Reviewer's report

Title: Euthanasia and other end-of-life decisions: a mortality follow-back study in Belgium

Version: 2 Date: 12 January 2009

Reviewer: Reidun Førde

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Minor Essential Revisions

This is a well written, well structured and interesting paper which should be published after minor revisions.

The paper finds differences in end of life decisions within the same country with the same legal system and health care system. My main complaints is that these differences are not discussed extensively enough. This would make the paper more interesting.

I agree that physicians' attitudes probably can account for differences both in the decisions themselves and in the physicians' reporting of these. What do we know of the cultures in these two regions which can explain the figures? The Belgian and Dutch Medical Associations had different policies on euthanasia before laws was changed- has this influenced the two regions? Are there any other cultural differences between these two regions?

If the French speaking doctors to lesser degree accept interventions which shorten life, it is logical that they choose treatment with the likely result that the patient dies from his disease and not because of the intervention. E.g. the French speaking doctors more often administrate of fluids etc during palliative sedation - pain is relieved and life is (most likely)not shortened.

In the background (p.4) it is said that the comparison between countries is difficult because of different legal systems. Another well known difficulty when such comparisons are to be done is that the definitions of the different life ending decisions are different from study to study.

In this paper palliative sedation is not defined. Is pain relieving treatment which has sedation as a side effect included?

I also wonder how the GPs can know about what happened to the patients in hospital. This should be explained.

On p. 6 2.nd to last paragraph: GPs... registered all deaths of patients older than one year in their practice.

One important question from this reviewer is also how on p. 7.(2) intensifying alleviation of pain or other symptoms (taking into account or CO-INTENDING the hastening of death) can be separated from (3) and (4)? 28 % of the patients in this study received intensified symptom alleviation(apart from sedation). Is this much and should it be commented on more extensively? Also there were more
life ending interventions without the patient's request than with such request. Should this be commented on? This is more that in NL with the same legal system? Why

Can the authors also explain why one out of ten of the doctors did not answer whether they had discussed decisions with the patient?

On bottom of p.7 it is said that the researchers did follow up on the doctors to ensure data quality. Did this interfere with anonymity?

I had trouble reading table 4, can it be improved? May be euthanasia can be left out of the table, since explicit request from the patient is part of the euthanasia definition!

Early in the discussion section it is said that "These general figures correspond to the relative proportions found in other studies and countries WITH THE SAME LEGAL SITUATION? (In Scandinavia euthanasia is less frequent). The authors also say on p. 14 that life-shortening decisions are more prevalent in northern European countries: This must be excluding Scandinavia (See Griffiths' book Euthanasia and Law in Europe 2008.

**Level of interest:** An article whose findings are important to those with closely related research interests

**Quality of written English:** Acceptable

**Statistical review:** Yes, but I do not feel adequately qualified to assess the statistics.

**Declaration of competing interests:**

I declare that I have no competing interests.