



Psychiatric patients requesting euthanasia: Guidelines for sound clinical and ethical decision making



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ABSTRACT

Background: Since Belgium legalised euthanasia, the number of performed euthanasia cases for psychological suffering in psychiatric patients has significantly increased, as well as the number of media reports on controversial cases. This has prompted several healthcare organisations and committees to develop policies on the management of these requests.

Method: Five recent initiatives that offer guidance on euthanasia requests by psychiatric patients in Flanders were analysed: the protocol of Ghent University Hospital and advisory texts of the Flemish Federation of Psychiatry, the Brothers of Charity, the Belgian Advisory Committee on Bioethics, and Zorgnet-Icuro. These were examined via critical point-by-point reflection, focusing on all legal due care criteria in order to identify: 1) proposed measures to operationalise the evaluation of the legal criteria; 2) suggestions of additional safeguards going beyond these criteria; and 3) remaining fields of tension.

Results: The initiatives are well in keeping with the legal requirements but are often more stringent. Additional safeguards that are formulated include the need for at least two positive advices from at least two psychiatrists; an a priori evaluation system; and a two-track approach, focusing simultaneously on the assessment of the patient's euthanasia request and on that person's continuing treatment. Although the initiatives are similar in intent, some differences in approach were found, reflecting different ethical stances towards euthanasia and an emphasis on practical clinical assessment versus broad ethical reflection.

Conclusions: All initiatives offer useful guidance for the management of euthanasia requests by psychiatric patients. By providing information on, and proper operationalisations of, the legal due care criteria, these initiatives are important instruments to prevent potential abuses. Apart from the additional safeguards suggested, the importance of a decision-making policy that includes many actors (e.g. the patient's relatives and other care providers) and of good aftercare for the bereaved are rightly stressed. Shortcomings of the initiatives relate to the aftercare of patients whose euthanasia request is rejected, and to uncertainty regarding the way in which attending physicians should manage negative or conflicting advices, or patients' suicide threats in case of refusal. Given the scarcity of data on how thoroughly and uniformly requests are handled in practice, it is unclear to what extent the recommendations made in these guidelines are currently being implemented.

1. Introduction

In 2002, Belgium conditionally de-criminalised euthanasia performed by a physician, legally defined as 'intentionally terminating life by someone other than the person concerned, at the latter's request'. The Belgian Euthanasia Law, however, lays down several substantive

and procedural due care criteria that need to be fulfilled in order for euthanasia to be legally permissible (see Box A). On the basis of their freedom of conscience and their professional autonomy, physicians are at liberty to refuse involvement or to make their involvement dependent upon the fulfilment of additional requirements (Belgian Official Gazette, 2002).

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Euthanasia is only legally allowed in the BeNeLux countries (i.e. Belgium, the Netherlands, and Luxembourg), Canada, and Colombia. Laws on medical assistance in dying, excluding euthanasia, are implemented and effective in Switzerland and the following American States: Oregon, Washington, Montana, Vermont, California (Emanuel, Onwuteaka-Philipsen, Urwin, & Cohen, 2016), Hawaii, Colorado, and Washington D.C. (Death with Dignity National Center (DD), 2018). Recently and strictly taken, the Australian State of Victoria has legalised medical assistance in dying, though also euthanasia in case of a patient being physically incapable of the self-administration of the lethal drug substance (Parliament of Victoria, 2017).

Under the Belgian Euthanasia Law, euthanasia is allowed not only for patients who are expected to die within the foreseeable future but also for patients who are not expected to die within the foreseeable future (in which case the Law requires the fulfilment of additional due care criteria). The latter is almost always the case for psychiatric patients. In line with a general increase of euthanasia cases, the number of cases of euthanasia for psychological suffering is steadily rising (Chambaere, Vander Stichele, Mortier, Cohen, & Deliëns, 2015; Smets et al., 2009). Analysis of the biennial reports of the Belgian Federal Control and Evaluation Commission for Euthanasia (FCECE) indicate that, whereas euthanasia for psychological suffering in psychiatric patients was virtually nonexistent between 2002 and 2007, numbers increased to an average of eight per year between 2008 and 2010, then to approximately 30 per year between 2011 and 2013, and to approximately 60 per year in 2014 and 2015, before decreasing to approximately 40 per year in 2016 and 2017 (Dierickx, Deliëns, Cohen, & Chambaere, 2017; Federal Control and Evaluation Committee for Euthanasia, 2004, 2006, 2008, 2012, 2014, 2016, 2018).

Euthanasia for psychological suffering in psychiatric patients gives rise to significant concerns regarding the assessment of several of the due care criteria set out in the Law, including: 1) the patient's mental competence, as this might be affected by a psychiatric disorder; 2) the requirement for the psychiatric disorder to be incurable, as some (symptoms of) psychiatric disorders tend to change over time; 3) the requirement for the well-considered nature of the request, as a death wish may be a symptom of a psychiatric disorder; 4) the constant and unbearable nature of the psychological suffering, given that a clear definition and an effective assessment instrument are still lacking; and 5) the requirement of the non-alleviability of the psychological suffering.

As a result, the clinical assessment of these criteria is very difficult and extreme care should be required before a request from a psychiatric patient for euthanasia for psychological suffering is granted (Naudts et al., 2006). To illustrate the contentiousness of this issue, case reviews in the Netherlands suggest that in some of the reported cases of euthanasia on patients suffering from a psychiatric disorder some of the due care criteria may have been evaluated suboptimally (Doernberg, Peteet, & Kim, 2016; Kim, De Vries, & Peteet, 2016). Remarkably, however, no such research on Belgian cases has been conducted.

Prompted by the lack of clarity of some of the legal due care criteria, some hospitals have developed protocols to manage requests for euthanasia for psychological suffering (Behaegel, Vercoutere, & Matthys, 2015). In addition, three end-of-life consultation centres (ULteam in 2011, LEIF Western-Flanders in 2013 and LEIF.Ghent in 2015) have been established by the association LEIF (Life End Information Forum), which was founded in 2003 with the aim to provide information about, and assistance in, end-of-life care (Van Wesemael et al., 2009, 2010). However, the considerable increase in cases of euthanasia for psychological suffering and media reports on controversial cases – of which one has been referred to the public prosecutor (Mason & Weitenberg, 2015; Symons, 2015) and another one has been referred to the Court of Assize (Hope, 2018) – raise concerns about a potentially overly permissive approach (Clifford, 2017). As a consequence, some critics suggest the banning of euthanasia for psychological suffering, whereas some organisations and institutions have published guidelines that may

enhance the quality of practices.

The aim of our study is to analyse the five Belgian guidelines that have recently been issued regarding the Belgian practice of psychiatric patients requesting euthanasia for psychological suffering (see Box B), in order to identify and discuss: 1) the measures proposed to operationalise the legal requirements; 2) suggestions for additional safeguards going beyond the legal requirements; and 3) suggestions regarding the most important issues that are not addressed in the Belgian Euthanasia Law. These guidelines will be analysed using a critical point-by-point reflection, focusing on each of the substantive and procedural legal due care criteria. This allows us to formulate general recommendations for an ethically sound clinical practice in Belgium, and will allow readers in other jurisdictions considering adopting euthanasia legislation to identify helpful lessons regarding medical assistance in dying concerning this specific patient group.

Note that the Belgian Act on Euthanasia became effective in the same year as the Dutch ‘Termination of Life on Request and Assisted Suicide (Review Procedures) Act’. The Dutch Act contains similar substantive and procedural criteria that must be followed if a patient requests euthanasia. The Dutch Association for Psychiatry published its guidelines on how physicians should assess requests for euthanasia from patients with psychiatric disorders in 2009 (Tholen et al., 2009), the same year when Ghent University Hospital developed its step-by-step protocol (I). The other guidelines that we discuss in this paper (II–IV) are heavily inspired by the recommendations and suggestions made in the first two editions of the Dutch guidelines (published in 2004 and 2009), but adapted to the Belgian legal context (e.g. the requirement that for euthanasia of a non-terminally ill patient two physicians should be consulted instead of one, as prescribed by the Dutch Act).

Switzerland has no legislation on medical assistance in dying but its criminal law provisions on assistance to suicide (Article 115 of the Criminal Code) do not criminalise assisted suicide for non-selfish motives. Some non-profit organisations (e.g. EXIT and Dignitas) provide assisted suicide to terminally and non-terminally ill psychiatric patients who request physician assistance in dying, subject to the fulfilment of the due care criteria set out in the organisations' own dedicated protocols.

As for Canada, following the adoption of the Law on Medical Assistance in Dying, many provinces have developed policies for medical assistance in dying for terminally ill patients, e.g. Ontario's Policy Statement on Medical Assistance in Dying (CPSO (The College of Physicians and Surgeons of Ontario), 2016). A discussion to expand the Canadian Law to also include the non-terminally ill is still ongoing. The Council of Canadian Academies recently published three ‘final reports’ of Expert Panels on Medical Assistance in Dying for Mature Minors, on Advance Requests, and concerning cases in which a Mental Disorder is the Sole Underlying Medical Condition (Council of Canadian Academies, 2018).

This paper was constructed as follows. First, each of the substantive and procedural legal criteria was noted down in a structured bullet point list. Second, when reading the first guideline, every piece of information on the substantive and procedural legal criteria and on the possible additional due care criteria discussed in the guideline was systematically collected, noted down, and summarised under the relevant legal criterion on that list. This method was repeated for each of the subsequent guidelines. Subsequently, the similarities and differences between the guidelines were examined, with particular attention to the way in which they interpreted the legal criteria and to suggestions to include additional due care criteria.

2. The substantive criteria for eligibility for euthanasia in Belgium

2.1. Characteristics of the patient

The first substantive criteria concern two patient characteristics, namely the patient's age and mental competence.

2.1.1. The age of the patient

The Euthanasia Law stipulates that the patient who requests euthanasia must either be an adult (i.e. 18 years of age or older) or an emancipated minor (i.e. a minor who, as a result of marriage, or after the age of 15 and on the basis of an order by the juvenile court, is legally competent to autonomously make decisions that touch upon their person). In 2014, the Euthanasia Law was extended to all minors, regardless of age, who have the capacity for discernment, but only in relation to euthanasia for physical suffering and only if additional legal criteria are fulfilled (Raus, 2016; Van Assche, Raus, Vanderhaegen, & Sterckx, 2018).

2.1.2. Mental competence

To be eligible for euthanasia, the patient must have legal capacity (i.e. must not have been placed under guardianship). In addition, the Euthanasia Law requires patients to be able to make a well-considered request and so to have the necessary mental competence. This means that they need to be able to demonstrate the ability to understand the real implications of a euthanasia request. Finally, patients also need to be conscious at the moment of making the request.

Some physicians, including psychiatrists, question mental competence in (some) psychiatric patients who are suffering. The five guidelines that are the topic of this paper acknowledge that mental competence can indeed be reduced due to a patient's psychopathology (e.g. temporary psychoses), but they emphasise that this is not automatically the case. In that respect, mental competence should be considered as being task dependent. In the context of a euthanasia request, most of the guidelines (II–V) identify reasons to assume that some psychiatric patients can make a reasoned, well-considered choice for termination of life, accompanied by suitable emotions, and to a certain degree also irrespective of psychopathology. For example, some patients suffering from recurrent depressive, manic or even psychotic episodes find themselves also in temporarily symptom-free waiting periods of remission, before the eventual likelihood of symptom recurrence and/or relapse. Like the psychopathology itself, a patient's mental competence can thus change over time.

However, physicians face great difficulties regarding the evaluation of mental competence in psychiatric patients. Representing the professional group of psychiatrists, one of the guidelines (IV) specifies the clinical assessment of mental competence on the basis of four criteria. First, the degree of the following four cognitive competencies should be assessed in patients: 1) the ability to make and communicate personal choices; 2) the ability to comprehend the information provided; 3) the ability to apply this information to one's own context and situation; and 4) the ability to reason and deliberate. Second, a properly considered euthanasia request must be present (i.e. a 'flash of the moment'-decision must be excluded), and must be accompanied by appropriate emotions. In this respect, ambivalence could also be interpreted as a logical consequence of fear of death, rather than as a symptom of reduced mental competence. Moreover, ambivalence could also be used as a lever to get the patient to focus (again) on exploring options of recovery or rehabilitation. Third, a euthanasia request that could be attributed directly to a symptom of the patient's disorder must be rejected. Fourth, the presence of a sufficient degree of 'practical rationality' must be present. More specifically, the patient should be able to place her euthanasia request in the context of values and goals that are meaningful to herself and that are not overly influenced by her psychopathology.

Regarding the evaluation of the patient's mental competence, four of the guidelines highly recommend taking sufficient time and making use of hetero anamnesis (II–V) and interdisciplinary consultation (I–V). Suicidality receives specific attention in three guidelines (III–V), as this is inherent to many psychiatric disorders. A distinction is made between acute and rational suicidal ideations and plans. It is proposed that the latter should be subject to therapeutic treatment processes that can run parallel with the euthanasia procedure (starting after a euthanasia request has been formally expressed). Involuntary admission to a

psychiatric ward should only be considered in cases of acute suicidality, resulting from a serious psychiatric disorder, and only when the patient's safety cannot be ensured via voluntary treatment (IV).

2.2. Characteristics of the euthanasia request

The Euthanasia Law requires that the euthanasia request is "voluntary, well-considered and repeated, and not the result of external pressure".

2.2.1. Voluntary euthanasia request

Voluntariness implies that the patient's euthanasia request is not the result of mistaken beliefs or of coercion or undue influence. The exclusion of external pressure from the patient's social environment can be addressed by means of hetero anamnesis and observation of the patient's interaction with family and friends. However, some of the guidelines (II, IV,V) also recommend excluding irrational internal pressure originating from the patient's psychopathology in terms of a perceived sense of guilt or feeling of being a burden to others. In this regard, one of the guidelines (IV) indicates that the perception of being a burden can be grounded in the patient's awareness that this burden is a real and logical consequence of one's psychopathology. For instance, in cases of chronic behavioural disorders, the burden on families can be manifold: from emotionally coping with a patient's distressing behaviour, over disruption of household routine, to restriction of social activities. It is argued that this type of rational internal pressure need not be a reason to reject the patient's euthanasia request in advance (IV).

2.2.2. Well-considered euthanasia request

This criterion, which is closely related to the issue of mental competence, is concretised as follows in the guidelines that elaborate on it (II,IV,V). The patient should express a clear and well-considered death wish, taking into account aspects of the patient's life that make it worth living, and based on sufficient self-knowledge and capacity to cognitively process all information on (the consequences of) the condition and the available treatment options. The legal condition of a well-considered euthanasia request presupposes that the patient has been well-informed by the physician concerning: 1) her (psycho)pathology; 2) possible ways to alleviate her suffering; 3) side effects of the available treatment options; and 4) the prognosis (with and without treatment).

In the context of euthanasia, physicians need to be alert to the patient's cognitive and emotional information processing and should inform the patient on: 1) the physician's own stance on euthanasia in general and the patient's euthanasia request in particular; and 2) available alternatives to euthanasia, including palliative care. When a physician decides to become involved in a patient's euthanasia procedure, clear information should also be given on the euthanasia procedure itself, including on the need for multiple consultations and the involvement of other physicians and, where relevant, important others.

One guideline (IV) also addresses the difficulties in case of a psychiatric patient's reduced awareness of illness. According to guideline V, that is precisely the reason why physicians need to act with the greatest caution. For a euthanasia request to be legally justifiable, the patient must be aware of the symptoms and the consequences of her disorder by way of her realising how it affects her behaviour and life situation. The following example has been given in guideline IV: "In case of depressive disorders, a patient can present and argue her euthanasia request from a pessimistic, nihilistic view of herself, her past, and future life, while more objective facts that shed a more realistic light on her past, present, and future do not enter the assessment process. The patient's opinions are then distorted, while not realising the consequences of her mental state." (Vlaamse Vereniging voor Psychiatrie, 2017, p. 23) In these clearly symptom-induced periods of psychopathology, the patient should not be considered eligible for euthanasia.

The guideline further defines a sufficient degree of self-knowledge and of awareness of illness as follows: “the patient’s knowledge of her own personal qualities that have an essential influence on her quality of life, implying the realisation of how certain character traits influence her perception of her interaction with others” (Vlaamse Vereniging voor Psychiatrie, 2017, p. 23). However, and especially in case of personality disorders, some guidelines (II and IV) acknowledge that the patient-physician-interaction can be strongly influenced by pathological personality characteristics of which the patient may be unaware. These characteristics do sometimes not only affect the patient’s suffering, but also the tendency to undermine treatment compliance and other life support, which is challenging in the context of a euthanasia request from a medical and ethical perspective. According to these guidelines, both the patient and the psychiatrist must endeavor to achieve a degree of insight that is as substantial as reasonably can be expected on the basis of the patient’s psychosocial and intellectual background. It is acknowledged that an optimal awareness of illness and an optimal self-knowledge may be essential for the success of a medical treatment or rehabilitation plan. Hence, an insufficient degree of self-knowledge and awareness of illness is, in their opinion, a reason to prolong the euthanasia procedure in order to provide sufficient time for patient information and psycho-education.

2.2.3. Repeated and durable euthanasia request

It should be the case that the patient repeatedly expresses a death wish towards the physicians involved. According to the guidelines, it is preferable that the patient has also expressed her death wish towards her close inner circle of family or friends (II–V). The patient’s request must be spread out over a period of several months, in order to exclude a ‘flash of the moment’-decision and to allow sufficient time to assess the origin and evolution of the death wish (I–V). In addition, the patient’s request should be durable. In case the abovementioned expressed ambivalence between the patient’s fear of death would over time diminish or even disappear and if, as a result, the death wish would become more pronounced, this would be a sign that the patient had made up her mind (IV).

2.3. Characteristics of the patient’s condition

According to the Euthanasia Law, euthanasia is only allowed if the patient who requests euthanasia is suffering from a serious and incurable condition, caused by illness or accident.

2.3.1. Serious character of the condition: the presence of a diagnosable condition

For a euthanasia request to be eligible, it needs to be based on a medical somatic and/or psychiatric disorder. Two of the guidelines (II, IV) introduce a further distinction between a euthanasia procedure involving a patient suffering from a psychiatric disorder and a procedure involving a patient suffering from a neuropsychiatric (e.g. dementia) disorder, declaring that the latter procedure requires a slightly different approach from the one discussed in their recommendations concerning the assessment of euthanasia requests from psychiatric patients. Regardless of the specific type of condition, the condition does not only need to be serious and incurable, but also medically diagnosable. Psychiatric disorders, even in the absence of somatic co-diagnoses, are recognised as diagnosable medical conditions.

2.3.2. Incurable nature of the condition

The evaluation of the legal requirement of incurability is left to the expert opinion of the physician involved as it should be based on the current state of the art of medicine. Different terminologies are used in practice to address this legal criterion. Some psychiatrists use the concept ‘medical futility’ in order to refer to treatment resistance, or to ineffective or inappropriate treatment. Some guidelines (III, V) refer to persisting intense debates in the literature regarding the question as to

whether, and if so when, a psychiatric condition can be considered incurable as these types of conditions frequently change over time (Broome & de Cates, 2015; Claes et al., 2015; Kelly, 2017; Schuklenk & van de Vathorst, 2015; Trachsel, Irwin, Biller-Andorno, Hoff, & Riese, 2016; Vandenberghe, 2017).

In some of the guidelines, to address this problem, the concept of ‘no reasonable treatment perspective’ was introduced, which had earlier been proposed and explained in the former guideline of the Dutch Psychiatric Association (Tholen et al., 2009). According to the former (and recently revised) guideline as well as some of the Belgian guidelines (II–V) discussed in this paper, therapeutic options for a particular condition should be considered if they meet the following three requirements: 1) a real prospect of improvement; 2) the possibility to administer adequate treatment within a reasonable period of time; and 3) a reasonable balance between the expected treatment results and the burden of treatment for the patient.

In an attempt to operationalise these three requirements, the following criteria have been formulated (IV). First, it is advised to fully apply the current psychiatric State of the Art Treatment protocol in terms of: 1) all indicated regular biological interventions; 2) all indicated psychotherapeutic interventions; and 3) social interventions that could alleviate the patient’s suffering. These interventions should be offered by qualified caregivers. Second, to assess what would count as a reasonable time period for these interventions, the following criteria should be taken into account: 1) the patient’s medical history; 2) the duration of suggested pharmacological and psychotherapeutic treatments; and 3) the patient’s age. Third, the benefits and disadvantages of interventions should be based on: 1) the plausibility, expected nature, and expected extent of improvement; 2) the plausibility, nature, and seriousness of side effects; and 3) the patient’s coping capacity.

In some cases of euthanasia for psychological suffering, a recently discovered (and thus previously missed) psychiatric diagnosis was invoked as an additional reason to consider the patient to be in a medical condition without prospect of improvement. One guideline (IV) strongly disagrees with such a view and recommends that new diagnoses should be seen as a reason to explore the possibility of improvement.

The guidelines differ in their recommendations for cases when patients refuse reasonable treatment options. One guideline (III) indicates that no consensus was found on this issue, while other guidelines (II, IV) recommend that the euthanasia must not be carried out in such a case.

2.4. Characteristics of the patient’s suffering

According to the Euthanasia Law, euthanasia is only allowed if the patient is in a condition of constant and unbearable physical or psychological suffering that cannot be alleviated. The guidelines formulate more objectifiable criteria in order to evaluate the various requirements for the patient’s suffering: the suffering should be assessed in multiple consultations with the patient that are spread out over time, and the assessment should, more specifically, be made by means of thorough patient observation and examination of the patient’s medical history and life context. With the consent of the patient, physicians can obtain access to the patient’s medical record. Without this consent and thus without access to the patient’s medical files, a euthanasia request cannot be legally admissible, as the law provides that all physicians involved need to have access to the medical record. An interdisciplinary evaluation of the patient’s suffering is strongly recommended by all the guidelines.

2.4.1. Physical or psychological suffering

According to the Law, a patient’s euthanasia request needs to be based on physical and/or psychological suffering that results from a serious and incurable condition. The consequences of the patient’s condition will typically not be restricted to physical and/or

psychological suffering alone, as they can also include social and existential aspects. The latter aspects cannot be fully evaluated from a medical perspective. Recent qualitative research has revealed that some socio-economic (e.g. social inequalities) and even financial issues (e.g. low income) are additional circumstances that can make patients consider requesting euthanasia (Verhofstadt, Thienpont, & Peters, 2017). This observation necessitates a broad societal debate, as euthanasia should never be used as a way to resolve society's failings (Verhofstadt et al., 2017). In this respect, it should be noted that physicians may play an important role in reducing patients' social suffering by strengthening their social environment, for instance by encouraging an open dialogue between the patient and her family and social network (Norwood, 2005, 2007).

According to the Law, the euthanasia request should be based on physical and/or psychological suffering that is directly caused by the patient's medical condition. The biennial reports from the Federal Control and Evaluation Commission for Euthanasia (FCECE) indicate that most cases of euthanasia that are reported involve a combination of physical and psychological suffering, as, for example, cancer patients might suffer from a perceived loss of dignity, whereas patients with anorexia nervosa can suffer from physical problems.

Diverging views exist on the precise meaning of the requirement of causality in the Euthanasia Law (III) ((Belgisch Raadgevend Comité voor Bio-ethiek (Belgian Advisory Committee on Bioethics), 2017). Taking into account the subjective nature of suffering, some experts are in favour of not strictly medicalising this criterion, out of fear that psychiatric patients, in whom tissue damage is not always apparent, might then be excluded from receiving euthanasia, whereas others argue that completely disconnecting the suffering and the medical condition (i.e. disregarding the causality requirement) would pave the way for physicians to grant euthanasia requests that have no medical basis and are therefore beyond their professional expertise. A key question in this regard is which physician should evaluate the causal relationship between the patient's medical condition and her suffering (III). If this prominent role is entrusted to the attending physician alone and not also to the two legally required consulted physicians, it can be problematic if the former is not a psychiatrist. This is one of the reasons why several of the guidelines (I, III–V) recommend that two of the consulted physicians should be psychiatrists – instead of one, as prescribed by the Euthanasia Law – and that in their assessment of the fulfilment of the due care criteria these psychiatrists need to pay specific attention to evaluating the causal relationship between the patient's medical condition and her suffering. Obviously, establishing this causal relationship is a complex task, even for experienced psychiatrists.

2.4.2. Constant suffering

The constant nature of the suffering can be operationalised when taking into account the origin, evolution, and continuity of the suffering. For psychiatric disorders, even those with an episodic character, symptoms can be chronically and severely persistent, progressive, and/or continuously alternating.

2.4.3. Unbearable suffering

The unbearability of suffering cannot easily be operationalised, as it is inherently a subjective criterion and objective parameters are lacking. Due to their predominantly non observable complaints and frequent lack of neurobiological markers in patients with psychiatric disorders, their suffering experiences are way more difficult to assess. There is no consensus on how and by whom (the patient and/or the attending physician and/or others) the unbearable nature of the suffering should be assessed (III). Some claim that this assessment should be totally left to the patient. Others suggest that unbearability always needs to include a medical component and that the requirement to ascertain unbearability is closely related to the physician's task to detect, suggest, and apply potential therapeutic solutions to alleviate the

patient's suffering. Despite these differences of opinion, a consensus can be observed in the guidelines in the emphasis on the physician's empathic understanding of the patient's perception and judgment of the unbearability of her suffering, in the light of the patient's current and past life context, the disabling consequences of her condition, her physical and mental strength, her coping capacity, and her personality (II–V).

2.4.4. Non-alleviability of the suffering

This criterion clearly encompasses a medical component and is closely related to the criterion that a prospect of improvement should be absent. It is left to the expert opinion of the physician(s) involved to judge whether there are therapeutic options left to alleviate the patients' suffering and to discuss these options with the patient. The Federal Control and Evaluation Commission for Euthanasia has repeatedly reported dissensus between its members regarding the question how to understand and evaluate the requirement of non-alleviability of unbearable (psychological) suffering (Federal Control and Evaluation Committee for Euthanasia, 2008, p. 31, 2010, p. 23). Guideline III questions the Commission's assumption that the final judgment on the non-alleviability of the suffering should be left to the patient herself, when the Commission states that euthanasia can be performed if the patient's refusal of further treatment options is based on 'severe treatment-related side effects or treatment applications perceived as unbearable'. According to this guideline, side effects can only emerge after a treatment option is applied. The Commission's view could then, for instance, pave the way for a severely depressed patient to refuse the state-of-the-art intervention of electroconvulsive therapy (ECT) on the ground of perceptions of it being unbearable. By contrast, guideline III explicitly prefers the approach as prescribed in the former (and adopted in the recently revised) Guideline of the Dutch Psychiatric Association, stating that it is part of the clinical and ethical duty of the psychiatric profession to follow all the state-of-the-art medical procedures before a request for euthanasia can be regarded as legally eligible.

3. The a priori procedure for decision-making regarding euthanasia

3.1. A two-track approach

As regards the decision-making process that precedes the granting or refusal of euthanasia requests, some of the guidelines clearly go beyond the legal requirements with their explicit recommendation of a two-track approach. This approach is characterized by focusing on life by way of continuing treatment of the patient, in parallel with a focus on death by way of assessing the patient's euthanasia request. This view is based on two fundamental, although not absolute, ethical values: respect for the autonomy of the patient by respecting and taking seriously a patient's death wish, and the duty to protect human life by first exploring meaningful life perspectives for a patient who has expressed a death wish (II, IV, V). The rationale behind this two-track approach is that it should not be ruled out that the euthanasia request is a cry for help and the result of suffering that might be adequately addressed by other means. For that reason, whereas on the death track the reasons for, and the eligibility of, a patient's euthanasia request will be explored, a life track will be pursued simultaneously, in which the alternatives to death will be explored from a medical and psychological as well as from a social and existential perspective.

First, the patient's current treatment must be evaluated, intensified, and/or otherwise adjusted, even if this means changing caregivers. Second, the potential of psychiatric rehabilitation options must be addressed in order to enhance the patient's autonomy, social participation (e.g. via social support groups or peer support groups) and, consequently, quality of life. In addition, attention should be paid to opportunities for so-called 'crustative care': a specialised, tailor-made 'palliative' psychiatric care for those patients for whom there are no

therapeutic options left in terms of alleviation of suffering, although their quality of life, perception of dignity, and connectedness with others could still be restored and enhanced. According to several guidelines (II, IV, V), connectedness with others is a crucial condition for the exercise of autonomy as patients can only make well-considered choices when they are closely connected with important others. Third, guidance needs to be offered in the search for potential sources, goals, and projects to regain meaning in life.

The physicians involved in the euthanasia procedure can focus on, or be involved in, both tracks to a different extent (IV). The main idea is that each physician may combine these two tracks or may decide to just focus on one track, but that both tracks should always be simultaneously explored. Interestingly, one guideline (I) emphasises that, as a quintessential premise of their protocol, their hospital's psychiatrists can only be involved in the assessment of a patient's euthanasia request while the patient's own physician remains responsible for the treatment of the patient's psychopathology. As for the other physicians involved, the consulted physicians normally will focus only on the death track.

It should also be pointed out that there is an overlap between the life track and the death track and between their underlying values (i.e. respect for the autonomy of the patient vs. duty to protecting life), as the death track might protect patients by preventing brutal suicide attempts, whereas the life track might exceptionally lead to additional suffering and even suicide attempts. Contrary to what has occasionally been reported in practice, a patient's request for euthanasia should not be a sufficient reason for withholding treatment or hospitalisation in a psychiatric ward.

3.2. Number and role of physicians involved

If the patient is not expected to die within the foreseeable future, the Law requires that the euthanasia request be assessed by at least three physicians: the attending physician and two consulted physicians. At least one of these consulted physicians needs to be a psychiatrist or a specialist in the patient's medical condition. To each of the physicians involved, specific and limited roles are allocated by the Euthanasia Law (Box A). The physician(s) should be independent from the patient and from each other.

It is advised by guideline IV that the attending physician is the first to be consulted by the patient. In that specific role, the attending physician should take the lead in the euthanasia procedure and refer the patient to the physicians who will be acting as consulted physicians. According to this guideline, this sequence is not always applied in practice, as sometimes physicians are already consulted during the euthanasia procedure before one of them refers the patient to a physician who would be willing to perform the euthanasia and therefore takes on the role of attending physician at the end of the euthanasia procedure. The latter illogical sequence is deemed ethically inappropriate in guideline IV, as it might cause the patient to be confused over the exact role of the physicians involved. Some guidelines (II, IV) recommend that both the attending and the consulted physicians have several conversations with the patient. This goes beyond the Law's requirements that, whereas the attending physician should have several conversations with the patient, the consulted physicians merely need to examine the patient and to review her medical record.

3.2.1. Specific role of the attending physician

The attending physician who approves a euthanasia request is not obliged to perform euthanasia herself. In the context of building a relationship of trust between the patient and the physician, the latter needs to conceive of herself as being able and willing to perform euthanasia if and when all legal requirements are fulfilled. The patient's treating physician may also be the patient's attending physician as long as the two-track approach and referrals to independent consulted physicians are guaranteed (IV).

3.2.2. Specific role of the consulted physicians

Due to the complexity of euthanasia requests for psychological suffering, it is suggested (IV, V) or prescribed (I) that two, instead of one, of the consulted physicians should be psychiatrists and that they should assess all substantive due care criteria, instead of only the criteria that the Law requires them to assess (IV, V). In addition, it is proposed (II, IV, V) or made mandatory (I) to also involve the patient's treating physician in the procedure, although never as one of the consulted physicians, in view of the risk of a biased assessment.

The Euthanasia Law requires the consulted physicians to be independent but does not specify how this is to be understood. However, in its information brochure for physicians, the Federal Control and Evaluation Commission for Euthanasia states that the consulted physicians must not have a therapeutic relationship with the patient nor be a relative or a hierarchical subordinate or superior to the attending physician (Federal Control and Evaluation Committee for Euthanasia, 2015). Moreover, in the legal literature the view is advocated that the consulted physician should not be a member of the attending physician's doctor's office or hospital department, although the condition of independence does not require that consulted physicians should come from outside the hospital where the attending physician is treating the patient (Delbeke, 2014; Vansweevelt, 2003).

One guideline (I) has formulated specific rules on how to handle euthanasia requests from patients who are referred from outside the hospital's walls. The protocol stipulates that the attending psychiatrist should only manage the patient's euthanasia request (i.e. should not take over her treatment) and should have as many consultations with the patient as needed to decide whether the legal requirements are met. The results of the consultation and evaluation must be communicated to the patient's treating psychiatrist. When the attending physician has ascertained that the legal requirements have been fulfilled, the patient must be referred to a second psychiatrist (i.e. the first consulted psychiatrist) within the hospital's department of psychiatry and, after that person has provided a positive opinion, also to an independent third psychiatrist (i.e. the second consulted psychiatrist) belonging to a department of psychiatry of another Flemish university hospital. The second and third psychiatrist should review the patient's medical file and have at least one consultation with the patient to independently determine whether all legal requirements are met. To ensure independent decision-making, the second consulted psychiatrist from outside the hospital is appointed by the multidisciplinary Hospital Ethics Committee. Only when the three psychiatrists involved have independently verified that all legal requirements are met, can euthanasia be performed.

According to guideline IV, all legal requirements should be assessed by each of the physicians involved, albeit not necessarily to the same extent. This guideline states that the first consulted psychiatrist, like the attending physician, needs to address the underlying reasons for the euthanasia request. This could lead to a strong relationship of trust that may include the risk of transference (i.e. the euthanasia request and procedure may provoke feelings in the patients) and counter-transference (i.e. the patient's euthanasia request may provoke feelings in the physician), that may decrease the objectivity and independent judgment. Hence, the role of the second consulted psychiatrist should be strictly limited to evaluating the legal due care criteria, with specific attention to the non-alleviability of the suffering. This should reduce the risk of bias due to (counter)transference.

3.3. Involvement of relatives or important others

The Euthanasia Law does not require the attending physician to involve the patient's relatives in the euthanasia procedure. However, the attending physician is required to ascertain that the patient has had the opportunity to discuss the euthanasia request with the persons whom she wants to talk to. Some guidelines consider this a quintessential criterion (II, IV, V). One guideline is more strict than the legal

requirement in that at least one other person in the patient's social circle has to be involved, even if the patient specifically refuses and asks that no relatives be involved (IV). The involvement of family members and/or important others does not mean that these persons need to approve the euthanasia request. However, an interpretative dialogue with the patient's family members and/or important others gives all actors a deeper insight into the patient's social context and background, and it might reveal opportunities to strengthen meaningful relationships, communication, and commitment. This might influence the patient's perspectives on her suffering and her death wish. If the patient would eventually receive euthanasia, having been involved might limit the psychological impact, grief, and bereavement of the relatives. If the patient rejects their involvement, the physician should look for the underlying motives and try to clarify them. Some guidelines point out that if the patient's resistance is unwarranted, the consultation procedure might be halted (II, IV, V).

3.4. Involvement of other caregivers

The Euthanasia Law stipulates that, if there is a nursing team that has regular contact with the patient, the attending physician needs to discuss the patient's euthanasia request with the nursing team or with members of that team. However, some guidelines also urge the involvement of all other important caregivers involved in the patient's treatment (II, IV, V). Besides the nursing team, guidelines II, IV and V recommend the inclusion of other current or even former caregivers in an interdisciplinary team in order to further explore and compare the patient's background and current life context with a view to detecting any unnoticed meanings of the patient's euthanasia request. As contacting relevant caregivers is deemed quintessential by these guidelines, the attending and consulted physicians might even need to refrain from the assessment procedure if the patient does not give permission to contact any of her caregivers.

Guideline II strongly advises not only the involvement of an interdisciplinary team but also the provision of extensive additional support. Going beyond the legal requirements, this additional support is recommended to involve: 1) a central, interdisciplinary End-of-Life Support Group (covering all the psychiatric centers of this network and open to external experts), established in order to gain objective and independent advice; 2) a local End-of-Life Support Group (covering one or more psychiatric centers in a specific region), established in order to gain objective, independent advice or practical support; and, optionally and especially in cases where the consultation procedure is in an advanced stage, 3) trained physicians of the Life End Information Forum (LEIF) (Van Wesemael et al., 2009) for support and advice regarding the performance of euthanasia.

3.5. Other procedural decision-making aspects

3.5.1. Decision-making procedures

The Euthanasia Law requires that, if the attending physician believes that the patient is not expected to die within the foreseeable future, a waiting period of at least one month should be respected between the patient's written request and the performance of euthanasia. In addition, as indicated above, the attending physician will need to consult two physicians instead of one. The advices issued by the consulted physicians are merely advisory (Delbeke, 2011, 2012; Vansweevelt, 2003).

The guidelines, however, plead for more stringent decision-making procedures. One guideline (IV) advocates detailed written reports of the physician's face-to-face discussions, accessible to all physicians and caregivers involved, so as to enable an open, transparent round-table discussion, preferably even before formal advices are obtained, in order to achieve a broader evaluation horizon and enhance the level of due care.

A built-in safeguard is provided in guideline I in terms of an

additional meeting with the Hospital Ethics Committee in order to a priori discuss and determine whether or not a euthanasia request can be declared admissible for further management and evaluation. Guideline II takes a more restrictive stance and establishes an a priori and interdisciplinary evaluation committee consisting of the following 3 groups: 1) staff members from the facility in question: the attending physician, the chief physician of the department, and two other staff members of whom at least one is a non-physician; 2) at least two staff members of the network, with expertise in euthanasia in the context of psychiatry, though not employed in the facility in question; and 3) at least two members from outside its walls and hence not employed in the facility, but with expertise in the euthanasia topic. The chief physician coordinates the evaluation committee. If consensus has been reached, an appropriate timing and place of death will be planned. In case of disagreement, the evaluation committee will advise the attending physician against performing euthanasia. Nonetheless, this cannot be enforced due to the physician's therapeutic freedom to act in conformity with her own moral and professional values.

In guideline III, some recommend the establishment of an authoritative a priori evaluation by an ad hoc committee. This committee would be complementary to the existing Federal Control and Evaluation Commission on Euthanasia's a posteriori review. Specifically in the context of euthanasia cases for psychological suffering, this type of a priori evaluation is recommended in view of the complexity of decision-making related to the patient's disorder (e.g. unpredictable prognosis of a non-terminal illness), the multifactorial reasons underlying the patient's death wish and the irreversibility of euthanasia. However, others involved in the drafting of this guideline oppose this proposal, arguing that an a priori review is against the 'spirit of the Law' and would lead to euthanasia procedures resembling 'tribunal hearings'.

As for the number of consultations and the duration of the euthanasia procedure, the guidelines recommend that the consultations be spread over a longer period than the legally required one-month waiting period. Some guidelines do not specify the required duration (I, IV), whereas others advocate a waiting period spanning at least 6 months (II) or 1 year (V) taking into account the involvement of all important actors. In guideline III, some Committee members are in favour of maintaining the minimum of one month to avoid suicide attempts 'out of despair', also in respect of many patients' long medical history. They also fear the phenomenon of patients 'shopping' for more permissive psychiatrists if the attending physician is inclined to take his or her time. Other members prefer a waiting period of at least one year (as the psychiatric state-of-the-art protocol includes one year to give therapeutic alternatives a fair chance of success and because the euthanasia procedure creates a new patient-physician dynamic that needs to be fully explored). As observed in practice, the euthanasia procedure might offer sufficient peace of mind, which could be a signal to explore opportunities for extended aid, rehabilitation, etc. (Thienpont et al., 2015). Most of the guidelines (I, IV, V) are more restrictive than the Law as they argue that performing euthanasia is only justifiable after obtaining at least two uniformly positive advices from at least two consulted psychiatrists. In case of negative advices, these should also be taken into account. However, none of these guidelines describes to what extent possible negative advices should affect the euthanasia procedure and/or the final decision.

3.5.2. (After)care for the relatives and friends

As mentioned above, the involvement of the patient's relatives and important others is quintessential according to several of the guidelines (II, IV, V). During the assessment of the euthanasia request, these actors need to be informed regarding: 1) the euthanasia procedure; 2) the patient's life perspectives; and 3) the physician's final decision regarding granting or refusing the euthanasia request. This can take place in close collaboration with the treating physician.

If the patient's relatives and important others are already involved in the euthanasia procedure, the attending physician should inform and

invite them for information on the final outcome of the euthanasia procedure. In addition, the involvement of the treating physician (responsible for the life-track), other caregivers, or a religious official who has a close connection to the patient's relatives and important others, can be sought. After the euthanasia has been performed, appropriate aftercare is important to deal with the grief and to soften the mourning. However, this aspect receives little attention in the guidelines.

3.5.3. Conscientious objection and other value-related factors

In order to balance the respect for the autonomy of the patient who requests euthanasia and the physicians' freedom of conscience and professional autonomy, the Euthanasia Law stipulates that no physician may be forced to perform euthanasia and that, similarly, no other person may be obliged to assist in performing euthanasia. This provision is grounded in the right to conscientious objection, a general principle which is itself founded on the freedom of thought, conscience, and religion.

Some of the guidelines (II, IV, V) emphasise the need for physicians to explore their own values and emotions towards euthanasia in general and their role in the decision-making process and outcomes. However, the right to conscientious objection should not be seen as a mechanism to pave the way for 'absolute value-driven medicine', as other ethical principles, such as respect for patient autonomy and compassion with suffering, should also be held in the highest regard. On the other hand, concerns are expressed regarding some physicians' exclusive focus on the patient's self-determination, which might render them blind to relational and social aspects that may underlie the euthanasia request and to mechanisms such as projection, transference, and countertransference.

As stated in the Law and in an attempt to reconcile respect for patient autonomy and the physician's right to conscientious objection, an attending physician who refuses to perform euthanasia must inform the patient clearly and in a timely fashion on (the reasons for) this refusal in order not to create false expectations. If the refusal is based on medical considerations, these should be noted in the patient's medical record. Furthermore, a physician who refuses to perform euthanasia must share the patient's medical record with another physician designated by the patient, if the patient so requests.

When confronted with conscientious objection within the context of performance of euthanasia, the guidelines agree with the advice of the National Board of Physicians ([Nationale Raad Orde der Artsen \(Belgian National Board of Physicians\), 2017](#)) that the patient – after being adequately and timely informed – should be referred to a medical institution concerning the further assessment of the euthanasia request. However, the physician does not need to ensure this medical institution's stance and conceivability towards euthanasia performance. Hence, in case of a physician's conscientious objection, the patient requesting euthanasia should thus be referred to a colleague physician inside or outside the physician's affiliated health care facility.

Considering that exploring the underlying reasons for a euthanasia request might open the door for transference and countertransference, decision making may be seriously affected by such occurrences. Physicians themselves may be confronted with their own mortality or loneliness, but also with feelings of helplessness resulting from the inability to sufficiently alleviate suffering, irrational rescue phantasies, or even complete intolerance towards the patient. Intervention, supervision or even referral to another, more neutral physician might be needed. One guideline (I) mentions some procedural guidelines to proactively protect the integrity and the well-being of the physicians involved.

4. Medically careful performance of euthanasia

According to the Belgian Law on Euthanasia, the act of euthanasia can only be performed by the attending physician administering a lethal dose of a suitable drug to the patient. If none of patient's treating physicians conceives of performing euthanasia herself, the attending

physician can appeal to the competence and expertise of Life End Information Forum (LEIF)-physicians and/or -nurses to support or even assist the performing physician if and when needed. One guideline (II) refers to the particularly challenging situation of euthanasia in an institutional context as this could act as a potential pull factor for other patients. The utmost caution needs to be exercised to prevent potentially traumatic effects on other patients. Therefore, it is necessary that the caregivers involved look for a course of action that maximally prevents and limits a traumatic impact on fellow patients, both in the processes of the preparation and performance of euthanasia and at the stage of aftercare. Another guideline (I) stipulates that euthanasia must not be performed in the psychiatric ward, but in a single-bed room on a somatic ward, in the presence of the patient's treating and attending psychiatrist, and with an anaesthesiologist on stand-by. The required lethal dose must be prescribed by the staff member of the psychiatry department. Guideline IV refers to the LEIF-brochure in which is stated that the performing physician should not be identified at the end of the euthanasia procedure, in order to create a trust-based relationship with the patient and to ensure that all legal requirements are met. This guideline also refers to the LEIF-brochure for a correct clinical performance of euthanasia.

5. A posteriori control: Reporting to the Federal Control and Evaluation Commission for Euthanasia

In accordance with the Law, the Federal Control and Evaluation Commission for Euthanasia is composed of 16 members, appointed on the basis of their knowledge of, and experience with, issues surrounding euthanasia. Eight of its members are physicians, of whom at least four are Professors at a Belgian university. In addition, four of its members are Professors of Law at a Belgian university or practising lawyers, and the remaining four members are persons who deal with incurably ill patients on a regular or day-to-day basis. One guideline (V) recommends that at least one Commission member needs to be a psychiatrist.

The Law stipulates that the attending physician must submit a report within four days after the euthanasia has been performed. This report consists of an anonymous part and a part with the identifying data of the persons involved. The anonymous part includes information on: 1) the nature of the condition from which the patient suffered; 2) the nature of the patient's suffering; 3) the reasons why this suffering could not be alleviated; 4) the elements that assured the physician of the voluntary, well-considered, and repeated nature of the patient's euthanasia request; 5) whether the patient was expected to die within the foreseeable future; and 6) the capacity of all persons consulted and, with regard to the advising physician(s), their qualifications and findings.

If there is doubt as to whether the legal criteria were met, the Commission can by a majority decision decide to open the part which contains the names and addresses of the patient, the attending physician, the consulted physicians, and the other consulted persons. This allows the Commission to request the attending physician to provide any information from the medical record that relates to the euthanasia. If upon this examination the Commission decides with a two-thirds majority that the legal criteria have not been met, it is required to refer the case to the Public Prosecutor.

According to one guideline (I), the patient's death certificate and the other documents that should be submitted to the Commission for a posteriori review should be filled out by the attending psychiatrist and not by any of the other physicians or healthcare professionals involved. In addition to the document drafted by the Commission that has to be submitted to it as an official report for each of the cases of euthanasia performed, the Flemish Association of Psychiatrists has developed an additional reporting form that could offer guidance for decision-making and final reporting concerning the euthanasia procedure. This document, attached as an appendix to guideline IV, contains questions to be

answered regarding the integration of the information collected from the consulted physicians and other persons, the assessment of all legal due care criteria, and the outcome of the patient's euthanasia procedure. The document can help physicians to obtain from colleague-physicians essential information concerning the patient and her euthanasia wish. It could also help the attending physician to fill in the report that needs to be sent to the Federal Control and Evaluation Commission for Euthanasia within four days after the euthanasia performance.

Guideline III recommends following the Dutch model, where it is not left to the attending physician to indicate the nature and the content of the advices obtained from the consulted physicians, but the latter are themselves required to submit a report to the Commission. This recommendation was prompted by evidence that in Belgium euthanasia cases are sometimes performed in complete disregard of two negative advices of the consulted physicians or in the absence of sufficient advices (Chambaere, Vander Stichele, Mortier, Cohen, & Deliens, 2019; Van Wesemael et al., 2011). Moreover, this guideline calls upon the FCECE to follow the Dutch example and thus to increase transparency by means of: 1) reporting on its website anonymised data regarding 10% of the reported cases of euthanasia (in proportion to the types of disorder); and 2) including already in the first part of the report the identifying data of the physicians involved, which would allow the members of the FCECE to have this information without first having to agree on the opening of the second part of the report.

For an overview of the operationalisations of the substantive and procedural legal criteria, and of the additions to the procedural legal criteria recommended by the guidelines, see Tables A and B.

6. Discussion

In the 16 years since the adoption of the Belgian Euthanasia Law, the number of cases of euthanasia for psychological suffering involving psychiatric patients has significantly increased, as has the number of healthcare organisations (e.g. hospitals and nursing homes) that have developed and implemented written clinical-ethical policies on the management of such requests (Gastmans, Lemiengre, & de Casterlé, 2006; Lemiengre, Dierckx de Casterlé, Denier, Schotsmans, & Gastmans, 2008, 2009; Lemiengre, Dierckx de Casterlé, Schotsmans, & Gastmans, 2014).

One guideline (I) that we have analysed is an example of such a protocol, in that it is describing a transparent procedure to be followed for requests of euthanasia for psychological suffering. The other guidelines discussed in this paper are published by organisations at the intermediate level between specific, local mental health institutions such as hospitals and nursing homes, and overarching bodies such as the National Board of Belgian Physicians. They contain detailed practical advice for interpreting and assessing the requirements of the Euthanasia Law, and for dealing with various challenges in euthanasia practice (see Tables A and B).

In many respects the guidelines are more stringent than the Law, for instance by stipulating that at least two positive advices should be obtained from at least two psychiatrists, by requiring physicians to follow a two-track approach, and by proposing a more stringent a priori evaluation system. Although these guidelines contain recommendations that resemble the ones put forward in the former Guideline of the Dutch Psychiatric Association, there are minor differences, for instance regarding the eligibility of a euthanasia request if a psychiatric patient rejects reasonable treatment options, or regarding the involvement of important others.

Some guidelines put more emphasis on the practical aspects of the clinical assessment (I, II and IV), while others focus more on a broad ethical reflection (III and V). Some of the differences between the guidelines reflect different ethical stances towards euthanasia, while others reflect differences in views regarding the practical implementation of the legal due care criteria, e.g. the involvement of a Hospital

Ethics Committee (I) versus the establishment of local and central support groups (II) for preliminary reflection, and different stances on whether or not (III), and if so to what extent, the waiting period from the euthanasia request to the performance should be extended (II, IV, V).

Notwithstanding the major added value of these guidelines, some shortcomings remain, as listed in Box C. Although all the guidelines stress the importance of a decision-making policy that includes many actors (e.g. the patient's relatives and other care providers) and although they emphasise the importance of good aftercare for the bereaved, not much attention has been paid to the aftercare of patients whose euthanasia request is rejected. One guideline (I) refers the patient back to his or her treating physician. By contrast, the other guidelines only mention the (not legally required!) referral procedure in case of conscientious objection by the physician. This is remarkable, as evidence from the Netherlands shows that requests for euthanasia from psychiatric patients (as well as from patients suffering from severe dementia and patients being tired of living) are much less likely to be granted as compared to requests for euthanasia from patients suffering from physical disorders, and that only a minority of physicians are willing to perform euthanasia for psychological suffering (although the number is increasing over time) (Bolt, Snijdewind, Willems, van der Heide, & Onwuteaka-Philipsen, 2015; Kouwenhoven et al., 2013). Well-founded responses are thus needed concerning the aftercare for patients whose euthanasia request is not granted. Recent qualitative research shows that a death wish might diminish, but rarely disappears, in patients whose euthanasia request has been refused, yet very few treating physicians further discuss or evaluate the patient's death ideation or situation after the refusal (Pasman, Willems, & Onwuteaka-Philipsen, 2013). Moreover, none of the guidelines explicitly addresses how, and to what extent, treating and/or attending physicians should handle negative or conflicting advices, or suicidal threats by the patient in case of refusal.

Furthermore, in the context of conscientious objections attention should be paid to avoiding a potential 'revolving door' scenario in which a treating physician who is opposed to euthanasia would refer the patient to potential attending or consulted physicians, assuming that they will refuse or advise negatively. This scenario might increase feelings of despair and suicidal ideation in the patient and may prompt patients to shop around for physicians who are willing to get involved in the euthanasia procedure.

Another aspect that could contribute to the risk of the revolving door and of shopping around by patients, is that different guidelines (some more restrictive than others) may put at risk the uniformity of the physician's own approach regarding practice of euthanasia for psychological suffering involving psychiatric patients and of the patients' right of equality in mental health care and that they might also lead to patients directly contacting the end-of-life centers (which take a more permissive approach) at their own initiative, without discussing it first with their treating physician.

Despite the guidelines' commendable efforts that may enhance clinical euthanasia practice, a significant knowledge gap remains about how thoroughly and uniformly euthanasia requests are handled in Belgium. Moreover, it is unclear how these guidelines are affecting euthanasia practice, and more specifically euthanasia for psychological suffering. Unfortunately, empirical research regarding euthanasia practice remains scarce and is complicated by the lack of an obligation to register (i.e. only the registration of performed euthanasia requests is legally required) (Dierckx et al., 2017). Moreover, except from one study on 100 psychiatric patients in one private clinical practice (Thienpont et al., 2015), very little is known about the number of euthanasia requests being granted, refused, denied, ongoing or withdrawn (Van Wesemael et al., 2010). This lack of transparency is surprising, especially taking into account the heated debate. Although cases of euthanasia for psychological suffering are still rare, the number is increasing. In Belgium, as one of the pioneering countries on euthanasia,

the clinical and scientific scrutiny must be rigorous in order to improve transparency and to ensure the quality of euthanasia practice. Therefore, the guidelines discussed in this paper should be welcomed given their strong commitment to mitigate against potential abuses.

It is noteworthy that most of these guidelines were only published approximately 15 years after the adoption of the Euthanasia Law. This might be due to increased speculations regarding a slippery slope concerning euthanasia based on psychological suffering, potentially related to the increase of these euthanasia cases since 2008. This increase in turn might be related to the increasing number of hospital-based ethics policies and to the foundation of several end-of-life consultation centers since 2011, after which the number of performed euthanasia cases for psychological suffering quadrupled. Moreover, the euthanasia case that has been referred to the Belgian public prosecutor in 2015, as well as strong disagreement between some of the end-of-life consultation centers regarding different approaches in the management of euthanasia requests (Cheng, 2017), have contributed to the need for more ethical reflection and transparency on the clinical practice regarding euthanasia based on psychological suffering (Haekens, Calmeyn, Lemmens, Bazan, & Van de Vijver, 2017).

In these respects, the guidelines can be considered as potentially important instruments to prevent potential abuses by means of providing information on, and proper operationalisations of, the legal criteria, recommending more stringent procedural criteria and/or practical step-by-step decision-making and reporting forms in order to improve the quality and transparency of Belgian euthanasia practice. However, the question remains whether and to what extent it might influence the practice of euthanasia for psychological suffering involving psychiatric patients and whether, paradoxically, the development and implementation of several different guidelines may fail to achieve the goal of protecting patients' right to an equal consideration of their interests in this specific domain of end-of-life care. In this respect, it should be noted that equality does not require uniformity of treatment for all patients, but rather receiving a treatment that conforms to the regulatory framework and is tailored to the specific situation of the patient. Every patient is entitled to an equal consideration of her (medical) interests.

One end-of-life center is already collaborating with academic researchers for the prospective longitudinal registration of requests for euthanasia for psychological suffering (including euthanasia requests being carried out, refused, denied, ongoing or withdrawn). We would warmly recommend other end-of-life centers to follow this example. Moreover, guideline III calls upon the Federal Control and Evaluation Commission for Euthanasia to increase transparency. However, the Commission is not legally obliged to do so and is in fact installing more barriers to research. In contrast to the situation in the Netherlands, in Belgium developments in the interpretation and operationalisation of the substantive and procedural legal requirements, and the potential problems and complexities of the review system are not the subject of systematic scientific research.

In addition, remaining bottlenecks beyond the medical profession should also be addressed on the political and societal agenda in order to reduce the socio-economic inequalities that may contribute to unbearable suffering and may make patients consider euthanasia. The medical profession is not meant to resolve society's failings by means of euthanasia. On the contrary, it can facilitate and improve rehabilitation and aftercare (e.g. peer-oriented support groups for patients with rejected versus withdrawn euthanasia requests or crustative care).

Another highly important recommendation for the Belgian practice would be for medical professional organisations (e.g. the National Board of Physicians) to issue guidelines in an attempt to avoid bottlenecks and close loopholes, rather than relying on bottom-up approaches (e.g. initiatives of hospitals and nursing homes) that might impede the uniformity, transparency, and quality of the euthanasia practice.

As for the latter, these guidelines are established to assess the euthanasia request, and to manage the euthanasia procedure, of patients

who primarily suffer from severe mental disorders. It is noteworthy that mental disorders can vary greatly, especially since the current DSM-5 indicates that an insufficient scientific basis exists to make distinctions in the type of mental disorders via the multi-axial system.

As a consequence, the former distinction between Axis I (all clinical psychiatric disorders except personality disorders and mental retardation) and Axis 2 (personality disorders and mental retardation) was abandoned. Mental disorders can also vary greatly from patient to patient, even among those who are diagnosed with the same disorders. Moreover, due to the variety in severity of the mental disorders, the patient's treatment may take place in a variety of settings (ambulant versus residential in- or outpatient psychiatric treatment) in the absence of a one-size-fits-all approach. As a consequence, the guidelines concern the assessment of all psychiatric patients, irrespective of the nature of their psychiatric disorder (no explicit distinction between former Axis I and II disorders) or treatment setting, but excluding neuropsychiatric disorders (e.g. dementia) and without considering the particular situation of mental retardation and involuntarily committed persons.

As mentioned in some of the guidelines (II and IV), a distinction needs to be made between the euthanasia request and procedure involving patients suffering from psychiatric disorders and those suffering from neuropsychiatric disorders (e.g. dementia). We believe that another distinction needs to be made, and thus an additional guideline is needed, with regard to psychiatric patients who are involuntarily committed (e.g. in prison). As prisoners do have the same rights to medical care as any other Belgian citizen, this implies that they can also request, and die by means of, euthanasia. Moreover, euthanasias have already been performed in the medical facilities of Belgian prisons, based on terminal cancer. However, during the last decade, 20 requests were registered from mentally ill offenders that were primarily based on psychological suffering (Gutwirth, Devynck, Lemmens, Distelmans, & Snacken, 2015; Witkowski, Hudson, Batson, Moore, & Mitchell, 2017). Such requests raise additional ethical and legal dilemmas that should be further discussed and adequately addressed in additional guidelines.

As regards the value of these guidelines in an international context, one cannot readily transpose existing guidelines from one jurisdiction to another. This is not only due to the slightly different legal requirements (e.g. eligibility criteria, procedural safeguards, and reporting requirements) regarding this specific context of end-of-life care. Interpreting these guidelines for Canada and other countries which might be considering euthanasia or other means of medically assisted-dying should also take into account the characteristics of the healthcare system and the regulatory framework, as well as the differences in culture, geographies, and demographics.

Nevertheless, there are lessons that can be learned from the Belgian situation, other than the top-down approach to address the great need for guidelines to elaborate and operationalise the legal criteria. For example, more built-in safeguards are needed to improve the patient's well-being after refusal and to protect the physicians involved from a potential passing-the-buck and revolving-door scenario.

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Author's contribution

MV and SS designed the framework of this critical review study, with input from all authors.

SS drafted the list of all substantive and procedural legal criteria. MV drafted a so-called 'skeleton version', in which every piece of information on the legal criteria and on possible additional due care criteria discussed in the guidelines, was noted down and summarised. MV and KVA wrote the first drafts with the point-by-point critical reflection on the criteria with input from all authors. All authors performed a critical revision of the final manuscript.

Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ijlp.2019.04.004>.

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