IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY

CIV-2015-485-235

UNDER	The Declaratory Judgments Act 1908 and the New Zealand Bill of Rights Act 1990
BETWEEN	LECRETIA SEALES
	Plaintiff
AND	ATTORNEY-GENERAL
	Defendant

AFFIDAVIT OF PROFESSOR ETIENNE MONTERO ON BEHALF OF THE DEFENDANT [DATE]

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I, Etienne Montero, professor, of Brussels, Belgium, do solemnly and sincerely affirm:

1. I am a Full Professor at the University of Namur (Belgium) and Dean of the Faculty of Law. I attach to this affidavit an updated copy of my curriculum vitae (exhibit "EM-1").

2. I studied law at the Université Saint-Louis (Brussels) and at the Université catholique de Louvain (UCL). I hold a Doctorate in Law with the highest distinction (*summa cum laude*) from UCL.

3. My teaching and research focuses primarily on issues of private law. I was a visiting professor at UCL (graduate level courses, 1999-2002), at the Université de Paris Est (graduate level courses, 2002-2008), at the Université de Ouagadougou, Burkina Faso (doctorate level courses, 2005-2008) and at other universities. I have led many research projects, primarily on behalf of the Belgian federal government, the Wallonia region and the European Commission.

4. I have taken part in the drafting of various legislative and regulatory instruments and led numerous consultancies and expert missions for government, national and international organisations, and for private and public companies. I edit a collection of works by Éditions De Boeck/Larcier and am a member of a number of editorial boards of law journals.

5. For some twenty years now I have also been conducting research on the theory of law, bioethics and biolaw. From 1998 to 2008 I served as a representative of the Faculty of Law with the Centre Interfacultaire Droit, Éthique, Science de la santé (CIDES) of the University of Namur and facilitated within that framework a seminar on bioethics. I am President of the European Institute of Bioethics (EIB).

6. I am the author of a large number of articles on issues of bioethcs and biolaw and have long been involved in public and academic debate on these issues, by participating in conferences and symposia, and debates in print and broadcast media. I have been consulted as an expert on end-of-life issues in various legislative and judicial contexts.

7. I have recently authored a book entitled [TRANSLATION] *Rendez-vous with death: Ten years of legal euthanasia in Belgium* (Brussels: Anthemis, 2013 [French]; also published in Spanish as *Cita con la muerte: Diez años de eutbanasia legal en Bélgica*, Madrid: Rialp, 2013). I have also co-edited and co-authored a book on euthanasia entitled *Suffering and Dignity in the Twilight of Life* (Kugler, 2004; also published in French and Italian).

8. The purpose of this affidavit is to report the findings of my research and express my opinion on the experience in Belgium of euthanasia legislation. In particular I describe the practical operation of the Belgium laws and their ineffectiveness in preventing an ever-increasing group of people from meeting the criteria and opting for euthanasia. I offer this opinion as an expert in the area of bioethics and biolaw, particularly on euthanasia in Belgium.

9. I have read and agree to comply with the Code of conduct for expert witnesses, High Court Rules, sch 4. I understand that, according to that Code of conduct:

   (a) an expert witness has an overriding duty to assist the Court impartially on relevant matters within the expert's area of expertise;

   (b) an expert witness is not an advocate for the party who engages the witness.

I. Methodology

10. In order to express myself objectively, cautiously and with appropriate nuances on the practice of euthanasia and medically assisted suicide in Belgium, I have chosen to rely heavily on statements, opinions, data and figures from official documents: preparatory parliamentary work for the Act on euthanasia and reports of the Commission fédérale de contrôle et d'évaluation de l'application de la loi [Federal Commission for Monitoring and Assessment of Law Enforcement] (hereinafter "Control Commission" or "Commission"). The data, findings and considerations contained in these reports are assessed and put into perspective not only in light of the extensive preparatory parliamentary work for the Act on euthanasia, which reveal the intentions of Parliament, but also in comparison with other relevant information (scientific publications, investigations, news articles) not included in the registration

documents submitted to the Control Commission. Despite their value, I have deliberately not included testimony or witness statements about illegal euthanasia and other forms of abuses or and excesses.

11. It cannot be forgotten that the control exercised by the Commission is necessarily limited as it deals only with registration documents completed and disclosed by the same physicians who themselves practised euthanasia. Hence, the usefulness of reporting and analysing certain recent cases widely covered by the media. A number of protagonists in the cases reported confided in the media prior to being euthanised, thus providing first-hand information or allowing *ex propriis sensibus* [first-hand] findings. These cases, and the comments made by the members of the Control Commission about them, are very insightful in that they illustrate the interpretation given to certain legal conditions in the Commission's reports. In order to provide an overview of the movement that has been emerging in Belgium since the inception of the Act on euthanasia, the numerous new legislative initiatives aimed at relaxing or extending this Act that have passed into law or are currently before Parliament will also be discussed.

12. Many reported cases, studies and documents tend to support my analysis and to show, on the one hand, that the provisions of the Act on euthanasia, as seemingly strict as they are, cannot be strictly enforced and controlled, and on the other hand, that legislative openness to euthanasia inevitably leads to certain abuses and excesses, to a violation of the letter and spirit of the law, and to a broadening of the scope of the Act beyond the borders initially and firmly established. In order to illustrate this slippery slope effect, reference is made in the footnotes to each of the relevant studies, reports and documents.

II. Short presentation of the Belgian Act on euthanasia

Introduction

13. First, it is useful to create a backdrop. In 2002, Belgium successively adopted three laws involving patients: (1) la loi du 28 mai 2002 relative à l'euthanasie ("Act on euthanasia"); (2) la loi du 14 juin 2002 relative aux soins palliatifs ("Act on palliative care"); (3) la loi du 22 août 2002 relative aux droits du patient ("Act on rights of patients"). I will focus in particular on the first one.

14. The Act on euthanasia defines euthanasia as [TRANSLATION] "intentionally terminating life by someone other than the person concerned, at the latter's request" (section 2). Under section 3, §1, this third party must be a physician. Medically assisted suicide is not defined in the Act on euthanasia since the legislature clearly wanted to exclude it from the scope of application (see *infra*, §§ 53-55). It is commonly understood to be the act by which a person ends his or her own life with the help of a physician. In other words, the physician provides the patient with a lethal product, which the patient administers him or herself.

15. It is relevant to note that in the beginning, the conditions of the Act were extremely strict. This has been stated again and again. If this were not the case, the bill would certainly not have won a Parliamentary majority in 2002. The legislature's intention was for patients with psychiatric problems, dementia or depression to be excluded *(infra,* §§ 38 and ff.), for physician-assisted suicide to be outside the scope of the Act (*infra*, §§ 53-55), for the bill to provide neither the right to euthanasia nor the obligation to perform it (*infra*, §§ 56-59) and for hospital institutions to have the right to refuse to assist in the practice of euthanasia (*infra*, §§ 60-64). However, legal boundaries are almost impossible to control, or are interpreted with surprising flexibility.

1. Overview of the conditions of the Act on euthanasia

16. In theory, euthanasia cannot be performed on a person unless that person requests it (section 2). The Belgian law recognises two situations: euthanasia on a *conscious person* (section 3) and euthanasia on an *unconscious person* who previously expressed in a written document the desire to be euthanised in specific circumstances (section 4).

17. According to the wording of the Act of May 28, 2002, a physician does not commit an criminal offence when he or she performs euthanasia on a person who is of age or is an emancipated minor capable and conscious at the time of his or her request. This request must be voluntary, well considered and repeated; it cannot result from external pressure and must be made in writing. The patient must also be in a medically futile condition and constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident. The

physician must also respect many other conditions and procedures: inform the patient about his or her health condition and life expectancy, possible therapeutic and palliative courses of action; have discussions with the patient spread out over a reasonable period of time, to be certain of the patient's persistent suffering and durable nature of the request; consult another independent physician competent to give an opinion about the disorder in question, and who reports on his or her findings; discuss the patient's request with one or more members of the medical care team and, if the patient so desires, with his or her relatives.

18. Euthanasia is not reserved for terminally ill patients. It is also possible if the physician feels that death is not expected in the near future, in which case two additional conditions apply: (1) the physician must consult with a second independent physician, psychiatrist or specialist in the disorder in question; (2) there must be at least one month for reflection between the patient's written request and the act of euthanasia.

19. Lastly, any capable adult or emancipated minor may, for cases in which he or she can no longer express his or her wishes, draw up a written statement of his or her will for a physician to perform euthanasia if the physician ensures that (1) the patient suffers from a serious and incurable disorder caused by illness or accident and (2) the patient is in a state of *irreversible unconsciousness.*

2. Control mechanism

20. Belgium's Parliament opted for *a posteriori* control of the practice of euthanasia (sections 6 to 13 of the Act). To this end, it established the Control Commission, composed of 16 members: eight physicians, four jurists and four members from groups that deal with the issue of incurably ill patients. They are appointed by royal decree by the Council of Ministers from a double list of candidates prepared by the Senate, for a renewable four-year term; this is done while respecting the usual language (French/Dutch), philosophical pluralism and gender parities.

21. The physician who performs euthanasia is required to report it to the Control Commission by providing it with the duly completed registration form within four business days. This document, established by the Commission, has two parts:

21.1 The first part is sealed by the physician and contains personal information about the patient, the physician and, when relevant, the support person(s);

21.2 The second part is not anonymous and contains data regarding the Act of euthanasia (the illness, nature of the suffering, procedure followed, qualification of the physician(s) consulted, manner in which the euthanasia was performed, means used, etc.).

The Commission, based solely on the second part of the registration form, is responsible for determining whether the euthanasia was performed in accordance with the basic conditions and the procedures set out in the Act. In case of doubt, it may decide by simple majority to revoke anonymity and examine the first part of the registration document. It may ask the attending physician additional questions or request the entire medical record. The Commission makes a decision within two months. The case is only sent to the public prosecutor if, in a *two-thirds majority* decision, the Commission determines that the legal conditions were not fulfilled.

III. Interpretation of the legal conditions required for euthanasia

22. We should begin by questioning the efficiency and reliability of the control mechanism provided by the Act on euthanasia (see above). Given that euthanasia produces irreversible effects, the principle of *a posteriori* monitoring (after the Act on euthanasia) is questionable as it depends solely on trusting information supplied by the physician who has carried out the euthanasia (self-reporting). To be precise, it is his or her responsibility to complete a special form ad hoc and submit it to the Control Commission whose duty it is to check whether the legal conditions have been met. It seems obvious that this control system, which operates after the fact [*ex post*], is not capable of protecting patients against euthanasia procedures that violate the statutory conditions. It is at best naive to assert that physicians will report their own failure to comply with the fundamental conditions or procedures prescribed by law. It is more likely that a physician will fail to report euthanasia that did not meet the statutory conditions or will report them such that he or she cannot be faulted. In this regard, an independent research carried out in Flanders presents

evidence of around 50% underreporting.[1] This figure confirms what had already been observed in anterior researches.[2]

23. In its successive reports, the Control Commission confesses to feeling powerless, stating quite realistically that it does not have the possibility of assessing the number of reported euthanasia cases versus the number of euthanasia cases actually performed[3]. Yet, in 2002, the goal of taking euthanasia out of the shadows was a strong argument made by people who were in favour of decriminalising it. Ever since its first official report, the Commission has stated that it is "aware of the limitations of the controls on the enforcement of the Act of 22 May 2002, which control is the Commission's task". The Commission acknowledges that: "It is clear that the effectiveness of its [the Commission's] mission relies, on the one hand, on medical professionals' compliance with the requirement to report performed cases of euthanasia and, on the other hand, on how these reports are prepared".[4] In other words, the Commission sees only what the physicians it oversees decide to show it... One should not be surprised that in 12 years, not a single case has been taken to the public prosecutor.

24. Twelve years of experience with legal euthanasia in Belgium have taught us that it is an illusion to think that euthanasia can be permitted as a narrowly circumscribed, well-defined exceptional practice to which "very strict" conditions apply and which is under rigorous control. Once euthanasia is allowed, the limiting conditions established under the law fall away, one after the other, and it appears practically impossible to maintain a strict

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[1] K. Chambaere, R. Vander Stichele, F. Mortier, J. Cohen, L. Deliens, "Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium", *The New England Journal of Medicine* (2015) 372 (12): 1179-1181.

[2] Cf. R. Cohen-Almagor, "First do no harm: pressing concerns regarding euthanasia in Belgium", *International Journal of Law and Psychiatry* 36 (2013):515-521 (50% of euthanasia cases allegedly are not reported); J. Cohen, Y. Van Wesemael, T. Smets, J. Bilsen, L. Deliens, "Cultural differences affecting euthanasia practice in Belgium. One law but different attitudes and practices in Flanders and Wallonia", *Social Science & Medicine* (20 12) 75 (5): 845-853 (73% of euthanasia cases were reported by Flemish physicians to the Commission de contrôle, whereas 58% of cases by their Walloon counterparts); T. Smets, J. Bilsen, J. Cohen, M.L. Rurup, F. Mortier, L. Deliens, "Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases", *BMJ* (20 10); 341:1-8 (approximately 50% of euthanasia cases reported in Flanders); K. Chambaere, J. Bilsen, J. Cohen, G. Pousset, B. Onwuteaka-Philipsen, F. Mortier, L. Deliens, "A post mortem survey on end-of- life decisions using a representative sample of death certificates in Flanders", *BMC Public Health* (2008) 8: 299 (53% of euthanasia cases were reported in Flanders).

[3] Control Commission, Premier rapport aux chambres législatives [First report to the legislative chambers] (years 2002-2003), 2004, p. 14; Deuxième rapport [Second report] (2004-2005), 2006, p. 22; Troisième rapport [Third report] (2006-2007), 2008, p. 22; Quatrième rapport [Fourth report] (2008-2009), 2010, p. 22; Cinquième rapport [Fifth report] (2010-2011), 2012, p. 14; Sixième rapport [Sixth report] (2012-2013), 2014, p. 14.

[4] Control Commission, First report, 2004, p. 23.

interpretation of the statutory conditions and to prevent the extension of the law.

25. Such a statement can be made, supported and illustrated. To this end, as already stated, it suffices to compare the requirements for impunity for euthanasia, as originally proclaimed and cast in the Act of 28 May 2002, with the interpretation of these requirements by the Commission charged with monitoring the implementation of the law. The comparison covers eight topics.

1. The requirement of a serious and incurable disorder

26. To gain access to euthanasia, the patient has to manifest a *serious and incurable disorder* caused by illness or injury.[5] Such a condition seems objective and verifiable, but we must not be deceived by this apparent simplicity. The notion of "incurable disorder" is imprecise and not defined, and the list of incurable diseases is practically endless: diabetes, rheumatism, arthritis, heart failure, emphysema, chronic bronchitis, chronic renal failure, hepatitis, and so on.[6] This observation helps us put the legal requirement into perspective: officially, it will almost always be possible to state that it has been met.

27. However, it does not stop there. For the Control Commission, the seriousness of the patient's condition may be the result of "multiple disorders", none of which, taken individually, is *serious and incurable.* This expression was invented by the Commission: there is no trace of it in the thousands of pages of reports of the parliamentary discussions.

28. Many members of the Control Commission acknowledge that the absence of a serious and incurable disorder poses a problem. Nevertheless, they specify that in elderly people, the cumulative effect of a combination of ailments may cause unbearable suffering and justify euthanasia.[7]

29. The public was apprised of the notion of "multiple disorders" through the extensive media coverage of the controversial cases.

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[5] Article 3, § 1er, third point, of the law.

[6] See, e.g., Audition of Prof. W. Distelmans, Annexe au rapport fait au nom des Commissions réunies de la Justice et des Affaires sociales [Appendix to the report written on behalf of the joint Commissions for Justice and Social Affairs], by Laloy and Van Riet, 9 July 2001, *Doc. parl.*, Sénat, sess. ord. 2000-2001, n° 2-244/24, p. 664.

[7] J. Herremans, member of the Control Commission and President of ADMD [Association for the Right to Die with Dignity] (Belgium), *Le Vif/L'Express*, 25 January 2008, p. 36; Dr M. Englert, member of the Control Commission and of the ADMD, "L'euthanasie des patients âgés" [Euthanasia of elderly patients], p. 12, www.admd.be/medecins.html.

30. The case of Jeanne is emblematic. She was 88 years old, was completely sane and wanted to die. She did not have any serious incurable diseases. She was euthanised. Officially, the conditions of the legislation had been met: she had "multiple disorders", none of which was serious in itself, but taken together, caused her unbearable pain. For her son, as well as for Jeanne's former attending physician, it was obvious that she did not have a serious incurable disease, as required under the Act on euthanasia.[8]

31. The case of Amelie Van Esbeen also made headlines.[9] Unless old age is considered an incurable disease, there is no reason to believe that this 93-year-old woman met the statutory conditions for euthanasia.[10] Her death was, however, caused by a physician other than her attending physician, who had refused to grant her request for euthanasia. Officially, here too, all the statutory conditions had been met.

32. The Control Commission is thus approving more and more euthanasia cases at the request of people who, although unable to prove that they have a serious and incurable disorder, suffer from various ailments related to old age, for example, people suffering from polyarthritis, who have reduced mobility, do not see well and become deaf.[11] The first report to the legislative chambers identified three cases of "multiple disorders", the second report 20 cases, the third report 16 cases, the fourth report 30 cases, the fifth report 39 cases and the sixth report 166 cases.[12]

33. In its sixth report, the Commission points out that the number of euthanasia cases by reason of "multiple disorders" is "clearly higher than in 2010–2011": indeed, the number rose from 23 in 2011 to 57 in 2012 and to 109 in 2013.

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[8] Cf., e.g., P. Gruber, "Jeanne avait décidé de mourir " [Jeanne had decided to die], *Le Vif/L'Express* (Belgique), 21 January 2008, pp. 36-40; F. Delpierre, "Jeanne – 'Ma mère ne répondait pas aux critères pour être euthanasiée' " [Jeanne – My mother did not meet the criteria for euthanasia], *Le Soir*, 15 January 2011, p. 12; E. Saget, "L'euthanasie, ma mère et moi" [Euthanasia, my mother and I], *L'Express* (France), 24 April 2008.

[9] Cf., e.g., M. Lamensch, "Amelie Van Esbeen", *Le Soir*, 24 March 2009, p. 19; M. Lamensch and F. Soumois, "La vieille dame de 93 ans a obtenu l'euthanasie" [The old lady of 93 obtained euthanasia], *Le Soir*, 2 April 2009, p. 8 and the editorial "Les leçons d'un cas très médiatisé" [Lessons from a highly publicised case], p. 22.

[10] F. Keuleneer, alternate member of the Control Commission, "Puntjes op de 'i' in het euthanasiedebat. Euthanasie veeler inperken dan uitbreiden" [Dotting the 'i's in the debate on euthanasia: limit rather than extend euthanasia], *Tertio*, n° 477, 2009, p. 10; A. Hovine, "Le douloureux destin d'Amelie Van Esbeen" [The painful destiny of Amelie Van Esbeen], *La Libre Belgique*, 2 April 2009.

[11] Cf. Dr M. Englert, member of the Control Commission and of the ADMD, "L'euthanasie des patients âgés" [Euthanasia of elderly patients], p. 12, www.admd.be/medecins.html; Prof. W. Distelmans, President of the Control Commission, "De euthanasiewet is geen dwangbuis" [The law on euthanasia is not a straitjacket], *De Standaard*, 16 October 2003.

[12] Control Commission, First report (years 2002–2003), 2004, p. 8; Second report (2004-2005), 2006, p. 16; Third report (2006-2007), 2008, pp. 16-17; Fourth report (2008-2009), 2010, p. 16; Fifth report (2010-2011), 2012, pp. 8-9; Sixth report (2012-2013), 2014, p. 8.

The fourth, fifth and sixth reports highlight the divergent views that have arisen within the Commission with respect to the justification for euthanasia for very old patients with multiple disorders; some members thought that this suffering was more related to *the natural consequences of old age.*[13]

2013	109
2012	57
2011	23
2010	16
2009	18
2008	12
2007	10
2006	6
2005	11
2004	9
2003	3

Table 1. Euthanasia cases declared for "multiple disorders"

34. It is remarkable that the Commission agreed to collapse into a single condition two conditions that are distinct in the legislation: 1) the necessity of demonstrating a serious and incurable disorder that 2) results in constant and unbearable physical or mental suffering that cannot be relieved. This approach, combined with the absence of a definition of a "serious and incurable disorder" and the fact that euthanasia is legally possible for patients who are not expected to die in the short term, seems tailor-made to permit euthanasia for patients who claim to be suffering unbearably because of their old age, social isolation or world weariness.[14]

35. While this point of view is of course understandable, we must nonetheless point out that it contradicts the *principle of strict interpretation of penal texts* and the frequently reaffirmed will of the legislature to lock up permission to euthanise under "very strict" conditions. This represents slippage in the indications required for euthanasia, which manages to be justified for elderly people who would like to end their life. Even if they can't prove that they have a serious and incurable disorder, or truly unbearable suffering, they should be able to benefit from medical assistance to die. A "quality of life" deemed to be

[13] Control Commission, Fourth report (years 2008-2009), 2010, p. 22; Fifth report (2010-2011), 2012, p. 14; Sixth report] (2012-2013), 2014, p. 15.

[14] Explicit reference [*expressis verbis*] to the latter expression, Prof. W. Distelmans, President of the Control Commission, "De euthanasiewet is geen dwangbuis" [The law on euthanasia is not a straitjacket], *De Standaard*, 16 October 2003.

insufficient seems to be gradually replacing the medical indications and legal conditions for euthanasia.

2. The requirement of physical or mental suffering

36. Among the conditions for euthanasia, Belgian law requires the presence of constant and unbearable physical *or* mental suffering that cannot be relieved.[15] The tone was set as early as the First Report: the Commission felt from the beginning that the assessment of the *unbearable* nature of the suffering was largely "subjective and depends on the patient's personality, ideas and values".[16] As for *cannot be relieved*, the Commission stated that it had to take into account the fact that "the patient has the right to refuse treatment for pain, even palliative treatment, for example, when the patient deems the side effects or methods of treatment administration to be unbearable".[17] In reality, any notion of a "palliative filter" is scorned by partisans of euthanasia. Physicians have to limit themselves to giving information on the possibilities provided under palliative care, which admittedly is not the same as experiencing the benefits provided by this type of care. How can we assert that the patient's suffering "cannot be relieved" if he or she refuses any type of palliative care? In practice, the Commission exercises very lax control over the unbearable and unrelievable nature of the suffering, a criterion that is nevertheless central in the legislation.

37. The experts (including the key proponents of euthanasia in Belgium) generally acknowledge that most requests for euthanasia do not stem from *physical pain,* which can be controlled,[18] but from *mental suffering:* loss of meaning, loss of independence, loss of dignity, solitude, weariness of living and a need for control over one's death.[19] Psychological pain is especially difficult to assess because the factors that trigger and fuel it are complex. Psychological

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[15] Article 3, § 1er, third point, of the law.

[16] Control Commission, First report (years 2002–2003), 2004, p. 16.

[17] *Ibid.*

[18] Although it is true that the resources available in medicine today are increasingly effective in treating and managing physical pain, the expertise of a certain number of physicians with respect to managing pain and symptoms is often lacking. See, for example, hearing of Dr M. Desmedt, Rapport fait au nom de la Commission de la Justice [Report written for the Justice Commission], by Th. Giet, A. Van De Casteele, A. Barzin and J. Schauvliege, 23 April 2002, *Doc. parl.*, Ch. repr., n° 50 1488/009, p. 135; Hearing of Dr. J. Menten, tumorous disease and radiotherapy service (University Hospital of Louvain), in Annexe au rapport fait au nom des Commissions réunies de la Justice et des Affaires sociales [Appendix to the report written on behalf of the joint Commissions for Justice and Social Affairs], by Laloy and Van Riet, 9 July 2001, *Doc. parl.*, Sénat, sess. ord. 2000-2001, n° 2-244/24, p. 683.

[19] See, for example, Prof. Dr Wim Distelmans, Chairperson of the Control Commission, "De euthanasiewet is geen dwangbuis" [The law on euthanasia is not a straitjacket], *De Standaard*, 16 October 2013; similarly, *De Standaard Magazine*, 21 December 2013, p. 58.

distress may stem from social isolation and fear of real or imaginary future pain.[20] Many converging studies have demonstrated that depression is common in the terminally ill, especially for those in the advanced stages of cancer, and that patients suffering from depression are 25 times more likely to commit suicide than the general population.[21] Very often, depression is not treated properly or even diagnosed.[22]

38. When the Belgian Act on euthanasia was being developed, it was stated repeatedly that *patients with psychiatric disorders, dementia or depression were excluded from the Act.*[23] Logically, the neuropsychiatric condition of these patients pointedly raises the serious issue of the validity of their requests, as it is difficult to confirm the voluntary, well-thought out and lucid nature of the request. However, *the Control Commission approves an ever-increasing number of euthanasia cases for patients with psychiatric disorders, dementia or depression.*

39. For example, in mid-September 2012, a 48-year-old prisoner with psychiatric problems was euthanised in a prison. This action in a prison environment, which was confirmed by the penitentiary administration, was deemed to be in compliance with Belgian legislation on euthanasia. The notion of psychological pain appears to be a delicate one here. [TRANSLATION] "Even if the request for euthanasia meets all the statutory conditions, the burning question in this social debate is whether the inmate would have made this decision under the appropriate psychiatric treatment", noted Dr Marc Moens.[24] In response to a parliamentary question on January 17, 2013, the Minister of Justice replied that

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[20] See, for examples and references, Hearing of Dr M. Desmedt, Report written for the Justice Commission (23 April 2002), *Doc. parl.*, Ch. repr., n° 50 1488/009, p. 137.

[21] W. Breitbart, B. Rosenfeld, H. Pessin, M. Kaim, J. Funesti-Esch, M. Galietta, et al., "Depression, hopelessness, and desire for hastened death in terminally ill patients with cancer", *Journal of the American Medical Association* (2000), 284 (22): 2907-2911; B. Rosenfeld, W. Breitbart, S. Krivo, H.M. Chochinov, "Suicide, assisted suicide, and euthanasia in the terminally ill", in H.M. Chochinov & W. Breitbart (eds), *Handbook of psychiatry in palliative medicine* (New York: Oxford University Press, 2000) 51-62; H.M. Chochinov, K.G. Wilson, M. Enns, N. Mowchun, S. Lander, M. Levitt and J.J. Clinch, "Desire for Death in the Terminally Ill", *American Journal of Psychiatry* (1995), 152: 1185-1191.

[22] H. Pessin, B. Rosenfeld, W. Breitbart, "Assessing Psychological Distress Near the End of Life", *American Behavioral Scientist* (2002), 46 (3): 257-372, spec. 358; S.D. Passik, W. Dugan, M.V. McDonald, B. Rosenfeld, D.E. Theobald, S. Edgerton, "Oncologists' recognition of depression in their patients with cancer", *Journal of Clinical Oncology* (1998), 16: 1594-1600; H.M. Chochinov, K.G. Wilson, M. Enns, S. Lander, "Are you depressed? Screening for depression in the terminally ill", *American Journal of Psychiatry* (1997), 154: 674-676; R. Fresco, neuropsychiatrist, "Menace suicidaire et demande d'euthanasie: des équivalents dépressifs ?", in M. Abiven, C. Charcot and R. Fresco, *Euthanasie- Alternatives et controverses*, Paris, Presses de la Renaissance, 2000, pp. 212 et s., and the studies cited.

[23] Report written for the Justice Commission, by Th. Giet, A. Van De Casteele, A. Barzin and J. Schauvliege, 23 April 2002, *Doc. parl.*, Ch. repr., n° 50 1488/009, p. 52, p. 56, p. 217, p. 243, p. 244, p. 245, etc.

[24] Dr Marc Moens, President of the "Association Belge des Syndicats Médicaux (ABSyM), press release [TRANSLATION] "Psychiatric inmates have the right to medical care" (13 September 2012).

five other long-term inmates have also requested euthanasia.[25] More recently, many requests were made following the media coverage of the case of F. Van Den Bleeken. Knowing the pitiful state of our prisons, the phenomenon of prison overcrowding and the insufficient financial means to monitor psychiatric inmates, assessing psychological pain seems to be a singularly sensitive issue. In these conditions, we can also wonder about the free and voluntary nature of the request for euthanasia. The moment euthanasia is allowed in the case of purely psychological pain, we could consider long-term incarceration to constitute sufficient pain to justify euthanasia.

40. Another example is the case of the transgender 44 year-old Nathan Verhelst (born Nancy). After a botched sex change operation, he was euthanised on October 1, 2013, under the supervision of Professor Dr Wim Distelmans of the VUB [Free University of Brussels]. He stated that all the conditions of the legislation had been met: [TRANSLATION] "This was clearly a case of unbearable psychological pain".[26] However, we may well wonder what incurable disease he had.

41. The case of Ann G. is also emblematic. In late 2012, she was euthanised as she had requested. The doctors who administered the lethal substance estimated that her request was in compliance with the Belgian legislation in that Ann G. was suffering from a psychiatric disability that caused her unbearable pain. A few months earlier, Ann appeared on television accusing her psychiatrist of having unwanted relations with her. In 2007, having already suffered from anorexia for 25 years, the patient got in touch with a writer, Kristien Hemmerechts, because she wanted her story to be told in a book. She also announced that she wanted to commit suicide as soon as the book was published.[27]

42. We can see from the Belgian experience how *extremely difficult it is to stick to the initial statements and intentions of the legislature* and to ensure that the originally "very strict" statutory conditions have been met. In 2013, the President of the Control Commission was proud that in Belgium, several dozen people had

[25] Oral question from Senator L. Ide to the Minister of Justice on [TRANSLATION] "Requests for euthanasia from prisoners", n° 5-791, *Annales*, Senate, 17 January 2013.
[26] Cf. *La Libre*, 1st October 2013.
[27] Cf. "Euthanasie na strijd van 25 jaar tegen anorexia" [Euthanasia after the 25 year fight against anorexia], *Nieuwsblad*, 28 January 2015.

been euthanised because of their "mental suffering".[28] Confusion between mental suffering and mental illness remains common.

43. In its second report, the Commission approved nine cases of euthanasia for patients with a neuropsychiatric disorder (one case of Creutzfeldt-Jacob disease, three cases of Alzheimer's disease, one case of Huntington's disease and four cases of untreatable depression).[29] A Flemish association that actively supports people suffering from depression (*Netwerk Depressie Vlaanderen* [*Flanders Depression Network*]) was upset by this, stating that it sets a dangerous precedent: "The door to euthanasia is open for thousands of depressed and suicidal people to kill themselves legally".[30] In later reports, these figures continue to rise.[31]

2013	67
2012	53
2011	33
2010	25
2009	21
2008	13
2007	4
2006	5
2005	3
2004	6
2003	--

Table 2. Euthanasia cases declared for neuropsychiatric disorders

44. Starting with its third report, the majority of Control Commission members also decided, following lively debate, that "a *foreseeable* dramatic change ... suffices to constitute unbearable, unrelievable mental suffering within the terms of the Act".[32]

45. It emerges from the fourth and fifth reports that certain members of the Commission thought that mental suffering had been interpreted too broadly, because a foreseeable dramatic change could not constitute unbearable, unrelievable mental suffering in the here and now [*hic et nunc*], as required under the terms of the Act on euthanasia. However, the majority of Commission

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[28] Interview with Prof. Wim Distelmans, *De Standaard Magazine*, 21-22/12/2013, p. 60.
[29] Control Commission, Second report (2004-2005), 2006, p.16 and p.22.
[30] Proposal put forward in the article "Quatre cas pour dépression majeure irréductible" [Four cases of untreatable serious depression], *La Libre Belgique*, 2 February 2007.
[31] Control Commission, Third report (2006-2007), 2008, p. 16 and p.22; Fourth report] (2008-2009), 2010, p. 16; Fifth report (2010-2011), 2012, p. 8; Sixth report (2012-2013), 2014, p.8.
[32] Control Commission, Third report (2006-2007), 2008, p. 24.

members did not share this point of view.[33] In other words, the degree of suffering required to gain access to euthanasia could include *anticipated future suffering*.

46. Since the case of Hugo Claus, the famous Flemish writer who chose to be euthanised at the age of 78 (March 2008), from the appearance of the first symptoms of Alzheimer's disease,[34] we often hear about euthanasia practised out of fear of future pain. Professor Dr Wim Distelmans, President of the Control Commission, recently noted: [TRANSLATION] "Like Hugo Claus, dozens of people are euthanised here in the early stages of dementia, as a preventive measure".[35]

47. From among many other cases of *euthanasia out of fear of future suffering*, two cases illustrate well this questionable and much discussed interpretation of the condition of constant and unbearable suffering.

48. Emiel Pauwels, a 95-year-old athlete, was euthanised on January 7, 2014, after uncorking some champagne, surrounded by many family members and friends. The press, which was also invited to the party, widely reported on the event. The athlete had been diagnosed with cancer of the stomach and intestines a few weeks earlier. In March 2013, he had won the title of European Champion in the 60 metre sprint at the Veteran Games organised in San Sebastien (Spain). Given his excellent physical condition, radiation therapy was being considered and had been suggested to him. He refused: [TRANSLATION] "I opted for euthanasia because I did not want to suffer." It is *future pain* that is being referred to and, in fact, the man did not seem to be in [TRANSLATION] "constant unbearable physical or mental suffering that cannot be alleviated," according to the precise terms of the legislation.

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[33] Control Commission, Fourth report (2008-2009), 2010, p. 33; Fifth report (2010–2011), 2012, p. 16.

[34] Cf., e.g., "L'écrivain belge Hugo Claus a choisi l'euthanasie" [The Belgian writer Hugo Claus has chosen euthanasia], AFP, 19 March 2008; "En Belgique, le départ choisi d'Hugo Claus" [In Belgium, the exit chosen by Hugo Claus], *Libération*, 21 March 2008. See also the opinions and analyses published in *De Standaard*, 22-23-24 March 2008, pp. 22-23; "Euthanasie kent Claus-effect" [Euthanasia sees a Claus-effect], *De Standaard*, 21 May 2008. The case was declared to the Control Commission, which deemed it acceptable with respect to the legal requirements. The dossier was not sent to the public Prosecutor.

[35] Prof. W. Distelmans, Chairperson of the Control Commission, *De Standaard Magazine* (21 December 2013), p. 60. He cited about 50 cases of "preventive" euthanasia last year.

49. Twins Eddy and Marc Verbessem, born deaf, were euthanised together, at their request, on December 14, 2012.[36] They were 45 years old. Their request for euthanasia was based on a diagnosis of glaucoma, which, it seems, was gradually making them blind. The psychological pain referred is the result, here too, of the anticipated future pain associated with blindness and loss of autonomy. This euthanasia case was approved by the Control Commission. This is nevertheless troubling: everything happens as though, imperceptibly, euthanasia were becoming the most humanly dignified response to pain. As the threshold for tolerating disease and pain diminishes, euthanasia seems to be becoming more commonplace. Although the choice of the twin brothers is understandable and deserves respect, we may wonder whether society has provided them with enough support to build a quality of life despite their disabilities. Their situation challenges medicine and society to imagine ways to support people in pain on the path of life and not only on the path to death.[37]

3. Conditions that are difficult to verify

50. For the sake of brevity, I will not provide a detailed critical commentary on each condition stipulated in the Act and the way in which each one is controlled. In any case, we may well wonder whether it is impossible in practice for the Commission to verify that most of the "strict legal requirements" for euthanasia have been met. Several examples suffice.

51. How can we be sure after the act of euthanasia [*ex post*] that the request was fully voluntary, well thought out and not due to external pressure? Many people who live in situations of chronic suffering express two opposite wishes: to live and to die, to obtain relief or to "end it all". How can we be sure that they received support not just for their wish to die? How can we be sure that the information on diagnosis, prognosis, possible treatments and options provided as part of palliative care is accurate, and was provided in an appropriate climate of dialogue and empathy?

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[36] *De Standaard*, 14 January 2013, pp. 2, 6 et 23; *De Standaard*, 15 January 2013, p. 10; *Artsenkrant*, n° 2291, 18 January 2013, p. 4. The request for euthanasia of the twins Eddy and Marc Verbessem, who were born deaf, was due to the diagnosis of glaucoma, which apparently would have gradually led to blindness. It was the expectation of a future loss of autonomy that motivated their request. This latter request is understandable and deserving of respect, but one might wonder if society furnished them with sufficient support. On this topic, see the opinion expressed by the directors of two institutes specialised in supporting people who are deaf and blind, *L'Avenir*, 18 January 2013.

[37] On this topic, see the opinion expressed by the directors of two institutes specialised in supporting people who are deaf and blind, *L'Avenir* (18 January 2013).

52. How can we sure that the physician who agrees to a request to perform euthanasia, the second physician consulted and especially the members of the Control Commission really are able to take the full measure of the constraints and pressures, including the sometimes subconscious ones, that most patients face? How can we ensure that the compulsory consultation of a second physician does not become a routine performed for form's sake [*pro forma*] with physicians who are particularly open to the practice of euthanasia,[38] which is necessarily the case for EOL and LEIF physicians, to whom recourse is usual?[39]

4. From euthanasia to physician-assisted suicide

53. The Belgian legislature very clearly intended to exclude physician-assisted suicide from the scope of the Act on euthanasia. This intention was criticised and extensively debated when the Act was being developed.[40] Several amendments to incorporate physician-assisted suicide into the law were tabled, but they were all rejected,[41] to the Council of State's astonishment.[42] After the Act was passed, some members of parliament deemed it necessary to table bills of law to amend the Act on euthanasia to include physician-assisted suicide performed under the same conditions as those that had been specified for euthanasia.[43] It is clear that, in their minds, physician-assisted suicide is not

[38] Not all physicians are convinced of the usefulness of a second opinion, and it sometimes happens that it is not requested or that euthanasia is performed despite a negative opinion. Cf. J. Cohen, Y. Van Wesemael, T. Smets, J. Bilsen, L. Deliens, "Cultural differences affecting euthanasia practice in Belgium. One law but different attitudes and practices in Flanders and Wallonia", *Social Science & Medicine* (2012), vol. 75, 5: 845-853 (55% of the physicians in Wallonia and 71% of those in Flanders find it useful to consult a second physician); R. Cohen-Almagor, "First do no harm: pressing concerns regarding euthanasia in Belgium", *International Journal of Law and Psychiatry* 36 (2013): 515-521 (in 35% of the cases, the opinion of the second independent physician was apparently not solicited and in 23% of the cases, euthanasia apparently was performed despite a dissenting opinion).

[39] In the French Community of Belgium the EOL (End-of-Life Doctors) forum was created in 2003 as an initiative and with the logistical support of the Association pour le Droit de Mourir dans la Dignité (ADMD) [Association for the Right to Die with Dignity], which campaigns for the right to euthanasia. LEIF (LevensEinde [End of Life] Information Forum) is the Flemish counterpart of EOL, which arose from the R.W.S. association (Flemish counterpart of A.D.M.D.).

[40] Report written on behalf of the Justice Commission, 23 April 2002, *Doc. parl.*, Ch. repr., n° 50 1488/009, p. 55, p. 57. See also the Report written on behalf of the joint Commissions for Justice and Social Affairs, 9 July 2001, *Doc. parl.*, Senate, session 2000-2001, n° 2-244/22, p. 545 and ff., p. 581 and ff., p. 613 and ff.

[41] Cf., e.g., the discussion on page 190 of the Report written on behalf of the Justice Commission, 23 April 2002, *Doc. parl.*, Ch. repr., n° 50 1488/009.

[42] Proposed law on euthanasia, Opinion of the Council of State, 2 July 2001, n° 2-244/21, pp. 14-15. The Council of State infers this clear intention of the legislature to reject the amendments n°s 5, 24 and 97, p. 14, note 3.

[43] Cf., e.g., Bill to amend the law of 28 May 2002 on euthanasia and to introducing the concept of assistance for self-euthanasia, 26 May 2008, *Doc. parl.*, Senate, sess. 2007-2008, n° 4-7841/1. This bill incorporates, with some modifications, the text of a bill that had been previously tabled in the Senate on 2 October 2003, *Doc. parl.*, Senate, sess. extr. 2003, n° 3-220/1.

covered by the Act on euthanasia and therefore constitutes an illegal practice according to the current Act.[44]

54. Therefore, it is astonishing that the Control Commission regularly approves physician-assisted suicide cases reported to it and has been doing so since its first official report,[45] stating that the practice "falls within the scope of the Act, as it is currently written, according to which the physician is in control of the process of dying until the end, regardless of the means".[46] In its second report, the Control Commission appears to identify ten cases of physician-assisted suicide and specifies that its interpretation is in line with the position of the National Council of the College of Physicians.[47] The third,[48] fourth[49] and fifth[50] reports indicate 24, 14 and 12 cases of physician-assisted suicide, respectively. Inasmuch as physician-assisted suicide complies with the conditions of the Act on euthanasia, it seems logical and reasonable to handle it in the same way. Nonetheless, it must be noted that a practice that the legislature intentionally excluded from the scope of the Act has been endorsed. This suggests slippage, as it is neither for the National Council of Physicians nor for the Control Commission to decide that they are above the law.

55. In addition, it is absolutely not clear that physicians feel legally obliged to report to the Control Commission the situations in which they helped a patient to end his or her own life, given that the Act requires only "the physician performing euthanasia" to report it to the Control Commission (article 5 of the Act). This also means that we cannot rely on the figures for "physician-assisted suicide" provided by the Control Commission.

5. From exception to "legal right"

56. In 2002, euthanasia was presented as an ethical transgression, an exceptional act, a last resort for extreme cases. Now we are told, "euthanasia is neither an

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[44] See the memorandum explaining the bill to amend the Act of 28 May 2002 concerning euthanasia and the Royal Decree of 2 April 2003 laying down the conditions on which the advance directive of euthanasia should be written, confirmed, revised or withdrawn, 18 October, 2007, *Doc. parl.*, Senate, sess. 2007-2008, n° 4-301/1. This bill incorporates, with some modifications, the text of a bill that had been previously tabled in the Senate the 25 April 2006, sess. 2005–2006, n° 3-1671/1.

[45] Control Commission, First report (22 September 2002 - 31 December 2003), 2004, p. 17.

[46] Control Commission, First report (22 September 2002 - 31 December 2003), 2004, p. 24. Cf. National Council of the Order of Physicians, Opinion of 22 March 2003 on palliative care, euthanasia and other medical decisions concerning the end of life, *Bulletin*, vol. XI, June 2003.

[47] Control Commission, Second report (2004 and 2005), 2006, p. 24.

[48] Control Commission, Third report (2006-2007), 2008, p. 24.

[49] Control Commission, Fourth report (2008-2009), 2010, p. 24.

[50] Control Commission, Fifth report (2010-2011), 2012, p. 17.

exception nor an ethical transgression and its practice, properly regulated, is part of end of life care".[51] Yet if the legislature chose not to adapt the Penal Code, it was to signal the fact that euthanasia remains a criminally punishable form of homicide. It is only *by exception*, under the conditions laid down by the law, that it loses its unlawful character. During the development of the future Act, all the stakeholders – parliamentarians and experts who were heard – agreed that the bill should not provide a "right to euthanasia", and the bill limited itself to decriminalising, under certain conditions, the action of a physician who freely agrees to a request to perform euthanasia.[52]

57. Twelve years later, there are countless news articles, web sites[53], official documents[54], information brochures[55] and bills[56] stating that a "right to euthanasia" exists. This preponderant focus generates troublesome misunderstandings because patients apparently believe that they have a right to euthanasia and that they can determine when it will take place without any input from the physician.[57]

58. During the development of the future Act, it was often argued that euthanasia – even if it is entrusted to the doctor – is not a "medical procedure" but intrinsically an infraction.[58] Indeed, the law took away its unlawful character as soon as the fundamental conditions and procedural requirements had been met. Nonetheless, the law provides such a special act to be subject to social control. How else can we explain that the act of euthanasia, and it alone of all the actions of a physician, must be reported to the Control Commission?

59. Now, euthanasia and physician-assisted suicide are considered medical procedures or acts of health care. In the "Belgian model of integral palliative care", they are classified without any special distinction as acts of health care

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[51] Dr. D. Lossignol, "Soins palliatifs et euthanasie: la fin du conflit" [Palliative care and euthanasia: an end to the conflict], *La revue des soins palliatifs en Wallonie*, n° 14, 2012, p. 24.
[52] Report written for the Justice Commission, by Th. Giet, A. Van De Casteele, A. Barzin and J. Schauvliege, 23 April 2002, *Doc. parl.*, Ch. repr., n° 50–1488/009, p. 34, p. 176, p. 153, p. 337, p. 347, etc.
[53] http://www.admd.net/international/la-belgique.html.
[54] Cf. Portail Belgium.be, http://www.belgium.be/fr/sante/ (topic to choose on the site : soins de sante/fin de vie/euthanasie).
[55] Brochure published by one of the largest mutualities (health insurance companies) in Belgium, available at: http://www.mutsoc.be/.
[56] Proposed law amending the Act of 28 May 2002 on euthanasia, 7 July 2004, *Doc. parl.*, Senate, sess. 2003-2004, n° 3-804/1, p. 1.
[57] E.g., "Prise de position de l'Association belge des praticiens de l'art infirmier" [Position taken by the Belgian Association of Nursing Practitioners], November 2009, p. 3, http://www.infirmieres.be/admin/files/euthanasie%20avis%20com%20ethique%20acn.pdf.
[58] Report written on behalf of the Justice Commission, 23 April 2002, *Doc. parl.*, Ch. repr., sess. ord., 2001-2002, n° 50-1488/009, pp. 172-173, p. 151, p. 159, p. 172, p. 173, p. 183, etc.

among others in the set of end of life health care acts.[59] Since euthanasia has insinuated itself into palliative care, the image of the latter has become blurred: in Belgium, people at the end of their life do not dare to go to a palliative care unit and moreover fear the use of opioids that have legitimately been proposed to alleviate their pain and, even more, recourse to palliative sedation to treat refractory symptoms that is in keeping with established clinical practice. This means that we are measuring the impact of the law concerning euthanasia on the perception, effectiveness and development of palliative care.[60]

6. Health care institutions' freedom?

60. The Act on euthanasia explicitly states that the request and the written declaration in advance of the patient's wishes "have no binding force" (art. 14, para. 1). Similarly, a refusal clause, also called a "conscience clause", has been written into law. The result is that "no doctor is forced to perform euthanasia" and "no other person is forced to participate in euthanasia" (art. 14, para. 2 and 3). According to the standpoint of the legislature in 2002, the Act upholds "the measured faculty to make a request [for euthanasia]" and states that no criminal offense is committed by the physician "who freely agrees to respond positively".[61] No obligation is associated with this request, other than that, imposed on the physician who refuses to perform euthanasia, to inform "within a useful time" the patient or the trusted person, and to state his or her reasons. At the most, at the request of either of these people, the physician also has to transfer the patient's medical file to the physician appointed by the patient or by the trusted person (art. 14, para. 4 and 5).

61. Several bills tabled in Parliament seek to oblige a physician who refuses to approve a request for euthanasia to forward the file to another physician favourable to this practice.[62] If this type of proposal were adopted, it would

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[59] Cf. various works by Professors J. Bernheim, W. Distelmans et al., notably: "Questions and Answers on the Belgian Model of Integral End-of-Life Care: Experiment? Prototype?", *Bioethical Inquiry* (2014) 11: 507-529; "The Belgian model of integral end-of-life care: palliative care and euthanasia as complementary developments. I. Historical, epidemiological and regulatory data", *British Medical Journal* (2008) 336: 864-867; "Het Belgisch model van integrale levenseindezorg: palliatieve zorg en wettelijke euthanasie als aanvullende, niet tegenstrijdige ontwikkelingen. I. Historische, epidemiologische en regulatorische gegevens", in *Tijdschrift voor Geneeskunde* (2012), 68 (11): 539-548; "Euthanasia and Palliative Care in Belgium: Legitimate Concerns and Unsubstantiated Grievances", *Journal of palliative medicine* (2010) 13 (7): 798-799; "Development of palliative care and legalisation of euthanasia: antagonism or synergy?" *British Medical Journal* (2008) 336: 864-867.

[60] C. Dopchie (oncologist), "L'euthanasie tue-t-elle les soins palliatifs ?" [Is euthanasia killing palliative care?], *Les Cahiers francophones de soins palliatifs*, vol. 13, n° 2, 2014, pp. 28-41.

[61] G. Schamps and M. Van Overstraeten, "La loi belge relative à l'euthanasie et ses développements" [Belgian law on euthanasia and its evolution], in *Liber amicorum Henri-D. Bosly*, Bruges, La Charte, 2009, p. 352.

[62] E.g., Bill to amend the Act of 28 May 2012 on euthanasia, 9 May 2012, *Doc. parl.*, Senate, sess. 2011-2012, n° 5-1611/1; Bill, tabled the 16 August 2010, *Doc. parl.*, Senate, sess. extr. 2010, n° 5-22/1; Bill amending the Act of 28

constitute a serious breach of the physician's freedom of conscience because it would in fact oblige him or her to collaborate indirectly in an act that his conscience condemns.

62. The intention is also to oblige physicians to warn the patient on very short notice of their refusal to perform euthanasia.[63] In practice, things are not so simple, inasmuch as the refusal may result not from an objection of principle, but from the physician's inability to arrive, with the patient, at the conviction that there is no reasonable alternative (art. 3, § 2, 1°, of the law). It is especially common today for a patient, immediately upon learning of a disturbing diagnosis, to make a vague request for euthanasia; it is understandable that the physician wants to start by reassuring him or her, indicating that the disease is in the very early stages, that its evolution can be slowed or that the disease is curable, that therapies are possible...[64] Ultimately, these proposals intend to "associate the request for euthanasia with an additional binding condition" and thus "give more body to the right, cautiously established in 2002, to request death".[65] The claim, initially surreptitious (through manipulation of the language), but later more blatant, that there is a real "right to euthanasia" has been accompanied by a growing controversy about the institutional dimension of the "conscience clause".[66]

63. It seemed clear, during the preparatory work on the Act on euthanasia, that hospitals would be able to refuse to lend their assistance in the practice of euthanasia after the bill came into effect. In the report of the Justice Commission, for example, the following is stated: "The speaker (...) is expressly asking all members of the Commission whether they agree with the stance that

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May 2002 concerning euthanasia to introduce an obligation for the doctor who refuses to perform euthanasia to refer the patient to a colleague, 5 October 2012, *Doc. parl.*, Senate, session 2011–2012, n° 5-1798/1 (according to this latter proposal, the obligation would devolve on the social service of the institution).

[63] E.g., Proposed law amending the Act of 28 May 2002 concerning euthanasia to introduce an obligation for the doctor who refuses to perform euthanasia to refer the patient to a colleague, and to send the patient's medical file to a commission in the case that he or she has refused the patient's request, 26 June 2013, *Doc. parl.*, Senate, session n° 5-2172/1; Proposed law mentioned above, 10 January 2013, *Doc. parl.*, Senate, sess. 2012-2013, n° 5-1919/1. See the Flemish Government Decree of 14 September 2012 relating to programming, under the conditions of approval and the scheme for subsidising the organisations that offer health care and housing services and associations of users and close caregivers, their offering of family support services and complementary home care and day care centres - Appendix IX - Day care centres, *M. B.*, November 14, 2012, p. 68342.

[64] Information drawn from converging witness statements of medical oncologists.

[65] G. Schamps and M. Van Overstraeten, *op. cit.*, p. 353.

[66] For a summary of the debate, see S. Tack, "Recht op (uitvoering van) euthanasie? [Right to (performance of) euthanasia?] Instellingsbeleid en de professionele autonomie van de arts" [Institutional policy and the professional autonomy of the physician], *Revue de droit de la santé*, n° 12, 2013, pp. 7-22 and Comité consultatif de bioéthique de Belgique [the Bioethics Advisory Committee of Belgium], *Avis n° 59 du 27 janvier 2014 relatif aux aspects éthiques de l'application de la loi du 28 mai 2002 relative à l'euthanasie*, 2014, spec. pp. 13 to 43.

the bill under review will give hospitals the option of prohibiting the practice of euthanasia. The chairperson has concluded that, based on the correct interpretation of the bill under review, hospitals have the right to prohibit the practice of euthanasia within their walls. *No member* disputed the chairperson's interpretation".[67]

64. Today, however, hospitals that refuse to practice euthanasia are often pilloried and threatened with losing their public funding.[68] Here too, we are imperceptibly departing from the legislature's initial intentions. Whatever anyone may say, the assertion of "the ultimate freedom" for some goes hand in hand with constraints and pressures exerted on the freedom of others (health care workers, on the one hand, and health care institutions, on the other).

7. Extension of the Act on euthanasia to minors

65. In 2002, euthanasia was limited to adults (and emancipated minors). Since the Act of 28 February 2014,[69] euthanasia is now available to minors, *regardless of age*, if they can show that they are subject to constant and unbearable physical suffering that cannot be relieved and which results from a serious, incurable injury or pathological condition and which will result in death in the short term. In addition, on the one hand, it is necessary for a child psychiatrist or psychologist to certify that the child has the mental *capacity for discernment*, and on the other hand, for the parents agree.

66. This text, whose form and substance have been criticised by many, carries the seed of discrimination that will immediately be challenged; the text limits euthanasia to cases of "physical" suffering and "death in the short term", whereas these conditions do not apply to adults.

67. This reform was passed quickly, without any real social demand for it, despite the opposition of numerous paediatricians, professors of paediatrics and other

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[67] Report written on behalf of the Justice Commission, 23 April 2002, *Doc. parl.*, Ch. repr., n° 50 1488/009, p. 178. The words in italics are in the text.

[68] Publicly well-known: often repeated on the radio and on television. In the written press, see, for example, the proposals of Prof. W. Distelmans, *Le Soir*, 22 January 2011 and the interview with Senator Ph. Mahoux, "La loi doit être appliquée partout" [The law must apply everywhere], *Le Soir*, 25 February 2014. Cf. also the bill to amend the Act of 28 May 2002 on euthanasia and the associated Act of 10 July 2008 on hospitals and other health care facilities, with the intention of ensuring respect for the conscience clause , 26 June 2013, *Doc. parl.*, Senate, sess. 2012-2013, n° 5-2173/1.

[69] Act of 28 February 2014 amending the Act of 28 May 2002 on euthanasia, with the intention of extending euthanasia to minors, *Moniteur Belge*, 12 March 2014, p. 21053.

practitioners experienced in caring for seriously ill children.[70] Moreover, the extension to minors was adopted without going before the Public Health Commission of the Senate, after having refused to conduct all the expert hearings requested at the House of Representatives and, last but not least, without a request for an opinion from the Council of State. It is still to be mentioned that so far, no case of euthanasia for minors has been notified to the Control Commission.[71]

8. Euthanasia of the mentally incompetent

(a) Euthanasia for dementia patients

68. According to article 4, § 1 of the Act of 28 June 2002, any capable adult or a capable emancipated minor may, in the case that he or she can no longer express his or her wishes, draw up a written directive of his or her wish that a physician perform euthanasia if the physician confirms that (1) the patient suffers from a serious and incurable disorder caused by illness or injury and (2) the patient is in a state of irreversible unconsciousness.

69. Some bills tabled at Parliament have aimed at simplifying the wording and the confirmation of the *advance directive* by reducing the number of witnesses required, extending its period of validity, and even removing the obligation to confirm the directive.[72]

70. A number of new bills aim to extend the decriminalisation of euthanasia on the basis of an advance directive for the case where the physician believes that the patient, while not in an *irreversible coma* (whose criterion is a strict and objective

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[70] Opinion signed by 38 paediatricians, "Fin de vie des enfants: une loi inutile et précipitée" [Children's end of life: a useless and premature law], *La Libre Belgique*, 29 January 2014. The list of signatories grew in just a few days to nearly 200 paediatricians. Cf. A. Hovine, "Il faut reporter le vote sur l'euthanasie des enfants" [It's necessary to delay the vote on euthanasia of children], *La Libre Belgique*, 12 February 2014, p. 9. Information published in numerous other newspapers.

[71] "Nog geen euthanasie toegepast bij minderjarigen" [Euthanasia not yet applied to minors], *De Standaard* (23 April 2015).

[72] I shall limit myself to mentioning just the most recent bills: Bill to amend the Act of 28 May 2002 on euthanasia removing the limitation on the validity of the advance declaration to five years and permitting the patient to specify the validity period, 26 June 2013, *Doc. parl.*, Senate, n° 5-2171/1; Bill to amend the Act of 28 May 2012 on euthanasia regarding the registration process for advance directives, 24 January 2013, *Doc. parl.*, Senate, sess. 2012-2013, n° 5-1942/1; Bill to amend the Act of 28 May 2002 on euthanasia, 10 January 2013, *Doc. parl.*, Senate, sess. 2012-2013, n° 5-1919/1; Bill to amend the Act of 28 May 2002 on euthanasia removing the limitation on the validity of the advance declaration, 5 October 2012, *Doc. parl.*, Senate, sess. 2011-2012, n° 5-1799/1. Cf. also the Bill tabled 9 May 2012, *Doc. parl.*, Senate, sess. 2011-2012, n° 5-1611/1, Bill tabled 16 August 2010, *Doc. parl.*, Senate, sess. extr. 2010, n° 5-24/1.

test that is currently in force), is progressively losing his or her cognitive abilities and is no longer self-aware.[73]

71. Regularly, there are calls to extend the law to adults who are incapable of expressing their informed wishes, and in whom moments of conscious and lack of consciousness alternate, that is, people affected by degenerative mental illnesses (Alzheimer's disease and other forms of dementia).[74] Certain bills combine this standpoint with permitting an unlimited validity period for advance directives.[75] It is intriguing to note in how far these new bills ignore the prudential considerations stated during the development of the 2002 Act.[76]

(b) Euthanasia for newborns

72. Some parliamentarians are also arguing for the legalisation of neonatal euthanasia. This would involve newborns with a fatal disease or those who are very premature. It is apparent from one bill that it is "urgent to extend the Act on euthanasia to minors" by providing that "where the child does not have the capacity to discern" the parents may request euthanasia.[77]

73. Others favour adopting a protocol, outside of the Act,[78] based on the model of the Groningen Protocol adopted in the Netherlands for the euthanasia of newborns.[79]

(c) Unrequested euthanasia

74. There are currently calls to legalise unrequested euthanasia. As one critical care physician stated in a recent news article (25 February 2014), it is not a matter of increasing doses of analgesics to relieve pain or other symptoms, "but rather a matter of administering significant doses of sedatives to hasten death when the

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[73] E.g., Bill to amend article 4 of the law of 28 May 2002 on euthanasia, 8 April 2008, *Doc. parl.*, Senate, n° 4-676/1, which incorporates the text of a bill previously tabled 14 December 2005, *Doc. parl.*, Senate, sess. 2005-2006, n° 3-1485/1.

[74] Cf. statements by W. Distelmans, *De Standaard*, 16 February 2015; Ph. Mahoux, "La loi sur l'euthanasie: un débat à poursuivre" [The law on euthanasia: a debate to watch], *Le Soir*, 11 December 2014, p. 24.

[75] E.g., Bill to amend the Act of 28 May 2002 concerning euthanasia with the intention to extend this to people affected by an incurable and irreversible brain disorder, and who have expressed their will in an advance directive on euthanasia, 3 July 2013, *Doc. parl.*, Senate, n° 5-2184/1; Bill to amend the Act of 28 May 2002 on euthanasia, 9 May 2012, *Doc. parl.*, Senate, session 2011-2012, n° 5-1611/1.

[76] Cf., e.g, Report written on behalf of the joint Commissions for Justice and for Social Affairs, *Doc. parl.*, Senate, sess. ord. 2000-2001, n° 2-244/22, pp. 80, 329 to 334, 386 and ff., etc.; Report written on behalf of the Justice Commission, *Doc. parl.*, Ch. repr., sess. ord. 2001–2002, n° 50-1488/009, p. 249.

[77] Bill complementing, with respect to minors, the Act of 28 May 2002 on euthanasia, 9 May 2012, *Doc. parl.*, Senate, sess. ord. 2011-2012, n° 5-1610/1. Going in the same direction, previously, see *Doc. parl.*, Senate, n° 3-1993/1 and n° 4-431/1; *Doc. parl.*, Ch. repr., n° 2553/1 and n° 611/1.

[78] For example, Report written on behalf of the joint Commissions for Justice and Social Affairs, by Ms. Khattabi and Ms. Van Hoof, 4 December 2013, *Doc. parl.*, Senate, sess. ord. 2013-2014, n° 5-2170/4, p. 13.

[79] E. Verhagen, P.J. Sauer (2005), "The Groningen protocol – Euthanasia in severely ill newborns", *N. Engl. J. Med.*, 352 (10): 959-962.

quality of life has become insufficient".[80] The Belgian Society of Intensive Care Medicine published an article in the *Journal of Critical Care* (2014) clearly stating that it is about being able to practice euthanasia without an explicit request, with the assistance of analgesic agents or sedatives, even in the absence of discomfort, in full consideration of the family's wishes.[81]

IV. Reflection from the Belgian experience

75. Twelve years of experience in Belgium have taught us that, by various means, indications for euthanasia constantly multiply, despite the legislature's initial statements and intentions. This predictable evolution will inevitably continue not only because of the symbolic force of law and its immanent dynamic, but also for obvious logical and psychological reasons.

76. The law, general and abstract, disposes for the future. It conveys social, moral and cultural values; it structures social behaviour. The laws on health, life and death have a considerable impact on the mentality and *ethos* of a society. So it is with the law on euthanasia, which, far from being neutral and referring each person to his or her own autonomy, carries a specific anthropological vision and imposes it on one and all. From the moment that such a law leads to a substantial change in the mission entrusted to physicians, the conception and image of medicine are at stake. One cannot emphasise strongly enough the eminently symbolic, pedagogical and institutive functions of the law, particularly in the field of criminal law.

77. This evolution of euthanasia, from its inception as an exceptional practice and an ethical transgression into a practice that is ever more readily accepted, also for scenarios where it was initially not permitted, invites us to pay attention to the *logic that operates in the dynamics of law-making and implementation*.[82]

78. Indeed, enactments do not have an autonomous life that plays out solely in accordance with the will of the legislature that created them. They are part of the legal system, which, like any system, has its own dynamic determined by

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[80] J.-L. Vincent, Professor of intensive care (Free University of Brussels), "Maintenons la santé, mais pas la vie à tout prix" [Let's preserve health, but not life at any price], *Le Soir*, 25 February 2014, p. 26.

[81] J.-L. Vincent, M. Schetz, J.J. De Waele, S. Clément de Cléty, I. Michaux, Th. Sottiaux, E. Hoste, D. Ledoux, A. De Weerdt, A. Wilmer, On behalf of the Belgian Society of Intensive Care Medicine, "Piece of mind: End of life in the intensive care unit – Statement of the Belgian Society of Intensive Care Medicine", *Journal of Critical Care*, 29 (2014): 174-175.

[82] The following reflection takes its inspiration from the explanation of Mr. F. Keuleneer in the context of his audition, Report written on behalf of the Justice Commission, 23 April 2002, *Doc. parl.*, Ch. repr., n° 50 1488/009, p. 159 and ff.

macro principles (hierarchy of rules, principles of interpretation, principles of equality and non-discrimination, principles drawn from logic or common sense, such as "He who can do more can do less", etc.). It is legitimate to draw attention to real cases for which the law does not provide a satisfactory solution and to ask that the law be amended to achieve a desirable result for those cases. But we should ask at the outset whether the proposed approach will result in injecting a dynamic into the system that will have unforeseeable and unwanted effects.

79. In our constitutional systems, the fundamental principles of equality and non-discrimination have acquired an importance that is not lost on anyone. They dictate that similar legal treatment must apply to objectively similar situations and different legal treatments to objectively different situations. But we know that the assessment of situations (are they similar or not?) and the qualification of their legal treatment (are they similar or not?) are controversial questions.

80. Once euthanasia was decriminalised under certain conditions, it was logical that a tendency developed to consider very similar or even "slightly different" situations as similar and to invoke the principles of equality and non-discrimination to request euthanasia. For example, in the name of these principles, euthanasia, initially reserved for adults, will have to be opened to minors. As was foreseeable, the limit of 18 years was soon attacked as being arbitrary and a source of unjust discrimination. Another example: there is a requirement for constant and unbearable physical or mental suffering resulting from a serious and incurable disorder. However, in the name of the same principles, it quickly becomes difficult to refuse euthanasia to a person who reports only unbearable psychological suffering, but is not able to show a serious and incurable disorder. The Belgian experience attests to that.

81. Finally, in keeping with the philosophy of autonomy that is the foundation of the law, it seems logical and natural that, sooner or later, the "strict" legal conditions weigh less than the firm and specific wishes of the patient. Not surprisingly, euthanasia supporters assert: "Who, other than the person in question, can reasonably determine [the severity of his or her condition]?"[83] Similarly, a member of the Control Commission wrote: "Again, it comes down

[83] J.P. Jaeken, "Mise au point concernant des patients âgés" [The state of the art concerning elderly patients], *Bulletin de l'ADMD*, n° 112, June 2009, p. 10.

to the heart of the legislation that decriminalises euthanasia: respect for an individual's autonomy".[84] Although these views are rooted in common sense, they seem to disregard the other "strict conditions" of the law.

V. Final considerations

82. By way of conclusion, allow me to present a quick reflection based on extensive reading and considerable experience, sustained by regular contacts and discussions with physicians, nurses and palliative care workers.

83. The decriminalisation of euthanasia (or medically assisted suicide) is invariably justified by reference to the right to autonomy, self-determination or the "right to make one's own decisions". In a pluralist society that respects the autonomy of individuals, as is often repeated, no one can impose their convictions on others, and everyone must be able to choose their death. We can celebrate the remarkable advance of the idea of autonomy of the person and the political secularisation of society.

84. However, we are not obliged to adhere to the *ideology of autonomy*. The absolutisation of autonomy does not do justice to the complexity of things and is based on questionable assumptions. The Act on euthanasia conveys an unreal and fictitious picture of patients, cognisant of their own desires or wishes, sheltered from all influences and pressures, who have a completely free will and are masters of their choices despite oppressive suffering. In addition, it is abstractly believed that the request for euthanasia is a matter of purely personal choice: "my-choice-that-is-nobody-else's-business". The persons involved say they are the sole masters of their death, but other people experience it: the caregivers asked to end the life and their families who survive them.

85. Euthanasia (or assisted suicide) is not a private issue that involves only the person in question. It is always a public issue with an indisputable socio-legal-political dimension. There is a concern that fragile persons (gravely ill, the elderly, the disabled...) are under pressure, conscious or unconscious, and, fearful of being a burden for their families and society, find themselves under a *moral obligation* to exercise their right to euthanasia. [TRANSLATION] "Today,

[84] J. Herremans and P. Galand, Carte blanche "Euthanasie : entre l'application de la loi et son extension" [Euthanasia: from the application of the law to its extension], *Le Soir*, 2 April 2009, p. 14, published also in the *Bulletin de l'ADMD* (Belgique), n° 112, June 2009, p. 13.

dying with dignity ... is refusing to impose one's deterioration on others and a heavy and, unfortunately, useless burden on society", says writer Régine Deforges.[85]

86. Unlike suicide, which does not involve the medical community and does not receive society's approval, euthanasia results in a substantial change to the missions entrusted to doctors and affects foundations of the rule of law and the social order. The *conception* and *image* of medicine are in play because once euthanasia is legalised *all* physicians are given the power to administer death, if only on request, which risks altering patients' trust in the medical community and causing tension within medical teams and families. The integration of euthanasia into end-of-life care – following the so-called "Belgian model of integral end-of-life care" – is disastrous: in Belgium, persons who are at the end of their lives do not dare go to a palliative care unit and even fear the use of morphine, legitimately suggested to relieve their pain.

87. We must not delude ourselves: initially, euthanasia was presented as an ethical transgression, an exceptional act reserved for "extreme cases". Rapidly, by blurring the standards, euthanasia became a norm: "In the longer term, normalising the practice of euthanasia in institutions should be encouraged by the government (...)".[86] Euthanasia (or physician-assisted suicide) became one medical procedure among many others, and then a right to be claimed. "We are simply asking that our view be respected: we want to let people choose to stay in control of their body, their life and their death".[87] As was predictable and as we observe in reality today, supply creates demand... and tends to multiply it artificially. We are even seeing a spurt: five euthanasia cases a day were declared in 2013, and that's without counting all those that are not declared. Year after year, the number of euthanasia cases declared to the Control Commission continues to rise exponentially.

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[85] See http://www.admdblog.fr/Deces-de-Regine-Deforges-une-grande-militante-du-droit-de-mourir-dans-la-dignite-qui-nous-quitte_a2187.html.

[86] Cf. Collective of authors, "Actualisons la loi sur l'euthanasie" [Let's modernise the law on euthanasia], *Le Soir*, 14 June 2013, p. 14. See too the Opinion of Dr M. Cosyns, who opposes all conceptual distinction between legislation on euthanasia and that on patients' rights and palliative care, *De Standaard Magazine*, 21 December 2013, p. 58; Dr D. Lossignol, "Soins palliatifs et euthanasie : la fin du conflit" [Palliative care and euthanasia: an end to the conflict], cited above, 2012, p. 24.

[87] Collective of academics and physicians, "Dix ans d'euthanasie: un heureux anniversaire!" [Ten years of euthanasia: Happy Birthday!], *La Libre Belgique*, 20 June 2012, in response to a critical opinion previously published by a collective of academics and physicians, "Dix ans d'euthanasie: un heureux anniversaire?" [Ten years of euthanasia: Happy Birthday?], *La Libre Belgique*, 12 June 2013, p. 54.

2013	1454	353	1807
2012	1156	276	1432
2011	918	215	1133
2010	809	144	953
2009	656	166	822
2008	578	126	704
2007	412	83	495
2006	340	89	429
2005	332	61	393
2004	304	45	349
2003	199	36	235
	in Dutch	in French	Total

Table 3. Evolution in the number of registered euthanasia cases

88. It is also striking that more and more people ask to be euthanised although their death is not expected in the short term (17% of the total number of euthanasia cases declared in 2013 and 13% in 2012[88] versus 6% in 2006 and 2007[89]).

89. One might worry that, unwittingly, society is becoming ever more ready to put euthanasia forward as the most humane solution or the most dignified exit, as the level of tolerance for illness or suffering decreases and the bonds of solidarity wither. To tell the truth, this phenomenon is already perceptible, barely twelve years after the adoption of the law.

90. However, *society cannot yield to every individual request without endangering itself.* There are powerful social, psychological, legal and political reasons to resist the temptation to include the euthanasia exception in the law ... it quickly becomes clear that it cannot be contained within the limits assigned at the outset. A society is not an aggregate of autonomies. Limits must of necessity be assigned to individual wishes if we want to build a community.

91. In the end, in a secular and pluralistic democracy, euthanasia may be rejected in the name of public interests, such as protecting:

91.1 The specificity, moral integrity and image of medicine, whose mission is to restore health, save lives, alleviate pain, and undoubtedly not to provoke death;

[88] Control Commission, Sixth report (2012-2013), 2014, p. 8: 167 cases declared in 2012 and 266 cases in 2013.
[89] Control Commission, Third report (2006-2007), 2008, p. 15: 26 cases declared in 2006 and 28 cases in 2007.

91.2 The most vulnerable people of our society, which is the primary role of law; and

91.3 One of the essential foundations of the rule of law, according to which no one can deliberately dispose of the life of another person (except in case of legitimate defense against an unjust aggressor).

92. How to deal then with a chronically or terminally ill person requesting euthanasia or physician-assisted suicide? The appropriate response of medicine and society should be to avoid any form of therapeutic obstinacy; professionally relieve pain and other symptoms; and provide comfort care and good human support. The most ardent advocates of euthanasia admit themselves that the number of euthanasia requests due to physical pain is very limited; which is moreover confirmed by official figures. The latter is noticeably linked to the fact that modern medicine clearly has the resources to alleviate pain and make it bearable.[90]

93. Patients do not request to die if they are accompanied and affectionately surrounded, if they benefit from quality palliative care and if their pain and symptoms are treated with a high degree of professionalism. Relief of pain through proper administration of analgesics – or, in case of refractory symptoms, through palliative sedation in line with best-practice standards – obviously requires science, art and skill. If here and there people die 'badly', it is still too often because caregivers obstinately persist in keeping patients alive at any price and are unable to adequately relieve symptoms of discomfort. Experience shows that most requests for euthanasia are made by people who report a psychological suffering, most commonly due to a situation of loneliness or abandonment. Society would show little creativity and solidarity towards those people if she had nothing better to offer them than provoked death. Some euthanasia requests are also made out of philosophical beliefs but it must be said that society cannot have the right to comply with such requests, without putting itself in danger.

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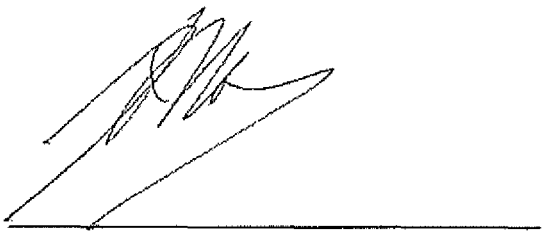
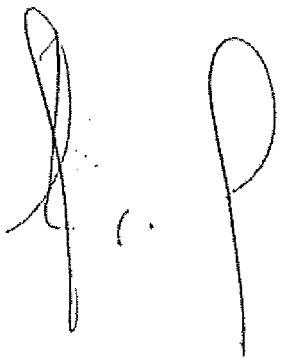
[90] See, for example, Report written for the Justice Commission], by Th. Giet, A. Van De Casteele, A. Barzin and J. Schauvliege, 23 April 2002, *Doc. parl.*, Ch. repr., sess. ord. 2001-2002, n° 50 1488/009, pp. 69-70, p. 83 and *passim.*

AFFIRMED)
at Brussels this sixth day of) 
May 2015)
before me:)

Etienne Montero

Guy CAEYMAEX
NOTAIRE
Rue Van Orley, 1
1000 BRUXELLES

A person authorised to administer oaths by the law of Belgium



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FORMATION ACADÉMIQUE

Études de droit aux Facultés Universitaires Saint-Louis à Bruxelles (1982-1984) et à l'Université Catholique de Louvain (1984-1987).

Docteur en droit de l'Université Catholique de Louvain, mai 1996, avec la plus grande distinction (*summa cum laude*).

EXPÉRIENCE PROFESSIONNELLE

Carrière académique

Actuellement, **professeur ordinaire** à l'Université de Namur.

Auparavant, successivement, chercheur (1988), puis assistant (1989-1996) et maître de conférences (1992-1996), chargé de cours (depuis 1996), puis professeur à l'Université de Namur.

Charges extérieures d'enseignement

- Professeur invité à l'Université Catholique de Louvain (1999 à 2002).
- Professeur invité à l'Université de Paris Est (2002-2008).
- Professeur invité à l'Université catholique d'Afrique de l'Ouest (UCAO), Abidjan (Côte d'Ivoire), pour un cours de master 2, avril 2015.
- Professeur invité à l'Université de Séville (Espagne), pour un cours de master, novembre 2014.
- Professeur invité à la faculté de droit de l'Université de Ouagadougou (Burkina Faso), dans le cadre du DEA en droit privé (février 2005, mars 2006, mars 2007, mars 2008).
- Professeur au Centre Universitaire de Charleroi (CUNIC) (1993 à 1995).
- Conférencier invité pour un cours de « Droit médical et bioéthique » (20h.), Faculté de droit de l'Université de Kinshasa en collaboration avec le Conseil National de l'Ordre des Médecins et le CEFA, août 2001.

Fonctions à l'université

-**Doyen** de la Faculté de droit, Université de Namur (septembre 2009-septembre 2013 ; réélu pour un second mandat).

-Vice-doyen de la Faculté de droit (sept. 2007-sept. 2009)
-Directeur du département de droit à la Faculté de droit (2003 à 2007).

-Membre de nombreuses instances institutionnelles (conseil académique, assemblée générale, bureau de faculté, conseil de faculté…).
-Directeur de l'Unité de Droit des obligations (2004-…).
-Représentant de la faculté de droit au Centre interfacultaire droit, éthique, sciences de la santé (CIDES) des F.U.N.D.P. et animation d'un séminaire de bioéthique (1998-2008).

Charges hors université et missions d'expertise

Président de l'Institut européen de bioéthique, Bruxelles.

Membre titulaire de l'Observatoire des Droits de l'Internet, auprès du Service public fédéral Economie (2001-2008).

Direction scientifique de plusieurs recherches ayant conduit à la rédaction de trois avant-projets de loi, un décret et deux arrêtés royaux d'exécution pour le compte du gouvernement fédéral belge, de la Région wallonne (Belgique) et du Gouvernement du Burkina Faso (projet financé en collaboration avec la Banque Mondiale).

Missions d'expertise régulières pour des entreprises privées ou des organismes publics (ONU, Commission de l'Union européenne, Parlement fédéral belge, Etat fédéral…).

Dernières missions d'expertise :

- **concernant la fin de vie**

- Affidavit pour la Cour Suprême du Canada, dans l'affaire *Lee Carter c Canada* (Procureur général), 2015 CSC 5.
- « Avis concernant différentes notions juridiques utilisées dans la proposition de loi modifiant la loi du 28 mai 2002 relative à l'euthanasie (doc. Sénat n° 5-2170/1) », à la demande des présidents des Commissions réunies de la Justice et des Affaires sociales du Sénat de Belgique, publié dans les Annexes du Rapport fait au nom des Commissions réunies de la Justice et des Affaires sociales, par Mmes Khattabi et Van Hoof, *Doc. parl.*, Sénat, sess. 2013-2014, n° 5-2170/4, p. 91 et s.
- Audition par Madame Mary Porter, Vice-Présidente du Parlement de la région de Canberra (Australie), dans le cadre d'une mission sur la fin de vie, Bruxelles, 26 juin 2013.
- Audition dans le cadre de la mission d'information sur la fin de vie confiée au Professeur Didier Sicard par le Président de la République Française, François Hollande, 29 novembre 2012.
- Rédaction d'un Affidavit, à la demande du Procureur général du Canada et du PG du Québec, pour la Cour Supérieure du Québec, dans le cadre de l'affaire *G. Leblanc c. Procureur général du Canada (défendeur) et Procureur général du Québec*, C.S. 400-17-002642-110, août-septembre 2012, 50 p.

➢ autres

- Audition dans le cadre des états généraux des médias d'information, Parlement de la Fédération Wallonie-Bruxelles, 25 octobre 2012.
- Expert des Nations Unies (CNUDCI) pour une mission à Libreville (Gabon) : participation à un atelier international organisé par l'Union internationale des télécommunications (UIT), en collaboration avec le Secrétariat général de la Communauté économique des Etats d'Afrique centrale (CEEAC) et la Commission de la Communauté économique et monétaire de l'Afrique centrale (CEMAC), du 28 novembre au 2 décembre 2011.
- Expert invité à collaborer avec la « Commission de suivi des abus sexuels dans le cadre de relations d'autorité » pour la mise au point d'un centre d'arbitrage en matière d'abus sexuels sur mineurs (avril 2011- avril 2012) et actuellement membre du Comité scientifique du Centre d'arbitrage.
- Consultance pour la Fédération Royale des Notaires de Belgique (FRNB) (2010).
- Consultance pour La Poste (2010).

Participation à des comités de rédaction de revues scientifiques

- Directeur de la collection du CRIDS aux éd. Bruylant (2002-2011), puis aux éd. De Boeck/Larcier (2011-...).
- Membre du comité international de Juriscom.net – droit des technologies de l'information.
- Membre du comité de rédaction de la *Revue Ubiquité – Droit des technologies de l'information* (depuis 1998).
- Membre du comité de rédaction de la *Revue internationale de droit des affaires* (depuis 1999).
- Président du Comité de rédaction belge de la Revue française *Droit de l'informatique et des télécoms* (1991-1999).
- Responsable du secteur "droit civil" et éditorialiste à l'*I.D.J.*, Kluwer (1995-1996).

Participation à des jurys de thèse de doctorat

- Promoteur de quatre thèses défendues à la Faculté de droit de Namur (avril 2009, juin 2012 et mars 2014).
- Promoteur de 3 autres thèses en cours.
- Membre de 5 jury de thèses : Université de Versailles Saint Quentin, décembre 2011 ; Université Pierre Mendès-France (Grenoble II), déc. 2008 ; Université de Namur, févr. 2006, juin 2004 et mai 2004.
- Présidence de nombreux jurys de thèse.

DOMAINES DE RECHERCHE

- Droit privé
- Droit privé et TIC
- Théorie du droit, bioéthique et biodroit

PUBLICATIONS

En droit privé :

- Auteur de **cinq ouvrages**
- Auteur de **onze livres** parus dans des traités collectifs
- Directeur scientifique de **neuf ouvrages**
- Auteur d'**une centaine d'articles** parus dans des revues scientifiques ou des ouvrages collectifs

En théorie du droit, biodroit et bioéthique :

A. Ouvrages

- E. MONTERO, *Rendez-vous avec la mort. Dix ans d'euthanasie légale en Belgique,* éd. Anthemis, Bruxelles, 2013.
- E. MONTERO, *Cita con la muerte. Diez años de eutanasia legal en Bélgica,* ed. Rialp, Madrid, 2013.

- E. MONTERO et B. ARS (co-dir.), *Suffering and dignity in the twilight of life,* The Hague, Kugler, 2004.
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- E. MONTERO et B. ARS (co-dir.), *Eutanasia – Sofferenza & dignità al crepuscolo della vita*, préface Prof. Francesco D'Agostino, Milan, Edizioni Ares, 2005.

B. Études, articles, dossiers

- "L'adoption consécutive à un contrat de mère porteuse", obs. sous Jeugdrechtbank Brussel, 4 juin 1996, *Rev.Dr.Santé*, 1997-1998, pp. 124-128.
- "Vers une légalisation de l'euthanasie volontaire? Réflexions à propos de la thèse de l'autonomie", Cahiers de la Faculté de droit de Namur, n° 3, juillet 1998, 15 p.
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- *quater*. "El derecho a la autonomía en el debate sobre la legalización de la eutanasia voluntaria", in *La Justicia Uruguaya* (Montevideo), tome 121, 2000, D 31-41.
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INTERVENTIONS DANS LES MEDIAS

En droit privé :

Une **douzaine d'interventions** dans la presse écrite et audiovisuelle.

En bioéthique :

- Interview sur le problème de l'euthanasie, *La Libre Belgique*, 10-11 nov. 1999.
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- Interview sur le processus législatif en vue de légaliser l'euthanasie en Belgique, dans *Yomiuri Shimbun* (Japon), 25 janvier 2000.
- Participation à l'émission télévisée « Mise au point » (débat sur l'euthanasie), R.T.B.F., dimanche 6 février 2000, de 11h45 à 12h45.
- Interview sur l'euthanasie dans *Vers l'Avenir*, 10 mars 2000.
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- Interview sur le thème « Quel bilan pour la loi sur l'euthanasie ? », *La Libre Belgique*, samedi 19-dimanche 20 mai 2012, p. 59.
- Participation à l'émission « Face à l'info » à propos de l'euthanasie, sur la Première (radio), RTBF, 5 juin 2012.
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- Interview en lien avec la mission présidentielle (française) sur la fin de vie, *Le point*, 13 décembre 2012, p.101.
- « Verbond tot de dood », *Tertio* (hebdomadaire flamand), n° 677, 30 januari 2013, p.13.
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