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Published in:
Medical Law International

DOI:
10.1177/09685332231204737

Publication date:
2023

This is not an act of euthanasia: legally correct but ethically problematic?

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Introduction

In Belgium, incurable patients in a situation of intolerable physical and/or psychological suffering due to a medical condition may request euthanasia.[1] An additional condition of their eligibility for euthanasia is that the suffering they experience cannot be alleviated. The group of patients who meet these conditions also includes those who are not terminally ill or, in other words, who "will not die in the foreseeable future".

Stricter conditions apply for this latter group than for patients who will die in the foreseeable future. Non-terminal patients must wait at least one month between their written request and the performance of the euthanasia. Further, in addition to the initial advice of an independent physician, the performing physician must consult a second independent physician who is either a specialist in the patient's condition or a psychiatrist.

In Belgium, the Federal Commission for the Control and Evaluation of Euthanasia (FCCEE) is tasked with the *ex post* control of the practice of euthanasia, functioning as a buffer between the physician who declares that an instance of euthanasia has occurred and the criminal justice system. The FCCEE evaluates cases using the written reports completed and submitted by physicians who have performed euthanasia.

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[1] Law on Euthanasia of May 28, 2002, *Belgian Official Gazette,* June 22, 2002.

In 2015, for the first time since its establishment in 2002, the FCCEE referred a physician to the public prosecutor's office. At the time, the FCCEE co-chair stated to the press that the Commission was discharging its functions properly.[2] However, some commentators argue that the FCCEE has made too few referrals to the public prosecutor over the course of its existence.[3] The FCCEE's decision to report the physician was based on the report of euthanasia performed on a non-terminally ill 85-year-old woman—a case in which the legal conditions were thought to have been violated. There was no second independent opinion from a psychiatrist, and in an Australian documentary film covering the case,[4] the physician involved stated that the patient had requested euthanasia not because she was depressed, "but because she had had enough".[5] The absence of a medical diagnosis and of a second independent medical opinion in the case of a non-terminal illness are two violations of the euthanasia law.[6]

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[2] *De Morgen,* October 30, 2015. https://www.demorgen.be/leven-liefde/wie-de-juiste-woorden-kiest-krijgt-euthanasie-zo-door-de-controle~b1fe0b76/ (accessed May 16, 2023).

[3] K. Raus, B. Vanderhaegen, S. Sterckx, 'Euthanasia in Belgium: Shortcomings of the Law and Its Application and of the Monitoring of Practice', *J Med Philos,*1(2021), pp. 80-107.

[4] Dateline, 'Allow me to die' (Season 2015 Episode 31), *SBS Australia.* https://www.youtube.com/watch?v=hCRpuTRA7-g&t=65s (accessed March 22, 2023)

[5] *De Standaard,* October 28, 2015. https://www.standaard.be/cnt/dmf20151028_01943198 (accessed March 22, 2023).

[6] For patients with mental illness, a diagnosis is crucial to verify that sufficient time has been taken to try all "reasonable" treatment options. This is a prerequisite to determining that a patient is "untreatable."

However, in 2019, the Antwerp court sitting in chambers decided not to pursue the physician in criminal court. The court did not make the reasons for its decision public. News reports suggested that the court had ruled that this was not a case of euthanasia because the patient imbibed the lethal potion herself.[7] Yet the physician had declared the situation to the FCCEE in 2015 and therefore had understood themself to have performed an act of euthanasia.

This commentary examines the ethical questions and legal uncertainty created by the decision of the Antwerp court. After twenty years of euthanasia practice, it appears that the strict conditions set by legislators can be circumvented relatively easily. Different parties appear to interpret the law in different ways. Therefore, we advise amending the Belgian Euthanasia Law to remove any remaining ambiguities. Countries preparing physician-assisted dying legislation should take note of the Belgian situation to avoid similar problems.

Legal aspects

Belgian legislators have defined euthanasia as the deliberate ending of the patient's life *by someone other than the subject involved* at the subject's request. The person performing the euthanasia must be a physician.[8] The euthanasia law does not cover any other end-of-life decisions, such as termination of life without a patient's request.

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[7] *De Juristenkrant,* November 6, 2019, pp. 12-3.

[8] Law on Euthanasia, 2002.

The Belgian euthanasia legislation, in contrast to the Netherlands and Luxemburg legislation, does not include the term *physician-assisted suicide*.[9] This means that, in principle, a doctor administers the lethal agent to the patient, either via an intravenous infusion, or by directly injecting the lethal agent. Some doctors prefer that the patient self-administers the lethal drug, for example by opening the infusion tap of a pre-placed infusion or by drinking the lethal agent. The law does not specify the manner in which euthanasia must be performed.

When legislators were drafting the Belgian Euthanasia Law, some tried in vain to add the term "physician-assisted suicide" so that it would be clear that the law should treat the two practices equally. They argued that an arguably less far-reaching action by a doctor should not be subject to stricter conditions.[10] This could be the case when physician-assisted suicide falls outside the scope of the legal permission granted by the Euthanasia law. The opposition to including "physician-assisted suicide" in the legislation appears based on misconceptions. While "euthanasia" was significantly associated with the terminal phase, the term "physician-assisted suicide" became associated with the non-terminal phase and with a practice less subject to criteria of due care.[11] Of course, neither associations are necessarily true of physician-assisted suicide. Some legal commentators have proposed amending the law to add the term "physician-

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[9] E. Delbeke, 'Assisted suicide: the need for a separate criminalisation with a conditional ground of justification' (in Dutch), *Tijdschrift voor Gezondheidsrecht*, 12 (2011), pp. 263-275.

[10] E. Delbeke, 'Assisted suicide', p. 272.

[11] Op cit., p. 273.

assisted suicide*"* for the sake of legal certainty.[12] Such proposals have not yet been successful.

The FCCEE treats both types of administration–the physician administering the drug or the patient self-administering the drug–as equivalent as long as the legal conditions for euthanasia are respected and the physician remains with the patient until the time of death.[13] It thus *de facto* condones a form of physician-assisted suicide. The National Council of the Order of Physicians also follows this view as outlined in one of its recommendations.[14]

While the Antwerp court's reasoning in this case remains unclear, news reports suggest that the judge may have ruled that no act of euthanasia took place. Rather, he or she may have determined that the conduct in question amounted to physician-assisted suicide, which, strictly speaking, is not covered by the law.[15] Were this indeed the underlying reasoning, the question arises as to whether the prosecution should have been based on other grounds, namely *unintentional manslaughter due to imprudence, violations of the legislation on psychotropic substances,* and *culpable failure to provide*

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[12] M. Adams, H. Nys, 'Euthanasia in the low countries. Comparative reflections on the Belgian Euthanasia Act' (in Dutch), *Tijdschrift voor Privaatrecht*, 40(2003), pp. 11-48.

[13] Federal Commission for the Control and Evaluation of Euthanasia (FCCEE), 'First report to the Parliament 2002-2003' (in Dutch and in French), 2004. https://overlegorganen.gezondheid.belgie.be/nl/documenten/fcee-euthanasieverslag-2004 (accessed March 22, 2023)

[14] Belgian National Board of Physicians, 'Advice from March 22, 2003 concerning palliative care, euthanasia and other medical end of life decisions' (in Dutch and in French), *Tijdschrift Nationale Raad,* 11(June, 2003).

[15] De Juristenkrant, p. 12.

assistance.[16] The intention cannot be that physician-assisted suicide should be allowed to occur under less strict conditions than those applicable to euthanasia. Furthermore, there is no separate criminalization for assisted suicide in Belgian criminal law.[17] Thus, assisted suicide also cannot be prosecuted on the basis of secondary criminal liability because suicide is not punishable in Belgium.

When evaluating the alternative grounds for prosecution, some legal experts have concluded that these grounds do not fully respond to the specific context of physician-assisted suicide.[18] We argue that Belgian legislation can be amended to resolve these problems. For example, legislators could elaborate a separate penal provision for assisted suicide in the criminal code.[19] The Euthanasia Law could then be expanded to regulate assisted suicide in a medical context.

In 2022, Belgian politicians agreed on a new penal code, expected to enter into force in 2025. It will include the offence of "incitement to suicide".[20] It is possible that this addition to the law will solve part of the problem outlined above.

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[16] E. Delbeke, 'Assisted Suicide', p. 264.

[17] E. Delbeke 'The punishability of assisted suicide by a non-physician' (in Dutch), *Tijdschrift voor Gezondheidsrecht*, 16(2015), pp. 297-304.

[18] E. Delbeke, 'Assisted suicide', p. 264.

[19] Op. cit., p. 272.

[20] Het Laatste Nieuws, November 5, 2022. https://www.hln.be/binnenland/nieuw-strafwetboek-milieuschade-en-aanzetten-tot-zelfdoding-voortaan-strafbaar~a493bb00/ (accessed May 16, 2023)

Ethical aspects

The Belgian Euthanasia Law is founded on the principle of respect for the patient's autonomy. Unlike in the Hippocratic tradition,[21] in which the medical practitioner determines what benefits or harms the patient using their own judgement, in euthanasia, it is the patient who makes the decision. The Belgian Euthanasia Law does not cover end-of-life decisions in which the patient is (often) not consulted, or where this is impossible – such as allowing non-viable babies to die, discontinuing futile treatments, or not starting or continuing life-saving treatments. The focus on patient autonomy is consistent with contemporary views of medical ethics, which typically associate autonomy with well-being. If well-being depends on one's aims and values, then self-determination is valuable in promoting that person's well-being.[22] At the heart of voluntary physician-assisted dying, then, is the idea that only the incurable patient can decide whether their life still has value. The Belgian Euthanasia Law emphasises

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[21] The Hippocratic Oath is part of the Corpus Hippocraticum, some 60 medical tracts from the fifth and fourth centuries BC, which have been traced to many ancient Greek authors. The Oath established several general ethical principles for the medical profession. Traditionally, physicians relied almost entirely on their own judgement about what was good for the patient in terms of information and treatment. The principle of respect for the autonomy of the patient did not become part of biomedical ethics until the late 1970s, see: Etienne Vermeersch, *From Antigone to Dolly. Forty Years of Critical Thinking* ed. J. Braeckman and H. Van den Enden (Antwerpen/Baarn, Hadewijch, 1997), pp.168-172**.**

[22] Allen Buchanan, Dan Brock, *Deciding for Others: the Ethics of Surrogate Decision Making,* (Cambridge, Cambridge University Press, 1989), pp. 36-40.

this by stipulating that the patient must have decision-making capacity and have made a voluntary request free of external pressure.[23]

The principle of autonomy is not absolute in this case. The implementation of the patient's decision requires the intervention or the help of a physician (in Belgium, several physicians must cooperate). Physicians, together with the patient, must conclude that the conditions laid down by the law are satisfied.[24] Moreover, according to the Belgian Euthanasia Law no health worker can be required to support patients in their request for euthanasia.[25] Here, the law emphasises the freedom of everyone involved to act following their own moral framework. In 2020, the Belgian Euthanasia Law was amended in several ways, further promoting patient autonomy. Medical practitioners who refuse euthanasia based on freedom of conscience have the duty to inform the patient of this refusal within seven days of the written request and refer them to another physician appointed by the patient. A refusal on medical grounds must also be communicated and recorded in the medical file. In the event of a refusal, the physician is obliged to provide the patient with the contact details of a centre specialising in euthanasia law. The medical file must be provided to a medical practitioner appointed by the patient.[26]

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[23] Law on Euthanasia, 2002.

[24] Belgian Advisory Committee on Bioethics, 'Opinion no. 59 of 27 January 2014 on ethical aspects of the application of the Law of 28 May 2002 on euthanasia', 2014, 1-66.

[25] Law on Euthanasia, 2002.

[26] Law of 15 March 2020, amending the Law on Euthanasia of May 28 2002, *Belgian official Gazette*, 23 March, 2020.

A physician's resistance to participating in voluntary physician-assisted dying need not always be based on ethical considerations; it could also have psychological grounds. Surveys in countries without end-of-life legislation seem to indicate that physicians are generally more open to physician-assisted suicide than euthanasia.[27] Some may experience more emotional distress in the case of euthanasia because of the more far-reaching actions required of the physician. Administering lethal medication to end a patient's life requires a greater commitment from the medical practitioner than in physician-assisted suicide. Furthermore, personal values and norms, such as religious beliefs or ethical convictions, can play a role in physicians' willingness to support patients in their request for physician-assisted dying. A Belgian survey among psychiatrists at the university centre, "Universitair Psychiatrisch Centrum K.U. Leuven", indicates that there is a substantial difference between religious and non-religious physicians, in their views on the issue of euthanasia for psychological suffering caused by a psychiatric disorder.[28]

In Belgium, legislators only included the possibility of euthanasia in the law. The question arises whether it would not be better also to include physician-assisted suicide. We believe several arguments support this position. A major argument is that both end-of-life decisions serve the same purpose: promoting the well-being of patients facing unbearable suffering by respecting their decisions and removing suffering that

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[27] I. Torjesen, 'BMA should drop its opposition to assisting dying, say members in landmark poll', *BMJ*, 371 (2020).

[28] S. Wouters, J.Vandenberghe, J.De Lepeleire, et al., 'Euthanasia: opinions and experiences of university employed Flemisch psychiatrists' (in Dutch), *Tijdschrift voor Psychiatrie*, 5(2021), 336-343.

cannot be alleviated by other means. Since they rest on the same foundation, one could argue they should be treated with the same care and require similar monitoring of the practice to prevent abuse. Furthermore, although the relevant end-of-life decisions share this common goal, they evoke different emotions among physicians. We view this as another argument for ensuring the law covers both options. If both end-of-life decisions are legally regulated, doctors and patients can engage in whatever practice they see as best.

In what follows, we give some arguments for why one of the two relevant end-of-life decisions may be preferred. In addition to the previously mentioned argument that administering medication can be more emotionally demanding than just delivering it, there is a second argument for physician-assisted suicide. This argument is that having the patient take the lethal drug themselves is the ultimate proof of fully autonomous choice. It can be argued that physician-assisted suicide assumes the patient's willingness to take responsibility for the decision to terminate life. However, some doctors and patients might prefer the practice of euthanasia to that of physician-assisted suicide, for example, because the direct injection of the lethal agent ensures a faster dying process. A second argument in favour of euthanasia stems from practices in certain countries related to laws regarding physician-assisted suicide. In these countries, the doctor delivers the medication, and the patient takes it at a chosen time without anyone else present. In Oregon, for example, patients can ask their doctor to be present when they take their medication, but this certainly does not always happen.[29] Some

[29] In Oregon, a total of 133 physicians wrote 383 prescriptions for lethal medication to end a patient's life during 2021. Prescribing physicians were present at time of death for 36

believe this should remain a matter between patient and doctor.[30] However, patients' responses to medication can differ greatly from one individual to another. There is always a risk that the dying process will take longer than anticipated or that the patient will vomit the lethal agent, thus interrupting the dying process. When conducting euthanasia – an act that takes place in the presence of a physician – the physician can still intervene if this occurs.

Finally, there are potential issues of discrimination when only one of the two end-of-life decisions is legally regulated. In the case of physician-assisted suicide, patients who can no longer take the lethal agent orally themselves are discriminated against when other options are not available. For example, this may occur in patients with oesophageal carcinoma. When only euthanasia is regulated, a similar problem occurs when intravenous administration is difficult. If both end-of-life decisions are available, one can fall back on the patient's oral drug intake.

Conclusion

Countries currently working on legislation to permit euthanasia and/or physician-assisted suicide should consider the scope of the law and the legal

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(15%) of the 238 patients who died using physician-assisted suicide, see: Public Health Division. Center for Health Statistics, 'Oregon Death with Dignity Act. 2021 Data Summary', 2022, 1-19. https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/index.aspx (accessed July 19, 2023)

[30] D. Orentlicher, T. M. Pope, B.A. Rich, 'Clinical Criteria for Physician Aid in Dying', *Journal of Palliative Medicine,* 3(2016), 259-262).

terminology used in this context. If they decide to allow one of these end-of-life decisions, we believe they would be well-advised to also expressly allow the other.

We argue that euthanasia and physician-assisted suicide have the same moral purpose: to remove unbearable and hopeless suffering at the patient's explicit request by having their life ended and respecting the principle of autonomy.

We have provided several arguments for why physicians may prefer one kind of end-of-life decision over another. These arguments can be of an ethical, theological, psychological, or practical nature.

We believe that making the two options discussed here legally viable, makes for an ethical gain. The availability of both options promotes the autonomy and rights of both the patient and the physician by allowing them to engage in the mode of life-ending conduct that is best in the specific circumstances of the case. Provided that the same due care criteria apply, both the option for euthanasia and physician-assisted suicide should exist. Furthermore, a thorough monitoring of the practice of both relevant end-of-life decisions is necessary to prevent abuse.

A major legal problem may have been uncovered in Belgium in 2019: physicians would not be prosecuted performing "euthanasia" under conditions that are less strict than those provided for in the Law on Euthanasia of 2002. This issue is undoubtedly related to the terminology used, which is apparently still insufficiently clear and allows for different interpretations. Although there are many similarities between euthanasia and physician-assisted suicide, there is a legal distinction between the two, which is reflected in the description of euthanasia as a life-ending action by *a person other than the patient*.[31] This formulation excludes physician-assisted suicide.

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[31] Law on Euthanasia, 2002.

This problem could lead to the acquittal of doctors who violate the terms of the law. Whether this occurred in the case discussed here remains unclear because the judge in chambers did not disclose the reasoning behind his judgement.

A simple solution to this problem could be to adjust the legal framework. For example, legislators could elaborate a separate penal provision for assisted suicide in the criminal code.[32] In addition, they could expand the euthanasia law to regulate assisted suicide in a medical context.

[32] E. Delbeke, 'Assisted suicide', p. 272.