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Belgian euthanasia law: a critical analysis

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ABSTRACT

Some background information about the context of euthanasia in Belgium is presented, and Belgian law on euthanasia and concerns about the law are discussed. Suggestions as to how to improve the Belgian law and practice of euthanasia are made, and Belgian legislators and medical establishment are urged to reflect and ponder so as to prevent potential abuse.

This study is based on a critical review of the literature supplemented by interviews I conducted in Belgium with leading scholars and practitioners in February 2003 and February 2005 about the practice of euthanasia. I first provide background information about euthanasia in Belgium and then discuss its law on euthanasia and voice some concerns, suggesting some constructive ideas to improve the practice of euthanasia.

BACKGROUND

In April 2002, the Netherlands completed the legislation process of the euthanasia law.^{1,2} Belgium debated whether to follow the path of its Dutch neighbour. For some time, there were no formal registration and authorisation procedures for end-of-life decisions in medical practice in Belgium. Although euthanasia was illegal and was treated as intentionally causing death under criminal law, prosecutions were exceptional, and—generally speaking—the practice of euthanasia was tolerated.

Studies have shown that more than one in 10 deaths among the country's 10 million people were the result of "informal" euthanasia, in which doctors gave patients drugs to hasten their death.³ There are more studies in the Dutch-speaking north than in the French-speaking south. In the south people tend to rely on physicians, whereas in Flanders the focus is on patients' autonomy. The Flemish are more open about euthanasia than the French. In the north (Flanders) the reporting percentage is higher. Requests for euthanasia are more common. There is more emphasis on quality of life (personal communication; interviews with Professor Guido Van Steendam, Director, Biophilosophy Center, STARLAB, Brussels, 5 February 2003, and Professor Pierre-François Laterre, Director, Intensive Care Unit, St Luc Hospital, Brussels, 16 February 2005). Also in Flanders, there are hundreds of physicians gathered in consultant teams for euthanasia, called Leifartsen. The Leifartsen is comparatively small in the south (personal communication; interview with Professor Freddy Mortier, professor of ethics and dean of the Faculty of Arts and Philosophy, Ghent University, 14 February 2005).⁴ Large hospitals in Flanders are more likely to have an

ethics policy on euthanasia.⁵ A study conducted in Flanders in 1998 showed that despite lack of legislation permitting euthanasia, end-of-life decisions were common among general practitioners. In Flanders, where 60% of the population resides, more than 5% of all deaths in general practice (an estimated 1200 cases) resulted from the use of drugs with the explicit intention of shortening the patient's life.⁶ The rate of administration of lethal drugs to patients without their explicit request was according to one research paper 3.2%⁷ and according to another published paper, stemming from the same study, 3.8%—three times more frequent than euthanasia.^{1,6} That is, more than three in 100 deaths in the Flemish region every year were the result of lethal injection without the patient's request.⁸ Professor Luc Deliens (Department of Medical Sociology and Health Sciences, Free University of Brussels) said that countries that lack euthanasia law have more cases of the ending of life without the patient's request than of real euthanasia on the explicit request of the patient (personal communication; interview, 17 February 2005). At the same time, Deliens and colleagues wrote in an accompanying paper on the use of drugs for euthanasia that their study results indicate an inconsistent, poorly documented and substandard medical approach to euthanasia in Flanders.⁹ Interestingly, among the 25 observed euthanasia cases in this study, three physicians reported an explicit request by the patient and, at the same time, the patient's incompetence.⁷ Confusion was not lacking in the end-of-life decision-making process.

The Flanders study also showed that the incidence of euthanasia and physician-assisted suicide was 1.5%.⁶ In most cases, euthanasia and physician-assisted suicide were discussed with relatives and non-staff members, and in just under half with other physicians or nurses.⁷ The decision was not discussed with the patient in three out of four decisions at the end of life.⁶ In general, the patient was perceived by the physician as competent. For all deaths preceded by an end-of-life decision, the time by which life was shortened was estimated by the physician as less than a day in just under a quarter of cases, with most (80%) by less than a week. End-of-life decisions taken without previous discussion with the patient or a previously stated wish were made in about two-thirds to three-quarters of all categories apart from euthanasia. Life was ended without a request and by the withdrawal or withholding of treatment mainly for incompetent patients.⁷ A colleague was consulted in one in four end-of-life decisions.^{6,10}

¹ The difference between the figures can be explained by the fact that the latter figure, 3.8%, relates only to general practitioners.

Discussion with colleagues took place more often in these cases than for patients who received opioids with a potential life-shortening effect.^{7 11}

THE BELGIAN LAW

On 20 January 2001, the euthanasia commission of Belgium's upper house voted in favour of proposed euthanasia legislation that would make euthanasia no longer punishable by law, provided certain requirements were met.¹² On 25 October 2001, Belgium's senate approved the proposed law by a significant majority: 44 for, 23 against, 2 abstentions and 2 senators who failed to register a vote. In society at large, an opinion survey showed that three-quarters of those asked were broadly in favour of legalising euthanasia.^{ii 3} On 16 May 2002, after 2 days of heated debate, the Belgian lower house of parliament endorsed the bill by 86 votes in favour and 51 against, with 10 abstentions.^{iii 13}

The legislation lays out the terms for doctors to end the lives of patients who are hopelessly ill and are suffering unbearably. Potential candidates for euthanasia need to reside in Belgium to be granted this right. Patients must be at least 18 years old and have made specific, voluntary and repeated requests that their lives be ended. Section 3 of the law speaks of patients who are adults or emancipated minors, capable and conscious at the time of their request. *Emancipated minors* is meant to refer to an autonomous person capable of making decisions (personal communication; interview with Laterre, 16 February 2005). Freddy Mortier explained that *emancipated minors* relates to "boundary cases of 16–17-year-old patients" (personal communication; interview, 6 February 2005). Guido Van Steendam further explained that the legislators made the phrase vague on purpose, as a matter of principle, in order to defend the autonomy of as young patients as possible (personal communication; interview, 5 February 2003).

Euthanasia requests are approved only if the patient is in a hopeless medical condition and complains of constant and *unbearable physical or mental pain* that cannot be relieved and is the result of a serious and incurable accidental or pathological condition. At least 1 month must elapse between the written request and the mercy killing.¹⁴ The 1 month requirement is valid only when the patient is not considered "terminally ill" (ie, in neurological conditions such as quadriplegia).

The one-month requirement is a tricky issue, especially for patients and doctors in intensive care units. Professor Jean-Louis Vincent, Head of the Department of Intensive Care in Erasme Hospital (University of Brussels), explained that he and his staff do not wait for 1 month as the law requires: "The law is not applicable to ICU [intensive care unit]" (personal communication; interview with Vincent and his assistant, Dr J Berre, 6 February 2005). He maintained that the average stay in his department is 3.5 days, and treatment depends on the condition. When doctors see that there is no help available, they put patients to sleep. Beneficence is the guiding rule.

The patient's physician must inform the patients of the state of their health and of their life expectancy and discuss with the patients their request for euthanasia and the therapeutic

measures that can still be considered as well as the availability and consequences of palliative care.¹⁴ This provision is crucial, as sometime the patient's decision might be influenced by severe pain.^{iv 15 16} Indeed, Caritas Flanders, the Flemish Christian-inspired umbrella organisation for cooperation and consultation in healthcare and public welfare, installed the so-called "palliative filter procedure", intended to ensure that all palliative possibilities are investigated and that all persons involved consult each other thoroughly on the euthanasia request as well as the remaining palliative possibilities.¹⁷

Mortier explained that for some time palliative care was viewed with reluctance, as palliation seemed to be opposed to euthanasia. People who supported the euthanasia law thought it would be contradictory to the practice to include palliative care. Many adversaries of euthanasia thought that providing palliative care might eliminate euthanasia. During the debate in 2000 and 2001 before the passage of the law, people mainly from the Catholic universities argued that euthanasia will disappear once palliative care is provided. Consequently, inclusion of a requirement to consult an expert in palliative care was rejected in parliament. However, together with the euthanasia bill, another bill was passed for organised palliative care (personal communication; interview with Mortier, 14 February 2005). This bill provided the basis for a steep increase in the means that were already available for palliative care. Mortier maintained that the situation has changed for the better since 2000 and 2001. There is dialogue between proponents of euthanasia and proponents of palliative care. The mood is more favourable to the inclusion of the provision of palliative care in the process. Mortier noted that palliative care specialists were consulted in 40% of the reported cases concerning terminal patients. For non-terminal patients, 20% included consultation with palliative care specialists. Palliative care physicians are involved in the process (personal communication; interview with Mortier, 14 February 2005).¹⁸ On the other hand, Hubert van Humbeeck noted in his remarks on a draft of this paper that palliative care was growing in importance but as the political urgency evaporated politicians became less keen to provide more money. Palliative care is expensive, and thus palliative care units are struggling (personal communication, 27 June 2007).¹³

CONCERNS ABOUT THE LAW

In 2003, Pierre-François Laterre thought that the law was inefficient, because there were not enough safeguards; he thought we had better work on adequate care, palliative care. To his mind, if care was organised carefully there was no need for euthanasia (personal communication; interview, 16 February 2003). Two years later, he thought that the law reflected the common denominator. He and Luc Deliens thought that the law was neither too wide nor too narrow. The law did not change the practice as far as Laterre was concerned, as an intensive care specialist. Laterre testified that he did not need regulation to decide when to end life. He was in favour of limiting care, of withholding care when the quality of life is very poor. Here Laterre's view was similar to that expressed by Jean-Louis Vincent, who maintained that the law does not help very much because it deals with a very small subset of patients (personal communication; interview with Vincent and Berre, 6 February 2005). In a recent personal communication, Vincent wrote that the law may serve some who deal with slowly progressing diseases but is more harmful than helpful in the majority of cases—that is, in patients who are not fully conscious towards the end of their life. Vincent

ⁱⁱ Mortier said that several opinion polls indicated that 85% to 93% of the public supported the enactment of euthanasia law (personal communication; interview, 14 February 2005).

ⁱⁱⁱ The bill was on the website of the Belgian senate (http://www.senate.be/home/legislation_under_the_number_2-244/23) but is no longer available.

^{iv} See also *JAMA*, vol 290, no 18, 12 November 2003, devoted to pain and pain management.

asserted, "In the ICU we often increase the doses of sedative agents at the end of life, but the person has not signed any document, so that this may become unlawful." Vincent would prefer to see a law clearly emphasising that doctors must often do that as part of the beneficence principle (personal communication of Jean-Louis Vincent, 10 December 2008). The law did change Laterre's relationship with patients' families. After the enactment of the law they sometimes ask: Don't you believe that what you are doing is futile, constituting medical harassment? Don't you think you are doing too much? They ask, said Laterre, "Don't let my father survive like a vegy." Families are now feeling more confident expressing such views. Thus Laterre thought discussion about the law increased people's awareness about quality of life (personal communication; interview with Laterre, 16 February 2005). After further pondering, Laterre was not sure whether there was a need for a law, as the situation was good enough. He wondered whether a change was necessary, whether the law actually helped.

Luc Deliens begged to differ. He regarded the law as an important constitutional tool, as it had lifted a taboo. To his mind, while in most of the world physicians do not speak of end-of-life decisions openly, "in Belgium we speak openly about terminating life of dying competent patients". While in the wider world, physicians probably have the same practice but conduct it behind closed doors, "we believe it is better to discuss things, in order to have exchange of ideas and expertise" (personal communication; interview with Deliens, 17 February 2005).

Interestingly, Deliens thought that the drawbacks of the euthanasia law are that healthcare providers find themselves in a more complicated situation. They need to invest more in their patients, and communication is time consuming. Deliens argues that the healthcare system is based on treating the disease, but at the end of life the paradigm shifts from the disease to the patient. The patient is at the centre of care. The physician is now required to devote energy to the patients and their loved ones, to consult with other specialists, to spend time and improve the communication between all people concerned. Physicians find this difficult, because they are not adequately trained for it (personal communication; interview with Deliens, 17 February 2005). Indeed, the importance of palliative care as communicating with patients is a core skill of palliative medicine.¹⁹ Empirical evidence supports the effectiveness of clinicians' use of specific communication skills in enhancing disclosure of the issues of concern to patients and often their loved ones, decreasing anxiety, assessing depression and improving patients' well-being and the level of the patients' and the families' satisfaction with the treatment. Those communication skills include making eye contact with patients, asking open-ended questions, responding to patients' affect and demonstrating empathy.^{20 21}

Jan Jans remarked that while the bill on palliative care was clear on the need for substantial additional training and updating, the euthanasia bill did not translate this need into requirements with regard to competence in palliative care of the physician involved.²² Many physicians do not possess the necessary palliative know-how and experience.^{23 24}

Mortier thought that the law was too narrow, as it relates to adults, and he would have liked to expand it to include patients 16 years old and above. Although the law does mention "emancipated minors", boundary cases of 16- to 17-year-old patients, Mortier argued that there were very few cases of emancipated minors who received a doctor's help to die. He believed that 16-year-old cancer patients are capable of deciding their fate and therefore he would like to expand the law to

youths of 16 years and above. Furthermore, Mortier highlighted the fact that the law does not stipulate what drugs physicians should use. As a result, in the reported cases, various drugs were used: barbiturates, muscle relaxants, potassium chloride, morphine and insulin. Clear guidelines are needed. Mortier also favoured including physician-assisted suicide in the law (personal communication; interviews with Mortier, 6 February 2005 and 14 February 2005). Conversely, Van Steendam thought that the law is too wide, even wider than in the Netherlands. For instance, a mental condition that leads a patient to wish to die is accepted as grounds for euthanasia. Section 3 speaks of a patient who is in a hopeless medical condition and complains of constant and unbearable physical or mental pain that cannot be relieved and is the result of a serious and incurable accidental or pathological condition. Van Steendam maintained that the law increased public attention and awareness of euthanasia (personal communication; interview, 5 February 2003).

The law thus opens the door for physically healthy persons to ask to end their lives because they may be tired of life. Does a person who finds no meaning in life suffer unbearably? It would be very difficult, almost impossible, for an assessment committee to judge whether the criteria for euthanasia are satisfied if the symptoms cannot be interpreted in the context of the physical condition.²⁵

Another issue that is of concern is the prevalence of terminal sedation. This practice refers to the intentional administration of sedative drugs in dosages that lead to unconsciousness and later to death. Laterre said that terminal sedation happens frequently in intensive care units. This is the approach midway between euthanasia and withholding treatment (personal communication; interview with Laterre, 16 February 2005). According to Vincent, terminal sedation is the most common death in the intensive care unit, occurring in one half of all hospital deaths (Jean-Louis Vincent, personal communication, 10 December 2008). Terminal sedation is not euthanasia, or slow euthanasia, because euthanasia requires the consent of the patient, while terminal sedation does not by definition require consent. In many cases there is no knowledge of whether the patient's consent was sought or given. There is no formal scrutiny of how careful the procedure is. The physicians do not have any directives on this. There is no legal regulation. There is no knowledge of whether consultation was provided. There is no public or professional check. Mortier thinks that physicians should seek patients' consent for the procedure. When consent is granted, no problem arises. Problems arise when patients have not given their consent to the procedure (personal communication; interviews with Deliens, 17 February 2005, and Mortier, 14 February 2005).²⁶

CONCLUSIONS

Medical experts argued that the number of mercy killings carried out in Belgium has actually remained relatively constant and that the main difference since the new law was passed is that doctors no longer have to carry out illegally a service that some of their terminally ill patients requested.

In Belgian society, quality of life is important. Euthanasia is what the people want and now politicians are studying the situation before they decide to introduce further changes. Laterre and Deliens said that the government did not think there was a problem with the practice of euthanasia. Its wish was to have quiet, to remove the subject from the public agenda (personal communication; interviews with Laterre and Deliens, 16-17 February 2005). Wim Distelmans (personal communication,

2 July 2007), on the other hand, does not think that the debate is over. On the contrary, he said that the extension of the law to minors and adults affected by damaged brain function (as in cerebral metastases or dementia) is debatable. At present, the debate revolves around euthanasia of children and young people as well as of mentally ill and demented patients (personal communication, Jean-Louis Vincent, 10 December 2008).

Much of the success of the practice of euthanasia is dependent on the general practitioners. Physicians need to remain aware of the very powerful role their recommendations can play in people's treatment choices and of the undue ways in which their recommendations can influence patients. It is important to get patients to talk out loud about their values before making treatment recommendations. Often, this type of conversation will make it easier for physicians to determine what recommendation is most appropriate for a patient and whether the patient is comfortable deciding what to do without receiving a recommendation.

Luc Deliens noted that in Belgium, as in the Netherlands, there are only a few cases of physician-assisted suicide. He explains this by saying that in both countries there is a tradition of doctors administering drugs. It is a very different culture from the British and the American ones, where physicians are far more reluctant to use lethal drugs. In addition, there is also the issue of taking responsibility. Physicians like to have control over the process. To have better control, physicians prefer euthanasia to oral drugs (personal communication; interview with Deliens, 17 February 2005).

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REFERENCES

1. **The Termination of Life on Request and Assistance with Suicide (Review Procedures) Act, 1 April 2002, Royal Decree of 15 March 2002.** *OJ* 2002;165. <http://www.healthlaw.nl/index2.html> (accessed 14 Apr 2009).

2. **Cohen-Almagor R.** *Euthanasia in the Netherlands*. Dordrecht: Springer-Kluwer, 2004:37.
3. **Osborn A.** Belgians follow Dutch by legalising euthanasia. *The Guardian* 26 October 2001.
4. **Distelmans W**, de Strooper P. LEIFartsen (life end information forum—physicians): improvement of expertise on end-of-life care among physicians [poster 422]. *4th Research Forum of the European Association for Palliative Care, Collaborate to catalyse research*; 25–7 May 2006, Venice. <http://www.makeevent.it/ScientificProgrammeScheme/participationAbstract.jsp?id=27958> (accessed 14 Apr 2009).
5. **Lemiengre J**, de Casterlé BD, Verbeke G, *et al.* Ethics policies on euthanasia in hospitals: a survey in Flanders (Belgium). *Health Policy* 2007;**84**:170–80.
6. **Bilsen J**, Vander Stichele R, Mortier F, *et al.* The incidence and characteristics of end-of-life decisions by GPs in Belgium. *Fam Pract* 2004;**21**(3):282–6.
7. **Deliens L**, Mortier F, Bilsen J, *et al.* End-of-life decisions in medical practice in Flanders, Belgium: a nationwide survey. *Lancet* 2000;**356**:1806–11.
8. **Reuters.** *Lethal jabs study fuels Belgian euthanasia debate*. 24 October 2000.
9. **Vander Stichele RH**, Bilsen J, Bernheim JL, *et al.* Drugs used for euthanasia in Flanders, Belgium. *Pharmacoepidemiol Drug Saf* 2003;**13**:89–95.
10. **van der Heide A**, Deliens L, Faisst K, *et al.* End-of-life decision-making in six European countries: descriptive study. *Lancet* 2003;**362**:345–50.
11. **Mortier F**, Deliens L, Bilsen J, *et al.* End-of-life decisions of physicians in the city of Hasselt (Flanders, Belgium). *Bioethics* 2000;**14**:254–67.
12. **Weber W.** Belgian euthanasia bill gains momentum. *Lancet* 2001;**357**:372.
13. **Griffiths J**, Weyers H, Adams M. *Euthanasia and law in Europe*. Oxford: Hart, 2008.
14. **[Belgian Act on Euthanasia of May 28th 2002]**. Kidd D, trans. Chapter 2, section 3. Translation in *Ethical Perspect* 2002;**9**:182–8. <http://www.kuleuven.ac.be/cbmer/viewpic.php?LAN=E&TABLE=DOCS&ID=23> (accessed 14 Apr 2009).
15. **Cohen-Almagor R.** *The right to die with dignity: an argument in ethics, medicine, and law*. Piscataway, New Jersey: Rutgers University Press, 2001.
16. **Ruddick W.** Do doctors undertreat pain?. *Bioethics* 1997;**11**:246–55.
17. **Gastmans C**, Van Neste F, Schotsmans P. Facing requests for euthanasia: a clinical practice guideline. *J Med Ethics* 2004;**30**:214.
18. **Deliens L**, Bernheim J. Palliative care and euthanasia in countries with a law on euthanasia. *Palliative Med* 2003;**17**:393–4.
19. **Steinhauser KE**, Christakis NA, Clipp EC, *et al.* Factors considered important at the end of life by patients, family, physicians, and other care providers. *JAMA* 2000;**284**:2476–82.
20. **Morrison RS**, Meier DE. Palliative care. *New Engl J Med* 2004;**350**:2582–90.
21. **Romer AL**, Hammes BJ. Communication, trust, and making choices: advance care planning four years on. *J Palliat Med* 2004;**7**:335–40.
22. **Jans J.** The Belgian 'Act on Euthanasia': clarifying context, legislation, and practice from an ethical point of view. *J Soc Christ Ethics* 2005;**25**:171.
23. **Lemiengre J**, de Casterlé BD, Denier Y, *et al.* How do hospitals deal with euthanasia requests in Flanders (Belgium)? A content analysis of policy documents. *Patient Educ Couns* 2008;**71**:293–301.
24. **Cohen-Almagor R.** Dutch perspectives on palliative care in the Netherlands. *Issues Law Med* 2002;**18**:111–26.
25. **Huxtable R**, Möller M. 'Setting a principled boundary'? Euthanasia as a response to 'life fatigue'. *Bioethics* 2007;**21**:117–26.
26. **Cohen-Almagor R.** Euthanasia policy and practice in Belgium: critical observations and suggestions for improvement. *Issues Law Med* 2009;**24**:187–218.