



First do no harm: pressing concerns regarding euthanasia in Belgium[☆]



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ABSTRACT

This article is concerned with the practice of euthanasia in Belgium. Background information is provided; then major developments that have taken place since the enactment of the Belgian *Act on Euthanasia* are analysed. Concerns are raised about (1) the changing role of physicians and imposition on nurses to perform euthanasia; (2) the physicians' confusion and lack of understanding of the *Act on Euthanasia*; (3) inadequate consultation with an independent expert; (4) lack of notification of euthanasia cases, and (5) organ transplantations of euthanized patients. Some suggestions designed to improve the situation and prevent abuse are offered.

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1. Introduction

This article is concerned with the practice of euthanasia in Belgium. Euthanasia is defined as a practice undertaken by a physician, which intentionally ends the life of a person at her explicit request. Physician-assisted suicide is different than euthanasia in that the last act is performed by the patient, not by the physician. The physician provides the lethal drugs to the patient who takes them by herself.

Since the enactment of the Belgian *Act on Euthanasia* in 2002, biannual reports are being published by the Federal Control and Evaluation Commission assigned to monitor the law's application. A constant increase in registered euthanasia cases has been observed, predominantly in the Flemish part of Belgium. The number of reported euthanasia cases increased from 0.23% of all deaths in 2002 to 0.49% in 2007 (1.9% in Flanders) (Bilsen, Cohen, Chambaere, et al., 2009; Le Soir, 2011; Smets, Bilsen, Cohen, Rurup, & Deliens, 2010).

The methodology of this research is based on critical review of the literature supplemented by interviews and exchanges with leading scholars and practitioners during 2003–2011. After a brief presentation of the *Act on Euthanasia*, concerns are raised about (1) the changing role of physicians and imposition on nurses to perform euthanasia; (2) the physicians' confusion and lack of understanding of the *Act on Euthanasia*; (3) inadequate consultation with an independent expert; (4) lack of notification of euthanasia cases, and (5) organ transplantations of euthanized patients. Finally, some suggestions designed to improve the situation are offered. The Belgian legislators and medical establishment are invited to reflect and ponder so as to prevent potential abuse.

2. The Belgian law

On January 20, 2001, a commission of Belgium's upper house voted in favor of proposed euthanasia legislation, which would make euthanasia no longer punishable by law, provided certain requirements were met (Weber, 2001, p. 372). On October 25, 2001, the Belgium's Senate approved the law proposal by a significant majority: 44 for, 23 against, 2 abstentions and 2 senators who failed to register a vote.

According to the *Belgian Act on Euthanasia* of May 28, 2002, the patient's physician needs to inform the patient of the state of his/her health and of his/her life expectancy, discuss with the patient his/her request for euthanasia and the therapeutic measures which can still be considered as well as the availability and consequences of palliative care (Cohen-Almagor, 2009a, pp. 191–196).¹ This provision is crucial, as at sometime the patient's decision might be influenced by severe pain (Ruddick, 1997; Cohen-Almagor, 2002; Mäntyselkä et al., 2003).² In Oregon, about one third of patients who asked for physician-assisted suicide had inadequate pain control or were concerned about it (*Oregon's Death with Dignity Act, 2011*). Although most Flemish palliative care physicians agree that there may be circumstances in which a euthanasia request is justified, they also strongly believe in the effects of good palliative care and want the 'palliative filter' to be included in the law on euthanasia (Broeckaert, 2009).

The attending physician is required to consult another physician about the serious and incurable nature of the patient's condition.

¹ *Belgian Act on Euthanasia*, Chapter II, Section 3, no. 2(1), http://www.ethical-perspectives.be/page.php?LAN=E&FILE=ep_detail&ID=33&TID=59.

² See also *Scientists find connections in the brain between physical and emotional pain (2003)* and other articles in this *JAMA* issue, devoted to pain and pain-management.

[☆] All websites were accessed during July 2012.

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The consultant needs to study the patient's medical record, examine the patient and ascertain the constant and unbearable nature of the physical or mental suffering. S/he will then write a report of her/his findings. The consultant must be independent from the patient as well as from the treating physician, and be competent to evaluate the pathological condition of the patient.³ The physician who performs euthanasia is required to fill in a notification form and submit it within four working days to the Federal Control and Evaluation Commission. The Commission has to verify that the euthanasia was performed according to the prescribed procedure (*Belgian Act on Euthanasia*, Chapter IV, Section 5).

3. Concerns about the law

3.1. The role of physicians and nurses

Luc Deliens, a leading expert from the Department of Medical Sociology and Health Sciences at Vrije Universiteit, Brussels, has argued that the healthcare system is based on treating the disease, but at the end-of-life stage the paradigm has shifted from the disease to the patient. Following the enactment of the euthanasia law, physicians are required to devote their energies to patients and their loved ones. They are also required to consult with other specialists, to spend time and better the communication among all concerned. Physicians found this difficult because they did not receive adequate training.⁴ Indeed, the importance of palliative care as communicating with patients is a core skill of palliative medicine (Boult & Wieland, 2010; Steinhäuser et al., 2000) and palliative psychiatry. Sometimes patients are reluctant to talk to family members and friends about their illness and its impact on life because they do not wish to worry others or take up their time. As not all physicians are willing to have intimate conversations about patients' feelings and emotions, this is where a psychologist can come in, work with the patients and their loved ones as well as with the healthcare providers to devise a strategy for treatment. Palliative psychiatry can be helpful in managing symptoms alongside medical and nursing staff, such as pain, breathlessness, fatigue and treatment side-effects; clarifying issues of personal autonomy; coping with changes as a result of the patient's condition, and managing feelings of uncertainty (Mitchell & Owens, 2000; Monroe & Oliviere, 2003).

Another concern relates to the role of nurses at the end of life. The law clearly stipulates that only physicians may administer the lethal drugs for euthanasia. The law stipulates the physician's duties and actions, including specifically "The physician who performs euthanasia..." (*Belgian Act on Euthanasia*, Chapter III, Section 4, no. 2). Nurses believe that administering lethal medication is beyond their competence (Dierckx de Casterlé, Verpoort, De Bal, et al., 2006). But a recent study shows that 12% of nurses in Flanders administered the drugs, mostly without the physician co-administering (86%) (Inghelbrecht, Bilsen, Mortier, & Deliens, 2010, p. 907). In using life-ending drugs without explicit request, 48% of nurses helped prepare drugs, 56% were present during administering and 45% administered the drugs, mostly without the physician co-administering (82%) but under physician orders (98%) (Inghelbrecht et al., 2010). Another study concerning patients who were euthanized despite not having made an explicit request to die shows that in almost half of these cases (6 of 13) the final drug was given by a nurse (Meeussen, Van den Block, Bossuyt, et al., 2010, p. 186). Nurses should certainly be involved in the medical decision-making process, but the law should be scrupulously obeyed. Nurses should not be asked to assume the role of the physicians nor

voluntarily assume this role themselves. Physicians and nurses should have the required knowledge of the law to ascertain that each professional is acting in accordance with the legal responsibility assigned to him or her. Nurses should not perform acts of ending lives even if physicians explicitly order them to do so. Especially worrying is the high number of incidents where nurses administered lethal drugs to patients who did not explicitly wish to die; this was done mostly without the physician co-administering (82%). One may assume that this was no coincidence and that physicians wished to shift responsibility from themselves, by imposing it on nurses who could not refuse the order.

3.2. Physicians' confusion and lack of understanding of the law

A survey conducted among physicians in 2009, seven years after the legislation of the *Act on Euthanasia*, showed that there was no consensus among physicians either about the labeling of euthanasia and other end-of-life decisions, or about which cases were required by law to be reported to the Federal Control and Evaluation Commission. Belgian physicians were sent a questionnaire that included several case studies and they were asked to label each and every case as one of the following: euthanasia, palliative/terminal sedation, life-ending without explicit request, intensification of pain and symptom treatment, or other. Two out of 10 physicians, likely to be involved in the care of dying patients, failed to label a hypothetical case in which a physician ended the life of a patient at the patient's explicit request as "euthanasia". Three out of 10 did not know that the case had to be reported. Most physicians labeled the euthanasia case in which the physician ended the patient's life at that patient's explicit request using morphine as "intensification of pain and symptom treatment" (39%) or as "palliative/terminal sedation" (37%). Only 21% of physicians correctly labeled this case "euthanasia" (Smets, Bilsen, et al., 2011). Obviously, mislabeling of end-of-life practices could impede societal control over euthanasia. Care-givers in Belgium should undergo specific training designed to equip them with ample understanding of the *Act on Euthanasia* and what is required of them.

3.3. Inadequate consultation

A recent study conducted by Van Wesemael et al. revealed both the problem of inadequate consultation as well as the great importance of adequate consultation. In 35% of the cases (n = 235) physicians failed to consult an independent specialist (Van Wesemael, Cohen, Bilsen, Smets, et al., 2011). Physicians failed to adhere to the law in a significant number of cases. Of the cases where consultation was sought, there was disagreement between the first and the second physician in 23% of cases. Where the second physician had given a concurring advice, euthanasia was performed in 78% (n = 140) of cases, compared with 10% (n = 4) of cases where the physicians were in disagreement (Van Wesemael et al., 2011). Causes for disagreement show that medicine is not an exact science; hence the importance of having a second opinion. In matters of life and death, caution is a primary necessity. In 26% (n = 12) of cases, the consultant did not think that the patient had endured unbearable suffering. In 31% (n = 14) the consultant did not think that the patient suffered from a medically hopeless condition. In 10% (n = 5), the consultant thought the euthanasia request was not well considered. In 26% (n = 12), the consultant thought that there were palliative options that needed to be exhausted first (Van Wesemael et al., 2011).

Smets et al. found that physicians failed to consult a specialist due to various reasons:

- because they did not consider the case at hand as "clear case of euthanasia" (Smets, Bilsen, Van den Block, et al., 2010);
- because another case "was a case of euthanasia outside the euthanasia law" (Smets, Bilsen, Van den Block, et al., 2010);

³ *Belgian Act on Euthanasia*, Chapter II, Section 3, no. 2(3), <http://www.kuleuven.ac.be/cbmer/viewpic.php?LAN=E&TABLE=DOCS&ID=23>.

⁴ Interview with Prof. Deliens (February 17, 2005).

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