

View of the Brothers of Charity Group in Belgium of euthanasia for mental suffering in a non-terminal situation

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This text expresses the view of the Brothers of Charity Group in Belgium of euthanasia for mental suffering of patients in a non-terminal situation. The text is based on the ongoing reflection and previous documents on the subject. This view can also be applied with the necessary modifications to the elderly care and welfare sectors.

First, we present the ethical view, then the practical aspects of the two-pathway support, the due care requirements, and finally the decision and review.

1. ETHICAL VIEW

A. Fundamental values

From an ethical standpoint, there are three fundamental values at stake when it comes to euthanasia: the inviolability of life, the autonomy of the patient, and the care relationship between caregivers and patients (Ethics Advisory Committee, p. 1-2). We describe these three values and indicate the absolute and non-absolute interpretations of these values.

The **inviolability of life** is the fundamental value of choice because life is the foundation and the prerequisite for all other values. The inviolability is founded in life itself, not in its qualities. The value of life is protected by the fundamental principles of law, human rights, ideologies and religions. Some regard inviolability as absolute or sacrosanct so that no exceptions are allowed; others see it as the foundation of life, but still allow for a consideration of other values.

Patient autonomy is the fundamental value in modern-day society: People can make their own choices as long as they do not harm others. In health care, autonomy is guaranteed by the Belgian Act on Patients' Rights. Some conceive autonomy as absolute and individualistic so that people can decide about their own life and their own death; others view autonomy as a fundamental value that is balanced against other values, taking into account human solidarity and responsibility.

The **care relationship** is a fundamental value in the field of care itself. It is a relationship of trust in which patients and caregivers, and, with the patients' consent, those closely involved work together to give the patients the best care possible. Some consider the care relationship to be absolute and want to provide permanent care starting from that relationship; others take the care relationship as a fundamental and binding value when values are assessed in a concrete situation.

B. An area of tension between values

There is probably a broad consensus about the importance of these values, but less about the assessment of them. We want to think and act from relational care ethics on a personalistic basis (Ethics Advisory Committee, p. 1-2). This means that we never see any value as an absolute value that unconditionally takes priority over other values, but as a fundamental value that can be weighed against other values in a personalistic view of man. Equally, we do not regard values individualistically, but relationally, so to be realized in relations between people.

Because human situations are complex and ambiguous, no specific choice or action can fully realize all values. Inevitably, there will be an area of tension between these values. That is why we strive to respect and promote these values as much as possible, and threaten or violate them as little as possible. We weigh up the values and we try to strike a reasonable balance, the best humanly

possible, in a given situation. A personalistic key idea is to **connect values**: we focus on unifying values such as the care relationship, which connects different values, but which also connects those involved, allowing them to engage in dialogue.

The first value is the **inviolability of life**. This value is of prime importance to the Brothers of Charity Group. We regard inviolability as a fundamental value, as the foundation and prerequisite for all other values. Moreover, this value is vital in the context of euthanasia for mental suffering: after all, the patient is in a non-terminal situation in which a natural death will clearly not occur within the foreseeable future, while euthanasia immediately and irreversibly causes death. No matter how fundamental inviolability is, it is not absolute in the sense that, a priori, so in every situation, it takes priority over the other values. That is why we do everything reasonably possible, despite all the suffering, to seek alternatives to euthanasia for the patient to have a meaningful life perspective. This takes shape in the support in a first **life perspective pathway**.

At the same time we fully respect the value of **patient autonomy** by taking the desire not to go on living with unbearable and hopeless suffering and the request for euthanasia seriously. The patient is, after all, the first person concerned. Moreover, a carefully guided euthanasia can prevent more violent forms of suicide. However, we do not think of autonomy as absolute and individualistic, but as fundamental and relational. A dialogue with the other people involved is needed as well as patient support to clarify the underlying issues and to test the patient's situation against the provisions of the law. This results in a second pathway, the **euthanasia request pathway**, as part of the support.

Connecting the inviolability of life and the respect for autonomy happens from the unifying value of the **care relationship** with the patient. We build a relationship of trust in which we discuss support as much as possible in a dialogue with the patient and with those closely involved. This value is also not absolute, but fundamental. We do not need to engage in endless dialogue and support, as sometimes it is better that others take over the care relationship with a new approach. We want to formulate and apply **due care requirements**, which serve as a guideline for the support in the care relationship. These tie in with the legal provisions, but are made concrete for the specific situation of the mental suffering of patients in a non-terminal situation. The due care requirements have both content and form, and relate to both the life perspective and the euthanasia request pathways.

2. TWO-PATHWAY SUPPORT

The fundamental ethical view is embodied in a two-pathway support: the pathway of the inviolability of life and of offering life perspective, and the pathway of patient autonomy and respect for the request for euthanasia (Board of Directors' Policy Paper, p. 3; Metaforum, p. 49). As the value of inviolability is so fundamental, the life perspective pathway is of prime importance to the Brothers of Charity Group. No matter how essential the search for life perspective is, it is not absolute in the sense that the request for euthanasia should not be fully taken seriously. The life perspective and the euthanasia request pathways remain connected to each other through the care relationship, and thus through dialogue. These are **two pathways of the same support**.

Caregivers deal with these two pathways in **different ways**. Some caregivers believe that they cannot combine offering life perspective and handling the euthanasia request as both pathways have different purposes. They choose to entrust the two pathways to different caregivers, or to assign the euthanasia request pathway to caregivers outside the Brothers of Charity Group. Other caregivers do find it possible to combine both pathways and, at certain times and in certain positions, focus more on life perspective or on the euthanasia request. In any case, it is essential that – when the patient voices a euthanasia request – both pathways are offered, and that caregivers continue to discuss both pathways with the patient, with each other, and with those closely involved. Both pathways are part of patient support.

A. The life perspective pathway

The support gains credibility if decent **alternatives** to euthanasia are provided, giving the patient a life perspective (Board of Directors, p. 2-3).

A first alternative is to expand and improve the **existing treatment** that is already available from a biological, psychological, social, and existential approach. For instance, what can be adjusted in terms of medication, therapy, or meaningful activities?

A second possibility is the further development of **recovery and psychiatric rehabilitation**. What can be done from a recovery-oriented perspective to still enhance the autonomy and participation of people in unbearable and hopeless mental suffering and improve their quality of life?

A third possibility is the development of **psychiatric palliation**. How can palliative care aimed at alleviating suffering and other problems of a physical, psychosocial, and spiritual nature, be meaningful to patients who suffer mentally in a non-terminal situation?

A fourth possibility is the further development of **support for meaning in life**. The request for euthanasia has to do with the meaning of life a person leads. By intensively supporting people who are open to it in working with their own life story, finding sources of meaning in it, and, from there, create a purpose and a project for their lives, they can succeed in finding meaning in their lives. This is a task for all caregivers, not just for pastoral caregivers.

These alternatives are not new forms of care, but existing elements of good care which caregivers reassess, readjust, and present with greater intensity. The condition is that the patient consents. It is also important to include those closely involved as much as possible in this care. These elements of good care have a preventive character, as well.

B. The euthanasia request pathway

The second support pathway takes the request for euthanasia seriously by clarifying the question and checking the **legal provisions**.

Clarification and checking are crucial and are done on the basis of specific **due care requirements** (Dutch Association of Psychiatry, p. 29-51; Central Support Group, p. 4-19). The underlying idea is that the law is primarily written for physical suffering in a terminal situation. The two additional requirements for a non-terminal situation, in particular the consultation of a third physician and a one-month waiting period, are inadequate for the complex situation of euthanasia for patients because of mental suffering. That is why, in the provisions of the law, we include additional due care requirements for mental suffering in a non-terminal situation. We formulate the due care requirements in a separate section because they do not relate only to the euthanasia request pathway, but also to the life perspective pathway.

Applying additional due care requirements is in **accordance with the law** which says that the legal provisions are to be observed “without prejudice to any additional conditions imposed by the physician on their own action” (Belgian Act on Euthanasia, s. 4 par. 2).

C. Support for caregivers

There are several ways to support caregivers in the two-pathway support (Board of Directors, p. 3-4). The first initiative is the **Central End of Life Support Group**. This group works for the Flemish

psychiatric centres in the Brothers of Charity Group, has an interdisciplinary composition, and relies on external experts. A facility's physician and team can consult the Central Support Group if the patient concerned gives their consent. The advice from the group applies to both support pathways and has an independent and objective character because it is given by an authority external to the facility. The physician and the team retain their autonomy in the support of the patient. As a guideline for the support, the Central Support Group has drawn up due care requirements.

A second initiative is the **Local End of Life Support Groups**. These groups work for one facility or several facilities in the same area, have an interdisciplinary composition, and can rely on external parties. A physician and a team can ask the Local Support Group for advice and support, for which the patient in question gives their consent. The advice applies to both support pathways. The Local Support Group can also provide practical support. The physician and the team retain their autonomy in the support of the patient.

A third possibility is the appeal to **LEIF physicians** (Life End Information Forum). This is the way to go if the patient's request for euthanasia persists, the alternatives for euthanasia offer no life perspective, and the procedure of euthanasia is being considered. At that point, the physician and the team, taking into account any possible recommendations of the Central and/or Local Support Groups, can rely on a LEIF physician from the area. This physician can give further advice and offer support in the euthanasia procedure.

3. DUE CARE REQUIREMENTS

To make the life perspective pathway and the euthanasia request pathway concrete, we have established due care requirements. Applying this due care gives caregivers a concrete footing for both support pathways. There are requirements in terms of content and form. They are consistent with the legal provisions, but specify and concretize them for the mental suffering of patients with a psychiatric disorder in a non-terminal situation.

A. Due care requirements in terms of content

We propose three due care requirements in terms of content that are in keeping with the legal provisions. We ask physicians and caregivers to apply them in order to achieve the utmost due care possible. The first two make the euthanasia request pathway concrete, the third, the life perspective pathway.

1. Competent request

The first due care requirement relates to the competent request: voluntary and well-considered, repeated and persistent. This requirement refers to the law that states that "the patient has attained the age of majority or is an emancipated minor [...] and conscious at the moment of making the request" (Belgian Act on Euthanasia, s. 3 par. 1). The law also states that "the request is voluntary, well-considered and repeated, and is not the result of any external pressure" and that the physician must be certain of the "durable nature" of the request (Belgian Act on Euthanasia, s. 3 par. 1-2). The due care requirement that says that the request is voluntary, well-considered, repeated, and persistent means that the patient is sufficiently competent to make this decision.

Voluntariness implies that the patient has made the request independently of coercive influences of others (Dutch Association of Psychiatry, p. 30). After all, patients are often dependent on others and may feel compelled by pressure or a sense of guilt or burden to request euthanasia.

Due consideration means that, upon their request, the patient is independent of coercive influences from the inside, which may be of a pathological nature (Dutch Association of Psychiatry, p. 30-33). For that, there are two criteria. First, the patient makes a **clear choice** not to go on living with unbearable and hopeless suffering, and chooses death. The choice, however, is usually ambivalent and therefore a clarification of the meanings and messages of the euthanasia request is necessary. Secondly, there is a **process of assessment** for the patient between choosing to continue living with permanent limitations and choosing not to continue living. For that, the patient understands the information about their situation and prospects, and the patient has adequate illness awareness and self-knowledge. The patient substantiates the choice not to continue living within his or her intellectual capabilities.

Thirdly, the patient's request is **repeated and persistent** (Dutch Association of Psychiatry, p. 33-34). The **persistent desire** not to go on living is shown in how this desire arose and develops in the course of time. A period of at least several months of deliberate and repeated request is necessary.

2. Medically futile condition

The following due care requirement is about the medically futile condition. This is consistent with the law that states that "the patient is in a medically futile condition of unbearable and hopeless physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident" (Belgian Act on Euthanasia, s. 3 par. 1). The due care requirement specifies the unbearableness and hopelessness of suffering, and its medical cause.

Unbearableness is the subjective experience that the suffering cannot be endured (Dutch Association of Psychiatry, p. 34-35). Yet there are elements to evaluate this. Assessing the unbearable nature depends on the palpability of the suffering and on the proportion between coping capability and burden. The constant nature depends on the onset, the course, and the persistence of the suffering.

Hopelessness means that there are no possibilities to alleviate the suffering and that the psychiatric disorder is therefore untreatable (Dutch Association of Psychiatry, p. 35-36). Theoretically, it can never be said that the disorder is untreatable in the future or that the patient's health and well-being will not improve in the future. Indeed, it is always possible that new treatments will be found or that spontaneous recovery will occur. In practical terms, caregivers cannot guarantee the realization of these opportunities in the future, while in the meantime the patient's unbearable suffering continues. Therefore it is better to speak of '**no reasonable treatment perspective**' than of untreatability, see the third due care requirement in terms of content.

Thirdly, there is the **medical cause** of suffering. It is the result of a severe and incurable disorder. So the disorder can be medically diagnosed, is considered severe and incurable, and is caused by an illness or an accident.

3. No reasonable alternative

The third due care requirement is about life perspective and argues that euthanasia is only acceptable if there is no reasonable alternative. This refers to the following provision of the law: "Together with the patient, the physician must come to the belief that there is no reasonable alternative to the patient's situation and that the patient's request is completely voluntary" (Belgian Act on Euthanasia, s. 3 par. 2). This implies that there is no more reasonable treatment perspective.

Such a **reasonable treatment perspective** must meet three conditions (Dutch Association of Psychiatry, p. 37-39). First, the **proper treatment offers a potential for improvement**. Proper

treatment is understood to mean that all biological and psychological treatments, all social interventions and support for meaning in life that are appropriate for the patient's problems have actually been applied. Secondly, there needs to be potential for improvement **within a foreseeable future**. The duration of the previous treatment and of the proposed treatment is taken into account in this. Thirdly, there must be a **reasonable ratio between the results and the burden**. It is about the ratio between the extent and the likelihood of the expected results on the one hand and the burden and side effects of the treatment for the patient on the other. The assessment of these conditions should not lead to therapeutic obstinacy. This due care requirement is extremely important because it connects with the first life perspective pathway for the patient.

Next, it is necessary that the patient **consents** to the treatment, is willing and believes it is meaningful to participate in the treatment (Dutch Association of Psychiatry, p. 39-40). If the patient refuses to consent, this will be assessed from the reasonableness of the treatment perspective. There is no question of hopelessness if the patient refuses a reasonable treatment perspective. Refusal of a reasonable treatment perspective means that euthanasia cannot be carried out.

Finally, **transference and countertransference** may play a role in the assessment (Dutch Association of Psychiatry, p. 40-41). Being attentive to countertransference feelings, such as feelings of anxiety or powerlessness, or rescue fantasies, and making them open to discussion is indispensable.

B. Due care requirements in terms of form

The formal due care requirements are in line with the formal legal provisions, but they specify and concretize them for the mental suffering of patients in a non-terminal situation.

1. Conferring with the patient

The first formal due care requirement is to confer with the patient. This refers to the law that states that the physician has the following task: "inform the patient about his/her health condition and life expectancy, discuss with the patient his/her request for euthanasia and the possible therapeutic and palliative courses of action and their consequences" (Belgian Act on Euthanasia, s. 3 par. 2). In the case of euthanasia in a non-terminal situation, there is an additional statutory requirement, "allow at least one month between the patient's written request and the act of euthanasia" (Belgian Act on Euthanasia, s. 3 par. 3).

It is about informing the patient about their situation, prospects, and possible treatments (Dutch Association of Psychiatry, p. 36). In order to take this process of conferring seriously, sufficiently **frequent and intensive meetings** are needed. The physician is attentive to the cognitive and emotional processing of the information by the patient. A sufficiently long period of conferring is needed, as well. With euthanasia in a non-terminal situation one month is too limited. A period of **at least six months** is in fact necessary.

2. Consultation of physicians

The second due care requirement concerns the consultation of two physicians. The statutory provision reads "consult another physician about the serious and incurable character of the disorder and inform him/her about the reasons for this consultation. The physician consulted reviews the medical record, examines the patient and must be certain of the patient's constant and unbearable physical or mental suffering that cannot be alleviated. The physician consulted reports on his/her findings. The physician consulted must be independent of the patient as well as of the attending physician and must be competent to give an opinion about the disorder in question. The attending physician informs the patient about the results of this consultation" (Belgian Act on Euthanasia, s. 3

par. 2). In case of a non-terminal situation, the physician should “consult a second physician, who is a psychiatrist or a specialist in the disorder in question”. The tasks of the third physician are the same as those of the first physician consulted, except that, on top of that, this physician needs to ascertain “the voluntary, well-considered and repeated character of the request,” and this physician must be independent “of the physician initially consulted” (Belgian Act on Euthanasia, s. 3 par. 3).

The formal due care requirement entails that the three physicians examine the patient and each test the **three due care requirements in terms of content**: the competent request, the medically futile condition, and the belief that there is no reasonable alternative. Moreover, it is essential that the three physicians consult with each other and develop a **consensus** in their assessment of the three due care requirements in terms of content. Not least, the physicians consulted need to be **independent** of the patient and of the attending physician. This means that the physicians consulted are not involved in the patient’s treatment and do not work in the same facility as the attending physician (Dutch Association of Psychiatry, p. 41-45).

3. Conferring as an interdisciplinary team

The following due care requirement is about conferring as an interdisciplinary team. The law requires the physician to do the following: “if there is a nursing team that has regular contact with the patient, discuss the request of the patient with the nursing team or its members” (Belgian Act on Euthanasia, s. 3 par. 2).

The due care requirement states that this conferring is not optional but necessary and that the nursing team is extended to include an interdisciplinary team. In order to take this conferring seriously, sufficiently **frequent and intensive meetings** are needed. In those, the physician and the interdisciplinary team seek a **consensus** in their assessment of the three due care requirements in terms of content. With the patient’s consent, the physician can also consult previous caregivers and the general practitioner (Dutch Association of Psychiatry, p. 46).

4. Conferring with family and loved ones

The fourth due care requirement is to **confer with family and loved ones** designated by the patient. The law requires the physician to do the following: “if the patient so desires, discuss his/her request with relatives appointed by the patient; be certain that the patient has had the opportunity to discuss his/her request with the persons that he/she wanted to meet” (Belgian Act on Euthanasia, s. 3 par. 2).

Conferring with family and loved ones is an important due care requirement. After all, they are **closely involved** with the patient. Conferring with them is essential for the physician and the caregivers. The physician informs them about the life perspective pathway and the euthanasia request pathway, while they can provide additional information and prepare for dealing with grief associated with euthanasia. If the patient does not want to confer, the caregivers look for any underlying motives and try to clarify them (Dutch Association of Psychiatry, p. 46-47).

5. Support group advice

The last due care requirement is specific to the Brothers of Charity Group and implies that the physician seeks **advice from the Central or Local End of Life Support Group**. This advice serves as a guideline and is not binding for the attending physician.

4. DECISION-MAKING AND PRELIMINARY REVIEW

A. Physician’s decision in accordance with their conscience

When the physician, during the process of testing euthanasia against the provisions of the law and the specific due care requirements, comes to the conclusion that these provisions and requirements are actually met, he or she faces the decision whether or not to carry out the euthanasia himself/herself. Based on his or her **moral judgement**, the physician has full freedom to decide whether or not to perform euthanasia. After all, the law provides for the freedom of conscience of the physician. The law also provides for the freedom of conscience of other caregivers who may be asked to assist in performing euthanasia. The law explicitly states: “No physician may be compelled to perform euthanasia. No other person may be compelled to assist in performing euthanasia” (Belgian Act on Euthanasia, s. 14).

If the physician will not perform euthanasia because of conscientious objections, it is important that he or she **informs the patient timely and explicitly** so not create mutual wrongful expectations. The physician will refer the patient in time to a colleague who also works in the facility or to another physician who is not affiliated with the Brothers of Charity Group.

B. Additional point of concern in euthanasia in a residential context

The physician and patient decide together on the **most appropriate location** for carrying out euthanasia. They do so preferably in consultation with the family and loved ones, and with the interdisciplinary team. When considering whether the facility is the most suitable location, they take into account the experience and living environment of the other patients.

A mental health care facility is a living and residential community after all. The procedure of euthanasia can have a traumatic effect on other patients. Therefore it is necessary that the physician and the team of caregivers look for a **course of action that prevents and limits a traumatic impact on fellow patients as much as possible**, both in the preparation and performance of euthanasia as well as in the aftercare.

C. Preliminary review

If the euthanasia procedure takes place in a facility of the Brothers of Charity, a preliminary review is necessary. The reason is that, on the one hand, we want to respect the physician’s therapeutic freedom, but on the other hand we want to go about euthanasia being performed in a facility of the Brothers of Charity with the **utmost caution**. The connection between the therapeutic freedom and the utmost caution we make by a preliminary review. Now the law only provides a review after euthanasia is performed: “Any physician who has performed euthanasia is required to fill in a registration form, drawn up by the Federal Control and Evaluation Commission established by section 6 of this Act, and to deliver this document to the Commission within four working days” (Belgian Act on Euthanasia, s. 5). This review is very formal and happens after euthanasia is performed. The utmost caution can only be achieved by means of a preliminary review.

This preliminary review is done first by the attending physician himself. We ask the physician to present a **detailed written statement** of reasons for the decision to perform euthanasia, containing the grounds of four elements: (1) the legal provisions, (2) the specific due care requirements, (3) the decision to perform euthanasia himself/herself in the facility, and (4) the additional point of concern when euthanasia is carried out in a residential context. This statement is intended primarily as a personal reflection and account of the physician.

The written character of this statement enables others to review it, as well. We ask, therefore, that the physician presents the written statement to the chief physician who has the legal obligation to review the level of due care of the medical practice in the facility. The chief physician convenes an **evaluation committee**. This is an interdisciplinary committee composed of a workable number of

people. It consists of three sections. The first section are the staff from the facility in question: the attending physician, the chief physician, and two other staff members, of whom at least one is a non-physician. The second section consists of at least two staff members from the Brothers of Charity Group who have expertise on the matter and are not employed in the facility in question. The third section consists of at least two people from outside the Brothers of Charity Group who are experts in this field. The chief physician of the facility coordinates the evaluation committee.

If this evaluation committee deems that **sufficient due care** was observed with regard to the statement of the above four elements, the attending physician, in consultation with the patient, the family, those closely involved, and the team, may perform euthanasia or have it performed in the most appropriate and suitable location. If the committee deems that insufficient due care has been observed, they will insist that the physician refrains from performing euthanasia. Nevertheless, the physician retains his or her therapeutic freedom.

SOURCES

This outline is based on the ongoing reflection and previous documents on the subject in the Brothers of Charity Group, of which the following notes are the most important:

- Begeleidingscommissie ethiek GGZ Broeders van Liefde (Brothers of Charity Mental Health Care Ethics Advisory Committee), *Begeleiding van psychiatrische patiënten met een verzoek tot euthanasie in een niet-terminale situatie*, 2006, zie:

<http://www.fracarita.org/document/ethiek/Ethisch%20advies%20GGZ%20-%20%20Euthanasie%20060111.pdf>

- Raad van Bestuur vzw Provinciaal der Broeders van Liefde (Board of Directors of vzw Provinciaal der Broeders van Liefde), *Standpunt euthanasie bij psychisch lijden van psychiatrische patiënten in een niet-terminale situatie*, Gent, Onuitgegeven Beleidsnota Provinciaal der Broeders van Liefde, 2012.
- Centrale Supportgroep Levenseinde (Central End of Life Support Group), *Zorgvuldigheidsvereisten voor euthanasie bij patiënten met een psychiatrische aandoening in een niet-terminale situatie*, Onuitgegeven nota, 2014.

Other key documents related to euthanasia and mental suffering:

- *Wet betreffende euthanasie (Belgian Act on Euthanasia)*, 2002, zie:

http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=nl&la=N&cn=2002052837&table_name=wet

- Nederlandse Vereniging voor Psychiatrie (Dutch Association of Psychiatry), *Richtlijn omgaan met het verzoek om hulp bij zelfdoding door patiënten met een psychiatrische stoornis*, Utrecht, De Tijdstroom, 2^{de} herziene editie, 2009, zie:

http://steungroeppsychiaters.nl/wp-content/uploads/Richtlijn-hulp-bij-zelfdoding_NVvP-2009.pdf.

- Werkgroep Metaforum (Metaforum Working Group), *Euthanasie en menselijke kwetsbaarheid*, KU Leuven, 2013, zie:

https://www.kuleuven.be/metaforum/docs/pdf/wg_9_n.pdf