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Published in:
International Journal of Law and Psychiatry

DOI:
10.1016/j.ijlp.2024.101961

Publication date:
2024

License:
CC BY-NC-ND

Document Version:
Final published version

Link to publication

Citation for published version (APA):
Verhofstadt, M., Van Assche, K., Pardon, K., Gleydura, M., Titeca, K., & Chambaere, K. (2024). Perspectives on the eligibility criteria for euthanasia for mental suffering caused by psychiatric disorder under the Belgian Euthanasia Law: A qualitative interview study among mental healthcare workers. *International Journal of Law and Psychiatry*, *93*, [101961]. https://doi.org/10.1016/j.ijlp.2024.101961

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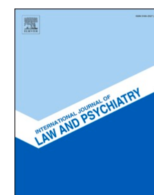
Download date: 17. Jul. 2024

International Journal of Law and Psychiatry 93 (2024) 101961

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

journal homepage: www.elsevier.com/locate/ijlawpsy



Perspectives on the eligibility criteria for euthanasia for mental suffering caused by psychiatric disorder under the Belgian Euthanasia Law: A qualitative interview study among mental healthcare workers

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ARTICLE INFO

Keywords:
Euthanasia
Assisted dying
Mental disorders
Psychiatry

ABSTRACT

Introduction: Euthanasia in adults with psychiatric conditions (APC) is allowed in Belgium and impacts a variety of workers in this field, including psychiatrists, psychiatric nurses, psychologists, and support "buddies". This study examines their perspectives on the appropriateness of the current legal criteria for, and practice of, euthanasia in the context of psychiatry, and their suggestions to properly implement or amend these criteria.
Methods: Semi-structured interviews were conducted with 30 Dutch-speaking mental healthcare workers who had at least one experience with an APC requesting euthanasia, in Flanders and Brussels (Belgium), between August 2019 and August 2020. Interview transcripts were analyzed through qualitative content analysis.
Findings: Our study shows that, for these mental healthcare workers, only one of the legal eligibility criteria to assess euthanasia requests by APC (i.e., unbearable suffering) is rather straightforward to interpret. In addition, there was a lack of consensus on what aspects of the Euthanasia Law should be modified and in what way.
Conclusions: Many mental healthcare workers do not well understand or misinterpret the legal criteria for euthanasia involving APC. Criteria are sometimes defined so narrowly that euthanasia requests by APC are generally deemed ineligible or, alternatively, are stretched to allow for inclusion of cases that go beyond what the Law intended. Our study indicates the need for an authoritative professional code of conduct offering clear advice for Belgian euthanasia practice in the context of psychiatry. It is also recommended that future trainings are standardized, supported by the most important professional associations in the field, and freely available to all who are confronted with euthanasia requests from APC or who offer support to APC who consider euthanasia.

1. Introduction

Euthanasia, defined as the intentional termination of life by a physician at the patient's request, is currently decriminalized in Australia, Belgium, Canada, Colombia, Luxembourg, the Netherlands, Portugal, Spain, and New Zealand (Mroz, Dierickx, Deliens, Cohen, & Chambaere, 2021). Belgium (Belgian Official Gazette, 2002a) is one of a very few countries – along with the Netherlands (Dutch Official Gazette, 2002), Luxembourg (Luxembourg Official Gazette, 2009), and Spain (Spanish Official Gazette, 2021) – that extends eligibility for euthanasia to Adults with Psychiatric Conditions (APC) (see BOX A for the legal requirements). Canada was working to expand its legal framework to APC as of March 2023, but this date has been delayed by one year (Government of Canada, 2023).

Euthanasia is legal in Belgium since 2002, making the country a pioneer in this field. Since 2002 until 2022 there have been 409 officially reported cases of euthanasia performed predominantly for psychological suffering caused by a psychiatric condition (FCECE (Federal Control- and Evaluation Committee on Euthanasia), 2022; Verhofstadt, 2022, p. 52). These cases account for <1.5% of all registered euthanasia cases (Dierickx, Deliens, Cohen, & Chambaere, 2017; FCECE (Federal Control- and Evaluation Committee on Euthanasia), 2016, 2018, 2020, 2021,

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https://doi.org/10.1016/j.ijlp.2024.101961
Received 29 August 2023; Received in revised form 22 December 2023; Accepted 1 February 2024
Available online 7 February 2024
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2022, 2023). However, there is reason to believe that the total number of APC who request euthanasia is several times higher. Recent studies revealed that the vast majority of surveyed psychiatrists and psychiatric nurses in Flanders have been confronted with euthanasia requests from APC (De Hert et al., 2015; Demedts, Roelands, Libbrecht, & Bilsen, 2018; Verhofstadt et al., 2020a). In addition, around 100 APC per year consult Vonkel (Vonkel, 2020, 2022; Vonkel, 2021), one of the few end-of-life consultation centers, along with REAKIRO and LEIF Ulteam, founded with the aim to provide assistance in the management of complex euthanasia cases.

A variety of stakeholders working professionally or as volunteers in this field are involved in current euthanasia practice. These include psychiatrists, psychiatric nurses, and paramedical personnel such as psychologists. Consultation centers also rely on volunteers or “buddies”, who are entrusted with the task to support these patients throughout the euthanasia procedure. A recent interview study revealed that all of these professional healthcare workers and volunteers are strongly affected by and have an important role in euthanasia procedures. Therefore, they may have a unique perspective to reflect on euthanasia legislation and practice concerning APC (Verhofstadt et al., 2022). However, their perspectives regarding the legal criteria are largely understudied. To date, the scarce extant research has merely focused on psychiatrists' (Pronk, Evenblij, Willems, & van de Vathorst, 2019; Verhofstadt et al., 2020b) – and to an even lesser degree – psychiatric nurses' attitudes regarding euthanasia legislation and practice (De Hert et al., 2015; Demedts et al., 2018). In addition, research examining physicians' perspectives has focused only on some of the legal criteria, including APC's mental competence, the irremediableness of mental illness and the persistence of mental suffering (Doernberg, Peteet, & Kim, 2016; Schweitser, Stuy, Distelmans, & Rigo, 2020; van Veen et al., 2020; van Veen, Ruissen, & Widdershoven, 2020; Verhofstadt et al., 2021). As a result, Belgian and Dutch studies show that the assessment outcomes of eligibility criteria differ between individual physicians (i.e., to some extent due to their personal values and belief system) (Evenblij, Pasman, Pronk, & Onwuteaka-Philipsen, 2019; Pronk et al., 2019; Schweitser et al., 2020; Monica Verhofstadt et al., 2021), which has led to disagreement among physicians in the final assessment (Doernberg et al., 2016; Kim, De Vries, & Peteet, 2016). No such research on other legal and due care criteria, such as the age limit and safeguards regarding the monitoring and evaluating of the euthanasia practice, has been conducted.

Considering the ongoing debate, the purpose of this research is to explore mental healthcare workers' perspectives regarding the practice of euthanasia under current legal criteria in the context of psychiatry, to what extent they deem these criteria (in)appropriate, and their suggestions for further legal amendments. Their first-hand experiences can be important from a legal, ethical, and clinical perspective, for all countries considering a framework regarding medically assisted dying that includes APC.

2. Method

2.1. Study design and participants

The qualitative interview research design consisted of semi-structured face-to-face or online interviews with healthcare workers, in Flanders and Brussels (Belgium), between August 2019 and August 2020. All the participants were Dutch-speaking and needed to have at least one concrete experience with euthanasia requests from an APC and/or a euthanasia procedure involving APC between the years 2016 and 2020. No further exclusion criteria were employed.

2.2. Recruitment and interview procedure

Recruitment procedures were developed with the intent of creating a heterogeneous sample, in terms of socio-demographics, clinical profile and clinical setting. Purposive sampling was therefore used, to also ensure diversity in participants' affiliation with institutions holding different stances on euthanasia and psychiatry, in the amount of experience (sporadically versus regularly), and in the nature of the experiences (e.g., confronted with or engaged in euthanasia procedures that were still under review or that had been rejected, granted, performed, or withdrawn).

Participants were recruited with the assistance of our contact persons at: 1) End-of-Life Consultation Center Vonkel; 2) the Brothers of Charity; 3) REAKIRO; and 4) the Review Belgian Euthanasia Law for psychological suffering (REBELpsy) group. Participants were also recruited via a notice on the websites, newsflashes and/or online newsletters of LEIF (Life End Information Forum), Recht op Waardig Sterven (the Flemish Right to Die with Dignity Society), and Vlaamse Vereniging voor Psychiatrie (Flemish Association for Psychiatry, (Vlaamse Vereniging voor Psychiatrie), 2017). See BOX B for more information on these organizations and advocacy groups.

Potential participants contacted MV, KC or a study assistant by phone or mail. All interviews were conducted by MV or a study assistant, who both have experience in conducting interviews on end-of-life topics. Interviews were held at the participant's location of choice, except for five interviews which were held online by Whereby[14] due to the Covid-19 crisis lockdown regulations.

Interviews lasted between 55 and 120 min and were audio recorded. The online interviews were recorded by Whereby's software and immediately transferred in an mp3 format.

2.3. Measurement

The interviews were conducted with the use of a semi-structured interview topic guide (see OSF). The topics reported on in this study were introduced via the following main questions: 1) What is your personal stance on the (in)appropriateness of euthanasia in the context of psychiatry, with respect to the various legal criteria; and 2) What are your suggestions to improve the Euthanasia Law and its implementation in the psychiatric practice?

2.4. Data analysis

All interviews were transcribed verbatim and anonymized by the interviewers. We integrated an inductive and deductive coding and classification development as our study was explorative in nature regarding the arguments in (dis)favor and suggestions for law amendment but was also based on the Belgian legal framework (i.e., a criterion-referenced legal framework) (Clarke, Braun, & Hayfield, 2015). The coding procedure consisted of five phases; 1) line-by-line coding of all transcripts (MV); 2) substantive discussion leading to consensus on the labeling of codes by means of the presentation of at least one fragment per code (MV, KVA, KC); 3) the placing of the codes in categories (MV, KVA, KC); 4) the placing of these categories in overarching main categories (MV, KVA, KC); and 5) the comparison and discussion of the findings, resulting in the coding structure (MV, KVA, KC, KT, KP). We adopted a sampling-based saturation model known as inductive thematic saturation (Saunders et al., 2018). This approach involves the emergence of new themes, typically defined as 7 consecutive interviews without new themes arising.

2.5. Ethical considerations

The research team consisted of two clinical psychologists (MV and KP) and one medical sociologist (KC), each possessing specific expertise in qualitative research related to medically assisted dying in general (KP and KC) and/or euthanasia in psychiatric patients in particular (MV). The team was further strengthened by the inclusion of a legal expert (KVA) and a psychiatrist (KT) with specialized knowledge in medically assisted dying. A PhD student (MG), new to this field due to the absence

of a legal framework on euthanasia for psychiatric reasons in her home country, also contributed to the team.

The authors brought diverse backgrounds to the study, including professional experience in psychiatric practice in both outpatient and residential settings (KVA, KP, and KT). Some authors have first-hand experience in the practice of psychiatric euthanasia (MV and KT). All authors have their own personal and interpersonal experiences with death ideation and/or death seeking behavior.

Consequently, the authors' perspectives varied significantly, influenced by their primary experiences as patients, close relations, healthcare professionals, or academics. While they do not hold firm normative stances for or against euthanasia in psychiatric contexts, their perspectives spanned a broad spectrum. Some authors lean towards a conditional acceptance of euthanasia in APC, endorsing it under specific, carefully assessed and closely monitored conditions, while others tend to oppose euthanasia in APC allowing exceptions only in rare circumstances. All authors maintain a critical viewpoint, emphasizing the need for the careful consideration and scrutiny of euthanasia laws and practices, particularly in the context of psychiatry.

In an effort to uphold objectivity in interpreting the data, the team regularly organized discussion sessions. These meetings were crucial for sharing direct experiences from interviews and their outcomes, fostering reflective deliberations among team members. This proactive approach aimed to mitigate the impact of personal and professional biases on the analysis and interpretation of the data.

3. Findings

The sample consisted of 16 physicians, including general physicians, psychiatrists, and other specialist physicians. The sample also consisted of 14 non-physicians, including psychiatric nurses, psychologists, social workers, spiritual carers, experts by experience, and buddies. Participants' main characteristics are listed in Table 1.

The results are presented as follows: we first list the substantive legal criteria and then the procedural legal criteria. For each of these criteria, we indicate what the Belgian Euthanasia Law stipulates, followed by whether and why the participants found it an appropriate criterion (see Tables 2 and 4). If deemed inappropriate, participants' suggestions to improve the Law, in terms of ways to relax, clarify, strengthen, or restrict the current Law are provided (see Tables 3 and 5). Interview fragments are used throughout to illustrate or clarify key findings.

4. Arguments regarding the substantive legal criteria

4.1. Characteristics of the APC herself

First, the Law stipulates that each patient who requests euthanasia must be either an adult (i.e., 18 years of age) or an emancipated minor (i.e., a minor who, based on marriage or a court order, is deemed legally competent to autonomously make decisions). In 2014, the Euthanasia Law was extended to all minor patients, regardless of age, who have the capacity for discernment. However, the amended Law specifies that these minors can only receive euthanasia for *physical* suffering and if they are expected to die within the foreseeable future (Raus, 2016; Van Assche, Raus, Vanderhaegen, & Sterckx, 2018), a scenario that is unlikely to occur in the context of psychiatry.

Many respondents in our sample disagreed with the age limit of 18 years old. One physician did not have a specific age-limit in mind but stated, “The younger the patient, the more stringent the legal and due care criteria should be.” Some participants suggested raising the age threshold for APC to a minimum of 25 years old, based on the biological theory of brain maturity. Some suggested an even higher age limit, set to around 30 or 40 years old, believing that aging may bring along substantial changes in emotional, cognitive, and social functioning, due to, for instance, better coping strategies.

Table 1
Mental healthcare workers' main characteristics ($N = 30$).

Characteristics	Healthcare workers $N = 30$
Biological Sex	
Male	18
Female	12
Age Category	
< 30 years	2
31–40 years	2
41–50 years	5
51–60 years	7
> 61 years	14
Type of work environment[1]	
Specialized end-of-life centres	10
Psychiatric units/Psychiatric Hospitals	9
Private or Group Practice	5
Psychiatric Care Homes	5
Other	4
Background qualifications[2]	
Psychiatrists	10
General Practitioners	5
(Secretary) consultants at end-of-life centres[3]	4
Psychiatric nurses	3
Psychologists	3
Spiritual carers	3
Buddies	3
Social Workers	2
Experts by experience[4]	2
Specialist Physicians (other than psychiatrists)	2
Other	4
Number of concrete experiences in the year prior to the interview[5]	
1–2 cases	4
3–5 cases	7
> 5 cases	19
Physicians' specific role in recent euthanasia assessment procedures[6]	
Attending/referring physician[7]	7
Advising physician	10
Performing physician	2
None[8]	1

[1] Some have more than one work environment.
[2] Some have more than one specific academic and/or professional background or medical end-of-life training.
[3] These people are entrusted with e.g., the patient-intake and referral at end-of-life information or end-of-life consultation centers.
[4] Experts by experience, i.e. people classified with a (proneness to) mental illness, that are trained to provide support for someone who is ‘new’ to the experience or entering rehabilitation approaches.
[5] With concrete experience, it is meant ‘being confronted with and/or actively engaged in a euthanasia procedure, predominantly based on psychiatric conditions’.
[6] Some had experience in >1 role.
[7] Some of these physicians hold a normative stance against euthanasia in the context of psychiatry but fulfilled the minimal physician requirement of referring a patient to a colleague-physician upon the patient's explicit request ($n = 4$).
[8] This physician expressly refused to fulfill the minimal physician requirement due to conscientious objection.

> “I would say: not before you turn 30, but well, I don't know if that's possible. Currently, the limit is set at 18 years old... What is 18 years old? When you go for a walk with our group, everyone is over 18, but your brain continues developing until you're 25. I mean, there is still so much potential, and you can really make an effort to rectify things that have gone wrong while your brain is still developing. I genuinely believe that they should consider this scientific knowledge separately, apart from the legally determined age of adulthood.”
>
> (Psychiatric nurse)

Some participants supported keeping the current age limit for all individuals, as they believed that APC should not endure longer suffering as compared to their peers who primarily suffer from somatic

Table 2
Healthcare professionals and volunteers' ideas regarding SUBSTANTIVE criteria in APC.

	Accepting arguments	Critical arguments
Age limit at 18 years	Higher age threshold for APC only would be stigmatizing	Brain maturity (~25 yrs.) Better coping skills with age Concern for 'contagion' among youngsters Unfair: stigma, arbitrary re minor APC
Competence	Presupposed incompetence in APC is stigmatizing (can be impaired also in ASC due to medication, …) Excluding APC would be based on paternalism in psychiatry Mental competence assumed until proven otherwise Consistency APCs competence not in doubt for other critical decisions (e.g., marriage/ divorce/have kids, rent or buy a house) APCs consent is also routinely sought for regular treatments and interventions (i.e., voluntary admission to a psychiatric ward)	Contra-indications per definition: borderline / bipolar / substance abuse disorders Extreme caution in practice for APC with 'fluctuating affective states of mind' (borderline/ bipolar) Assessment not objectifiable (physicians, even psychiatrists, may not be able to reliably determine this criterion)
Voluntary request (incl. no external pressure)	Excluding external pressure should be excluded, can be assessed (via hetero-anamnesis) & can be excluded	Euthanasia requests are always based on 'internalized' pressure ('not wanting to be a burden to others, to society') Non-existence of a 'free will' per definition Difficulty of euthanasia being suggested/induced by health care professionals
Repeated/sustained request	Excluding flash of the moment decision should be excluded, can be excluded (e.g. multiple consultations, spread over time)	How to deal with ambivalence, especially in APC with 'fluctuating affective states of mind' Difficulty to implement due to its vagueness: what is meant with 'sustained'? Two consultations sufficient for a request to be repeated?
Constant unbearable physical and/or psychological suffering	Unbearable suffering possible in APC Psychological suffering valid Psychological/existential suffering can be as bad or even worse than physical suffering. Excluding 'psychological' would be unfair because it amounts to discounting mental pain on the sole ground of 'not being measurable' Psychological suffering always present in euthanasia wishes Superfluous to mention the nature of the suffering Euthanasia requests are always based on psychological suffering as bodies do not suffer, but persons do, e.g. 'loss of dignity' in case of function loss	Unclarity about interpretation 'Psychological': does it include/exclude emotional, existential, social suffering? 'constant' = too unspecified to apply to APC: (e.g., continuously present or 'sustained', 'persistent'?)
Suffering *caused by* medical disorder or accident	Physicians entrusted with euthanasia assessment, so it has to be based on a medical disorder Excluding adults who are not ill is unjust because it amounts to discounting their suffering experiences (e.g. tired of life, accumulation of many tragedies and losses)	Concern over interpretation of 'accident' e.g. traumatic events, accumulation of losses one cannot overcome A mental illness can always be formulated (e.g. under the classification of polypathology, adjustment disorder, PTSD)
Medically futile condition without prospect of improvement	Medical futility exists in psychiatry, evidence of some APC with treatment refractory symptoms or whose suffering is deemed incurable from a medical point of view. Denying this criterion in psychiatry leaves the door open for 'therapeutic tenacity' Determining irremediability and prognosis in psychiatry is feasible APC should not have to wait for treatment options: (yet) inexistent or lengthy treatment that 'might' have a promising effect (as ASC are not expected to do so) Counter-evidence of e.g., 'spontaneous recovery' is not unique to psychiatry Psychiatric treatment can also be more damaging, counterproductive than helpful to APC	It undermines the core principle of psychiatry: no mental illness can be considered irremediable per definition It undermines the rehabilitation and Quality of Life approaches in psychiatry Too little attention for the role of non-medical factors (spontaneous recovery in psychiatry due to changes in the course of life) Complexity of assessment due to: subjective internal/ external factors in psychiatry; unpredictable prognosis in psychiatry (e. g. recovery-rate, change in diagnoses)

What are healthcare professionals and volunteers' ideas regarding the legal criteria for euthanasia in the context of psychiatry?
APC = Adults with Psychiatric Conditions; ASC = Adults with Somatic Conditions; EOLC = End of Life Care; FCECE = Federal Control and Evaluation Committee on Euthanasia.

(physical) conditions solely because of their age. Hence, they supported the equal consideration and treatment for all individuals, regardless of their underlying medical condition or age.

They further emphasized that some APC endure more adversity in early life than many others will throughout their entire life. The same reasoning was used by others, who argued for lifting the current age limit, as this may be deemed stigmatizing to all minor patients.

> Interviewee: "For some people, that is indeed very young, and I can understand that. But doesn't it depend on what you have already experienced in your life? Very young? Well, yes, you can go through so much hardship in just 2 years that someone who is 80 has never experienced, right? So much suffering... That's why it is highly individual, isn't it? Children are already allowed to have euthanasia, right? From the age of 16 or something like that, with the involvement of parents, isn't that the case? There is no age limit."
>
> Interviewer: "But for minors, euthanasia is only allowed in cases of physical suffering, right?"
> Interviewee: "But it does happen, right? As a society, we have to make a decision about what we want. Do we make the same rules for this case as well? Because currently, we don't have the same rules for different situations. For one thing, we do, for another, we don't. Age is also arbitrary, isn't it?"
>
> (Psychiatrist)

Irrespective of their stance on the current age limit, some participants who work with young adults in psychiatric settings raised concern

Table 3
Suggested law amendments re substantive criteria in APC, and arguments provided.

	To relax or maintain legislation	To add to or tighten legislation
Expand/restrict base eligibility	+ The Law should no longer exclude: • People who are tired or through with life (irrespective of age) • Minor APC + Integrate Euthanasia in the Law on Patient Rights	+ The Law should no longer include: • any APC • APC younger than 30 / 35 / 40 years of age • people with personality disorders, bipolar disorders, substance abuse disorders
Futile medical condition without prospect of improvement: add operational criteria		+ Inclusion of State-of-the Art treatment protocol to be followed (and not just tried for a few weeks but tried over a reasonable period of time, to give it a fair chance of success) + Inclusion of necessary treatments tried (e.g., at least ECT treatment; at least one residential stay) + Inclusion of a measure of length of treatment as proxy for the futility and lack of improvement prospect 'many years of treatment' (for at least a decade or two) + Inclusion of proper psychodiagnostic testing
Unbearable suffering: deletion	+ Delete 'physical OR psychological' (cf. The Netherlands)	
Suffering caused by medical disorder or accident: deletions	+ Delete 'accident' + Delete the causality criterion 'suffering and medical condition'	

that the susceptibility of young persons to copy-cat self-destructive behavior was not being considered. More specifically, they explained that in their view the Law on Euthanasia had introduced a new way of death-seeking behavior. According to them, there is not only a "contagion-effect" that is caused by suicidal behavior (which occurs when exposure to a peer's suicide or suicide attempt leads to others engaging in suicidal behavior), but also one resulting from euthanasia-seeking behavior.

Second, to be eligible for euthanasia, the Law requires patients to be able to make a *well-considered* request and therefore to also have the necessary *mental competence*. This means that they need to be, inter alia, conscious at the moment of making the euthanasia request and demonstrate the ability to understand the real meaning and implications of such a request. Although there was a broad consensus on this being a key criterion, opinions differed on whether it can be fulfilled by APC and reliably assessed. Some participants reported that APC do not lack the decisional capacity to request euthanasia per definition, as they may also have the required capacity to make other critical decisions in life, including the decision to marry, to have kids and to rent or buy a house.

> "You have to evaluate your own situation, but self-evaluation can sometimes be precluded by the illness itself, which makes it challenging. I'm thinking specifically about depression. When experiencing depressive symptoms… One of the characteristics of depression is hopelessness, helplessness, an inability to use executive functions, where people are unable to generate solutions to life's easily solvable problems. This can lead to suicidal thoughts and a lack of a sense of a future as symptoms of the disease.

Table 4
healthcare professionals and volunteers' ideas regarding PROCEDURAL criteria in APC.

	Accepting arguments	Critical/rejecting arguments
Referral	Understanding of physicians not willing/ capable to be involved for whatever reason	Risk of passing-the-buck to already overburdened EOLC centers Concern 'empty criterion': one may refer to a colleague, knowing that she will advise negatively
Consultation: at least one advising psychiatrist, with expertise in the specific disorder	Necessary due to psychiatrist's expertise (e.g., general physicians are not or less familiar with complex psychiatric disorders)	Psychiatrists' expertise = overvalued (i.e., psychologists, general physicians and other caregivers often spend more time with the patient/ may know the patient better) One psychiatrist should not carry such a huge responsibility alone Problem if most psychiatrists are reluctant to get actively involved (and thus also, when the assessment is in the hands of very a few psychiatrists)
Consultation: involving the nursing team	They are often more involved in the care for APC Function of heteroanamnesis (they often know the patients and their psychosocial environmental dynamics better > completion of the whole puzzle) Function of 'aftercare' (for patients AND their closest inner circle)	Insufficient for entire picture: other caregivers should be consulted to further assemble the whole medical and non-medical picture Risk that other caregivers are side-lined who are (also) strongly involved in the psychotherapeutic trajectory
Independency of physicians involved	- Increases objectivity	- Reading a medical file is also a sort of priming - Consultation of other physicians/caregivers = sort of priming - Treating physicians can assess independently the legal criteria in their own patients
Consultation: social inner circle (not mandatory)	Responsibility towards those affected by euthanasia Needs to be/stay non-mandatory as APC can have good reasons for their non-involvement (e.g., history of abuse, broken relationships) Heteroanamnesis can provide additional insights in APC's personality structure, suffering and life circumstances Additional care for the APC who can fall back on these people during the whole euthanasia procedure Evidence that it may rule out forms of internalized pressure (feeling a burden to others) Evidence of rehabilitation (even in the most soured	Needs to be mandatory

(*continued on next page*)

Table 4 (*continued*)

	Accepting arguments	Critical/rejecting arguments
	relationships) Evidence that it may lead to their better understanding or even greater acceptance of APC's euthanasia request It can soften the mourning of the bereaved	
One-month waiting period	Enough time to exclude flash-of-the-moment decision Enough time, APC's medical file is 'clear and almost beyond dispute' in some cases A longer period of time might increase the risk for suicidality	Unrealistically short period of time for adequate euthanasia assessment in APC. Should be extended to at least one year (at least for patients younger than 30 or 40). It creates a level of unrealistic expectations in APC (and potentially increased suicidality as soon as the APC realise it will take more time) Irrelevant criterion as one should foresee a sufficient number of consultations between the patient and all physicians involved (to rule out advices after 1 or 2 consultations) + one can backdate the written request Unclear criterion: one month between what? + what if the waiting period due to 'waiting lists' is interpreted as 'waiting period'?
A posteriori evaluation by the FCECE	It should be properly monitored as a person's life is taken Good to collect statistics	Insufficient: a priori evaluation needed Evaluation should (also) precede the act of euthanasia/death Insufficient: additional monitoring is needed by independent research Empty box, e.g. evidence on carried out cases not being reported to the FCECE Mistrust in FCECE (members)

> Consequently, euthanasia may seem like a possible answer for them. I want to emphasize that I use the term "seem" because these individuals do not qualify for euthanasia at that moment since they cannot make judgments about it. However, it does not mean that patients with depressive or bipolar disorders, like manic depression, can never qualify for euthanasia. If they are out of an episode, when the depression is gone and they are thinking clearly, and they say, "The suffering is so immense, and I have had this kind of episode for the 15th time, and it cannot be stabilized with any medication, I have tried everything", then these individuals might be eligible. The issue is that the organ that allows us to assess the future may be impaired in psychiatric patients, whereas that is not the case for individuals with cancer."
>
> (Psychiatrist)

Excluding APC based on presupposed incompetence would be deemed stigmatizing, based on paternalism in psychiatry and even hypocritical, as the factor of (in)competence would then also need to apply to APC's consent for advanced psychotherapeutic treatments such as electro convulsion therapy (ECT), deep brain stimulation, and

Table 5
Suggested law amendments re procedural criteria in APC, and arguments provided.

	To relax or maintain legislation	To add to or tighten legislation
Modify procedural criteria for APC (general)	+ Make procedural criteria equal for the terminally and non-terminally ill	+ Distinct procedural criteria for the terminally ill, the non-terminally ill ASC, and the non-terminally APC
Patient-physician consultation: minimal number of psychiatrists		+ At least 2 psychiatrists should be consulted, as additional safeguard)
Patient-physician consultation: minimal number of contacts		+ Minimal number of consultations to establish a repeated, sustained request + Minimal number of consultations to accompany the one-month waiting period
Patient-physician consultation: independency		+ the 2nd physician should not be affiliated with life-end-information or consultation centers
Roundtable meeting (with all physicians involved)	+ Striving for consensus is in contradiction with independent formal advices + Only to protect the physicians at the detriment of APC's wellbeing + Impractical due to the geographical distance vs incompatible agendas + Irrelevant: in practice, physicians already do consult each other regularly by mail or phone + Unrealistic: voice of authority will prevail	+ Minimal concession in the absence of an a priori review committee + Collective responsibility + Additional support for all physicians involved: reassurance, more broad-based decision + Safeguard for all actors involved + Added value of heteroanamnesis: detecting and resolving blind spots
Consultation with other healthcare staff mandatory	+ Concern: "deploying an army of professionals on the patient" + Reported by buddies only: not needed to be consulted due to their specific function and trust relationship with the patient	+ Not only the nursing team, but all caregivers should be at least informed and consulted + A (minimal) selection of caregivers should be involved, e.g., general physician/psychiatric nurses/ psychologist
Consultation with 'relatives' mandatory	+ Practical unfeasibility of involving the patient's relatives + Increased risk of biased evaluation for physicians involved + Non-physicians can be entrusted as they already function as an intermediate	+ Euthanasia cannot be performed without their agreement + The family should be involved (even in case of conflicted/broken relationships, even in case of abuse) + At least the nuclear family (including the parents) should be informed + At least APC's children and partner should be informed and involved
A priori review	+ Unfeasible as: • decision would be based on a short summary of a long-term procedure from one (or all?) physicians involved; • the euthanasia practice is already short on manpower; • higher risk of therapeutic tenacity if 'a bunch of people',	+ Suggested composition: physicians, ethicists and one representative of APCs' relatives (a non-beneficiary) + Helps prevent against potential abuse (e.g. 'cowboys') + Independent case review (to further exclude subjectivity) + Needed as death = irreversible

(*continued on next page*)

Table 5 (*continued*)

	To relax or maintain legislation	To add to or tighten legislation
	including some non-caregivers, would speak on a priori grounds + Unnecessary as at least 3 independent physicians are already involved (in most cases, APC's caregivers and nearest are also involved) = a priori review + Violates the spirit of the law: violates principle of a dignified death if a patient should open up to 'an army of people' (= degrading) + Concern about unfairness: tribunal hearing on the basis of (one or more?) 'closed-hearings', with a bunch of people who do not know the patient sufficiently, e. g. ethicists, legal experts + Violation of the doctor-patient secrecy + Including an APC's relative is overburdening and an abdication of responsibility + Considered a delay tactic from the 'contra lobby' to complicate an already extremely complicated euthanasia procedure that will add additional suffering to the APC	
A posteriori evaluation by the FCECE		+ composition or even a split must be considered to prevent situations in which the judge is judged + additional monitoring is needed by independent research + reports should be subject to serious parliamentary debate
Criminal sentencing		**Proportionality in sentencing** - to reflect the various degrees of seriousness - to reflect the various degrees of physician responsibility

voluntary admission to psychiatric wards. Finally, it would also be unjust, as the criterion of decisional capacity in people suffering predominantly from somatic conditions is generally not questioned but may also be impaired.

> "Mental capacity is a significant concern in psychiatry, but I believe it is sometimes abused. People often assert that individuals are capable of making decisions when they accept our treatment, avoiding any discussions. However, when they present difficult questions, we invoke the issue of capacity to avoid engaging with them. I think determining capacity is not easy, but it is perfectly achievable for many individuals with psychiatric illnesses. On the other hand, there is the question of whether capacity is ever questioned in somatic cases, even though it can be an issue there as well, but often not even considered or contemplated."
>
> (Psychiatrist)

Other participants agreed not to rule out APC based on presumed mental incompetence but stated that extreme caution is still needed to assess this criterion in some subpopulations of APC, more specifically those with fluctuating affective states of mind. Only few would, therefore, exclude APC who suffer from borderline, bipolar disorders, or substance use disorders from euthanasia.

4.2. *Characteristics of the euthanasia request*

To be eligible for euthanasia, the patient must express a repeated and voluntary euthanasia request, that is free from any external pressure. As regards the latter, some participants mentioned that external pressure should and can be reliably assessed, by means of heteroanamnesis. Some participants, however, mentioned the evidence of the option of euthanasia being suggested by APC's healthcare professionals as a "complicating factor" in the assessment of this criterion.

> "We must be cautious as healthcare providers to avoid introducing the question of euthanasia and life termination in patients. I have personally witnessed situations where some practitioners broach the topic quickly and even suggest the possibility to patients."
>
> (Psychiatrist)

Other participants, all holding a normative stance against euthanasia in psychiatry, point to the underlying reasons for requesting euthanasia, such as the perception of not wanting to be a burden to loved ones or to society, due to which "internalized pressure" cannot be excluded per definition. Whereas one participant voiced that all APC euthanasia requests were prompted by the patient's social environment, another participant held an even stronger normative stance by suggesting that a free will is an illusion. They both considered it a sufficient reason to exclude APC from euthanasia, but did not want the criterion of voluntariness to be deleted, as manifest manipulations of this criterion can be reliably assessed and ruled out in non-APC.

Most participants were also in favor of maintaining the criterion of a "repeated request", as a spur of the moment decision should be avoided at all costs. However, concerns were expressed over clarity, possibly implying that these criteria could be interpreted such that two consultations may be sufficient for a request to be considered *repeated*. Furthermore, these and other participants expressed concern on how to adequately deal with this ambiguity, especially in APC with "fluctuating affective states of mind". It was suggested to amend the Law so as to explicitly include a sufficient number of patient-physician consultations, spread over a sufficient period of time, as an additional safeguard for APC. In this respect, it is important to note that these participants referred to a timeframe extending over several years as optimal for ensuring thorough patient-physician consultations. However, the participants did not specify the total number of consultations or the exact duration that these consultations should span. Instead, their emphasis was more on advocating for a legally mandated minimum number of consultations (exceeding the current requirement of just 2) and a duration stretching over years, not months, to properly assess a repeated and sustainable euthanasia request.

4.3. *Characteristics of the suffering*

According to the Law, the physician entrusted with the evaluation of the patient's euthanasia request, must ascertain that the patient experiences *constant* and *unbearable physical* or *psychological suffering that cannot be alleviated and that results from a serious and incurable disorder caused by illness or accident.*

First, regarding the duration of the suffering, a few participants raised concern on the sub-criterion of *constant* suffering. This sub-criterion is deemed too unspecified to apply to APC, as the question

can be raised whether the suffering should be continuously present, sustained, or persistent, considering that much more time may be needed for treatment to be successful in a psychiatric context. Some participants questioned once again whether APC with fluctuating states of mind can meet this criterion.

> “You can really see people who have been hopeless for a long time, they can really change, improve, and even recover, I have experienced that. A few decades ago, I treated someone who was extremely depressed. Every time she started to feel a little better, she would do dangerous suicide attempts. We tried all conceivable treatments, applied multiple courses of ECT, and for years, we did not get the impression that anything substantially changed. She repeatedly asked for euthanasia, which was not legally regulated at that time. Sometimes I thought, well, that may be indeed something she could hope for. She was admitted to our facility for several years, and in the penultimate year, she met [sums up life changes, e.g., a partner relationship], and all her problems seemed to disappear as if by magic. This is someone who, nowadays, would certainly be deemed eligible and granted euthanasia.”
>
> (Psychiatrist)

Second, all participants found it logical that the experienced suffering must be perceived as unbearable before euthanasia can be carried out and they confirmed that APC can indeed suffer unbearably.

Third, opinions differed regarding the appropriateness of the description of the *nature* of the suffering. Arguments in favor of maintaining the reference to “psychological” in the legal wordings highlighted that suffering on psychological grounds can be as bad as physical suffering. Excluding the reference to “psychological” would then be unfair because it amounts to discounting mental pain on the sole ground that it may be more difficult or even impossible to measure. Irrespective of their stance on euthanasia in APC, some participants suggested to delete the reference to the specific nature of the suffering. Some viewed the mentioning of psychological suffering as superfluous since “*euthanasia requests are always based on psychological suffering because bodies do not suffer, but persons* do,” as a buddy stated. Others pointed out that there is an inextricable unity between psyche and soma, as “*psychiatric patients can suffer from somatic complaints and vice versa*,” as a psychiatrist stated. Others expressed concern over the potential lack of clarity of this concept, and wondered whether emotional, existential, and/or social suffering also fall under the umbrella of “psychological suffering”.

Fourth, according to the Euthanasia Law, euthanasia is only allowed if the patient's suffering cannot be alleviated and is the result of a serious and incurable disorder caused by illness or accident. Since the Belgian legislature entrusted the evaluation and performance of euthanasia requests only to the medical profession, most but not all participants agreed with the legal criterion that a medical disorder should be central to the suffering experiences.

> Interviewee: “The weariness of life, the unbearable lightness of being. If that is how you feel, then that is how you feel, but then you have to figure it out on your own.”
> Interviewer: “But then it's not a matter of medical expertise, but of...”
> Interviewee: “A personal choice. For me, all people are free to commit suicide. It boils down to this; you don't need a doctor to pass judgment on that, nor to request assistance in carrying it out. I believe that you shouldn't ask a doctor for help in such a situation.”
>
> (Psychiatrist)

Fifth, concern was raised over the potential misinterpretation of the term “accident” in the context of psychiatry. Some warned that the accumulation of traumatic events and losses might wrongly be viewed as qualifying as an “accident,” further validated with a diagnostic label such as complex mourning, adjustment disorder, PTSD, and polypathology. Others had made use of this interpretation, as they believed that excluding adults who are not ill (in the strict medical sense of the word) would be unjust and inhumane because it amounts to discounting their (accumulation of) intolerable suffering experiences.

> [a shortened and paraphrased excerpt from one interview]
> I encountered a deeply distressing narrative involving severe childhood neglect, possible abuse, and the resulting inability of the individual to care for themselves. Despite potential post-traumatic stress, the person lacked a specific psychiatric diagnosis, making it challenging to provide appropriate therapy. It was a huge, tremendous tangle of misery. Moving frequently between different locations, the individual resisted treatment and lived in poor conditions. She did nothing, just smoked cigarettes, and that was it. Her food was prepared for her, she ate it, but she didn't clean up after herself. Then motivated caregivers came in and cleaned up everything. That was the situation. Despite the doctor's efforts, the psychiatric field offered no support. Eventually, the doctor, facing a seemingly insurmountable situation, took responsibility and facilitated the euthanasia procedure. It wasn't declared hopeless by psychiatric professionals due to the absence of a clear medical condition; rather, it was a situation where the individual couldn't cope due to severe trauma from past neglect or abuse.”
>
> (Physician)

4.4. Characteristics of the mental disorder

The Belgian Law stipulates that the patient should find herself *in a medical condition without any prospect of improvement*. Participants in favor of maintaining this criterion reported that medical futility does exist in the context of adult psychiatry, based on experienced evidence of some APC with treatment refractory symptoms or whose suffering could be deemed incurable from a medical point of view. According to them, determining irremediability and poor prognosis in psychiatry is feasible. However, they noted that some of their colleagues believed that a psychiatric condition always holds potential for improvement – a viewpoint they disagreed with.

> “And the psychiatry field also plays a negative role by claiming to be able to do things it can't and by not admitting at a certain point, ‘We don't know either’. In my experience, we are still not as advanced as we are in most other areas of medicine, where it's easier to say, ‘We don't know anymore’, and everyone agrees. But when you say that about someone with a psychiatric condition, people respond with, ‘No, that's not acceptable’. That's the difference, in my opinion. A doctor can say, ‘I don't know anymore, we're going to stop, it's not making any sense.’ I don't know many psychiatrists who say that. Yes, they might say, ‘It's not working, and there's no trust, so I'll refer you elsewhere or not give you any more appointments.’ And I've also said it here during a forced admission, ‘Your Honor, there simply is no treatment available.’ But as a society, we need to be able to experience and accept that, isn't it.”
>
> (Psychiatrist)

According to them, it would be unfair to expect APC to wait for (yet) non-existent, lengthy, additional treatment options that *might* have a promising effect, as 1) adults suffering predominantly from somatic conditions are not expected to do so; 2) it would leave the door open for “therapeutic tenacity”; and 3) it denies the evidence of treatment options, even state-of-the-art treatment options, that can be more damaging and counterproductive than helpful to APC. One psychiatrist pointed to colleagues who ‘fire blind’ with medical or even pseudo-medical interventions. The phrase ‘firing blind’ implies that these interventions are sometimes carried out without precision or careful consideration of the specific nature of the disorder or the potential consequences of the treatment on the patient. It denotes an approach

that may lack a thorough understanding of the patient's condition or the potential harmful side effects of the intervention. These participants even countered some colleagues' belief in spontaneous recovery, as this is deemed not unique to psychiatry but also applicable to somatic medicine.

Other participants reported that the criterion of irremediableness undermines what they consider to be a core principle of psychiatry, namely that no mental illness can be considered irremediable per definition. Most of them pointed to the evidence of their own patients showing spontaneous recovery, even after decades of treatment, due to sudden changes in the medical and/or non-medical course of life, for instance when a love interest or financial windfall occurred. They criticized the attitude to focus on irremediableness purely from a medical point of view, as it discounts the influential role played by non-medical factors, such as rehabilitation and quality of life approaches, considered in psychiatric care. Assessment of irremediableness was deemed highly complex due to these and other subjective internal and external factors in psychiatry, including poor reliability, changes in diagnoses, and unpredictable recovery rate.

For some, the aforementioned arguments were sufficient reason to oppose euthanasia in the context of psychiatry. Others, however, agreed with the criterion but suggested to clarify how this criterion should be assessed in psychiatric practice. More specifically, to protect APC against potential wrongdoing, they proposed to include in the Law the requirement that proper psychodiagnostics testing and state-of-the art treatment protocols should be followed, and that all these treatments should be tried over a reasonable period of time to allow for a fair chance of success. Some were of the opinion that the following treatment options should be tried, even if they were not recommended by the state-of-the art protocols: at least one series of ECT and at least one long-duration residential stay in a psychiatric ward. Finally, some participants felt a measure of length of treatment should be expressed by law as a proxy to determine medical futility. For some the wording of 'many years of treatment' would suffice, for others reference should be made to 'at least a decade' or even 'at least two decades' during which all the state-of-the arts protocols have been tried.

> "It's already challenging to find beds for babies, let alone for chronic psychiatric patients who also have less rights to have access to a bed for an extended period. They are not given the time they need or deserve, and there's always pressure on the patients, like 'you should be better after a year' or 'definitely after two years'. Some people may need 10 years, and that number may decrease, or some might require 20 years or lifelong treatment. The fact that this choice and possibility still exist, and there are people willing to care for others throughout their whole lives, provides them with a sense of security and peace. It can even mean that very long treatments may not be necessary after all, but if this option is not given, then, I think, people will die because of it. That's the problem with modern psychiatry; it's becoming more and more standardized, putting immense pressure on short-term treatments. People who need long-term hospitalizations are no longer getting them, which leaves them with almost no option other than considering euthanasia. The healthcare provider also has fewer long-term treatment options than before, making it very difficult in psychiatry to continue treating people for many years and still carry the burden of hopelessness as a caregiver."
>
> (Psychiatrist)

5. Arguments concerning the procedural legal criteria

Whereas the Belgian Law does not distinguish between the nature of the patient's disorder and the suffering resulting from it, it contains a distinction between patients who are expected to die "in the near future" (the terminally ill) and those who are not (the non-terminally ill), which almost always is the case in the context of adult psychiatry. If the attending physician, entrusted with the task to evaluate the fulfilment of the substantive criteria, is of the opinion that the patient is not expected to die "in the near future", a formal advice on the euthanasia request must be obtained from at least two (instead of one) independent advising physicians. This additional advising physician must be a psychiatrist or another specialist in the patient's medical disorder and must ascertain the presence of constant and unbearable suffering that cannot be alleviated as well as the voluntary, well-considered, and repeated nature of the euthanasia request. If the attending physician, after having consulted at least two independent physicians, concludes that the euthanasia request from a non-terminally ill patient meets the eligibility criteria, the euthanasia can only be performed after at least one month has passed since the request was first made. Most participants could understand the logic in these additional requirements due to the requirement to as adequately as possible predict patient outcomes. Whereas the probability of a foreseeable death verges on certainty for the terminally ill, one can only make a rough estimation for the non-terminally ill, since a possibility that the medical condition would improve, or the suffering could be alleviated cannot always be excluded.

A few participants were not in favor of this distinction and suggested making the procedural criteria the same for the terminally and non-terminally ill, more specifically by applying the criteria currently in place for terminally ill patients also to the non-terminally ill, due to the inseparability of psyche and soma, and as some psychiatric conditions or symptoms might sometimes also be considered terminal, such as anorexia and suicidality.

Others stated that the Law should be changed so as to include a distinction between the following subgroups: 1) the terminally ill; 2) the non-terminally ill predominantly suffering from somatic conditions; and 3) the non-terminally ill predominantly suffering from psychiatric conditions. The proposal suggests that the criteria should be most lenient for the first category (terminally ill) and least lenient for the last category. The proposal to apply even stricter criteria for APC was due to: 1) the higher degree of complexity in assessing APC's euthanasia requests, that were considered more often based on non-medical factors that point to society's failure, such as socio-economic inequities, staff shortages, and waiting lists in mental healthcare services; 2) the differences in the nature and course of the somatic versus psychiatric illness, in terms of more accurate diagnostics, more accuracy in establishing the causal link between suffering and the medical condition, and more certainty regarding prognosis in somatic medicine; and 3) the difference with regard to patient characteristics, as multiple participants mentioned tendencies for "*impulsivity", "ambiguity," and "manipulation*" in APC.

5.1. Referral

Although every APC has the right to request euthanasia, no physician can be compelled to perform – and no other person can be compelled to assist in – the practice of euthanasia, on whatever grounds. This right to conscientious objection is enshrined in the Euthanasia Law. However, a minimum of physician engagement is legally required and made more stringent by a legislative amendment in 2020 (the year in which this study was conducted). If the physician is confronted with a euthanasia request and refuses to practice euthanasia, they must inform the patient of this fact, indicating the reasons for refusal, no later than 7 days after the request. In addition, the contact details of another physician and of an association or center specialized in end-of-life consultations must be provided to the patient. In addition, even if the physician does not want to be engaged, they should provide, upon the request of the patient, the patient's medical file to the physician appointed by the patient within 4 days following the patient's request.

All the participants in our sample stated that the conscientious objection clause should remain, based on the understanding that physicians may not be willing or capable to actively engage in euthanasia assessment procedures, for various reasons. However, some warned for a revolving door scenario, where a physician refers APC to a colleague

physician who is opposed to euthanasia, knowing that they will advise negatively, and for a passing-the-buck scenario, where APC's treating physicians opt for an easy way out by (too) quickly referring to the end-of-life consultation centers that are already overburdened due to growing waiting lists and being understaffed.

5.2. Consultation of at least one advising psychiatrist

At least three physicians need to be involved in the assessment of a euthanasia request from a non-terminally ill patient: the attending physician and two advising physicians. Among the advising physicians, at least one must be a psychiatrist or another specialist in the patient's disorder. Translated to the context of psychiatry, the two advising physicians must be psychiatrists. For some participants in our sample, this is a logical and necessary criterion, as other physicians are simply less or not familiar with complex psychiatric disorders and psychiatrists are most qualified to take such a big responsibility. Others did not agree and stated that the psychiatrist's expertise is overvalued as compared to the expertise of other professionals, such as general practitioners, psychologists, and psychiatric nurses, who often spend more time with the APC and, by consequence, may know the patient better, and whom the patient might find easier to approach.

> "I'm not sure if the second physician necessarily needs to be a psychiatrist. However, they should be a medical professional with an understanding of psychiatric conditions and possess relevant knowledge. It's quite intriguing because I often hear from individuals with psychiatric vulnerabilities that they find it distressing to have to consult with a psychiatrist again in this procedure, especially considering that they may have had negative experiences with psychiatrists in the past. They often have more trust in psychologists than psychiatrists. So, I can imagine that if a psychologist were allowed to perform this role, it would be beneficial. In a multidisciplinary team, it would be wonderful if the psychologist could contribute to formulating the second opinion. This could potentially lead to additional insights and perspectives because of their background and expertise as a psychologist."
>
> (Expert by experience)

By contrast, some participants emphasized that – as it literally concerns a decision on life or death – two psychiatrists should be involved since a single psychiatrist should not be expected to carry such a huge responsibility alone. They suggested to mention this as a requirement in the Law and to also prescribe a minimum number of consultations per advising psychiatrist as an additional safeguard. This was also deemed necessary to allow the attending physician to ascertain the repeated, sustained, and voluntary nature of the euthanasia request and the irremediable nature of the suffering caused by the medical condition.

5.3. Independence

The physicians involved must be independent from the patient, from the attending physician and from each other. Our results revealed a broad consensus on the importance of this criterion as it may increase the level of objectivity in euthanasia assessment procedures. Participants also agreed that this criterion should be interpreted as meaning that the advising physicians should not have engaged in a long-term treatment relationship with the patient, and that they should not be in a personal or family relationship with the patient, the attending physician, and each other. Moreover, they should not work as a subordinate in the same facility as the attending physician. A few participants did not agree with this criterion and stated that physicians involved in the patient's treatment could also provide independent advice on the APC's euthanasia request. Furthermore, some of them questioned whether the provision of an independent advice is even possible, as one must examine the patients and their medical file, and consult with the attending physician, which can be deemed a sort of "priming" which might in theory preclude an independent judgment.

A practical issue arises from the fact that most psychiatrists are reluctant to get engaged in euthanasia assessment procedures. Consequently, many participants expressed concern that the assessment of most of the euthanasia cases falls into the hands of a small circle of psychiatrists, allegedly setting the bar low for the assessment of euthanasia requests, due to what was perceived as insufficient knowledge of the APC and her trajectory, and strong liberal attitudes towards euthanasia. According to some participants, it is not only necessary to engage at least two advising psychiatrists, but these need to have been trained to adequately deal with euthanasia requests and should also not be connected to any of the end-of-life information and consultation centers, since physicians connected to these centers were deemed to have an overly positive attitude towards euthanasia requests. These (and other) participants suggested that all physicians – and preferably also other mental healthcare workers – involved in the APC's clinical trajectory should engage in an open, transparent roundtable discussion on whether the APC would be eligible for euthanasia. It was argued that this would be of added value with regard to: 1) heteroanamnesis, which enables to detect and resolve remaining blind spots; 2) additional support and reassurance for all physicians involved, since the final outcome is not based on an individual but on a collective decision; and 3) collective responsibility, that allows for less patient and professional autonomy but provides more safeguards for all actors involved.

By way of counterarguments other participants emphasized that striving for consensus during a roundtable discussion would: 1) undermine the advising physicians' duty to provide "independent advice"; 2) be illusory, as the voice of authority would prevail; 3) be impracticable due to geographical distances and physicians' incompatible and packed agendas; 4) be irrelevant, as in today's euthanasia practice, physicians already tend to consult each other regularly by mail or phone; and, as a consequence of the former arguments, 5) only serve the physicians' interests, to the detriment of the wellbeing of the APC as it might make the euthanasia procedure more burdensome.

> "I think it's a natural escalation of an already difficult problem. It's already challenging for these individuals to receive a response to their request. Now, in addition to being a legal requirement, it has become an obligation. If I receive a complaint for not meeting this requirement, I could face suspension, which is also a kind of law, isn't it? I believe this puts too much burden on the people involved. I would hesitate about it. It would mean having to physically consult with three physicians instead of just receiving written opinions from one doctor. Let's be honest, physicians often communicate and discuss things without necessarily being physically present together. No, they just pick up the phone, send an email, or make a call."
>
> (Physician)

5.4. Consultation of the nursing team involved

It is a legal requirement to discuss the euthanasia request with the nursing team that are in regular contact with the patient. Some considered this requirement vital, as psychiatric nurses often know the APC and their psychosocial environment and social dynamics better. They may therefore be of help during and after the euthanasia assessment with heteroanamnesis and aftercare for the APC and their closest inner circle. Others stated that the involvement of the nursing team remains insufficient to provide the complete picture, as other caregivers, such as psychologists, often also spend a considerable time with the APC and may know different aspects of the APC's cognitive, emotional, and social functioning. Therefore, it was suggested that they should at least also be informed about the euthanasia request and preferably also be consulted to have a clearer view of the whole clinical and non-clinical context. In addition, some of the interviewed non-physicians discussed

their personal experiences of having been completely blindsided in the APC's euthanasia procedure and they suggested that this kind of situation should be avoided. As one psychiatric nurse who worked in a residential psychiatric setting testified:

> "With that one girl, we knew that the procedure was ongoing, but she mentioned once that it had been put on hold, and we didn't discuss it further here. We didn't hear anything more about it until we suddenly received a phone call informing us that she had died by euthanasia. It was a raw anger and powerlessness that overwhelmed me. As for the other person here, yes, that's a very different story, a very long and distressing one, which is why I wanted to participate in this study. These were not pleasant experiences, and I was angry about it for a long time. I don't think the feedback should have come through the patient; it would have been better if it came through the involved physicians. I wish we could have been more like partners on this journey. Now that the patient has passed away, I don't know if it would have been different, but it might have been more comforting if we had discussed our perspectives together in a team meeting, even with the patient present. That wouldn't have been a problem for me at all, but the way it was separated wasn't helpful. In both cases, the patients received treatment for a long time, and advice was indeed sought from our doctors, that's true. However, I think it would have been good to sit together around the table as a team and talk about it to understand why some doctors say 'yes'. For me, it was automatically a 'no', but I think it might have been due to the connection, the working relationship, but if we had discussed it more, I might have understood better and handled it differently, I think. I believe that the doctors probably talk a lot among themselves; I'm not entirely sure, but when you work together day in and day out, I think it wouldn't have been a bad idea to discuss it together. It would have been more meaningful if it wasn't so segregated, I think. And, well, yes, I was furious at those making the decisions. I also felt that our physicians lacked a shared vision, and we had different thoughts about it here. We were backed into a corner, and it felt like such an uneven struggle at one point, which was not enjoyable. Yes, I've been left with a bitter aftertaste from that. It's about someone's life, after all."

Counterarguments were also given. One psychiatric nurse stated that, "deploying an army of professionals on the patient must be avoided at all costs, as it does not facilitate a dignified dying process." Nevertheless, she and other participants agreed that a minimal selection of caregivers should be involved, including the APC's general practician and main psychiatric nurse and psychologist, if they are in regular and close contact with the APC. The participating buddies indicated that they did not feel the need to be consulted, as their formal involvement in the euthanasia procedure would jeopardize the unique trusting relationship with the patient.

5.5. *The non-mandatory consultation of family and/or friends*

The Euthanasia Law promotes the involvement of the relatives and friends of the patients, by requiring the attending physician to discuss, upon the patient's request, the euthanasia request with the relatives and friends designated by the patient, and to ascertain that the patient has had the opportunity to discuss the euthanasia request with everyone she wished to involve.

Our results revealed a consensus on the added value of the increased involvement of APC's support system, preferably in an early stage of the euthanasia assessment procedure. Participants mentioned that the early and active involvement of the patient's close family and friends allowed: 1) the substantive criteria to be more adequately assessed, as hetero-anamnesis can provide additional insights into APC's personality structure, suffering and life circumstances, and may rule out forms of internalized pressure; 2) additional care for the APC, who can rely on these persons during the whole euthanasia procedure; 3) a better understanding or even greater acceptance of APC's euthanasia request, or an improvement in restoring the relationship with the patient where this relationship had become strained; and 4) if the euthanasia is performed, easing the mourning of the bereaved.

Some participants stated that the consultation of relatives should remain non-mandatory as APC might have valid reasons for their non-involvement, such as a history of abuse. Instead, others stated that it should be made mandatory, although the level and extent of involvement may differ. For some, the APC's family should be involved only if they mean well with the APC. Some were of the opinion that at least the children and partner of the APC should be involved, regardless of the quality of their relationship. Others argued that at least the nuclear family, which also includes the parents, should be involved. Some of them insisted on – at least – informing them before the performance of euthanasia, whereas others suggested that they might also be informed afterwards. Still others reported that the broader family, also including siblings, should be involved. Some participants stated that the nuclear and, respectively, the broader family should even be involved in cases of a strained relationships and a history of abuse.

> "We are all human beings, connected to each other. So, yes. What did I want to say about this? I think that just because we are all interconnected as human beings, we automatically need to involve others when it comes to euthanasia requests. The family remains an important source of support, but even in cases of severe abuse, I still believe it's essential to maintain some form of contact or the possibility to communicate with each other. Perhaps that's a naive perspective, but I find it crucial that there remains a connection, even if the victim says they want nothing to do with the abuser. If cutting off all ties were to result in premature death, I would see that as a problem. Bringing families together, maintaining some form of contact, it's necessary, yes."
>
> (Psychiatrist)

Finally, a few participants stated that euthanasia should never be performed without the nuclear family's agreement.

> "If the immediate family, especially the partner, does not agree with the euthanasia, we do not carry it out. Sometimes, the patient comes with a partner who strongly opposes the request, and in that case, we will not proceed with the euthanasia. They can discuss and resolve it amongst themselves, as we will not perform euthanasia if the partner remains highly negative, you see? That becomes our condition. That is our additional requirement."
>
> (Physician)

Apart from these different opinions, participants expressed practical concerns about the increased risk of a biased evaluation for the physicians involved, and the unfeasibility of regularly involving the patient's relatives. As mentioned above, some participants agreed that non-physicians, such as psychiatric nurses and psychologists, can be entrusted to frequently inform and consult the APC's social inner circle as they already function as an intermediate.

> "When those people were with us two weeks before it actually happened, I genuinely tried to talk to them. They were all so focused during the conversation on making everything as good as possible for her, arranging the funeral, and ensuring the euthanasia would be done in the best way possible. I couldn't help but wonder, "Who is there for you?" "Who is supporting you?" They mentioned that they didn't receive much separate support from the [end-of-life consultation center]. They did have a few things with doctors where they asked some strange, abrupt questions. So, those people still had many questions, and they even spontaneously came to talk to us, to the psychologist and me, after the funeral. They wanted to discuss

how it all went, the last moments, and how they were coping. It was evident that they saw us as a source of support and naturally moved towards it. The psychologist continued with follow-up sessions with them, as we also work within a contextual approach."

(Psychiatric nurse)

5.6. One-month waiting period

From the euthanasia request from APC (and by extension, from all the non-terminally ill patients) to the performance of euthanasia, a waiting period of one month should be respected. Participants were in favor of preserving this criterion considering that this would prevent an impulsive decision. However, they feared that extending the waiting period might increase the risk for suicidality.

However, other participants criticized this legal criterion on the following grounds. First, it was deemed an unrealistically short period of time to ensure the adequate assessment of the eligibility criteria in APC. Some also expressed concern that this short period of time might create unrealistic expectations in APC regarding the duration of the process, which may lead to increased suicidality upon realizing that it will take more time. It was suggested that the Euthanasia Law should be amended to extend the waiting period to at least one year for all APC, or at least for APC younger than 30 or even 40 years old. The second criticism concerned the interpretation of the concept of "waiting period". In this regard, the question was raised whether the time between consultations as well as the time spent waiting for the actual euthanasia assessment procedure can count as part of the waiting period. Third, the waiting period was perceived by some as an irrelevant criterion since one can backdate the written request. Fourth, a sufficient number of consultations between the patient and every physician involved should be mandated, to rule out that approval would be obtained after just one or two consultations.

5.7. A posteriori evaluation

The physician responsible for the performance of euthanasia is required to complete an official registration form and to deliver this document to the Belgian Federal Control and Evaluation Committee for Euthanasia (FCECE) within four working days. The FCECE is established to ensure the a posteriori control of all euthanasia cases.

Most participants in our sample praised the a posteriori control, emphasizing that euthanasia cases should be properly monitored since a person's life was taken. Although it was deemed good that the FCECE was also entrusted with collecting statistics, some participants stated that this monitoring should be done by independent researchers. For others, this criterion was potential an empty shell, in light of anecdotal evidence of colleagues who had performed euthanasia without reporting this to the FCECE.

For many participants, control should best take place in advance by an a priori control committee: 1) to prevent against potential abuse; 2) to guarantee independent case review to further exclude subjectivity, especially considering the mistrust of some of the participants in some of the members of the FCECE (as it was indicated that e.g. its president, who is involved in performing euthanasia, also participates in the a posteriori approval by the committee); and 3) as death is irreversible. Some elaborated on the potential composition of such an a priori committee, suggesting that it should consist of independent physicians and ethicists. Some further suggested to also include at least one relative, and more specifically someone who would not gain any testamentary benefit from the euthanasia.

"Do you know how the composition of the evaluation committee is done? I do. Who does that? In the previous composition, [the chairman of the Federal Control and Evaluation Commission on Euthanasia] ensured that certain people put themselves forward as candidates. He called my colleague and asked, 'Would you like to be part of it as a significant pressure group?' There are 5 people from LEIF (Life End Information Forum) in the evaluation committee, you know. And who is the figurehead of LEIF? Don't even get me started on that. Yes, but no. You are supposed to apply for candidacy with the president of the Chamber, but who brings the candidates forward to the president of the Chamber? And that neuropsychiatrist who resigned, why, why, that was swept under the rug. The whole committee, it's not healthy. There is not just 1 committee in the Netherlands; they have 5 regional assessment committees. If there's an involved person in a specific region who knows that doctor, then it goes to another assessment committee, and every 5 years, they conduct an evaluation. Not just a report that gets adjusted, where they include some data and exclude some data, you know! Ah. So, that doesn't exist in the Netherlands; they deal with facts and figures, and it's all reviewed together. Then they say, 'Hey, what's here, and what's there? Can we...?' Yes, they present it in the Chamber of Representatives, and then the committee members, the parliamentarians, ask questions about what's in that report."

(Physician)

These suggestions were anticipated by participants who objected to an a priori review. The establishment of an a priori committee was deemed unjust because it would violate the spirit of the law, regardless of how the committee would be composed and organized. More specifically, it would violate the principle of respect for "a dignified death" if the APC would be expected to defend her case in front of "an army of people," which was considered "degrading". If the APC would not be heard by the committee, concerns were raised that decisions would be reached by people who may insufficiently know the patient and the field of psychiatry, such as ethicists and legal experts. Including someone from the social environment of the APC, such as a close family member, was deemed overburdening and an abdication of physician responsibility, would violate the physician's professional secrecy, and would be unnecessary as at least three independent physicians and in most cases also other caregivers and family and friends are already involved. Hence, it was argued that some type of a priori review is already in place. Moreover, from a practical point of view, some argued that an a priori review would be unfeasible as the decision would likely be based on a short summary of a long trajectory from only a small group of the mental healthcare workers involved. It might also prove to be an additional burden to the euthanasia practice which is already short on manpower, and it was feared that there would be a high risk of therapeutic tenacity if "a bunch of people", including some non-caregivers, would decide on a priori grounds. Finally, some participants considered this a delay tactic from the "lobby" opposed to euthanasia aimed to further complicate an already complex euthanasia procedure, in this way also causing additional suffering for the APC.

"No, look, I believe that the law provides criteria, and they are not taken lightly. To meet good medical practice standards, you have to fulfill many conditions, which can be quite demanding. I repeat, it's already challenging enough for the attending physician, the advisory physicians, and especially for the patient. If you then have to appear before a committee to discuss the whole context of 'how to write a report' and 'bring everything with you', that whole process must also be presented to the committee members, and their approval is required. Let the people who are directly involved handle that. How can we possibly summarize a two-year journey, the running around and searching for caregivers who have been following the patient for ten years, and the patient who asks for euthanasia every other week? Should I write that down? Should I testify? No. It's the responsibility of the physicians involved to carefully consider and weigh all aspects."

(Physician)

5.8. Criminal sentencing

Although it was not specifically asked, many participants spontaneously pointed to a fundamental deficiency in the Law on Euthanasia, in that it does not mention specific sanctions for violations of the Law. This objection is not surprising, as in 2018, a year prior to this interview study, three Belgian physicians faced a criminal trial for "murder by poisoning" for allegedly having failed to comply with the requirements of the Euthanasia Law. In 2020, all three physicians were acquitted before the Court of Assizes. Some of the participants reflected on this court case and suggested to change the Euthanasia Law to provide levels of punishment proportionate to the various degrees of physician responsibility as well as the seriousness of the breach of the Law. It should be pointed out that, during the subsequent civil trial against the performing physician, where the court eventually ruled in favor of the defendant, the Belgian Constitutional Court was seized to reflect on the issue of criminal sentencing (De Hert, Loos, & Van Assche, 2023a; De Hert, Loos, & Van Assche, 2023b). The Constitutional Court concluded that the Euthanasia Law must be amended to allow for a diversified sanctioning system, with penalties that are proportionate to the specific nature and degree of the violation (De Hert et al., 2023a; De Hert et al., 2023b).

6. Discussion

This is the first qualitative study that investigates the perspectives of healthcare workers on all the criteria in the Belgian Euthanasia Law that are applicable to euthanasia involving APC. Interviews were conducted with a relatively large sample of 30 important stakeholders, whose roles are largely unknown to the international readership, including buddies and experts by experience, who are specifically trained/experienced in supporting patients during their euthanasia trajectory. We achieved a unique and diverse sample of participants, varying in gender, work setting, attitudes, level of expertise, and extent of personal experiences with euthanasia practice in adult psychiatry. Nonetheless, selection bias may have occurred. Most of the physicians were older than 60, thus we have missed the voices and experiences of younger generations. Potential bias may also stem from the observation that some of the recruited healthcare professionals had very firm ideological stances and/or a high emotional investment in the issues being examined. Due to Covid-19 restrictions, several planned interviews were postponed and subsequently cancelled.

Additionally, our study was limited to participants from Flanders, the Dutch-speaking region of Belgium, due to language accessibility and practical considerations. We highly recommend future research to include healthcare professionals and volunteers from Wallonia, the French-speaking region. Previous research has highlighted significant cultural differences between these regions, particularly in terms of knowledge about and attitudes towards euthanasia, as well as the organization of euthanasia practices (Cohen, Van Wesemael, Smets, Bilsen, & Deliens, 2012). Moreover, there has been little scientific exploration of euthanasia in the context of psychiatry in Wallonia. Hence, it can be reasonably assumed that experiences vary between both regions, emphasizing the importance of comprehensive studies that cover a wider geographical and cultural scope.

Lastly, as our qualitative research focused on exploring themes, narratives, and shared experiences rather than on assuring high participation rates to achieve statistical generalizability, deriving definitive conclusions regarding the prevalence of each opinion, experience, or perspective across the entire practice of euthanasia is beyond the scope of our study.

6.1. Issues of interpretation of the Law and practice guidelines

This study confirms the difficulties in evaluating the fulfilment of the eligibility criteria for euthanasia in psychiatric practice (Evenblij et al., 2019; Pronk et al., 2019; van Veen, Scheurleer, et al., 2020; van Veen, Weerheim, Mostert, & van Delden, 2019; Verhofstadt et al., 2020a; Verhofstadt et al., 2020b; Verhofstadt et al., 2021). Except for the unbearableness of the psychological suffering of APC, none of the criteria was deemed to be straightforward to interpret and to assess. The biggest challenge is raised by the requirement to ascertain the irremediableness of the medical condition that causes the suffering, considering higher levels of medical uncertainty (Fox, 2000) regarding the etiology, diagnosis, and prognosis of mental illness (Nicolini, Kim, Churchill, & Gastmans, 2020).

Our study showed a lack of solid knowledge of the Belgian legal framework, even among highly experienced physicians. This is in line with a former study, that revealed that, although half of the surveyed psychiatrists considered themselves capable to engage in euthanasia procedures, only 5% of those surveyed had taken specific courses on medical end-of-life practices (Verhofstadt et al., 2020a). Furthermore, our study reveals the considerable extent to which the legal criteria might indeed be considered not well understood or misinterpreted. In this context, interpretations of the Law exist which seem to go against letter of the Law and, if acted upon, would be difficult to uphold in court. This might, for instance, be the case when elderly persons who have become 'tired of life' but whose suffering does not have a clear medical basis (Van Assche, Van Gucht, & Loos, 2021) would receive euthanasia, or when euthanasia is denied to all APC on the presumption that these patients always lack the required mental competence.

In addition, criteria are sometimes stretched to allow for inclusion of cases that, although not obviously in violation of the Euthanasia Law, go beyond what the Law intended. Here reference can be made to situations where an accumulation of traumatic events and losses is qualified as an "accident" that caused the unbearable suffering, in this way bringing an additional category of APC within the ambit of the Law. Alternatively, criteria are sometimes defined so narrowly that euthanasia requests by APC are generally deemed ineligible. For instance, some would consider APC with fluctuating affective states to be unable to make a well-considered euthanasia request.

Lack of clarity on how to evaluate the fulfilment of the eligibility criteria and on the procedure to be followed, as defined by the Law on Euthanasia, results in considerable variations in euthanasia practice in psychiatry. For example, our findings indicate disagreement on what are considered "reasonable state-of-the-art treatment options" in euthanasia involving APC as compared to in general clinical practice. For instance, some participants suggested that at least one intensive brain stimulation therapy, such as ECT or TMS, must have been tried before euthanasia on APC can be performed, regardless of possible counterindications, which in other contexts would have surely ruled out this option. On the other hand, as death is irreversible, the utmost caution must be exercised before euthanasia in APC can be performed. One participant mentioned an incident where it was alleged that a patient received euthanasia after undergoing only one type of treatment. This raised severe concerns regarding the decision-making process and the care taken to evaluate possible treatment options before euthanasia in these cases is considered. Hence, the euthanasia practice may benefit from clear and firm safeguards to ensure that euthanasia is not practiced prematurely or with undue speed, while at the same time not unnecessarily prolonging suffering.

Some participants in our study expressed concern that the assessment of most of the cases of euthanasia involving APC currently falls into the hands of a small group of psychiatrists, setting the bar for approval low, due to insufficient knowledge of the APC and her trajectory, or due to being overly conducive towards euthanasia requests for unbearable psychological suffering in APC. This concern is closely related to how the consulted physicians are selected. In this regard, the Euthanasia Law states in a general way that the physician who is considering a euthanasia request "must consult" one or, if the patient's death is not expected within the foreseeable future, two physicians. Whereas this requirement is unlikely to present challenges when the patient's unbearable suffering

is, for instance, caused by metastatic cancer or advanced neurodegenerative disease, the assessments by physicians could diverge significantly when the suffering is psychological in nature and, especially, when it is caused by a psychiatric condition. Here the outcome of the assessments may depend on the choice of consulted physicians. The attending physician might refer the patient to physicians who are known to support or even facilitate this type of euthanasia requests, or conversely, who are known to refuse or advise against it. Alternatively, as the Law does not specify who should select the physicians, patients might themselves seek out multiple opinions, or "shop around" for more permissive physicians, in the hope of obtaining approval for euthanasia. These findings seem to confirm worries that today's practice of euthanasia in APC may not always be managed and monitored in a sufficiently rigorous way (Verhofstadt et al., 2021).

In response, a group of physicians, including those from 'Rebelpsy', is advocating for the abolition of euthanasia for individuals with psychiatric conditions or seeks to strengthen eligibility and procedural criteria. Some suggest implementing a priori review committees, similar to the system in place in Spain (Velasco Sanz, Pinto Pastor, Moreno-Milán, Mower Hanlon, & Herreros, 2021), to increase the scrutiny of euthanasia requests from APC. However, others express concerns that an a priori review might discourage eligible individuals from submitting requests, as they may perceive it as a potentially adversarial process. This opposition aligns with the rationale behind the Euthanasia Law, leading it to focus on a posteriori control by the FCECE (Vansweevelt, 2003). Concern that, when an a priori review committee would be established, the perceived burden on patients may lead physicians to bypass it, may be justified, especially since a survey showed that currently only about 60% of euthanasia cases are reported to the FCECE (Dierickx, Cohen, Vander Stichele, Deliens, & Chambaere, 2018).

Considering the reliance on posteriori control by the FCECE, an alternative proposal could mandate attending physicians, when faced with a euthanasia request, to consult a committee that determines the physicians to be consulted, rather than granting them autonomy in selection. However, implementing this approach in Belgium would present significant challenges due to anticipated complexities in committee composition and creating a list of consultable physicians. Moreover, introducing this extra step might inadvertently prompt (more) physicians to perform euthanasia without following the procedure, bypassing reporting and oversight.

In this regard, it is noteworthy that professional guidelines ensure that the assessment of euthanasia requests from patients with psychiatric disorders adheres to minimum standards. These guidelines aim to enhance the quality of care and go a long way in reducing the risks inherent in assessing these requests. Importantly, a guideline issued by the Flemish Association for Psychiatry, (Vlaamse Vereniging voor Psychiatrie) (2017) recommends using a two-track approach. One track would focus on the possibility of death, encompassing a thorough evaluation of the patient's request for euthanasia, while the other track would remain focused on life in that it would continue to explore all remaining options for therapy or recovery (Flemish Association for Psychiatry, (Vlaamse Vereniging voor Psychiatrie), 2017). This implies that the patient's psychiatrist should remain involved throughout the entire procedure and that the patient will be required to continue or resume their treatment during the assessment of their request (Verhofstadt, Van Assche, Sterckx, Audenaert, & Chambaere, 2019).

In addition, in 2022 the National Council of the Belgian Order of Physicians has included various other recommendations from that guideline into formal deontological directives. Physicians involved in the assessment of a euthanasia request from a patient with a psychiatric disorder now have a deontological obligation to comply with the following principles, designed to guarantee a high standard of care (Belgian National Council of the Belgian Order of Physicians, (Nationale Raad Orde der Artsen), 2022). First, at least two of the legally required minimum of three physicians should be psychiatrists. Second, the attending physician should have regular meetings with the consulted physicians to review compliance with the legal criteria, and these consultations should be documented in a written report. Third, the patient's mental competence should be carefully and comprehensively assessed by all physicians involved. Fourth, physicians are prohibited from performing euthanasia if reasonable treatment options are still available. When a patient refuses to undergo these treatments, their request for euthanasia cannot be approved. Fifth, patients should be encouraged to involve their family in the euthanasia procedure, unless there are valid reasons not to do so. This involvement may help physicians in ascertaining that the euthanasia request is not the result of external pressure. Sixth and final, although legally, euthanasia on a patient who is non-terminally ill can be performed after at least one month has passed since the patient's initial request, the deontological rules indicate that this timeframe is too short for the comprehensive evaluation of a euthanasia request by a person suffering from a psychiatric disorder (Belgian National Council of the Belgian Order of Physicians, (Nationale Raad Orde der Artsen), 2022). By adhering to these deontological obligations, which complement the legal framework with several additional safeguards, it is possible to mitigate several risks that may arise in the context of euthanasia for psychological suffering caused by a psychiatric disorder.

Future law amendments may also benefit from the use of linguistic pragmatism and may add concept clarifications. For example, the legal framework of Western Australia makes explicit how to interpret decision-making capacity and stipulates that a patient is presumed to have this capacity in relation to voluntary assisted dying unless the patient is shown not to have that capacity (Government of Western Australia, 2019).

However, questions still remain about: 1) how detailed the legal framework should be with regard to the points of discussion regarding euthanasia in psychiatry; and 2) to what extent all kinds of potential misuses can be avoided. As earlier research revealed that a large percentage of psychiatrists and psychiatric nurses is in favor of maintaining the option of euthanasia for APC, a blanket exclusion of this population can be considered disproportionate. It may in addition be in breach of the constitutionally protected prohibition of discrimination, as indicated in the example of Canada, where a blanket ban on assisted dying for persons suffering predominantly from psychiatric conditions was rejected by court (BBC News, 2022; Government of Canada, 2023).

6.2. Suggestions to re-evaluate and modify existing legislation

Our interviews were held right before, during, and soon after the first high-profile euthanasia court case in Belgium. These legal proceedings may have impacted our study, as some interviews indicated frustration, disagreement, and high levels of uncertainty regarding the Belgian euthanasia legislation. However, critical voices on euthanasia performed in the context of psychiatry were raised many years earlier in the wake of an exponential increase in cases (the numbers doubled around 2011 and quadrupled around 2013) (FCECE (Federal Control- and Evaluation Committee on Euthanasia), 2012, FCECE (Federal Control- and Evaluation Committee on Euthanasia), 2014, 2016), increased media attention, and concerns about potentially overly permissive approaches and disputes among some of the physicians involved (Bazan, Van de Vijver, & Lemmens, 2015; Cheng, 2019; Claes et al., 2015; Clifford, 2017). The emotional statements made in our study reflect the contentious nature of the topic and the perceived lack of legal clarity and support. The concerns and suggestions expressed present an opportunity to policymakers and other stakeholders to re-evaluate the legal criteria for euthanasia in APC by using a bottom-up approach. The recommendations made by the participants in our study are particularly pertinent since they all had direct, personal experience in navigating the complexities of the eligibility and the procedural criteria in the Euthanasia Law. Although our study focused on the practice of euthanasia within adult psychiatry, it also highlights the challenges that are raised more generally by assisted dying requests. For example, several participants in

our study were in favor of eliminating the reference to *physical or psychological* suffering, arguing that the psyche and soma are inseparable and that in psychiatric cases also somatic suffering may be present and vice versa.

The participants in our study made suggestions to add and strengthen or, alternatively, to remove or ease certain requirements. However, the challenge in implementing these suggestions is the lack of consensus with respect to what aspects of the Law should be modified and in what way. Considerable variability exists in the perspectives and attitudes of our participants, which likely is indicative of the differences of opinion that can be found among other healthcare workers. Illustrative in this respect is the recommendation to modify the age threshold for APC. Participants who disagreed with raising the age threshold feared age-related discrimination, and expressed a preference to maintain the age of legal majority as the lower age limit, since this is when a person acquires full legal rights. By contrast, many who wished to modify the criteria suggested aligning the threshold with the neurobiological meaning of majority, when the prefrontal cortex and the limbic system that regulate cognition and emotions reach maturity. Participants who opposed a higher age threshold indicated that it would be unjust to differentiate between patient populations (i.e., APC and others) on such an arbitrary criterion. In addition, this *discussion can also be linked to the recommendation made by some to improve euthanasia practice in the context of psychiatry by requiring more time to guarantee that* a sufficient number of treatment options have been tried before treatment resistance and thus irremediableness can be concluded.

Additional guidance and clarification can also assist physicians in better understanding the opportunities and limits of the current legal framework. Our study found that many participants would seek a stronger involvement of the patient's relatives in euthanasia assessment procedures or even seek their consent before approving euthanasia. The involvement of relatives in the euthanasia trajectory can be extremely beneficial for all actors involved in terms of heteroanamnesis, reciprocal support, better mutual understanding, social rehabilitation, and better mourning, compared with death by suicide (Andriessen, Krysinska, Castelli Dransart, Dargis, & Mishara, 2020; Snijdewind, de Keijser, Casteelen, Boelen, & Smid, 2022; Verhofstadt et al., 2021). However, despite possible positive outcomes, greater involvement of relatives may violate the principle of shared decision-making by the patient and the physician enshrined in the Law on Euthanasia as well as the obligation to maintain medical confidentiality (Belgian Official Gazette, 2002b). Moreover, it will be important to determine who exactly will count as a relative and what role that person will play. The question can be raised whether the opinion of certain people should be taken into account merely because they legally are family, in recognition of the fact that violence, abuse and neglect in the family can cause or contribute to the mental problems of these patients (Spataro, Mullen, Burgess, Wells, & Moss, 2004; Weich, Patterson, Shaw, & Stewart-Brown, 2009). In this regard, the guidelines published by the Flemish Association for Psychiatry and the National Council of the Belgian Order of Physicians may serve as an inspiration, as they recommend involving at least one other individual who is in regular and close contact with the patient (e.g., a friend, buddy, or healthcare worker) if the patient opposes informing and involving her family (Belgian National Council of the Belgian Order of Physicians, (Nationale Raad Orde der Artsen), 2022; Flemish Association for Psychiatry, (Vlaamse Vereniging voor Psychiatrie), 2017; Verhofstadt et al., 2019).

Finally, with a view to a more substantial involvement of the patient's inner circle, guidelines should clarify the modalities to achieve this in the light of the different preferences and needs of patients. A recent interview study conducted in the Netherlands (Pronk, Willems, & van de Vathorst, 2021) examined the experiences of 12 'relatives' (i.e., parents, life partners, siblings, friends, and/or fellow patients) of individuals who requested euthanasia. The study explored the emotional impact of the euthanasia trajectory on the relatives and their desire to be heard, recognized in their roles, and acknowledged in the procedure. However, the study revealed considerable differences of opinion on the extent to which the relatives should be involved in the euthanasia assessment procedure, and it also highlighted varying support needs. The guidance that should be offered on this issue, should take proper account of this complexity so as to allow tailoring the approach to the patient context.

6.3. *Need for uniformity in policy and training*

In addition to amending the Law and issuing guidelines, it is important to harmonize the basic standards of practice, while leaving sufficient flexibility to handle case- and context-specific issues, and to provide better (access to) training in evaluating the fulfilment of the legal requirements. In this regard, our findings and recommendations align with those in a recent interview study, where healthcare workers expressed the need for more and better education about euthanasia in the context of psychiatry, both as part of the regular academic curricula and outside of academia.[23]

Responsibility for developing a more standardized policy extends beyond the legislature to professional associations. In recent years, several professional guidelines have been issued which operationalize the legal requirements and propose additional safeguards, many of which were mentioned in this study, with the aim of supporting physicians in adequately managing APCs' euthanasia requests.[48] However, the variety of recommendations made in these guidelines may preclude the harmonization of euthanasia practice.[48] In addition, recent studies disagreed about their practical value.[23,28] Whereas these guidelines were perceived as helpful by some, others saw them as redundant, impracticable, vague, lacking in different areas, and even flawed.[23]

In Belgium, the National Council of the Belgian Order of Physicians, which has the power to issue disciplinary sanctions, has some level of authority to impose uniformity in practice through directives. An important step towards the development of uniform practice in euthanasia in APC was taken when the National Council in 2022 issued its deontological directive on assessing euthanasia requests from APC, as discussed above. Updating this directive in a way that would also focus on issues that still remain unclear or have not yet been addressed (e.g., to what extent possible negative advices should affect the euthanasia procedure and/or the final outcome) however difficult that may be given the multitude of opinions in the field, would be welcome. In any case, Belgian euthanasia practice in the context of psychiatry would benefit from one single and inclusive guide tailored to the needs of psychiatric facilities and patient groups. This guide should be drafted not only for physicians but with all mental healthcare workers in mind.[23] Ideally, future training would be based on this text, supported by the most important associations in the field, and widely available to all healthcare workers who may be confronted with euthanasia requests from APC. In this respect, much can be learned from Canada, where the Canadian Association of MAiD (Medical Assistance in Dying) Assessors and Providers is funded by the Canadian government 'to develop and implement a national, fully accredited MAiD curriculum' (Domaradzki, 2021). It seems plausible that this phenomenon could also extend to euthanasia requests. More specifically, this could imply that exposure to information about individuals with a psychiatric condition who pursue euthanasia might lead to a perceived normalization or acceptability of euthanasia for individuals in similar circumstances. As a consequence, this may lead to an increased openness to consider euthanasia requests in a psychiatric context. Limited evidence from Dutch and Belgian practice indicates a rise in euthanasia requests in younger generations suffering from psychiatric conditions, particularly those under 30 years of age (Kammeraat & Kölling, 2020; Vonkel, 2023). Various factors, including a contagion effect, generational influence, or a transient surge due to high-profile cases (e.g., on social media), might contribute to this trend. In the light of the increase in euthanasia requests from young individuals, mental healthcare workers are urgently calling for more specific guidance (Verhofstadt et al., 2022). In addition, more attention

should be given to the mental health needs of this group. More generally, this evolution underscores the importance of carefully considering emerging demographic trends and their implications. In this regard, the guidance to be developed should also pay attention to monitoring trends within specific demographic groups (e.g., gender, age, ethnic background), and addressing the resulting challenges.

Funding

MV was funded by the Research Foundation Flanders via research project (G017818N), PhD Fellowship and a Junior Postdoctoral Fellowship (129423N).

Authors' contributions

The article has been developed with the following authors' contributions: MV, KC were responsible for the study methodology and managed ethical approval; MV conducted the interviews under the supervision of KC. MV drafted the main text with the help of KVA regarding the legal content, and of KVA and KC regarding English language editing. MV translated the selected fragments from Dutch to English. All authors were responsible for the coding structure and data interpretation and performed a critical review and revision of the final manuscript.

Transparency declaration

MV and KC are the guarantors of the manuscript and affirm that the manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancy from the study, e.g., that some of the interviews were held online due to the covid pandemic, have been noted and explained in the manuscript.

Ethical approval

This research project was performed in accordance with the Declaration of Helsinki and the European rules of the General Data Protection Regulation. It received ethical approval from the Medical Ethics Committee of the Brussels University Hospital with reference BUN 143201939499, from the Medical Ethics Committee of Ghent University Hospital with reference 2019/0456, and from the Medical Ethics Committee of the Brothers of Charity with reference OG054–2019-20.

Interviewees' involvement statement

All interviewees were given an information letter and detailed informed consent. The interviews were held upon signature of the informed consent.

CRediT authorship contribution statement

M. Verhofstadt: Conceptualization, Data curation, Formal analysis, Funding acquisition, Methodology, Writing – original draft, Writing – review & editing. **K. Van Assche:** Conceptualization, Writing – review & editing, Formal analysis, Writing – original draft. **K. Pardon:** Writing – review & editing. **M. Gleydura:** Writing – review & editing. **K. Titeca:** Writing – review & editing. **K. Chambaere:** Conceptualization, Data curation, Formal analysis, Funding acquisition, Methodology, Supervision, Writing – review & editing.

Declaration of competing interest

All authors declare no support from any organization for the submitted work; only MV has received research grants from the Research Foundation Flanders (FWO) (see below); no other relationships or activities that could appear to have influenced the submitted work were declared.

Data availability

Although data property rights are owned by the Vrije Universiteit Brussel (VUB) and Ghent University, researchers KC and MV held intellectual rights on data storage and use, only to the extent necessary for the abovementioned scientific research purposes, until the study was approved for publication. However, as for transparency and reproducibility, i.e., good scientific practice, full (though anonymized) data can be made accessible following procedures from Medical Ethics Committees involved (see below). To access the supplementary materials, see the Open Science Framework repository at: https://osf.io/j923k/.

Acknowledgments

The authors wish to thank dr. Steven Vanderstichelen for his help with the interviews (i.e., conducting and transcribing) and all the participants for sharing their professional and in some cases also personal experiences during the interview.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ijlp.2024.101961.

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