2.1 Compassion or self-determination?

Before suggesting the conditions of an acceptable policy of assisted-death in Canada, it is necessary to establish the foundations to rely on. This important initial step will dictate how to address the difficult task of drawing the lines of access to assisted death.

Turning first to Belgium, I will demonstrate that the central values behind the Belgium Law on Euthanasia are self-determination and compassion for the relief of suffering. Indeed, there is no doubt that Belgium followed the model of its neighbour, the Netherlands. It is therefore necessary to say a few words on the Dutch law to provide context. In the Netherlands, the law is rooted in a professional conflict of duties; the duty to save lives and the duty to alleviate sufferings. That concept legitimizes mercy killings when the only answer to a patient’s suffering is death and it is the patient’s wish. Experience shows that even the best medicine may be unable to alleviate all sources of suffering. Under this principle, compassionate grounds justify assisted death, whether it is assisted suicide or euthanasia in exceptional circumstances. It is important to mention that such basis for assisted death policy is very different than a policy that would recognize a right to die per se. It is not the case for either Belgium or the Netherlands. Again, assisted death is not to be a standard procedure. It only serves the purpose of resolving the above-mentioned conflict of duties.

It remains, however, that in Belgium the idea of self-determination was also significantly present in the legislation/adoption process. The most significant difference with the

45 Sumner, supra note 13 at 167.
46 Griffiths, Weyers & Adams, supra note 16 at 284.
Netherlands is that the legalization was not initiated by the medical community. Indeed, “if the Dutch process leading to formal decriminalization was a bottom-up one, the corresponding Belgian process was very much top-down.” The medical community chose to remain neutral and did not take a position against or in support of regulating the practice of assisted death. The euthanasia legislation in Belgium emerged mainly from rights-based movements. However, the element of suffering mirrored in the Netherlands’ policy is well present and leads me to conclude that the Belgium Law on Euthanasia is a priori grounded on compassion with stronger inclinations towards the principle of self-determination than its neighbour.

In Belgium, euthanasia was legalized, meaning the Penal Code was amended so that euthanasia would no longer fall within the definition of murder or manslaughter, a different approach to its neighbour the Netherlands who chose to keep the existing Criminal Code statutes but shape guidelines for prosecution in order to allow assisted death under certain conditions. I believe the choice of the legal construction is more than a simple matter of symbolism. It reflects a state’s values and founding principles. Keeping euthanasia as a punishable act leaves the Criminal Code its normative raison d’être and leaves control to the Attorney General to govern the matter. To completely decriminalize the practice of euthanasia would remove its exceptional character. And I have already established my support for a model in which assisted death is an exceptional medical procedure.

The alternative is to choose to base a policy exclusively on self-determination. In that case, the legislation adopted would resemble more to the legislation adopted in two states in Oregon and Washington in the United States, where assisted suicide but not euthanasia is legalized. For example, the Oregon Dying with Dignity Act is straight forward: no assessment of suffering, access to assisted suicide is only available to competent patients 18 years old and older, having 6 months or less to live. The criteria are strict; if you are an adult and two

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47 Dutch physicians advocated for regulations of assisted-death in order to consolidate the law with the practice that was already known and accepted.
48 Sumner, supra note 13 at 156.
49 Griffith, Weyers & Adams, supra note 16 at 287.
50 Shariff, “the slippery slope”, supra note 44 at 145.
51 Griffith, Weyers & Adams, supra note 16 at 284.
52 Ibid at 77. See also Sumner, supra note 13 at 151.
53 Shariff, “the slippery slope”, supra note 44 at145.
physicians have confirmed you have 6 months or less to live, your autonomy is fully respected and you have access to a prescribed medication that will kill you. The physician’s involvement is minimal and the fatal medication is self-administered.\textsuperscript{55} This represents more or less death on demand. Of course a legislature can impose a few conditions to qualify but the bottom line being self-determination, justifications to restrict the practice become hard to find and therefore inevitably leading the spectrum to become much wider sooner than later. For example, if a regime is based exclusively on values of respect for autonomy there is a case to be made that the choice falls solely on the individual no matter what the motivations are and that the practice does not have to involve doctors besides prescribing the drugs. In that case, assisted death does not hold its exceptional character.

In Canada, the value of autonomy is now the object of a wide societal and legal consensus.\textsuperscript{56} Therefore it would make sense for future Canadian assisted death regulations to make self-determination its foundation. But there is also a case to be made that it would be irresponsible as a society to just open the gates too wide and let the principle of autonomy rule above all other principle and core Canadian values, such as the protection of life and concern for society as a whole to name only two. As well articulated by Justice Smith in \textit{Carter}, while autonomy is fundamentally important and has long been affirmed in Canadian Common Law and Constitution, the principle at stake for patients seeking assisted death is not merely autonomy.\textsuperscript{57} “It is the autonomy to relieve herself from suffering.”\textsuperscript{58} Indeed, “assistance in dying […] cannot be solely a matter of patient choice.”\textsuperscript{59} As Sumner argues, any decent society should call for the two civic values of respect and compassion.\textsuperscript{60} Respect as in respecting others to choose to experience their life and manage their dying process the way they believe is best for them and one should be deprived of liberty or forced to suffer, without adequate cause.”\textsuperscript{61} Professor Battin explains that the two principles of autonomy and compassion (mercy) work in tandem:

\textsuperscript{55} \textit{Ibid.}
\textsuperscript{56} \textit{Ciarlariello v. Schachter}, [1993] 2 S.C.R. 119 at 135; \textit{Rodriguez, supra} note 5 at 84.
\textsuperscript{57} \textit{Carter, supra} note 3 at paras 1155-1156.
\textsuperscript{58} \textit{Carter, supra} note 3 at para 1156.
\textsuperscript{59} \textit{Ibid} at para 240 (Professor Battin’s testimony as an expert witness).
\textsuperscript{60} Sumner, \textit{supra} note 13 at 167.
\textsuperscript{61} \textit{Carter, supra} note 3 at para 239 (Professor Battin’s testimony as an expert witness).
Physician assistance in bringing about death is to be provided only when the patient voluntarily seeks it (autonomy) and only where it serves to avoid pain or suffering or the prospect of them (mercy). Because these principles do not operate independently, it cannot be claimed that permitting physician-assisted dying would require assisting lovesick teenagers who are not suffering from a serious medical condition to die: likewise it cannot be claimed that permitting physician-assisted dying on the basis of the principle of mercy would require involuntary euthanasia for someone who is in pain but nevertheless desires to stay alive. Both principles must be in play; but when they are in play, they jointly provide basis for permitting and respecting physician aid in dying.  

For the reasons stated by Professor Batting, I do not believe in an absolute principle of autonomy any more than I support the preservation of life at all cost. Indeed, an assisted death policy grounded both on the values of autonomy and compassion allows for a better balance in my opinion between an individual’s interests and the State’s interest to protect vulnerable citizens. In the context of assisted death, responsiveness to suffering acts as a condition to the exercise of ones autonomy in that a mere desire to end ones life is not acceptable and must be accompanied by suffering. It is the true basis of the Belgium Law on Euthanasia and I believe it should be the central element of a future Canadian policy as well.

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63 Sumner, *supra* note 13 at 172.
Who should perform the Act and all the involved parties

This section will address the provider(s) of assisted death in Belgium and the framework within which these individuals need to operate. Under Belgian law different persons play different roles. This section will provide observations and critiques of the Belgian statute as well as a discussion of the potential application in Canada.

3.1 In Belgium

In Belgium, euthanasia must be performed by a physician in order to be legal. But the legislation remains silent on any specific expertise the physician must have. For example, it does not have to be the patient’s family physician or a physician with expertise in palliative care.

Although no specific skills or specializations are required of the physician, this is not to say that there are no controls around the practice or that the physician may operate in isolation from the rest of the world. A certain number of people must be involved and the physician must perform specific regulatory verifications/consultations before assisting the patient.

First, the attending physician must have a numerous serious discussions with the patient about the request for assisted death. These include discussions about health condition, life expectancy, various therapeutic options and the pros and cons for each of the options. These discussions must lead the attending physician to be certain of the patient’s persistent physical or mental suffering and that the request is well-thought out and unchanging. Together, the patient

64 Throughout the entire statute and for every access condition mentioned in the legislation, physicians are referred to as the one performing the act.
and the physician must come to the conclusion that there is no reasonable alternative to the patient’s situation.

Following discussions with the patient, and if the patient so desires, the physician must discuss the request with the patient’s chosen family member(s), with whom the patient has already discussed his/her wishes. The physician must also have a discussion with the patient’s nursing team if one has regular contact with the patient.

A second physician, independent of both the patient and the attending physician, must be involved in a request for assisted death. The second physician must be informed of the reasons for the consultation, examine the patient and give an opinion about the serious and incurable character of the patient’s disorder. This physician must be qualified to give an opinion on the specific patient’s medical condition.

If the patient is not expected to die in the near future, a third physician must also be involved. Although the statute does not offer a definition of the notion of “near future”, the Federal Commission published an interpretation. It considers that a patient is expected to die in the near future if death is estimated to happen within a few months.65 The Federal Commission further considers that incidence of death remains a task that can best be done by the attending physician who should be the judge of whether or not the reinforced procedure is required (third physician).66 This additional physician must be a psychiatrist or a specialist in the patient’s disorder and must perform the same duties as the first consulted physician, notably examine the patient, confirm that the patient’s persistent and unbearable physical or mental suffering cannot be alleviated and confirm the voluntary, well-considered and repeated character of the euthanasia request. Like the second physicians, the third must be independent of the patient and the primary attending physician. The second consulting physician must be made aware of the reasons for the third consultation.

In both cases of consultation with other physicians, the patient’s attending physician must inform the patient of the outcome of the additional consultations. If the third physician is of the opinion that the requirements are met to perform euthanasia or assisted suicide, the law imposes

66 Ibid.
a month delay between the patient’s request and the commission of the act ending life. This additional delay will be discussed below when considering the patient’s medical condition (Chapter 4.2).

3.2 Canadian physicians?

Physicians’ involvement in assisted death creates a safeguard against abuse in the sense that physicians may allow or disallow the patient’s request in accordance with the conditions laid out in law. Downie and Bern argue that health care practitioners should be the only ones allowed to offer assistance because they are qualified to assess capacity and also in order to avoid failed attempts.

Physicians are professionally trained to help assess suffering, draw a portrait of patients’ health, give prognoses, estimate what the future may hold and explain the available alternatives and treatments. Although additional training to handle end-of-life care discussions with patients and families would no doubt be advantageous, physicians are already directly in contact with death and medical care and are in the best position to help patients make informed decisions.

The Royal Society of Canada Expert Panel on End-of-Life Decision-Making (the Canadian Expert Panel), in their proposal for Canadian reform, deliberately refer to healthcare professionals and not specifically identify medical doctors when they discuss the provider of an eventual regime. They do not speak for or against restricting the practice of assisted death to physicians or other health care professionals. They caution that restricting the practice to healthcare professionals may limit patients’ access and therefore limit patient’s autonomy. The Canadian Expert Panel expresses concerns over how actions of non-healthcare professionals might be regulated in order to limit the risk of abuse. They also made a general

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67 Belgium Law on Euthanasia, supra note 23 at s 3, para 3.
70 Ibid at 72-73.
recommendation that permission to provide assistance be granted only to those who have the
knowledge and skills necessary to ensure that the conditions for access have been met. Following that logic, the assistance access conditions laid out in the Belgian statute (competence, suffering, serious and incurable disorder, etc.) necessitates that the provider be a physician. Other professions may hold sufficient qualifications to evaluate conditions for access such as consent and capacity for example, but determining the seriousness and incurable nature of a disorder, which will be discussed later, can only be assessed by physicians. In fact, I believe physicians are the only ones who can test the entirety of the qualifying conditions I am supporting and that I propose throughout this paper.

Physicians will be involved one way or the other in a policy of assisted death as they play a key role in making sure the patient’s consent is informed, as will be discussed in chapter 4. It may be debated to what extent they should be involved but they will have to be at some point. At the very minimum, a physician would need to examine the patient and provide a drug prescription to end their life. This is more or less the situation in Oregon and Washington, where only assisted suicide is legalized. I believe the level of physician involvement constitutes an important safeguard against non-voluntary assisted death. Theoretically, a physician may see a patient once or twice and prescribe them end-of-life drugs. This may be acceptable for libertarians or defenders of a total and pure autonomy but as discussed above (Chapter 2), this is not the idea behind the Belgian Law on Euthanasia or the type of policy I recommend.

The physician’s role should be more than simply a prescription writer. They must be part of a contextual approach in which they are present with the patient throughout the entire process. If physicians are determining capacity, suffering and the full circumstances surrounding these requests, it seems to go without saying that they should be the providers. Such an approach provides a certain level of paternalism and reassurance to the public, a safeguard that I deem essential. Without placing physicians on a pedestal, our society respects physicians enough to trust them with most medical life and death decisions. Physicians already participate in other

71 Ibid at 73.

73 In these two states, the physician’s involvement is on the lesser side. It seems the legislator has decided to control the safeguards by restricting access to assisted suicide to a very limited type of patient. There is less room for physician’s professional judgment about subjective criteria. For example, suffering is not a criterion. The physician only has to attest that the patient’s medical condition is within the scope of the Dying with Dignity Act and that is it. It is a very different regime than the Belgian one.
crucial end-of-life decisions such as refusal of life-sustaining treatment, withholding life support, Do Not Resuscitate (DNR) orders and providing medication that may have the effect of hastening death. I do not see why assisted death should not be part of that spectrum. Physicians are required to respond to the highest professional and ethical standards. Therefore limiting the practice of assisted death to physicians seems to be necessary and part of a positive control. It is a measure that would certainly help society to gain trust in the system.

Sumner argues that assisted death should be offered by professional medical practitioners because it is a form of medical treatment. I agree that assisted death is a form of medical treatment and I am of the opinion that assisted death should be considered in the spectrum of end-of-life palliative care when appropriate, a suggestion that is reflected in the Commission Spéciale Mourir dans la Dignité (the Quebec Commission). The Quebec Commission reports that physicians should be the ones providing assistance because of the foundational principles behind the regime. Being very cautious of the sensitive nature of its proposal, the Quebec Commission insists that the context in which we should grant access to assisted death is one of accompaniment of patients as part of a continuum of care.

In that respect, the physician should be present at all times for the patient in order to protect/support the patient in case of complications such as regurgitation, failed ingestion or other unexpected situations. This is an important point to protect citizens. If a physician gives a prescription to a patient and the patient attempts to end life at home without medical supervision what is the certainty that nothing will go wrong? Do we know for certain that the methods are infallible for everyone? We will never know if there is no one on site to find out. Especially if the idea is to alleviate suffering, we certainly do not want the patient to experience a painful or traumatic death. One way to facilitate this is to have the physician on site from the beginning to the end. While the Belgian statute does not explicitly mention it, the Federal Commission ruled that the presence of the physician was an implied condition of the new regime. For the reasons

74 Sumner, supra note 13 at 173.
75 Quebec, Special Commission, supra note 7 (Of course this would not apply for patients for whom death is not imminent as they may not be palliative patients. This precision should be made clear in future assisted death regulations).
76 Ibid at 81.
77 Belgium, first report, supra note 33 at 17.
mentioned above, I believe the mandatory presence of the physician at all time should be explicitly mention in the legislation.

Importantly, assisted death should be available on request only and not be directly offered by the physician as one of the treatment options available to the patient. Physicians must be aware of the powerful role they play in their patients’ treatment choices and of the influence of their recommendations. Whether it is through palliative care services or not, death should be not itemized as one of the treatment options when a physician has a discussion with the terminally ill patient. I believe the request should be patient-driven, without suggestion at any point in time. This call for neutrality might seem at odds with the perceptions some physicians have of persuading their patients on the best treatment option. I do not see how, at any point in time, assisted death could be considered by the physician to be in the patient’s best interest if assisted death has not been brought up previously by the patient. Unlike discussions about other treatment options, patients do not need a physician to inform them of the option of euthanasia. Any state that attempts to regulate regulates assisted death practices can be sure to have the topic highly publicized and the regime will become common knowledge.

Another reason to require a number of conversations between the physician and the patient before allowing euthanasia is objectivity. By listening rather than leading, the physician will be in a better position to understand the patient’s values and wishes and to give appropriate recommendations. As recommended by Cohen-Amalgor, it would suffice for the physician to say: “I would be willing to assist you in every possible way, considering any of your wishes in order to relieve your suffering and help cope with your condition”. To propose death as a treatment option could damage the trust that is fundamental to the doctor-patient relationship. Offering death would constitute too big a shift from the current culture in the Canadian healthcare system. There is already a strong engrained culture that physicians are there to heal

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80 Maybe not all the details and application of the regime but it is fair to think that the legalization of the practice will be widely known, unlike a new medical treatment for example.
81 Cohen-Almagor, supra note 78 at 213-214.
and care for life. It is one thing to modify the practice towards allowing the relief of sufferings through assisted death but it is another to offer death to a patient as an alternative. This is an important distinction. Assisted death should be a form of medical treatment that remains exceptional and that emerges directly from the patient.

To that effect, some argue that it is inappropriate to have physicians assist in death because it is inconsistent with the Hippocratic Oath, which values the preservation of life and long-standing principle of “Do no harm” in medicine. In Belgium, the National Council of the Order of Physicians expressed the capital importance they attach to the physician-patient relationship and their concerns about their new connotation as “…bringer of death.” Notwithstanding the Hippocratic Oath, the practice of medicine, our laws and cultural norms have all evolved tremendously over time. As much as physicians are life-savers, they do encounter situations in which they are unable to preserve patient’s life, thus the origins of palliative care. In the face of death, there is a lot of value in palliative care, in providing comfort and practicing care adapted to each patient.

On a very different note, Carl Elliott came out with a bold proposal that assisted suicide and euthanasia ought to be provided by the philosopher. This solution, he said, would preserve the patient-physician relationship and resolve the conflict of the Hippocratic Oath. He goes as far as to say that assisted death should not be practiced by physicians because it would ultimately lead down the slippery slope to involuntary euthanasia. Although Elliott’s proposal is facetious, some of his concerns about conflict of duties and interest could be legitimate. Indeed, some similar objections were made by witnesses at the Senate Commission concerning the potential for physicians to be in a conflict of interest. If physicians are called to balance economic pressures on the health care system and still offer fiduciary duty to patients, it is unclear which of those duties would prevail. That conflict of interest, whether real or perceived, could put a dent in the important trust between patients and physicians. I therefore recommend that legislators

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82 Senate of Canada, Of life and death, supra note 22.
83 Carter, supra note 3 at para 314.
84 Adams & Nys, supra note 32 at 373.
85 Senate of Canada, Of life and death, supra note 22 at 31.
take this point into consideration and clarify the priorities and roles expected from the physicians.

Although the suggestion of philosophers assisting in end-of-life scenarios sounds like a nice fix to the objections brought against physician assistance, I believe it ignores a number of considerations. For example, philosophers do not hold special relationships with patients and there exists no philosopher-patient code of conduct. While physicians may not have sufficient or specific training to provide euthanasia and assisted suicide, neither do philosophers. As one of the most regulated professions in Canada, physicians are the obvious choice for such important considerations. While some physicians may find this too burdensome, I would remind them that in some respects they already carry this responsibility. Physicians may at any time be required to make life or death decisions.

In effect, the current situation leaves all the power in the physician’s hand. Consider the terminally ill patient who wants to end her life because she is suffering. She is at the total mercy of the physician who holds the ability to control her pain and provide drugs to end her life. Is this a burden that physicians appreciate? I doubt it.

Finally, to ease physicians’ perceived burden, any sensible policy of physician-assisted death should include a “conscience clause” that enables physicians to decline to offer the assistance on grounds of personal convictions.\(^{88}\) This clause must come with an obligation to refer patients to a service provider who is willing to help.\(^{89}\) According to Provoost, in Belgium physicians are not obligated to refer patients to another physician when they decide to decline the request.\(^{90}\) That is a shortcoming of the Belgian statute. With the freedom to refuse comes a certain responsibility. The responsibility is to not to abandon the patient but at a minimum guide them towards where they might find help. Consider how overwhelming it might be for someone already in a situation of unbearable suffering to have to do intensive research to find someone to help. Finding assistance to die should not be a major obstacle if this is truly the wish of the patient.

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\(^{88}\) The vast majority of the literature about regulating is in favour of including a conscience clause. See Sumner, *supra* note 13 at 173; Canadian Expert Panel, *supra* note 43 at 73.

\(^{89}\) Sumner, *supra* note 13 at 173.

\(^{90}\) From an interview Cohen-Almagor had with her and that was included in his published work, see Cohen-Almagor, *supra* note 78 at 197.
A conscience clause is a legal concept that already exists within Canadian health law. Indeed, the Canadian Expert Panel on End of Life Decision-Making concludes that in accordance with current Canadian health law, the obligation of a physician would not be to assist with death if he/she is not comfortable but to refer his/her patient to a professional who can provide assistance.91

In conclusion, over the past decades, technological advancements in medicine have contributed to prolonged life expectancy. This is a good thing. But sometimes prolonging life comes with a cost to quality of life and moves away from the patient’s true wish. I believe in a medical remedy to a situation caused by medical progress.

### 3.3 Which physicians?

Now that I have established that the provider of assisted death should be a physician, I would like to consider whether Canadian legislation should specify the type of physician required, or if it should follow the Belgian example.

Strictly speaking, the Belgium statute remains silent on the need for an established relationship between the patient and the physician despite the recommendation of the *Commission de la Santé Publique de la Chambre* to impose a consultation with the patient’s family doctor.92 The idea was initially brought up in response to concerns about the potential that only a few physicians would agree to practice euthanasia, thus creating little groups that would travel the country responding to the requests of patients wishing to end their lives.93 The idea of a group of “killing physicians” would not be easily accepted. In Canada, whose territory is much more vast than Belgium, it would be hard to imagine such a phenomena. I am not convinced physicians would travel to provide assistance to dying people.

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As pointed out by Adams and Nys, further reflection shows that it is implied in the law that the attending physician has the duty to establish some kind of relationship with the patient. Even if the physician and patient have not met prior to a request for assisted death, the regulatory requirement of several discussions to ensure that the patient’s request is well founded implies that a certain physician-patient relationship exists. It elevates the level of physician involvement. This is an important component of the legislation and an important safeguard against normalization of assisted death. It establishes a certain standard of care. Although the requirement for some form of relationship between patient and physician is only implied, Adams and Nys reasonably argue that this criterion emerges from the legislation itself. It then becomes \textit{prima facie} part of the expected standard of care in the practice of assisted death.

The discussion about requiring the family physician to perform assisted death must also consider the personal values of the physician. Would that requirement imply an obligation on the family physician to respond to a patient’s request even in cases where this practice is against the physician’s personal values? We have already established that the Belgian statute does not grant a right to assisted death \textit{per se} but allows one to request and receive it. We have also mentioned the need for physicians to have the right to reject a request. If there is a conscience clause, the regime cannot at the same time impose that the provider be the family physician. The law would be deemed incoherent.

Practically speaking, a requirement that assisted death could only be accessed through your family physician would not be viable in Canada. In 2011, 85% of Canadians said they had a family physician. The reality is very different from one province to another, particularly the Northern regions. Problems of accessibility to family physicians are encountered across the country. Where the patient lives could have an impact on the access to the service. Therefore, the application of such a requirement would be difficult in Canada. We can imagine that some disparity will exist within the different regions of Canada in terms of access to end-of-life care; we should not provoke greater disparities.

\begin{footnotes}
\item \textit{Ibid.}
\item Statistics Canada, \textit{Health indicator profile, annual estimates, by age group and sex, Canada, provinces, territories, health regions (2011 boundaries) and peer group} (Ottawa : StatCan, 2012), online: Human Resources and Skills Development Canada <http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=9>.
\end{footnotes}
I recommend against the inclusion of the requirement that assisted death to be practiced by a family physician. I believe Canada can model Belgium in this respect. I do not see a justification to change current Canadian law to require more than the currently existing obligation to refer. In addition, it seems reasonable to limit the imposition to physicians in general provided they take the time to examine and discuss the request at length with the patient, thus creating a certain familiarity.

Let us discuss now the requirement that the attending physician must obtain a second opinion. It is a safeguard that I would support in a Canadian regime. It is not practicable, realistic or possible to require all physicians to be experts in every medical condition. As previously discussed, under the Belgium Law on Euthanasia the second consulted physician must be qualified in the patient’s disorder. At risk of complicating the healthcare system, this additional step is necessary when dealing with such an important act. The expertise of the second consulted physician should prevent wrong prognostics and/or failure to present the patient with the best and most recent practices and available alternatives.

Under the Belgian statute, both the second and third (if required) consulting physicians must be independent from the attending physician. How realistic is this? It would seem likely, based human nature, for the attending physician to approach like-minded physicians. This is an important concern. The safeguard of requiring an additional consulting physician should not become a mere administrative technicality that would bog down the system. The independence must be real and not only an illusion based on a procedural formality. In cases of total independence, we can assume disagreements will occur; it is not clear what would happen then.

3.4 The third physician

If the second consulted physician is an expert in the patient’s condition, I do not see the need for the additional requirement of a third consulting physician in cases of non-imminent death. As

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96 Cohen-Almagor, supra note 78 at 204.
97 Ibid.
previously described, it is my understanding that the Belgian legislator, vis-à-vis some resistance from opposition with regards to non-terminally ill patients’ access to assisted death, used this element as an additional safeguard (the third physician) rather than limiting access to patients with terminal diseases. Considering the political climate in which the 2002 law emerged, it is plausible that the 30-day waiting period for non-terminal patients was a compromise position to accommodate certain members of parliament. But is it really useful? I do not believe so. Canadian parliamentarians must engage in fulsome discussion on all aspects of these issues. It is reasonable to include compromise dispositions that make sense when adopting legislative regimes but not simply to ensure that the legislation is passed. It is almost impossible to write perfect legislation and the law is constantly evolving. However compromises must make sense.

I do not see any justification requiring patients experiencing unbearable suffering due to non-terminal disease to wait longer than those with “short term” terminal disease to access assisted death. It is very hard to delineate whether or not a person is going to die in the “near future”. Physicians will provide an estimated prognosis if pushed, but we will only know for certain when the person is dead. Consider the injustice for someone who is given a prognosis of death that is one day or one week later than the definition of “dying in the near future”? How do we justify making that person wait longer and/or need to work harder to access assisted death if the test of the suffering and the other requirements are met? In fact an analysis of the Belgium Law on Euthanasia shows that some physicians confessed to ignoring the requirement of a third consulting physician. They justified their behaviour by invoking the principles of beneficence and compassion in not wanting to cause their patients additional suffering with further delays.  

In my opinion, the obligation of consultation for a second opinion is sufficient and there is no need for a third consulting physician to give approval. If we distinguish access to assistance in dying based on the imminence of death or the nature of the suffering, we only divert our attention from the values we want to protect, namely autonomy and compassion. If the facts remain that we are in presence of informed choices and suffering, the substantive conditions have been met. Non-terminal cases that are more complex situations such as psychological illness deserve special consideration and will be discussed in chapter 4.

98 Cohen-Almagor, supra note 78 at 193.
3.5 Pharmacology

Because medicine and research are making constant progress, it is a good idea to not specify within the legal text rigid medical procedures to be followed. The medical profession should determine what constitutes best practice in matters of end-of-life. Attending physicians should evaluate how to proceed according to each individual situation, whether by general anaesthesia followed by neuro-muscular paralyser, potassium chloride or morphine. We must recognise that there is no “one size fits all” way to help a patient transition from suffering to peaceful death. “The best care is personalized care”, hence the justification to leave the choice of drugs to use as fluid as possible. Such technical requirements are entrenched in the principle of due medical care, which comes under professional standards of practice and should be guided by medical professionals. However, the Belgian experience teaches us that physicians need to be accompanied as well since there is no consensus on the standard of care with regard to pharmacology. Before Canada adopts a permissive regime of assisted death, the terrain must be prepared through physician training, information campaigns, and development of practice guidelines from the government or governing physicians’ bodies. Physicians need guidance that includes pharmacological best practices and procedures that guarantee a quick, peaceful and certain death.

99 Those techniques were the majority of the ones used by the reporting physicians to the Belgium Federal Evaluation Commission.
100 Carter, supra note 3 at para. 253.
101 Robert H. Vander Stichele et al, “Drugs used for Euthanasia in Flanders, Belgium” (2003) 13:2 Pharmacoepidemiology & Drug Safety (2004) 89 at 95 (most physicians practicing euthanasia in Belgium were not well informed about the correct medications to use in different circumstances.); Cohen-Almagor, supra note 78 at 207 (some interviewees in Cohen-Almagor’s study disagree and say that since the existence of the 2002 Euthanasia legislation, physicians know what products to use or know where to find the information).
Chapter 4
The patient. Who should have access to assisted death

In Belgium, access to euthanasia is not open to everyone. The regulations apply only to patients who meet specific criteria. As discussed in the previous chapter only physicians are allowed to perform the acts of euthanasia and assisted death and the burden rests on them to ensure that patients meet the requirements. The Belgian statute divides the patients in two categories; conscious and unconscious. It enumerates requirements for each category. Let us begin by looking at the elements from the Belgium Law on Euthanasia about the conscious patient.

4.1 Age and state of mind

Le patient est majeur ou mineur émancipé, capable et conscient au moment de sa demande.

The patient has attained the age of majority or is an emancipated minor, and is legally competent and conscious at the moment of making the request.

Access to assisted death in Belgium has been opened only to adults and emancipated minors. The inclusion of minors in the legislation turned out to be so controversial during the parliamentary proceedings that it threatened approval of the euthanasia bill. Some argue that under the scope of the Belgium law on Euthanasia, emancipated minors refers to borderline cases of patients who are 16 or 17 years old. Others believe that the legislator consciously

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102 Belgium Law on Euthanasia, supra note 15 at c 2, s 3, para 1 [translated by author].
103 An emancipated minor is a minor that is deemed mature enough to make his or her treatment decision and in accordance, sees his or her autonomy respected. See Joan Gilmour, “Death, Dying and Decision-Making about End of Life Care” in Downie, Caulfield & Flood, supra note 9 at 441.
104 Griffiths, Weyers & Adams, supra note 16 at 312.
105 Cohen-Almagor, supra note 78 at 192.
decided to remain vague on the age factor in principle, in order to defend the autonomy of young patients.  

The age, competence and consciousness referred to in section 3 of the Belgian statute are elements rooted in the doctrine of informed consent. In the area of end-of-life decision-making, informed consent is required as the basis to ensure dying happens in accordance with a patient’s true wishes and helps to safeguard against involuntary termination of a patient’s life. In order to make a meaningful decision, the patient has to be able to understand his/her current diagnosis, prognosis, the options available, and all the implications of the decision. That means first and foremost that the patient has to be competent. The other element of informed consent refers to the individual right patients have to receive all the information available about the risks and benefits involved in undergoing or foregoing medical treatment.

Decisional capacity (being competent to make a decision) is often linked to age and mental health but conceptually it is not as clear as one might expect. Decisional capacity, as part of informed consent, will be analysed further below in the discussion about mental suffering. In Canada, the criterion to establish capacity are whether or not the patient has the ability to understand his/her decision and whether or not the patient has the ability to appreciate reasonable and foreseeable consequences of the decision. Is there an age that would guarantee our understanding and appreciation of an assisted death decision? This is relative. Like Belgium, Canada has a rule of mature minors as part of the common law and allows treatment decision making for certain minors who are able to understand the nature and consequence of their decision. However, it is not totally clear at this point if the same would apply for treatment that would not be in his or her best interest, i.e.: causing death. The issue of mature minor is outside the scope of this thesis but needed to be raised to remind the legislator to clarify to which

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106 Ibid.
107 The notion of informed consent directly refers to patient’s autonomy. It is the notion that every human being has the right to decide what is to be done to one’s own body and is fundamentally part of Canadian Common Law. It was embraced by the Canadian Supreme Court on numerous occasions, see Hollis v. Dow Corning Corp (1995) 4 S.C.R. 634 [Hollis]; Hopp v. Lepp (1980), 112 D.L.R. (3d) 67 S.C.C.; Reibl v. Hughes (1980), 114 D.L.R. (3d) 1 S.C.C.; Arndt v. Smith (1997), 148 D.L.R., (4th) 48 S.C.C.
108 Hollis, Ibid at para 24-25.
110 Joan Gilmour, “Death, Dying and Decision-Making about End of Life Care” in Downie, Caulfield & Flood, supra note 9 at 441.
111 Ibid at 441-442.
extent the autonomy of mature minors should be protected. In Belgium, *The Patient’s Rights Act*,\(^{112}\) adopted the same year as the *Belgium Law on Euthanasia*, speaks to the rights of emancipated minors. Article 12(1) deems that the parent or legal guardian of a minor patient is responsible to exercise the minor patient’s rights. Article 12(2) goes on to say that minors demonstrating enough maturity to appreciate their own interests may exercise their rights in an autonomous way. Although such a provision raises more questions that it answers, it is reasonable to expect that the minor’s maturity level will be determined by their acting physician. But it is not clear what kind of legal control or mechanism the emancipated minor has in order to exercise his/her decision-making autonomy. In contrast with article 12, article 15(2) of the same law states that physicians must deny minor patients the right to refuse treatment that the physician deems necessary.

The lack of definition of emancipated minor in the *Belgium Law on Euthanasia* and the *Patients Rights Act* is less than clear as to the extent a mature minor can exercise his/her and thus creates much legal uncertainty about adolescent access to euthanasia in Belgium. In addition, the Federal Commission has not been very transparent regarding incidences of euthanasia on minors. My findings following analysis of the Federal Commission biannual reports are as follows. The first report (covering years 2002-2003) stated one case of euthanasia on a patient in the age category of less than twenty years old and specified that the person was eighteen years of age.\(^{113}\) The second report (covering 2004-2005) declared two instances of euthanasia in the category of less than twenty years old, this time without any mention on the exact age of the two persons.\(^{114}\) The third, fourth and fifth reports (covering years 2006 to 2011) do not report any cases of euthanasia on patients of less than twenty years old. While the numbers are low, I believe that we should monitor more precisely the incidence of the mature minors euthanized in Belgium. Of three patients of less than twenty years old, we know the exact age of one. Consequently, the official control structure in Belgium does not allow me to confirm if euthanasia was or was not practiced on a minor and if so under what conditions. A Belgian study published in 2009 states 25 cases of minors who received lethal injections during the two-year study.\(^{115}\) Whether because

\(^{113}\) Belgium, *first report*, supra note 33 at 14.
\(^{114}\) Belgium, *second report*, supra note 33 at 22.
of legal uncertainties or poor reporting practices, the situation about Belgian minors electing euthanasia is not clear.

In Canada, the law on a mature minors’ decisional capacity with regard to medical treatments differs between provinces. Some provinces have specific legislation to deal with this issue while others do not and thus are bound by the common law. Amongst the provinces having legislations, they use different approaches. It is not clear in Canada whether or not courts or boards would allow emancipated minors to make treatment decisions that lead to their death. Some argue that the emancipated minor rule should apply to end-of-life decisions in exactly the same fashion as any other medical decision. Others believe the rule should be limited by the “welfare principle” according to which a minor can only consent to treatments that would be beneficial. The Supreme Court of Canada has yet to address this issue.

Sumner argues that mature minors should be able to request assisted death in the same way they are able to refuse of life-sustaining treatments. The rule of thumb, he suggests, should be a reverse presumption of capacity, which is to say that adolescents must demonstrate that they have the necessary maturity to make such important decisions. Moreover, he specifies that parents of emancipated minors should still be consulted. He also argues that if an adolescent is deemed to be competent to refuse life-sustaining treatments, he/she should be competent to ask for life-shortening treatment. Such an argument attempts to defend the minor’s autonomy against an undue paternalistic approach.

Similarly, the Canadian Expert Panel proposes that assisted suicide and euthanasia be provided in accordance with any provincial law on mature minors relevant to the patient, just as is the case for all other aspects of end-of-life decisions. That said, there is still much legal uncertainty in Canada with regard to mature minors and consent to treatment. It is clearly important for Canadian legislators to clarify the question of competence of mature minors before or at the time of adopting any assisted death policy. Official clear guidelines and training for

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118 Sumner, supra note 13 at 170.
119 Canada Expert Panel, supra note 69 at 72.
physicians to determine whether a mature minor is capable of making an informed consent with respect to end of life decision are a necessary important safeguard. As Downie argues, the status quo in Canada is too permissive in the sense that the competence of some patients might not be adequately assessed, allowing vulnerable minors to fall through the cracks, especially depending on their province of residence. While it is difficult to envision a justification for this lack of uniformity across the country when it comes to accessing assisted death. But the fact that this is the case at the moment in Canada for all other medical decisions and does not seem to be the cause of any problem makes it difficult to argue for a different legal application.

It is outside the scope of this paper to review the whole regime of emancipated minors for each province but I suggest an eventual assisted death policy to refrain from using the same vagueness as Belgium. Using the term ‘emancipated minors’ in law and then leaving it to the different provinces to interpret is inadequate. Current law needs to be addressed first. Either the legal policy should include a strict definition of emancipated minors or better yet describe explicitly its own application with regard to assisted death. In this case, considering the gravity of the decision, I recommend close scrutiny in the capacity assessment of the minor, or restricting the option of assisted death to adults only.

Making sure the intentions of the patient are genuine can be difficult when it comes to drafting good legislation. The best measurement remains the aforementioned doctrine of informed consent. In the case of the Belgium Law on Euthanasia, the informed consent requirement is both implicit and explicit. It serves to protect vulnerable people who might not be in a position to make decisions about what they truly desire with sound judgement. Iona Heath, President of the UK Royal College of General Practitioners believes it is impossible to draft a legislation that is robust enough to protect 100% of personal wishes. She argues that it would be “impossible to ensure that an apparently voluntary request for assisted dying is not in some small way coerced.” The same argument was brought up in Carter. So many aspects of our lives can influence our decision-making but that is true for just about every decision we make in our lives including withdrawing/withholding medical treatment. Forbidding people who want to have

120 Downie, supra note 117 at 84.
121 Gilmour, supra note 116 at 437 (An interesting legal review of emancipated minors decision’s making at the end-of-life).
recourse to medicine to die peacefully is not the answer. Of course, eliminating coercion or outside persuasion per se is difficult to achieve through legislation of a specific practice. As taken as a fact by Justice Smith, “influence can be subtle and exercised at an unconscious level.” However, she also accepts

“the conclusions that coercion and undue influence can be detected as part of a capacity assessment. To be accurate and reliable, clinicians who perform such assessments would have to be aware of the risks of coercion and undue influence, of the possibility of subtle influence, and of the risks of unconscious biases regarding the quality of the lives of persons with disabilities or persons of advanced age.”

Reflecting the longstanding established principle in health law to respect an individual wishes, the existing test of informed consent is the right one to apply to assisted death, just as for other end-of-life decisions.

As Sumner discusses, due to the finality of the decision, it is reasonable to set the bar high when it comes to assessing decisional capacity. However, that standard should not be higher than for those of other comparable end of life decisions, such as refusing life-sustaining treatment or requesting terminal sedation. Since informed consent is the current legal test and it is accepted practice in Canada to let someone die by refusing treatment such as food and water, there is no justification to make the test more demanding for medically assisted termination of life. This would result in inconsistencies across categories of assisted death. Unless we are prepared to argue that it is possible to ensure that individual decisions on other end of life measures such as treatment refusal are perfectly free of any source of coercion, we cannot demand a different standard for the voluntary character of assisted death requests. What safeguards are in place when it is time to fulfil someone’s wish to refuse treatment, to ensure this wish is not a result of undue pressure, whether it economic, associated to stigma or through feelings of being a burden to others? Nothing other than ensuring that consent is informed, as in other healthcare circumstances. A patient deemed competent, may refuse any treatment including water and food, which will clearly lead to death, the same finale than assisted death.

123 Carter, supra note 3 at para 815.
124 Ibid.
125 Sumner, supra note 13 at 169.
126 Downie, supra note 117 at 97.
In Canada decisional capacity for medical acts is regulated differently in every province. While it is outside the scope of this paper to review each jurisdiction, suffice to say that Canadian patients benefit from the presumption of having decisional capacity. A notable distinction between Belgium and Canada is that in Canada the age of consent varies from one province to another.\(^{127}\)

On the topic of informed consent, I would like to come back to an element discussed above in the chapter about the provider: the voluntariness of the consent. Requiring that physicians be the ones offering assisted death and assessing competency will help to ensure that this wish is not only informed, but purely genuine. It is not clear if, in Belgium, physicians are allowed to suggest euthanasia to patients. Nothing in the legislation prevents them from it and the topic has not been addressed by the Federal Commission. Cohen-Almagor reminds us of the importance that the patient be the one initiating the topic with the physician and not the other way around because of the great influence physicians have over their patients:

> With respect to professional ethics, talking about euthanasia upon a patient’s request, we are faced with the exceptional situation in which patient’s autonomy and the physician’s understanding of beneficence meet and manifest in the option of euthanasia. Thus, in this particular case, the healing model may be compromised in order to allow medical intervention based on a consensus between the patient and the physician in accordance with the principles of beneficence and patient autonomy. But when euthanasia is accentuated, the emphasis on euthanasia might undermine the patient’s voluntary wishes.\(^{128}\)

> It is important for patients to trust their physicians. For this reason, a physician’s attitudes towards assisted death may influence the patient’s choice. Already vulnerable, a patient must not feel that “he is being condemned to death and that he is wasting the physician’s time.”\(^{129}\) The way physicians frame the discussions with the patients and their loved ones will have a major consequence on the final choices. As Cohen-Almagor states it: “Caution is not only recommended, it is a must.”\(^{130}\) In this respect, physicians operating in a jurisdiction where

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\(^{127}\) Some provinces set the age of consent in line with civil age of majority, others adopt specific legislation dealing with age of consent, see e.g.\textit{Ontario Healthcare consent Act, SO 1996, c 2, Schedule A [Ontario Healthcare Consent Act]}.  
\(^{128}\) Cohen-Almagor, \textit{supra} note 78 at 202.  
\(^{129}\) \textit{Ibid.}  
\(^{130}\) \textit{Ibid} at 203.
assisted death is permitted but regulated should receive training and appropriate guidelines should be written.

Additional safeguards to ensure that patients affirm voluntary choice should also be considered in the requirement about the request itself, which we will discuss below as part of other determinants of informed consent.\footnote{As we have seen in chapter two, Section 2, paragraph 2 of the \textit{Belgium Law on Euthanasia} explicitly mandates physicians to provide the patient with the type of information needed to make an informed decision (obligation of the physician to discuss the details of the medical situation with the patient, etc.)}

\section*{4.2 The patient’s medical condition}

Section three of the \textit{Belgium Law on Euthanasia} limits its scope in accordance with the medical condition of the patient. It reads:

Le patient se trouve dans une situation médicale sans issue et fait état d’une souffrance physique ou psychique constante et insupportable qui ne peut être apaisée et qui résulte d’une affection accidentelle ou pathologique grave et incurable.

The patient is in a medically hopeless situation of constant and unbearable physical or mental suffering than cannot be appeased, resulting from a serious and incurable disorder caused by illness or accident\footnote{\textit{Belgium Law on Euthanasia, supra note 23 at c 2, s 3, para 2 [translated by author].}}

The following examines the different conditions that permit access to assisted death.

\subsection*{4.2.1 Medically hopeless situation of constant and unbearable physical or mental suffering}

At first read, a \textit{medically hopeless situation} seems legally difficult to define. The statute does not provide any definition. \textit{Hopeless} could lead one to believe the medical situation is one that has no cure but this is not to be mistaken with terminal. The legislator, later in the same sentence, describes a \textit{serious and incurable disorder}. Assuming that the legislator did not
intended to be repetitious and recognizing that in law every word has meaning, we can deduce that the terminology used indicates that the medically hopeless situation is the cause of the unbearable suffering and not the other way around. It is therefore the suffering that is the central element that needs to be assessed in order to determine if the medical situation is hopeless. Indeed, within the terms of the law, a paraplegic patient, with a stable condition (non-degenerative and non terminal) could meet the requirements of medically hopeless situation and have access to euthanasia in Belgium provided he or she is experiencing unbearable suffering.

Suffering is subjective and only the patient is able to determine definitively if it is unbearable. In its first report, the Federal Control and Assessment Commission takes a stand and interprets unbearable suffering as only to be determined by the patient.\(^{133}\) The Federal Commission issued an information booklet dedicated to physicians in which it provides information about the “unappeasable” character of the suffering. The booklet recognizes that the unbearable character of suffering is in large part subjective and dependent on the patient’s personality, conceptions and values.\(^{134}\) In other words, the health care practitioner can only acquiesce to the expression of suffering by the patient, verbally or otherwise. Because of this, the Federal Commission has been criticized for relinquishing its power and mission to control part of the legal requirement of the *Belgium Law on Euthanasia*.\(^{135}\)

Despite the fact that suffering has received a wide interpretation in Belgium, the concept is not frivolous. It remains that a serious discussion that must occur between the patient and the physician and that suffering must be rooted in a true medical condition.\(^{136}\)

The suffering also has to be constant. But how long must one suffer?\(^{137}\) This is also subjective. The purpose is not to allow suffering to continue until someone else judges it has been long enough. Prolonging suffering was clearly never the intention. The constant requirement of suffering is there to counter suffering that is intermittent or for a short term, in which case dying would not be the appropriate remedy.

\(^{133}\) *Belgium, first report, supra* note 33 at 16.

\(^{134}\) *Belgium, fifth report, supra* note 65 at appendice 4.

\(^{135}\) *Institut Européen de Bioéthique, Euthanasie : 10 ans d’application de la loi en Belgique* (Brussels, April 2012) at 6.

\(^{136}\) Shariff, “the slippery slope”, *supra* note 44 at 3.

\(^{137}\) *European Institut of Bioethics, 10 years of application, supra* note 135 at 5.
Medicine in general and palliative care specifically is very successful at making patients as comfortable as possible. But as previously mentioned there are rare cases where medical assistance is unable to alleviate a patient’s suffering and it is on that basis that assisted death should be available. This is the primary intent of the legislation. However, the booklet created by the Federal Commission reminds physicians that patients reserve the right to refuse treatment, even treatments that have the potential to appease suffering. Consider a patient who refuses a treatment because he/she judges its side effects would be unbearable. Remember the case of Pierre. Pain medication caused Pierre a number of unpleasant side effects (hallucination, dizziness, nightmares, insatiable feeling of thirst, etc.). After trial and error, it was concluded by the medical team that the only way to alleviate his suffering was to proceed with terminal sedation because only unconsciousness would appease his discomfort. Tired of suffering, he accepted that option and was put in a coma until he took his last breath. But what if Pierre did not want to be induced in a coma? And how can we be certain that the unconscious person’s suffering is alleviated if we cannot communicate? Imagine if it was the opposite - that the existing suffering persists and additional suffering appears from the incapacity to communicate! There is very little scientific data to support the argument that palliative sedation is certain to alleviate all suffering. According to the current state of Canadian law, Pierre had the right to refuse treatments including palliative sedation. And while it might have been more in line with his view to decide to opt for assistance in dying, Pierre did not have any alternatives other than to be induced into a coma to lie and wait for his heart to stop. Who is made to feel better by this scenario? Pierre? The physician? Pierre’s family? I am not sure. Nevertheless, the right to refuse treatment already established in Belgian health law remained intact with the avenue of euthanasia and so it should be for Canada as well.

The requirement of suffering may be difficult to apply but it comes from good intentions and reflects the value of compassion we want to offer patients. Whether or not suffering should be a requirement in a permissive assisted death policy truly comes down to the fundamental principles from which the regime emerges. I have already discussed this topic in the chapter about the spirit and intent of the law. Note that there is no mention about anticipated suffering. The medically hopeless situation has to be in the present. This issue presents some limitations

138 Carter, supra note 3.
with respect to patients trying to clarify their wishes ahead of time. There is no provision in place for patients to give advance directives in case they become incapacitated unless they are in a total state of unconsciousness. We will discuss further this vide juridique in the next section about mental suffering.

4.2.2 Mental suffering

Most of the euthanasia cases declared to the Commission include physical and mental suffering simultaneously.\(^{140}\) There is an ongoing debate about how to deal with patients who are affected by psychological suffering but are otherwise physically healthy. This element of the Belgian policy is highly controversial and the source of diverging opinions, even among the supporters of permissive assisted death regimes.\(^{141}\) Entering those slippery grounds, the Belgian legislator showed great prudence during the law’s preparation work about patients wanting to access euthanasia mainly for mental illness suffering.\(^{142}\) If there is legitimate fear of abuse in regulating assisted death for the average citizen, it is accentuated when we include people with mental illness in the discussion. Our highest court has recognized that “the stigma of mental illness can be very damaging.”\(^{143}\) The mentally ill have historically been the subjects of abuse, neglect and discrimination in our society.\(^{144}\) That said, mental suffering is not necessarily synonymous with mental illness. But in cases of mental suffering alone, Belgian law requires the suffering to be the result of a recognized mental disorder. To the same extent then as physical suffering, we must be able to link the suffering to a diagnosable medical condition. Mental illness might not be as visible but it is real and identifiable by health care professionals who are experts in this area. Physicians reserve the right to exercise their professional judgement when

\(^{140}\) In the fifth and most recent report from the Evaluation Commission (Belgique, fifth report, supra note 65) in 2086 cases of euthanasia, physicians reported physical suffering for 2012 patients and psychological suffering for 1570. It is conceivable to conclude that the majority of the psychological suffering was simultaneous to the mention of physical suffering.

\(^{141}\) Belgique, Commission Fédérale de Contrôle et d’Évaluation de l’Euthanasie, Quatrième rapport aux chambres législatives, (Commission plénière, 8 juin 2010) (the Commission admits that some of its members believe that the mental suffering has received an interpretation far too liberal).

\(^{142}\) European Institute of Bioethics, 10 years of application, supra note 135 at 6.


\(^{144}\) Ibid.
faced with a euthanasia request and any requests deemed to be groundless or frivolous have to be rejected.\textsuperscript{145}

While the most apparent and dramatic form of suffering may be physical pain, for some people the desire to die emerges from psychosocial concerns such as loss of independence and control, loss of dignity, sense of self, loss of meaning to their life, etc.\textsuperscript{146} However, what can be more relative than one’s sense of having a life worth living? At first sight, including psychological suffering in an assisted death policy makes the physician’s assessment of the patient’s condition appear pointless in the sense that the physician can only be a witness to the patient’s expressed wish. However, the subjectivity of suffering is real whether its nature is physical or mental. The same disorder may not manifest the same level of suffering in different people. Leleu and Genicot argue that we cannot let that subjectivity and relativity result in a weakening of the legal requirement of suffering.\textsuperscript{147} This reasoning applies to psychological pathologies as well.

One of the most challenging and debated issues about mental illness in healthcare is the capacity to consent. As the doctrine of informed consent was already discussed in Chapter 3 I will not repeat it here. With the requirement in Belgian law of continued suffering, the episodic nature of much mental illness\textsuperscript{148} adds to the difficulty in assessing a patient’s request. Some may argue \textit{a priori} that patients with mental suffering lack decisional capacity to begin with and therefore do not meet the requirements that allow them access to assisted death. Indeed, as discussed, it can be very difficult to ensure that capable patients are sharing authentic wishes and one would think that this becomes even more sensitive with mentally ill patients. But patients’ rights advocacy groups argue that testing decisional capacity should be applied to people with mental illness the same way it is for everyone else. This appears to be the route the Federal

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\item[145] Sumner, \textit{supra} note 13 at 171.
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Commission in Belgium decided to take when it deemed certain patients afflicted with major depression to be competent and allowed their request for assisted death.\textsuperscript{149}

In Canada, people suffering from mental illness should not automatically be deemed incompetent. Canadian law rejects global assumptions about decision-making capacity.\textsuperscript{150} The landmark case in Canada is \textit{Starson}.\textsuperscript{151} It concerns a bipolar patient who appealed the Consent and Capacity Board’s\textsuperscript{152} determination that he was incompetent to give or withhold consent to medical treatment. The Supreme Court of Canada allowed his appeal. The earlier discussion concerning emancipated minors and the assessment of their decisional capacity reflects the state of the current Canadian law and applies equally to mentally ill patients. The key point in \textit{Starson}, from the point of view of the Supreme Court, was that the Consent and Capacity Board appeared “…to be overly influenced by its conviction that the medication was in Professor Starson’s best interest.”\textsuperscript{153} Indeed, in Canadian discussions about access to assisted death by mentally ill patients, one has to remember that there is no standard of reasonableness or of best interest of the patient. On the contrary, \textit{Starson} represents a bold support of the principle of autonomy, which upholds the rights of patients to make decisions based on their personal values and beliefs.\textsuperscript{154}

\subsection*{4.2.3 Serious and incurable disorder}

This aspect of the medical condition of the candidate is more objective, therefore controllable. The seriousness and incurable dimension of the disorder is a condition that a competent physician will be able to assess quite objectively. In addition, as we have seen in

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\textsuperscript{149} Commission Fédérale de Contrôle et d’Évaluation de l’Euthanasie, \textit{Troisième rapport aux chambres législatives,} (Commission plénière, 20 mai 2008) [Belgium, \textit{third report}] (Indeed the European Institute of Bioethics refers to at least one case of irreducible depression that was endorsed by the Belgium Federal Commission of Control and Evaluation in its third report).

\textsuperscript{150} Carver, \textit{supra} note 148 at 414.

\textsuperscript{151} \textit{Starson v. Swayze, supra} note 109.

\textsuperscript{152} In Ontario, as per the \textit{Ontario Healthcare Consent Act, supra} note 127, it is the Consent and Capacity Board that is responsible to make decisions about patients’ capacity.

\textsuperscript{153} \textit{Starson v. Swayze, supra} note 109 at para 91.

\textsuperscript{154} Patricia Pepin, “Informed Consent” in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, \textit{Canadian Health Law and Policy}, 3\textsuperscript{rd} ed (Markham, ON: LexisNexis, 2007) at 206; Carver, \textit{supra} note148 at 418.
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chapter 3, this element needs to be corroborated by another physician, which adds another level of scrutiny.

The European Institute of Bioethics identified some concerns with the interpretation of the Belgian statute. As objective as serious and incurable disorder may sound, the Institute reports that the Federal Control and Assessment Commission is rendering a very liberal interpretation of the requirements. The report specifically refers to the serious and incurable character of the illness and voices concerns that over the years, pathologies due to old age such as arthritis, deafness or blindness have been considered serious enough to qualify for euthanasia requests. The European Institute of Bioethics considers the admission of these pathologies as a worrisome shift, since the legislation’s requirement were meant to be strict given the reservations expressed by the opposition in the Chamber of Representatives when the legislation was adopted.

Note here that there is no mention that the illness must be terminal, broadening the spectrum to many more disorders, including degenerative ones. Parliamentary proceedings show that the legislator chose to exclude that requirement from the regime, concluding it was impossible to define what “terminal” means. In exchange, the legislator imposed two extra conditions that non-terminally ill patients must meet. One is to that the diagnosis and prognosis must be validated by a third physician, a criterion examined above. The other is that one month must elapse between the request and the death, which will be discussed below. Griffiths and colleagues recognize that health practitioners cannot determine patients’ life expectancies in absolute certainty but they are not convinced that this is enough to leave out this condition. Deciding to put in place a policy restrictive to people who will die imminently is possible. The difficulty that remains is where to draw the line. Is it three months, three weeks or three days?

Closer to home, the Canadian Expert Panel would agree with the Belgian regime. The Panel recommends against restricting access to assisted death to terminally ill patients. It warns against potential Charter challenges since the term “terminal illness” is too vague. Terminal might mean that death will certainly occur from the illness but it could be years

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155 European Institute of Bioethics, 10 years of application, supra note 135 at 103.
156 Griffiths, Weyers & Adams, supra note 16 at 317 n 84.
157 Belgium Law on Euthanasia, supra note 23 at s3(3).
158 Griffiths, Weyers & Adams, supra note 16 at 317 n.84.
later. The Panel also warns against this model, contending that it is difficult or nearly impossible for physicians to give precise and accurate prognosis of death in terms of a specific length of time. It would also seem difficult to morally justify restricting access to assisted death to a suffering patient who has a prognosis of eight months and allowing access to one who has six months.

The legislator has not found a solution to the vagueness of the definition of imminent death. Instead it only moved the issue somewhere else. Adding the one-month wait requirement and another consultation for non-terminally ill patients still leaves physicians to decide which patients are subject to the additional requirements. How physicians should determine whether or not the death is imminent remains difficult to define. In the information brochure issued by the Commission to help physicians interpret the terms of the legislation, it is suggested that death should not be considered imminent if it is not expected to occur in the following months. It further mentions that only disorders that are non-progressive or with very slow progression should require the extra safeguards. If death is expected to occur in the following days, weeks or months, it can be considered to be imminent. The Federal Commission leaves a lot of freedom to physicians in this respect.

It is not clear what the legislator tried to do by imposing the waiting time on patients who do not face imminent death. If patients meet the requirements of unbearable suffering, how can we legally and ethically justify making them wait longer than other patients? I find this requirement to be against the bioethical principle of nonmaleficence. Perhaps the legislator thought that patients experiencing unbearable suffering could be influenced by their severe pain and imposing a cool-down period would serve to make sure their wishes were durable. Perhaps the legislator meant this delay as an additional protection in case people changed their minds. We have already argued that all kinds of influences will come into play in treatment decisions and physicians assessing capacity can tackle an acceptable level of influence. This is a good example

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159 Canada Expert Panel, supra note 69 at 72.
160 In Oregon for example, the right to assisted death is only to patients suffering from a terminal disease and having 6 months to live, see Oregon Death with Dignity Act, supra note 54 at s 2.01.
161 Canada Expert Panel, supra note 69 at 72.
162 Belgium fifth report, supra note 134 at 52-53 (Brochure à l’intention des médecins).
of how the different requirements work together and make sense as a whole. The fundamental principle of informed consent, operating along with other safeguards in the statute, respond adequately to risks of involuntary death caused by various influences. Trying to prevent patients from making the wrong decision under the influence of intense pain is legitimate. In this regard, the requirement of multiple discussions between the patient and their attending physician is necessary. Additionally, the consideration of all other treatment alternatives and clear prognosis as part of the informed consent requirement serve just as well the purpose of protecting individuals against ill-founded wishes. As far as the reliability of the request is concerned, it is ensured once again through the number of discussions the patient has with the physician. In conclusion, there is no need for an additional waiting period.

4.2.4 Due to illness or accident

The Belgium Law on Euthanasia also requires that the patient’s persistent and unbearable condition be due to illness or accident. This additional condition came about to ensure that euthanasia was open to people with real medical conditions, and not for those individuals with merely a state of mind to end their own life. In other words, it gave teeth to the concept of suffering. As harmless as these few words sounded at the time, they are central to a controversial emerging issue in Belgium; the case of people “tired of life”. In 2009, Amelie Van Esbeen, a 93-year-old woman went on a ten day hunger strike after being refused assistance to die because she did not meet the legal requirements of serious and incurable medical condition and unbearable suffering.\(^\text{164}\) In terms of jurisprudence, the widely publicized Brongersma case that took place in Belgium’s neighbour, the Netherlands. A perfectly healthy 86-year-old man requested euthanasia on grounds that his existence had become pointless and empty.\(^\text{165}\) The case provoked debate in Belgium about the application of their domestic euthanasia legislation to such cases. The Supreme Court of Holland held that unbearable suffering had to be linked to a


recognizable medical or psychiatric condition. Therefore, people tired of living were not meant to be included in the scope of the Belgium Law on Euthanasia. This landmark decision brought clarity to the potential of providing assisted death to people tired of life or in social and physical decline, such as the elderly. Even if this case law occurred in a different jurisdiction, it constitutes a significant reminder to use caution when assessing the law’s requirement and it gives meaning to the few words “due to illness or accident”. Belgium has the same legal requirement of suffering and as the legal landscape is defined with time, this decision can only serve to clarify the strict assessment physicians should make of suffering. The physical decline normally associated with aging should not be included in assisted death policy. Despite this important case law, in the Netherlands there are pressure groups advocating for people 70 years old and up to have the right to obtain assistance to end their life if they want to. This kind of end of life practice would be significantly remote from the initial intent of the law that aimed to eliminate suffering, based on compassion.\textsuperscript{166} It is therefore worthwhile to explicitly clarify this point in future policies.

Controversially, Griffiths and colleagues argue that the inclusion of this condition in the legislation is practically irrelevant, as they contend it will almost always be possible to discover some disorder that is connected with an elderly patient’s euthanasia’s request.\textsuperscript{167}

4.3 Unconscious patient

Section 4.1 of the Belgium Law on Euthanasia entitled “Advanced Directive” regulates the formal requirement imposed on the practice of euthanasia on unconscious patients.

\textit{Tout majeur ou mineur émancipé capable peut, pour le cas où il ne serait plus capable de manifester sa volonté, consigner par écrit, dans une déclaration, sa volonté qu’un médecin pratique une euthanasia si ce médecin constate:}

\begin{thebibliography}{99}
\bibitem{166}European Institute of Bioethics, \textit{supra} note 135 at 6.
\bibitem{167}Griffiths, Weyers & Adams, \textit{supra} note 16 at 318 n.87.
\end{thebibliography}
- qu’il est atteint d’une affection accidentelle ou pathologique grave et incurable;
- qu’il est inconscient;
- et que la situation est irreversible selon l’état actuel de la science.

In cases where one is no longer able to express one’s will, every legally competent person of age, or emancipated minor, may provide 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.\textsuperscript{168}

The first question that comes to mind when reflecting on advance directive is: when suffering is anticipated, who knows when it will actually occur?\textsuperscript{169} When a patient is unconscious how can we decide that he/she is experiencing the suffering required by law or even the suffering that was anticipated? But the legislation’s material requirements for current requests are not reiterated in the section about advance directives. Thus, the central requirement of unbearable suffering in a current request is no longer required. I presume this decision comes from the lack of scientific knowledge about the extent of suffering of unconscious patients, and the difficulty in applying the directive.

The only material element that is repeated from the current request requirement is the presence of a serious and incurable disorder. This is a “straight forward” objective criterion that can be assessed by a physician and does not pose any problem.

At first glance, the term “unconscious” patient does not seem controversial. But with further analysis and looking back at the last ten years of the legislation, it constitutes another part of the statute that deserves some clarification. In its literal sense, one might think the legislator intended “irreversible unconsciousness” to include patients in a persistent vegetative state (PVS).\textsuperscript{170} This is the way it has been applied in Belgium. The Belgium Federal Commission

\textsuperscript{168} Belgium Law on Euthanasia, supra note 23 s 4.1. [Translated by author].
\textsuperscript{169} Shariff, “Slippery Slope”, supra note 44 at 11.
\textsuperscript{170} Adams & Nys, supra note 32 at 370.
reports that physicians interpret the notion of irreversible unconsciousness in a strict way, i.e. patients in a coma. ¹⁷¹ Some members of the Commission believe that the definition could be interpreted in a less restrictive way but there is no official position on the matter, which implies that at the moment, the Commission accepts the strict interpretation of physicians. Raphael Cohen-Almagor raises some concern about the speediness to determine whether a patient’s unconsciousness is irreversible. He recommends the adoption of a policy that includes a two year waiting period for patients who are less than fifty years old and for whom the unconsciousness was caused by trauma. Cohen-Almagor’s fear is that treatment is withdrawn prematurely when consciousness could be regained. ¹⁷² There is some merit to the idea of imposing a certain delay for unconscious patients in case medical progress or nature surpasses expectations. However, waiting for the possibility that the patient regains consciousness might not be everyone’s wish and the policy should recognize that option. For example, a person may have written advance directives indicating that if he/she regained consciousness after having lost it but that his/her cognitive abilities are impaired, he/she does want to live that life. When comatose patients regain consciousness, it is unclear what mental capacity they will hold. If they regain consciousness but are not deemed to have decisional capacity, they would not fall within the scope of the Belgium Law on Euthanasia. But it remains that their prior wishes may have been to die in such circumstances. The value of compassion does not play to the same extent than for competent patients because of the difficulty with assessing their suffering. The main purpose of advanced directives is to protect a patient’s autonomy and allow the patient to determine what they feel would be in his/her best interest.

This is a clear example of why I suggest that the Belgium Law on Euthanasia should not have divided patients into categories of conscious or unconscious but rather into competent or incompetent with advance directives. Including incapacitated patients is more liberal in that it includes unconscious patients but the reverse is not true. I am of the opinion that the current Belgian statute is too restrictive with regard to advanced directive. Many people associate losing their capacity to a loss of dignity and their right of self-determination. I think the State should make a point to respect individual freedom of choice until the end, including those who have the misfortune at some point in their life to be robbed of their capacity. Of course, I do not refer to

¹⁷¹ Belgium, fifth report, supra note 134 at 25.
¹⁷² Cohen-Almagor, supra note 78 at 206-207.
incompetent patients who were never competent, as in such cases there are no prior wishes or directives to rely on. The euthanasia of such individuals would not be voluntary and as mentioned before, my suggested policy aims at permitting voluntary assisted death only. I support a policy that respects prior wishes through advanced directives for when people become incompetent on the same terms as when they become unconscious as per the Belgium Law on Euthanasia. Obviously, the requirement of suffering would no longer be mandatory because of the difficulty assessing incompetent patients but other grounds would stand.

The Belgian legislator wanted patient’s wishes to be somewhat current by limiting the validity of the advance directive to five years. However, as raised by Adams and Nys, the euthanasia statute was poorly written in this regard.\textsuperscript{173} The terms used state that the directive will be valid only “if it has been written or confirmed less than five years before the beginning of the person’s incapacity to express her wish.”\textsuperscript{174} More appropriate and verifiable language would have been to limit the validity of the advance request to a five-year period.\textsuperscript{175} In practice, it would be very difficult to determine the exact moment when the person lost the ability to express his/her wishes. I believe it is important to define a life span for an advance directive. It reinforces the voluntary character of the request. An amendment proposal was submitted to the Senate of Belgium on May 9\textsuperscript{th}, 2012 prolonging the validity of the advance directive indefinitely. The argument in favour of such a change is that dementia patients live on average seven years after being diagnosed but this many vary between 2-25 years of life expectancy. In this range, there is considerable variance for when a patient with dementia become incompetent. Therefore the five years life of the request is most likely inadequate to cover all patients with dementia. I am concerned that an advanced directive that never expires may become out-dated and end up not reflecting the patient’s wish any longer, creating a risk of involuntary euthanasia. I recommend using the average seven-year life expectancy of people with dementia as a reasonable alternative. In other cases of incapacitated patients, there is presently no data to justify extending the life of an advanced request. Alternatively, as suggested by the Expert panel,

\textsuperscript{173} Adams & Nys, \textit{supra} note 32 at 364.
\textsuperscript{174} Belgium Law on Euthanasia, \textit{supra} note 23 s 4 (1) [translated by the author].
\textsuperscript{175} Adams & Nys, \textit{supra} note 32 at 364.
advance directives could be handled in accordance with each province’s legal provisions on the matter.  

Shortly after the legislation was enacted, questions emerged about its applicability to elders with dementia. For instance, does serious dementia constitute an irreversibly unconscious situation given that the patients no longer possess any real powers of awareness? This seems to be a bit of a stretch. The practice we know and the liberal interpretation of the law from the Commission show the situation is still cloudy. Even today, dying assistance for people suffering from dementia is a hot topic. On May 9th, 2012, the Senate received a proposal to amend the Belgium Law on Euthanasia, which will be discussed later in this paper. In brief, the proposal aims to widen the application of the law to incompetent people suffering either from dementia or serious and irreversible harm to cerebral functions. The defenders of this proposal mention that the current Belgian legislation does not cover these types of patients. Interestingly, the Federal Commission has endorsed assisted suicide in cases of Alzheimer in the past. Indeed, neuro-psychological illnesses represent a distinct category of diagnoses in the Commission’s biannual reports and constituted 3% of the total number of euthanized patients in 2010-2011. It reveals that some of these cases were patients with dementia. The European Institute of Bioethics raises some questions when noting this expansion of the law. They suggest that we must not drift too far from the initial discussions that occurred when preparing the Bill. At the time, the Committee on Public Health was mandated to give its recommendations about the Bill to the Chamber of Representatives and were unanimously against opening the scope of the legislation to patients affected by depression, Alzheimer disease or dementia. But the proposal was rejected. It is questionable whether the legislator rejected the proposal because it had simply

176 Canada Expert Panel, supra note 69 at 67 (Most Canadian provinces have provisions in place dealing with advance directives in health care and it is recommended that the ones that do not, adopt necessary legislations. To elaborate on the type of legislation different provinces have would falls outside the scope of this paper).
177 Adams & Nys, supra note 32 at 370.
179 Belgium, fifth report, supra note 134 at 8. (for a total of 58 persons).
180 The European Institute of Bioethics, 10 years of application, supra note103 (the Institute refers to Belgium third report, supra note 117 that deemed acceptable euthanasia practiced on two persons suffering from Alzheimer, one person suffering from irreducible depression, one person suffering from psychosis and four persons suffering from Huntington’s disease).
181 Griffiths, Weyers & Adams, supra note 16 at 290; Belgium, Chamber of Representatives, Parliamentary proceedings, 2001-2 Sess, No 50 1488/005 (1 March 2002) at 9.
decided to expedite the adoption of the legislation and reject any amendment proposal, or if it rejected the Committee’s proposal because it clearly intended to leave the door open to psychiatric patients. One thing is clear, the legislator must clarify its intentions. For issues of this importance, it is not sufficient that the Federal Commission be the sole interpreter. Let us hope that current and future amendment proposals will achieve more clarity. There is much to learn and consider from this experience for future policy enactment.

A particular challenge with patients with dementia is that they suffer from progressive cognitive impairment. They may move in and out of the ability to make autonomous choices. If they were able to pass the test of decisional capacity, would these patients qualify as experiencing unbearable suffering? Cohen-Almagor does not think so. Stockman believes that suffering is certainly present at the early stage, when the patient has moments of awareness and sees his or herself deteriorating. But it is unclear how much knowledge is retained by these patients when they reach a stage of complete unawareness. Cohen-Amalgor argues that people with dementia should be excluded from euthanasia. Informed by the Dutch Alzheimer foundation, he deems patients with dementia incapable of make an informed request. Yet, they cannot be considered as unconscious, which means we have to deny them access to euthanasia. A better solution would be to allow people with dementia to protect their wishes at the early stage of their illness for when they become incompetent. That can be achieved by changing the application and scope of the advanced directive provisions to incapacitated patients instead of restricting it to unconscious patients. The need to determine whether or not patients with dementia are suffering would become irrelevant.

This is a very complex issue and the Belgian legislator should clarify its position one way or the other. The Federal Commission took a surprising position when it decided to endorse euthanasia for some patients with dementia under the category of conscious patients. The conclusion it reached (after much debate and not unanimously) was that in some cases of incurable and progressive diseases, the future dramatic development can be deemed as

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182 Ibid.
183 See discussion about decisional capacity determination in Canada in Chapter 3 (mental suffering).
184 Cohen-Almagor, supra note 78 at 208.
186 Cohen-Almagor, supra note 78 at 208.
unbearable mental suffering that cannot be appeased.\textsuperscript{187} Granted, this may potentially force patients with dementia to use euthanasia prematurely, i.e., before the \textit{dramatic development}. Otherwise, the Federal Commission is almost admitting its endorsement of future sufferings, which is a topic that is not covered at all in the statute. If doing so, the Federal Commission is adopting an interpretation that is more than liberal, and it stretches the law outside of its scope. It took the liberty to interpret what the legislation had not intended: the case of incompetent people and anticipated sufferings.

Taking a different approach, the May 2012 Senate proposal deems the inclusion of patients with dementia should by allowed through a modification of section 4 concerning unconscious people. Thus advance directive would widen its applicability not only to unconscious patients but patients who “are no longer conscious of their own person, their mental and physical state and of their social and physical environment.”\textsuperscript{188} This construct could end any discussion about whether patients with dementia meet the requirement of suffering or not and cover other types of degenerative mental illness. It also keeps away any possibility of practicing euthanasia on mentally ill people who never held decisional capacity.

What does the Belgium policy have to offer to patients with dementia? If they are diagnosed at a stage early enough to possess decisional capacity, they could potentially find physicians who would agree that they are experiencing unbearable suffering that cannot be appeased on the argument that the prospect of losing their mind is the worst thing that can happen to them. This seems to reflect the case in Belgium until now. But as I mentioned, I am concerned that such patients would have to end their life before they truly intend to. I strongly recommend that jurisdictions such as Canada, where hundreds of thousands of people are diagnosed with dementia each year,\textsuperscript{189} discuss the specifics of this type of illness. It is important to clarify that the autonomy of patients with dementia can still be respected as they are considered within the scope of the \textit{Belgium Law on Euthanasia} even after they become incompetent provided they have adequate advanced directives. I am not offering an opinion here

\textsuperscript{187} Belgium, \textit{third report, supra} note 149 at 24.
\textsuperscript{188} Belgium, Senate, \textit{Parliamentary proceedings}, 2007-8 Sess, No 4-676/1 (8 April 2008) (“Qu’il n’a plus conscience de sa propre personne, de son état mental et physique et de son environnement social et physique” [translated by the author]).
about assisted death towards incompetent patients without advanced directives, as such cases would be considered involuntary procedures and thus fall outside the definition proposed at the outset.

The flip side to provisions of advanced directive is that it is very difficult to ascertain that the prior wishes are still valid. Once we move away from relying on the patients themselves for answers about the treatment they wish to receive or reject, there is a risk that the wishes expressed in an advanced directive no longer corresponds with the actual wishes of the person once they have lost capacity. These patients are unable to tell us. What if a person shows signs of happiness at a late stage of dementia but has clear advanced directives to end her life when she would no longer have competence? This is a heart-breaking and terrible but realistic situation. However, I would argue that it would be the exact same heartbreaking and terrible situation if someone had to decide on withholding or withdrawing treatment for that same person, in which case we would be legally bound to put in motion the advanced directive. Whether it is to execute prior wishes of lethal injection or removal of the feeding tube of a dementia patient that seems happy, we are faced with the same degree of uncertainty about what the patient would choose if she were competent and aware of her situation.

Another consideration on advanced directives was proposed by the British Nuffield Council on Bioethics, which produced a comprehensive paper on how to address many issues of patients with dementia, including palliative care and end of life decision-making. They present a concept of autonomy that is richer than the individual autonomy we usually describe in bioethics that is based on personal interactions and values. The Council suggests that a richer concept of autonomy will apply better to patients with dementia and that this may help a person with even quite severe cognitive impairment make choices that reflect their values and wishes.

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191 For a credible reference in terms of bioethical principles including autonomy, see Beauchamp & Childress, supra note 163.
This is rooted in the philosophy of person-centred care that is also recommended by the Alzheimer Society of Canada.193

The issue of dementia is one that concerns not only assisted death but includes the whole sphere of end of life care. It would be beneficial to consider guidelines in this area to a much broader extent than possible in this paper.

In this chapter, we’ve analysed the different elements that qualify who should have access to assisted death. The state of health of the rightful candidate to assisted death requires clarity. Establishing clear lines about who can seek assisted death will be part of the answer to potential risks of a slippery slope. The *Belgium law on Euthanasia* covers the essential safeguards that I deem important. In sum, the patient should be carefully assessed and deemed competent; the patient should be in a situation of irrevocable physical or mental suffering; the suffering should originate from a serious medical disorder; and an exception must be made for incompetent patients when they have expressed prior wishes in writing. Future policy and regulation discussions must seek as much clarity as possible in the definition of the access criterions. What is clear is that slotting the patient in one of two categories, conscious or unconscious, as Belgium did was not advisable. A more encompassing division would be competent and non-competent patients, which automatically includes the non-conscious patients. It may then be easier to discuss and include people suffering from dementia and other progressive mental illnesses.

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Chapter 5
The Control Mechanism

The control of a regulated policy of assisted death is in my opinion one of the most fundamental elements for its success. It is required to avoid potential abuses and non-voluntary euthanasia. Control can be *a priori* and/or *a posteriori*. This chapter will discuss the situation in Belgium and implications for future Canadian policy.

5.1 *A priori* Control

The safeguards included in the law dealing with all the events taking place before access to assisted death constitute *a priori* control. Allowing only physicians as providers and regulating their qualifications, limiting euthanasia to exceptional circumstances and certain categories of patient all contribute to control the policy of assisted death. I will not reiterate what has already been discussed in previous chapters about the conditions imposed on the patient and the provider. I will share a few comments about the situation in Belgium and suggestions for future policies.

A study in Belgium demonstrated that a significant number of physicians practicing euthanasia consulted with more than the one physician the law requires.\(^{194}\) I take this as a very good sign. It shows the professionalism and seriousness with which physician address requests for assisted death. In some ways, they self-impose extra control *a priori* which is reassuring.

Another aspect that I consider part of Belgian control *a priori* is the creation of the Forum for End-of-Life Information (LEIF).\(^{195}\) This program was created in 2003 in Dutch-speaking Belgium as a service of specialised consultants for physicians exposed to end of life issues, not

\(^{194}\) Tinne Smets et al “Legal Euthanasia in Belgium Characteristics of All Reported Euthanasia Cases” (2009) 47:12 Med Care 187.
\(^{195}\) Levens Eind Informatie Forum, online: LEIF <http://www.leif.be/nl>.
limited to but including euthanasia requests.\textsuperscript{196} It offers training, information and advice to help prevent legal misinterpretations even before the fact. In Belgium, some attending physicians have turned to LEIF for various end-of-life issues including finding an appropriate consultant physician as required by law in cases of euthanasia.\textsuperscript{197} Although funded by the government, LEIF is voluntary and has no legal standing. Unfortunately, there is very little data available about the contribution of this program.\textsuperscript{198} More research is required to provide insight about the quality of the consultations.\textsuperscript{199} However, this type of resource centre would be beneficial to Canada or any other jurisdiction considering physician-assisted death regulation. It could constitute an important early quality control, especially during the first steps of a new policy, before all physicians receive adequate training and the practice becomes properly established. It would also provide a network of support for physicians dealing with euthanasia, a place of exchange where they would feel less alone. Such a team of healthcare practitioners possessing expertise in palliative care might allow cohabitation of palliative care and a policy of assisted death. A central consultant service such as LEIF has a distinct advantage of accessibility and chances are that consultants available would have rich experience and expertise to share with attending physicians. The disadvantage is the risk that attending physicians always refer to the same consultant and consequently erode the independence required by law.\textsuperscript{200} In sum, more thought must be given to the legal implications of such a consultation program, how it should be regulated and the place it should occupy in the overall practice of assisted death. I believe it would be important to create such an organisation with legal parameters and set goals and mission; this is a version of mentorship that could certainly be useful to implement a cultural change in the medical profession.

Belgium’s \textit{a priori} control is not flawless and the following issues raise serious concern. The act clearly states that the consulted physician should examine the patient in person.\textsuperscript{201} However, physicians have testified that in some instances, consultations were conducted by phone.\textsuperscript{202} Another requirement is that the patient’s request must be in writing. One study

\begin{footnotesize}
\textsuperscript{196} Yanna Van Wesemael et al, “Role and involvement of Life End Information forum Physicians in euthanasia and Other End-of-Life Care Decisions in Flanders, Belgium” (2009) 44:6 Health Serv Res. 2180.
\textsuperscript{197} \textit{Ibid.}
\textsuperscript{198} Griffiths, Weyers & Adams, \textit{supra} note 16 at 321-322.
\textsuperscript{199} Van Wesemael et al, \textit{supra} note 196.
\textsuperscript{200} \textit{Ibid.}
\textsuperscript{201} \textit{Belgium Law on Euthanasia, supra} note 15 at s 3(2)(3).
\textsuperscript{202} Cohen-Almagor, \textit{supra} note 78 at 203.
\end{footnotesize}
indicates that Flemish physicians frequently disregard this condition. Finally, the medications required to perform euthanasia were more often administered by nurses, while the provider is clearly supposed to be a physician. As much as physician-patient relationship is based on trust and is important, I believe the success of a regime will intimately depend on the quality of the control and the strict respect of the rules that have been adopted, especially when we deal with life and death.

5.2 A Posteriori Control

Let us now discuss what constitutes control a posteriori. This type of control happens after the act of euthanasia. The serious limitation with control a posteriori is that there is no going back. Redress can only be ad futurum. Part of the control a posteriori in Belgium is the obligation for physicians to report each individual case by completing and filing a specific form provided by the oversight body within four days of the act. The oversight body in Belgium is called the Federal Control and Evaluation Commission, to which I have already referred at length in this paper and which exercises most of the control and evaluation. It is composed of 16 members including eight physicians, four lawyers and four members involved in issues of patients with incurable illnesses. Its composition is therefore multidisciplinary and includes representatives of the different linguistic groups and religious perspectives. This independent entity reviews each case individually to evaluate if the death by euthanasia as reported to them meets the requirements for due care. The creation of such a committee takes away the full control previously held by the public prosecutor and concedes to professional and social assessment first. It creates a filter between the physician and the criminal judicial system with the purpose of encouraging physicians to report their practices of euthanasia with more ease.

\[^{203}\text{Ibid} \text{ at 205.}\]
\[^{204}\text{Pereira, supra } \text{note 40 at 2.}\]
\[^{205}\text{Belgium Law on Euthanasia, supra } \text{note 23 at ss. 5 and 7.}\]
\[^{206}\text{Canada Expert Panel, supra } \text{note 69 at 61.}\]
An alternative would be to leave the control to the regulators of the profession itself, such as Colleges of Physicians. Leaving oversight responsibility to the profession might be more attractive to physicians and make them feel comfortable to report. But my view is that such an internal mechanism would not reinforce a strong message of due diligence the practice deserves and the fact that assisted death should remain a case of exception. The margin is too wide going from a criminal code prohibition to only a professional offense. Furthermore, being evaluated by a multidisciplinary group provides different perspectives and is expected to open the communications channels for improvement of the practice of euthanasia.\textsuperscript{207} It is more representative of the society than only members of a professional order.

In Belgium, the Federal Commission has two months to make its determination on cases in compliance with the law. Before rendering its decision, the Federal Commission has the power to investigate and/or request more information from the submitting physician. If a case is not approved by at least two-thirds of the Commission members, it must be referred to the state prosecutor for further investigation.\textsuperscript{208} The Federal Commission is required to publish reports every two years that includes:

- A statistical summary of the information from the second part of the completed registration forms submitted by physicians pursuant to article 8;
- A description and evaluation of the implementation of the law;
- If appropriate, recommendations that could lead to new legislation or other measures concerning the implementation of the law.\textsuperscript{209}

In Belgium, the Federal Commission is centralized and there is only one Commission for the entire country. I would suggest that a country as large and diverse as Canada to create regional or provincial commissions.\textsuperscript{210} Simply considering processing time, administering to a

\begin{footnotes}
\item[207] Griffiths, Weyers & Adams, \textit{supra} note 16 at 324.
\item[208] Cohen-Almagor, \textit{supra} note 78 at 195.
\item[209] \textit{Belgium Law on Euthanasia}, \textit{supra} note 21 s 9 [Translated by Griffiths, Weyers & Adams, \textit{supra} note 16 at 326].
\item[210] Canada has a population of 35 millions people as opposed to Belgium’s 11 million. The land area in square kilometer is 8 965 121 for Canada and 30 528 for Belgium.
\end{footnotes}
population of 35 million people as in Canada is very different from administering to 11 million in Belgium. The geographic surface is also distinctly larger in Canada. These commissions must be accessible, provide feed-back and gain the trust of both the public and the medical community. The number of Commissions and commissioners should be prorated with the population but also thought of in accordance with the territory they will have to service.

Strict deadlines and timely determinations by the control body are required to improve efficiency and avoid legal uncertainties. Anything longer than the two months required in Belgium would be problematic. The older the cases to be reviewed, the greater the chance that events and details will be forgotten or misremembered. It is imperative that accurate and precise information regarding specific euthanasia cases is available. In addition, delays in the commission finding and reporting errors increases the chances of physicians repeating errors. Harm must be avoided as much as possible; the sooner after the death the determination is made, the better. I share the opinion of Smets et al that systematic feedback is required to exercise ideal control.\textsuperscript{212}

The constitution of the control body is important. The European Institute of Bioethics (EIB) has attacked the present Belgian Federal Commission, on the basis that close to half its members are also members of the Association pour le Droit de Mourir dans la Dignité, an advocacy group for euthanasia and the widening of the Act.\textsuperscript{213} Despite the initiative of the legislator in adopting detailed provisions to ensure the pluralistic character of the Federal Commission, the EIB is worried about the lack of neutrality of its representatives. In my view, the monitoring body is critical to gain and retain public trust in the system. Careful consideration should be invested in the creation of an impartial and neutral commission.

The Belgium Federal Commission took its first step on a difficult note. The case of Mario Verstraete, the first Belgian to use the Belgium Law on Euthanasia of 2002, was controversial. The 39-year-old man was afflicted with multiple sclerosis but was not in the final stages of a terminal illness. This is probably the most liberal and contested area of the legislation. Mr.

\textsuperscript{211}Statistics Canada, \textit{Canada Population Clock}, (Ottawa: StatCan, online: Statistics Canada) \texttt{<http://www.statcan.gc.ca>} (The last official public census was published in 2011 and reported a population of 33 676 388 citizens).

\textsuperscript{212} Tinne Smets et al, “The Medical practice of euthanasia in Belgium and the Netherlands; legal notification, control, and evaluation procedures” (2009) 90 Health Policy at 181.

\textsuperscript{213} Association for the Right to Die in Dignity [Translated by the EIB].
Verstaete received a lethal injection seven days after the introduction of the *Belgium Law on Euthanasia* despite the section 3 paragraph 3 requirement to let one month elapse between the request and the euthanasia. The case obviously attracted a lot of media attention and caused anger amongst opponents to the new regime. The focus was on the Federal Commission, which decided to not intervene or send the file to the public prosecutor. This is a difficult example because Mr. Verstaete qualified in many respect. He was not a victim of abuse; he had expressed his wish to die many times in the past, even publicly and was clearly suffering. Technically he was a “good candidate”. But the fact remains that the law was breached and the guideline to wait one month was interpreted very loosely.\(^2\) This was enough to damage the faith of some people in the system.

The trust of the public includes the trust of the medical community, which brings me to the importance of reporting. In order to exercise true societal control over assisted death and ensure high practice standards, it is necessary that all cases be reported.\(^3\) Reporting tendencies will be directly related to the way physicians feel about the control body. For them to feel comfortable reporting cases of euthanasia or even cases of grey zones, the oversight entity has to be transparent. For this reason the legislator must determine the constitution, authority and objectives of the control body in very clear terms. It must be accessible, meaning if it is too onerous or the reporting requirements become a procedural nightmare, physicians will understandably avoid reporting in order to dedicate their precious time elsewhere. This may well be what is happening now in Belgium for non-reported cases and in other countries like Canada where we know assisted death is happening.

Reporting is crucial to any control exercise. Indeed we cannot control what we are not aware of. Professor Keown who testified as an expert witness in the *Carter* trial is of the opinion that relying on physician self-reporting makes the control ineffective and therefore a useless safeguard.\(^4\) Smets and colleagues estimate the rate of reporting of euthanasia cases to the Federal Commission in Flanders (Dutch region of Belgium) at 52.8%.\(^5\) It is very difficult to have data on what is not reported so the study comes with obvious limitations. But if the

\(^2\) Cohen-Almagor, *supra* note 78 at 208.


\(^4\) *Carter*, *supra* note 3 at para 374.

\(^5\) *Tinne Smets et al*, *supra* note 215.
researchers estimation is correct, it is unfortunate that only about half of the cases are actually under some form of control. Another conclusion from the study that may be worrisome is that unreported cases were not handled in the same rigorous manner as the reported ones. The reasons given for the majority of non-reported cases, was that the attending physicians did not consider their actions to qualify as euthanasia. The same study “indicates that physicians who perceive their case to constitute euthanasia report 93.1% of the time.” Belgium is therefore faced with an issue of misunderstanding in contrast with an issue of reporting. It is of concern that confusion exists amongst physicians even at the level of the definition per se of euthanasia. It leads me to emphasize the conclusions of Smets and colleagues that legislation does not suffice. There is a need for training, terms clarification, and assistance for physicians who have to work with new legislation, hence the importance of reporting in order to adjust what needs to be adjusted. Consider also the interpretation of the researchers that the low reporting rate of Flanders cases of euthanasia could be partly explained by the fact that the statute is fairly recent and that physicians are slowly adapting to the new practice and its requirements (in contrast with the Netherlands whose practice is much older and reporting rate higher). We cannot totally control what happens outside of the legal scope there is always a risk that unlawful assisted death happens and is just not reported. This would be exactly the same as what may be happening now within a blanket prohibition. As small as the reporting rate may be, it will be better than our current zero percent. Liberalizing the practice will only gradually encourage practitioners to come forward and report, helping to protect against potential risks.

I would like to briefly discuss sanctions as another means of control. The power of dissuasion can be strong. One similarity between Belgium and Canada is that euthanasia is not described as a specific offense in the Criminal Code. This leaves much uncertainty as to how offenders would be charged. Prior to the Belgium Law on Euthanasia it was not clear in Belgium whether someone who committed euthanasia would be subject to charges of manslaughter, murder or something else. Canada shares this legal uncertainty and historically

218 Ibid (for a detailed analysis of other reasons invoked for non-reporting).
219 Carter, supra note 3 para 659.
220 Tinne Smets et al, supra note 215.
221 Ibid at 5.
charges have ranged from administering a noxious substance, to manslaughter, to murder.\footnote{Library of Parliament, Legal and Legislative affairs Division, Parliamentary Information and Research Service, \textit{Euthanasia and Assisted-suicide in Canada: Background paper}, by Julia Nicol, Marlisa Tiedemann &Dominique Valiquet, Publication No. 2010-68-E3 (Ottawa: Library of Parliament, 2010) at 4.} Surprisingly in Belgium, it is still not clear what offenders are up against. The \textit{Criminal Code} is unchanged and the \textit{Belgium Law on Euthanasia} does not specify what offense, if any, is committed by a physician who fails to comply with the norms and procedures established by the law.\footnote{Griffiths, Weyers & Adams, \textit{supra} note 16 at 327.} This uncertain situation alone is enough to discourage physicians to report cases. In addition, two legal problems arise from the lack of offense characterization. First, the infringement of the fundamental principle of legality in criminal law (\textit{Nullum crimen sine lege nulla poena sine lege}) according to which the legislative power has to enact and provide clear rules to the judiciary power.\footnote{Belgium, Senate, \textit{Parliamentary proceedings}, 2000-1 Sess, No 2-244/21 (2 July 2001).} In response, judges render decisions without arbitrariness and according to the exact terms of the legislation. The principle of the legality is also part of Canadian common law. To promote obedience of the law, it must be available, predictable and straightforward. Future regulations on assisted death will have to obey to this principle.

The second principle flagrantly ignored by the \textit{Belgium Law on Euthanasia} is proportionality.\footnote{Griffiths, Weyers & Adams, \textit{supra} note 16 at 327.} According to this principle, the legislator failed to differentiate the law’s essential conditions from the formalities required. This omission leaves room for arbitrary convictions. A physician who fails to fulfil a material formality of the law such as inadequately reporting a case of euthanasia should not face the same charges as another physician who performs euthanasia without informed consent from the patient. The difference should be made clear for citizens and judges. It is a recognized a principle in Canada that sentences cannot be grossly disproportionate to the seriousness of the offense. Again, Canada or any other jurisdiction enacting assisted death regimes should learn from this major legal \textit{faux pas} made by Belgium.
Chapter 6
Palliative Care

When discussions around assisted death arise, discussions around palliative care are not far behind. The aim of palliative care is to prevent and relieve suffering due to pain and other suffering, physical, psychosocial and spiritual.\(^{226}\) Palliative care is analytically connected to assisted death.\(^{227}\) There is concern that establishing a quick, painless death as a state-sanctioned option would also mean that society in general would become less committed to creating ways for patients to live longer and better. Even if the palliative care situation in Belgium seemed quite favourable before 2002, people were concerned. Some defenders of palliative care were in disfavour of assisted death since palliation seemed contrary to euthanasia.\(^{228}\) They argued that opening the door to assisted death was the beginning of the end of palliative care. They believed resources would start dropping (research, funding, etc.). Those concerns were wisely addressed in part on June 14\(^{th}\) 2002, almost simultaneously with the Belgium Law on Euthanasia, with the adoption of the Belgium Law on Palliative Care.\(^{229}\) Indeed, Belgium adopted a law that expressly recognizes a right to palliative care.\(^{230}\)

In Canada as well it is argued that there is an inevitable link between the lack of good palliative care and people’s desire to hasten death, compromising the true meaning of informed consent.\(^{231}\) There is assumption that, until every Canadian has the option to alleviate their suffering through palliative care, choosing death does not represent a meaningful choice.\(^{232}\) I cannot ignore that some patients’ choices at the end of life may be different if they had more treatment options or support offered to them. It has been established in Carter that “adequate palliative care can reduce requests for euthanasia or lead to their retraction.”\(^{233}\) Therefore, I

\(^{226}\) Sumner, supra note 13 at 48.
\(^{227}\) Ibid at 200-201.
\(^{228}\) Cohen-Almagor, supra note 78 at 193.
\(^{230}\) Ibid s 2.
\(^{232}\) Shariff, “The dying”, ibid at 7.
\(^{233}\) Carter, supra note 3 at para 189.
recognize that access to palliative care should be used as an additional safeguard to ensure voluntary assisted death. However, palliative care is not to be confused as a replacement of assisted death when the wish is authentic. Once again, there is a double standard in the argument that people want assisted death because they are deprived of good palliative care. The same argument might be made using poverty. Until no one lives in poverty in Canada, patients should not have access to assisted death to which they might resort for lack of better life outside poverty. In an ideal world, as we discussed earlier, the patient’s decision would be devoid of all external pressures and influences but unfortunately, life is not so. The patient’s right to refuse life-sustaining treatment is already an accepted concept in Canada and goes the same way. We are comfortable with letting people refuse life-sustaining treatments without regard to their access to palliative care services. So why would we be scrupulous by a different standard when it comes to assisted death?

I will admit that the Canadian experience with death is not at its best. I believe palliative care is the best thing that ever happened to the dying and according to Senator Carstairs report, our nation needs a nationwide palliative care strategy to improve the availability and the quality of palliative care in Canada. Indeed, Dr. Gallagher presented evidence that “unfortunately only 16-30% receive palliative care as part of their life threatening illnesses. […] There are many places in Canada, particularly in rural or remote areas, where there is little or no access to palliative care specialist nurses or physicians.” In my view, access to assisted death rolled in palliative care would serve as part of improving the spectrum of patient’s end of life care. Palliative care is dedicated to offer personalized care for each patient. It is all about respecting a patient’s wishes and preserving his or her dignity. The experience in Belgium and some studies show that regulating of assisted death is not antagonistic but complementary and synergistic with palliative care. Indeed, the Belgium debate on euthanasia made clear that palliative care supporters and assisted death advocates often shared the same values. Of

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234 Canada, the Senate of Canada, Raising the bar: A Roadmap for the future of Palliative care in Canada. (Ottawa: Library of Parliament, 2010) (Chair: Sharon Carstairs) [Carstair’s Report].
235 Carter, supra note 3 at para 192.
238 Ibid.
course some palliative care physicians can hold their personal views against euthanasia. But according to Dr. Ashby, a specialist and professor of palliative and pain medicine in Australia:

“The legalisation of euthanasia has enhanced as opposed to undermined, palliative care. Euthanasia is (in Belgium) an integral component of palliative care. In my opinion, the Belgian law is, in practice being complied with in terms of limiting the availability of euthanasia to persons meeting the qualification under the Act and is effectively protecting the vulnerable in the context of a permissive regime than was the case under the previous repressive regime. [...] Concerns of the “slippery slope” were understandable and legitimate but they have been assuage by the empirical evidence, and – if anything – Belgium has climbed up the “slippery slope” since the legalization and regulation of euthanasia.”

Belgium has one of the best palliative care system developed in western societies and has sustained it over the ten years in parallel with euthanasia legalization. There is no doubt that if the Canadian government was committed to improving palliative care services like the Belgium legislator by adopting a statute for palliative care, it would provide additional reassurance to the public and reduce the risk some invoke of non-voluntary assisted death. Indeed, as I mentioned earlier, I strongly support the way Belgium adopted a statute about palliative care in conjunction with opening access to assisted death. Making both complementary instead of adversary is the way forward in my opinion whether it is through law or by the development of a serious Canadian palliative care strategy as proposed by the Carstairs report. Assisted death brings to palliative care what it is presently missing to allow the discipline to come full circle. Patients have the full potential to express their autonomy through the dying process. Palliative care brings to assisted death the compassionate lens it deserves by offering the last resort option that exists.

Another way to add safeguard using palliative care is the implementation of a “palliative filter” in the legislation. Palliative care has a multidisciplinary character (it usually involves physicians, nurses, social workers, psychologists, etc.). Imposing a consultation with a

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239 Carter, supra note 3 at para 584.
241 Carstairs report, supra note 234.
specialised palliative care team has the advantage of keeping multiple caregivers involved to informed and address the multiple dimensions of the patient’s condition. In my opinion this constitutes an excellent safeguard. It responds to the context that is proposed by the Quebec’s Commission, one of care and compassion. It was strongly recommended to Belgium to include a palliative filter procedure in its Bill. But it was not retained, probably for the same reasons as all other amendments: any amendment proposal was rejected in order to speed up the adoption process. However, nothing prevents medical institutions from imposing additional procedural conditions such as an obligatory palliative team consultation, which is what some did.

242 Belgium, Chamber of Representatives, Parliamentary proceedings, 2001-2 Sess, No 50-1488/9 (23 April 2002).
Conclusion

I suggested in my introduction that regulating assisted death was a complex task. It is a real challenge to trace a clear line of conduct. Ideally, a good policy will age well, evolve with medical science improvement and be adaptable to every unique case without anyone falling between the cracks. If this is true for good legislation in general, it is even more important for laws regulating dying matters for when errors are made it is at the ultimate price. However, mistakes are possible.

Fear of abuse is legitimate. But fear alone must not keep us from moving forward. I think proponents and opponents of a permissive regime of assisted death would benefit a great deal from regulation of its practice. The status quo does not reflect the needs of the population or the current reality. We know that prohibition in Canada does not stop euthanasia from happening. That means that physicians sometimes end patients’ lives on their own terms without guarantee that they act after an honest discussion with the patient and after consultation with other physicians. This thesis hopes to add to the abundant and growing body of literature in favour of regulated assisted death in Canada. Inspired by the Belgium regime, this thesis has attempted to layout a model that may help put in place a regulatory policy based on our values of autonomy and compassion. Every day, too many people die in ways that offend their dignity and experience suffering that is unnecessary at a time where everybody deserve peace before the “long voyage”. With serious and substantial safeguards, the fears of can be addressed, allowing the law to develop in parallel with the experience of the new area of practice. This thesis is in line with the conclusions reached by Justice Smith in Carter to the effect that “risks can be avoided through carefully designed, well-monitored safeguards.” 244 Moreover, going from prohibition that is clearly imposing one side’s view on the other, I consider regulating assisted death as progress.

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244 Carter, supra note 3 at para 15.
I have demonstrated through this thesis that it is not desirable to simply transplant the Belgium model in Canada. Different jurisdictions share similarities but hold different histories, culture and law. Contrary to The Netherlands, Canada, like Belgium would initiate the law’s evolution rather than legislating existing accepted practice. Belgium took two years to discuss, put together consultative committees, ordered and conducted numerous hearings, investigations, amendments, and came up with four serious and well thought out legal routes, etc.\footnote{Leleu & Genicot, \textit{supra} note 147 at 21.} But despite all this, we have seen that the Belgium Policy is taxed with a number of faults because of the speedy context in which it was enacted. Thus, it is not an example that Canada should recreate in its entirety. Nonetheless it is without a doubt a source of great inspiration, in addition to providing invaluable experience. We have the privilege to learn from the criticism explored in this paper and offer to Canadians the best of both worlds: a regulation that does not dictate anyone to go against their own conscience. Being able to analyze 10 years of experience from Belgium, “…we can now more confidently rely on safeguards that have a proven record of being able to ensure, for example, the competency and voluntariness of the patient.”\footnote{Shariff, “the slippery slope”, \textit{supra} note 44 at 6.} As Sumner mentions: “An acceptable policy must include safeguards designed to reduce the probability of medical error to a minimum. But it cannot be reduced to zero and it would be cruel to deny the relief of an assisted death to those in need of it by insisting on medical infallibility.”\footnote{Sumner, \textit{supra} note 13 at 180.}

One of the main arguments I have attempted to make in this paper is that drafting good legislation is not enough. As the old adage says, law is only as good as its enforcement. Societal control both \textit{a priori} and \textit{a posteriori} is pivotal to an effective assisted death regime. This includes clear and well written legislation, training in medical schools about due care in the area of assisted death, resources and support for treating physicians to ensure that patients consent is well-informed and true to individual wishes, and also a credible, impartial and serious oversight and control body. At last, along the lines of the Quebec Commission assisted death must be considered in association with palliative care, embracing the values of compassion and respect. Approaching death as a part of life lifts a taboo. Regulating will allow physicians to talk openly about terminating the life of competent patients. It provides an exchange of knowledge and expertise as well as the development of best practices. It also provides support to physicians and
health care practitioners in general when they have to deal with death and requests for euthanasia.

Sometimes “medicine does not know when to stop”. Sometimes nature does not know to be clement. Then there is suffering. As Somerville said, “in the past, we used religion to give value and meaning to suffering. But now, in a secular society, suffering is often seen as the greatest evil and of no value.” I certainly do not believe suffering is a fundamental Canadian value and we should not accept any individual suffering under the justification that it is in the state’s interest to protect life as a Canadian value. Certainly, in 2012, we can do better. We can agree that life should not be depreciated, and individual suffering limited.

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248 Heath, supra note 122 at 2.
249 Margaret Somerville, “The case against euthanasia: There is a trend in western democracies these days of increasing activism to legalize euthanasia and physician-assisted suicide” The Ottawa Citizen (27 June 2008) online: <http://www.canada.com/ottawacitizen/news/story.html?id=de02045d-51b1-4f4b-aa1a-157f3f79651b>
250 Rodriguez, supra note 5 at 5.
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APPENDIX A

28 MAI 2002. - Loi relative à l'euthanasie

ALBERT II, Roi des Belges, à tous, présents et à venir, Salut.

Les Chambres ont adopté et Nous sanctionnons ce qui suit :
Article 1er. La présente loi règle une matière visée à l’article 78 de la Constitution.

CHAPITRE Ier. - Dispositions générales

Art. 2. Pour l’application de la présente loi, il y a lieu d’entendre par euthanasie l’acte, pratiqué par un tiers, qui met intentionnellement fin à la vie d’une personne à la demande de celle-ci.

CHAPITRE II. - Des conditions et de la procédure

Art. 3. § 1er. Le médecin qui pratique une euthanasie ne commet pas d’infraction s’il s’est assuré que :
- le patient est majeur ou mineur émancipé, capable et conscient au moment de sa demande;
- la demande est formulée de manière volontaire, réfléchie et répétée, et qu’elle ne résulte pas d’une pression extérieure;
- le patient se trouve dans une situation médicale sans issue et fait état d’une souffrance physique ou psychique constante et insupportable qui ne peut être apaisée et qui résulte d’une affection accidentelle ou pathologique grave et incurable; et qu’il respecte les conditions et procédures prescrites par la présente loi.
§ 2. Sans préjudice des conditions complémentaires que le médecin désirerait mettre à son intervention, il doit, préalablement et dans tous les cas :
1° informer le patient de son état de santé et de son espérance de vie, se concerter avec le patient sur sa demande d’euthanasie et évoquer avec lui les possibilités thérapeutiques encore envisageables ainsi que les possibilités qu’offrent les soins palliatifs et leurs conséquences. Il doit arriver, avec le patient, à la conviction qu’il n’y a aucune autre solution raisonnable dans sa situation et que la demande du patient est entièrement volontaire;
2° s’assurer de la persistance de la souffrance physique ou psychique du patient et de sa volonté réitérée. A cette fin, il mène avec le patient plusieurs entretiens, espacés d’un délai raisonnable au regard de l’évolution de l’état du patient;
3° consulter un autre médecin quant au caractère grave et incurable de l’affection, en précisant les raisons de la consultation. Le médecin consulté prend connaissance du dossier médical examine le patient et s’assure du caractère constant, insupportable et inapaisable de la souffrance physique ou psychique. Il rédige un rapport concernant ses constatations. Le médecin consulté doit être indépendant, tant à l’égard du patient qu’à l’égard du médecin traitant et être compétent quant à la pathologie concernée. Le
médecin traitant informe le patient concernant les résultats de cette consultation;  
4° s’il existe une équipe soignante en contact régulier avec le patient, s’entretenir de la 
demande du patient avec l’équipe ou des membres de celle-ci;  
5° si telle est la volonté du patient, s’entretenir de sa demande avec les proches que 
celui-ci désigne;  
6° s’assurer que le patient a eu l’occasion de s’entretenir de sa demande avec les 
personnes qu’il souhaitait rencontrer.  
§ 3. Si le médecin est d’avis que le décès n’interviendra manifestement pas à brève 
échéance, il doit, en outre :  
1° consulter un deuxième médecin, psychiatre ou spécialiste de la pathologie 
concernée, en précisant les raisons de la consultation. Le médecin consulté prend 
connaissance du dossier médical, examine le patient, s’assure du caractère constant, 
insupportable et inapaisable de la souffrance physique ou psychique et du caractère 
volontaire, réfléchi et répété de la demande. Il rédige un rapport concernant ses 
constatations. Le médecin consulté doit être indépendant tant à l’égard du patient qu’à 
l’égard du médecin traitant et du premier médecin consulté. Le médecin traitant informe 
le patient concernant les résultats de cette consultation;  
2° laisser s’écouler au moins un mois entre la demande écrite du patient et 
l’euthanasie.  
§ 4. La demande du patient doit être actée par écrit. Le document est rédigé, daté et 
signé par le patient lui-même. S’il n’est pas en état de le faire, sa demande est actée 
par écrit par une personne majeure de son choix qui ne peut avoir aucun intérêt 
matériel au décès du patient. Cette personne mentionne le fait que le patient n’est pas 
en état de formuler sa demande par écrit et en indique les raisons. Dans ce cas, la 
demande est actée par écrit en présence du médecin, et ladite personne mentionne le 
nom de ce médecin dans le document. Ce document doit être versé au dossier médical. 
Le patient peut révoquer sa demande à tout moment, auquel cas le document est retiré 
du dossier médical et restitué au patient.  
§ 5. L’ensemble des demandes formulées par le patient, ainsi que les démarches du 
médecin traitant et leur résultat, y compris le(s) rapport(s) du (des) médecin(s) 
consulté(s), sont consignés régulièrement dans le dossier médical du patient.  
Art. 3bis. Le pharmacien qui délivre une substance euthanasiante ne commet aucune 
infraction lorsqu’il le fait sur la base d’une prescription dans laquelle le médecin 
mentionne explicitement qu’il s’agit conformément à la présente loi. Le pharmacien 
fournit la substance euthanasiante prescrite en personne au médecin. Le Roi fixe les 
critères de prudence et les conditions auxquels doivent satisfaire la prescription et la 
délivrance de médicaments qui seront utilisés comme substance euthanasiante. Le Roi 
prend les mesures nécessaires pour assurer la disponibilité des substances 
euthanasiantes y compris dans les officines qui sont accessibles au public. 

CHAPITRE III. - De la déclaration anticipée  

Art. 4. § 1er. Tout majeur ou mineur émancipé capable peut, pour le cas où il ne 
pourrait plus manifester sa volonté, consigner par écrit, dans une déclaration, sa 
volonté qu’un médecin pratique une euthanasie si ce médecin constate :  
- qu’il est atteint d’une affection accidentelle ou pathologique grave et incurable;  
- qu’il est inconscient;
et que cette situation est irréversible selon l’état actuel de la science.
La déclaration peut désigner une ou plusieurs personnes de confiance majeures,
classées par ordre de préférence, qui mettent le médecin traitant au courant de la
volonté du patient. Chaque personne de confiance remplace celle qui la précède dans
la déclaration en cas de refus d’empêchement, d’incapacité ou de décès. Le médecin
traitant du patient, le médecin consulté et les membres de l’équipe soignante ne
peuvent pas être désignés comme personnes de confiance. La déclaration peut être
faite à tout moment. Elle doit être constatée par écrit, dressée en présence de deux
témoins majeurs, dont l’un au moins n’aura pas d’intérêt matériel au décès du
déclarant, datée et signée par le déclarant, par les témoins et, s’il échec, par la ou les
personnes de confiance. Si la personne qui souhaite faire une déclaration anticipée, est
physiquement dans l’impossibilité permanente de rédiger et de signer, sa déclaration
peut être actée par écrit par une personne majeure de son choix qui ne peut avoir
aucun intérêt matériel au décès du déclarant, en présence de deux témoins majeurs,
dont l’un au moins n’aura pas d’intérêt matériel au décès du déclarant.
La déclaration doit alors préciser que le déclarant ne peut pas rédiger et signer, et en
énoncer les raisons. La déclaration doit être datée et signée par la personne qui a acté
par écrit la déclaration, par les témoins et, s’il échec, par la ou les personnes de
confiance. Une attestation médicale certifiant cette impossibilité physique permanente
est jointe à la déclaration.
La déclaration ne peut être prise en compte que si elle a été établie ou confirmée moins
de cinq ans avant le début de l’impossibilité de manifester sa volonté. La déclaration
peut être retirée ou adaptée à tout moment.
Le Roi détermine les modalités relatives à la présentation, à la conservation, à la
confirmation au retrait et à la communication de la déclaration aux médecins concernés,
via les services du Registre national.
§ 2. Un médecin qui pratique une euthanasie, à la suite d’une déclaration anticipée,
telle que prévue au § 1er, ne commet pas d’infraction s’il constate que le patient :
- est atteint d’une affection accidentelle ou pathologique grave et incurable;
- est inconscient;
- et que cette situation est irréversible selon l’état actuel de la science;
- et qu’il respecte les conditions et procédures prescrites par la présente loi.
Sans préjudice des conditions complémentaires que le médecin désirerait mettre à son
intervention, il doit préalablement :
1° consulter un autre médecin quant à l’irréversibilité de la situation médicale du
patient, en l’informant des raisons de cette consultation. Le médecin consulté prend
connaissance du dossier médical et examine le patient. Il rédige un rapport de ses
constatations. Si une personne de confiance est désignée dans la déclaration de
volonté, le médecin traitant met cette personne de confiance au courant des résultats
de cette consultation.
Le médecin consulté doit être indépendant à l’égard du patient ainsi qu’à l’égard du
médecin traitant et être compétent quant à la pathologie concernée;
2° s’il existe une équipe soignante en contact régulier avec le patient, s’entretenir du
contenu de la déclaration anticipée avec l’équipe soignante ou des membres de celle-ci;
3° si la déclaration désigne une personne de confiance, s’entretenir avec elle de la
volonté du patient;
4° si la déclaration désigne une personne de confiance, s’entretenir du contenu de la
déclaration anticipée du patient avec les proches du patient que la personne de
confiance désigne.
La déclaration anticipée ainsi que l’ensemble des démarches du médecin traitant et leur résultat, y compris le rapport du médecin consulté, sont consignés régulièrement dans le dossier médical du patient.

CHAPITRE IV. - De la déclaration

Art. 5. Le médecin qui a pratiqué une euthanasie remet, dans les quatre jours ouvrables, le document d’enregistrement visé à l’article 7, dûment complété, à la Commission fédérale de contrôle et d’évaluation visée à l’article 6 de la présente loi.

CHAPITRE V. - La Commission fédérale de contrôle et d’évaluation

Art. 6. § 1er. Il est institué une Commission fédérale de contrôle et d’évaluation de l’application de la présente loi, ci-après dénommée « la commission ».
§ 2. La commission se compose de seize membres, désignés sur la base de leurs connaissances et de leur expérience dans les matières qui relèvent de la compétence de la commission. Huit membres sont docteurs en médecine, dont quatre au moins sont professeurs dans une université belge. Quatre membres sont professeurs de droit dans une université belge, ou avocats. Quatre membres sont issus des milieux chargés de la problématique des patients atteints d’une maladie incurable. La qualité de membre de la commission est incompatible avec le mandat de membre d’une des assemblées législatives et avec celui de membre du gouvernement fédéral ou d’un gouvernement de communauté ou de région. Les membres de la commission sont nommés, dans le respect de la parité linguistique – chaque groupe linguistique comptant au moins trois candidats de chaque sexe - et en veillant à assurer une représentation pluraliste, par arrêté royal délibéré en Conseil des Ministres, sur une liste double présentée par le Sénat, pour un terme renouvelable de quatre ans. Le mandat prend fin de plein droit lorsque le membre perd la qualité en laquelle il siège. Les candidats qui n’ont pas été désignés comme membres effectifs sont nommés en qualité de membres suppléants, selon une liste déterminant l’ordre dans lequel ils seront appelés à suppléer. La commission est présidée par un président d’expression française et un président d’expression néerlandaise. Les présidents sont élus par les membres de la commission appartenant à leur groupe linguistique respectif. La commission ne peut délibérer valablement qu’à la condition que les deux tiers de ses membres soient présents.
§ 3. La commission établit son règlement d’ordre intérieur.

Art. 7. La commission établit un document d’enregistrement qui doit être complété par le médecin chaque fois qu’il pratique une euthanasie. Ce document est composé de deux volets. Le premier volet doit être scellé par le médecin. Il contient les données suivantes :
1° les nom, prénoms et domicile du patient;
2° les nom, prénoms, numéro d’enregistrement à l’INAMI et domicile du médecin traitant;
3° les nom, prénoms, numéro d’enregistrement à l’INAMI et domicile du (des) médecin(s) qui a
(ont) été consulté(s) concernant la demande d’euthanasie;
4° les nom, prénoms, domicile et qualité de toutes les personnes consultées par le médecin traitant, ainsi que les dates de ces consultations;
5° s’il existait une déclaration anticipée et qu’elle désignait une ou plusieurs personnes de confiance, les nom et prénoms de la (des) personne(s) de confiance qui est (sont) intervenue(s).

Ce premier volet est confidentiel. Il est transmis par le médecin à la commission. Il ne peut être consulté qu’après une décision de la commission, et ne peut en aucun cas servir de base à la mission d’évaluation de la commission.

Le deuxième volet est également confidentiel et contient les données suivantes :
1° le sexe et les date et lieu de naissance du patient;
2° la date, le lieu et l’heure du décès;
3° la mention de l’affection accidentelle ou pathologique grave et incurable dont souffrait le patient;
4° la nature de la souffrance qui était constante et insupportable;
5° les raisons pour lesquelles cette souffrance a été qualifiée d’inapaisable;
6° les éléments qui ont permis de s’assurer que la demande a été formulée de manière volontaire, réfléchie et répétée et sans pression extérieure;
7° si l’on pouvait estimer que le décès aurait lieu à brève échéance;
8° s’il existe une déclaration de volonté;
9° la procédure suivie par le médecin;
10° la qualification du ou des médecins consultés, l’avis et les dates de ces consultations;
11° la qualité des personnes consultées par le médecin, et les dates de ces consultations;
12° la manière dont l’euthanasie a été effectuée et les moyens utilisés.


Art. 9. La commission établit à l’intention des Chambres législatives, la première fois dans les deux ans de l’entrée en vigueur de la présente loi, et, par la suite, tous les deux ans :
a) un rapport statistique basé sur les informations recueillies dans le second volet du document d’enregistrement que les médecins lui remettent complété en vertu de l’article 8;
b) un rapport contenant une description et une évaluation de l’application de la présente loi;
c) le cas échéant, des recommandations susceptibles de déboucher sur une initiative législative et/ou d’autres mesures concernant l’exécution de la présente loi.
Pour l’accomplissement de ces missions, la commission peut recueillir toutes les informations utiles auprès des diverses autorités et institutions. Les renseignements recueillis par la commission sont confidentiels. Aucun de ces documents ne peut contenir l’identité d’aucune personne citée dans les dossiers remis à la commission dans le cadre du contrôle prévu à l’article 8. La commission peut décider de communiquer des informations statistiques et purement techniques, à l’exclusion de toutes données à caractère personnel, aux équipes universitaires de recherche qui en feraient la demande motivée. Elle peut entendre des experts.


Art. 11. Les frais de fonctionnement et les frais de personnel de la commission, ainsi que la rétribution de ses membres sont imputés par moitié aux budgets des ministres qui ont la Justice et la Santé publique dans leurs attributions.

Art. 12. Quiconque prête son concours, en quelque qualité que ce soit, à l’application de la présente loi, est tenu de respecter la confidentialité des données qui lui sont confiées dans l’exercice de sa mission et qui ont trait à l’exercice de celle-ci. L’article 458 du Code pénal lui est applicable.

Art. 13. Dans les six mois du dépôt du premier rapport et, le cas échéant, des recommandations de la commission, visés à l’article 9, les Chambres législatives organisent un débat à ce sujet. Ce délai de six mois est suspendu pendant la période de dissolution des Chambres législatives et/ou d’absence de gouvernement ayant la confiance des Chambres législatives.

CHAPITRE VI. - Dispositions particulières

Art. 14. La demande et la déclaration anticipée de volonté telles que prévues aux articles 3 et 4 de la présente loi n’ont pas de valeur contraignante. Aucun médecin n’est tenu de pratiquer une euthanasie. Aucune autre personne n’est tenue de participer à une euthanasie. Si le médecin consulté refuse de pratiquer une euthanasie, il est tenu d’en informer en temps utile le patient ou la personne de confiance éventuelle, en en précisant les raisons. Dans le cas où son refus est justifié par une raison médicale, celle-ci est consignée dans le dossier médical du patient.
Le médecin qui refuse de donner suite à une requête d’euthanasie est tenu, à la demande du patient ou de la personne de confiance, de communiquer le dossier médical du patient au médecin désigné par ce dernier ou par la personne de confiance.

Art. 15. La personne décédée à la suite d’une euthanasie dans le respect des conditions imposées par la présente loi est réputée décédée de mort naturelle pour ce
qui concerne l’exécution des contrats auxquels elle était partie, en particulier les contrats d’assurance.
Les dispositions de l’article 909 du Code civil sont applicables aux membres de l’équipe soignante visés à l’article 3.

Art. 16. La présente loi entre en vigueur au plus tard trois mois après sa publication au Moniteur belge. Promulguons la présente loi, ordonnons qu’elle soit revêtue du sceau de l’Etat et publiée par le Moniteur belge.

Bruxelles, le 28 mai 2002.

ALBERT
Par le Roi :

Le Ministre de la Justice, M. VERWILGHEN
Scellé du sceau de l’Etat :

Le Ministre de la Justice, M. VERWILGHEN