

# Developments in end-of-life practice under Belgian euthanasia law

*Kenneth Chambaere*



# Conflicts of interest

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Nothing to disclose

# Background

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## Belgium legalised euthanasia in 2002

- Incurable illness
  - not necessarily terminal
- Constant and unbearable suffering
  - physical or psychological
- No prospect of improvement
- Competent patient
- Request = present, voluntary, repeated, no external influence

# Background

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## Concerns around legalisation of assisted dying

- Non-exhaustive list
  - Abuse: ending life without patient request
  - Negative impact on “vulnerable” patients
  - Negative impact on development of palliative care
  - Legal requirements not adhered to
- Some anticipated effects can be empirically tested

# Background

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Need for monitoring end-of-life practice

- Federal Control and Evaluation Committee
  - Limited to reported euthanasia cases
- Surveys based on death certificates
  - Other end-of-life practices
  - Ungranted euthanasia requests
  - Unreported euthanasia

# Data source

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## Death certificate surveys in Flanders, Belgium

- Large-scale sample of deaths (certificates) in Flanders
- Repeated: 1998 – 2001 – 2007 – 2013
- 2013: 6200 deaths
- Mail survey to attesting/attending physicians
- Absolute anonymity guaranteed
- 61% response, 3751 analysis cases

# End-of-life decisions

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- Intensified alleviation of pain or other symptoms  
Use of drugs in high doses with possible life shortening effect (opioids,...)
- Continuous deep sedation until death  
Keeping the patient in deep sedation or coma until death with the use of one or more drugs
- Non-treatment decision  
Forgoing treatment with potential life shortening effect (resuscitation, respiration, artificial nutrition/hydration,...)

# End-of-life decisions

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- Euthanasia

Administering drugs with the explicit intention of hastening death, at the explicit request of the patient

- Physician-assisted suicide

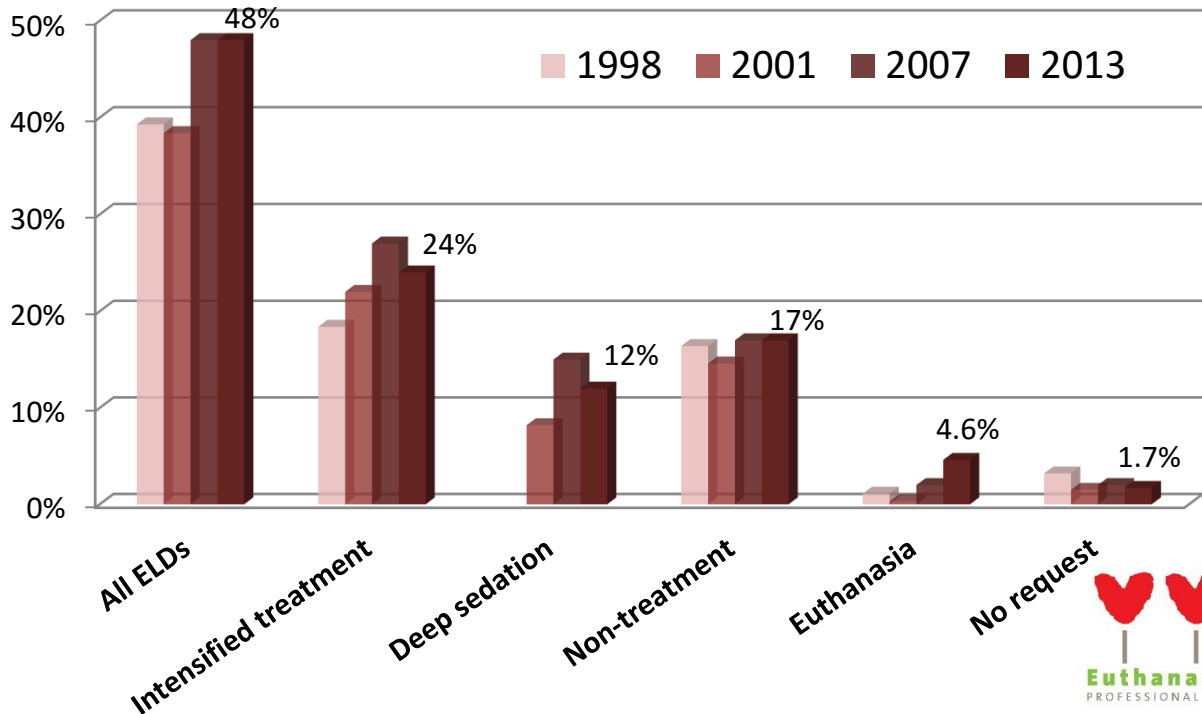
Supplying or prescribing drugs with the explicit intention of hastening death, at the explicit request of the patient

- Life-ending acts without explicit request

Administering drugs with the explicit intention of hastening death, without explicit request from the patient

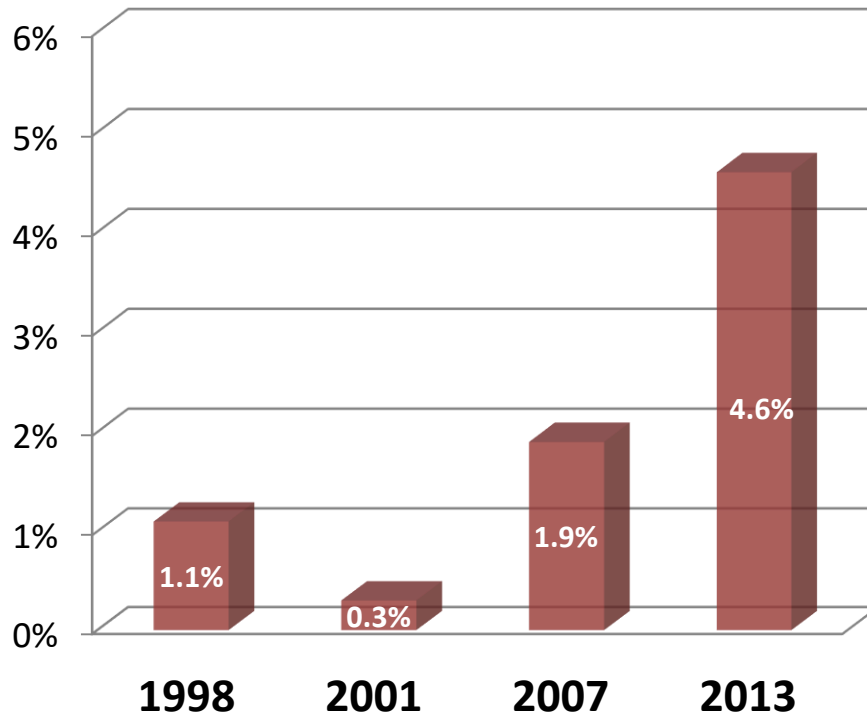


# Evolution ELDs 1998-2013



# Incidence of euthanasia

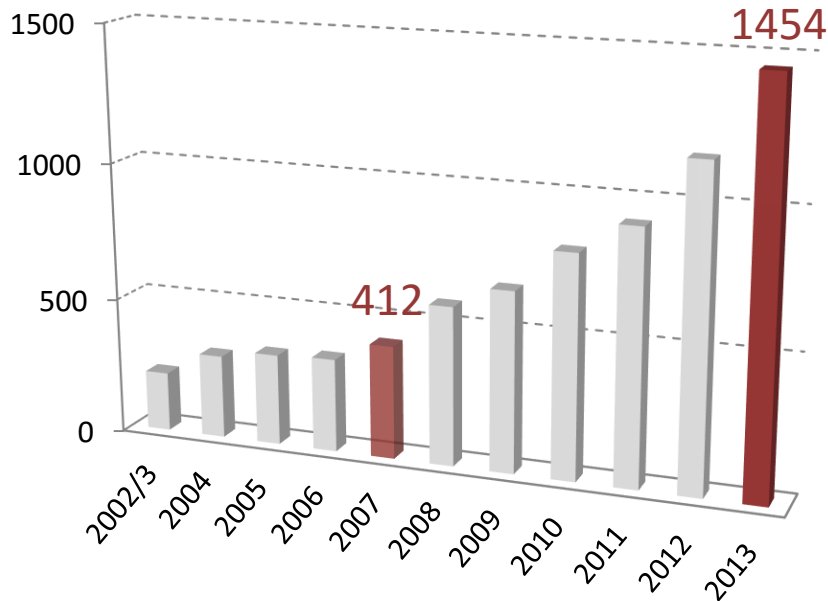
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# Incidence of euthanasia

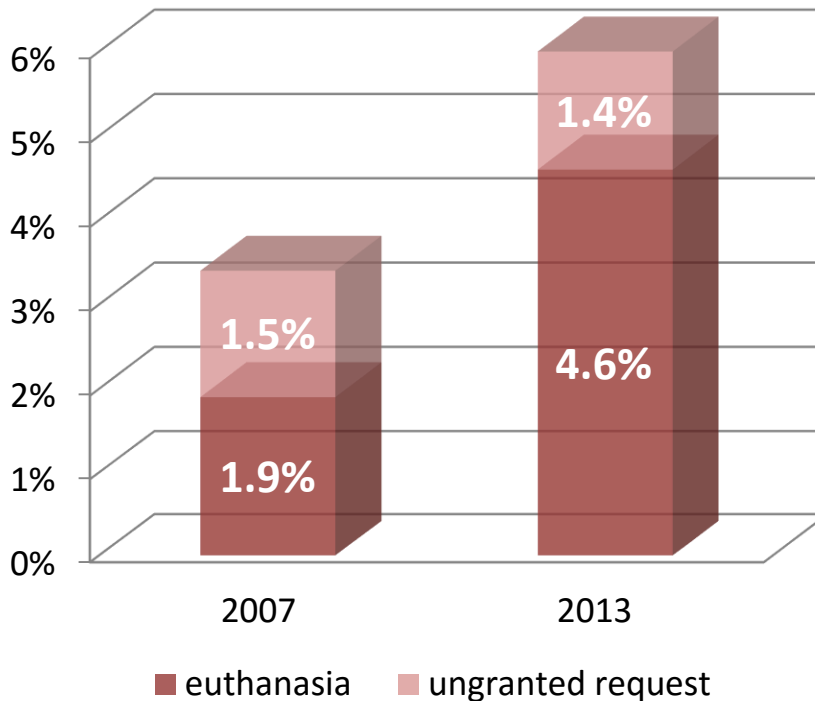
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*Federal Control & Evaluation Committee Euthanasia*



# Requests for euthanasia

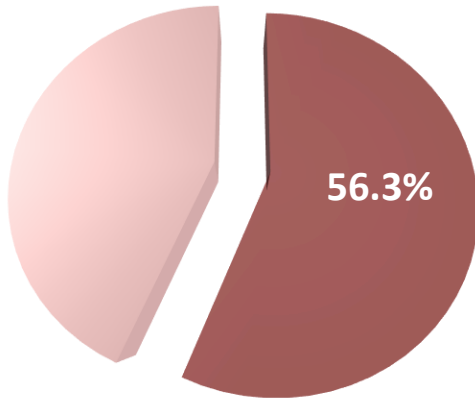
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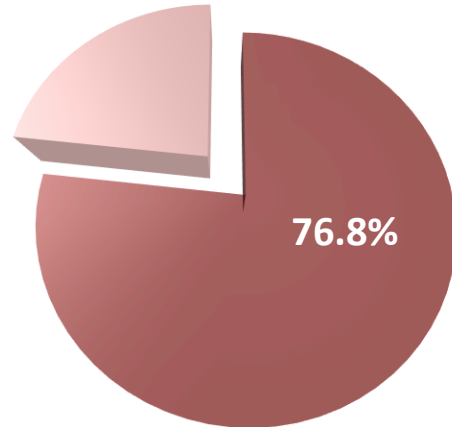
# Granted requests

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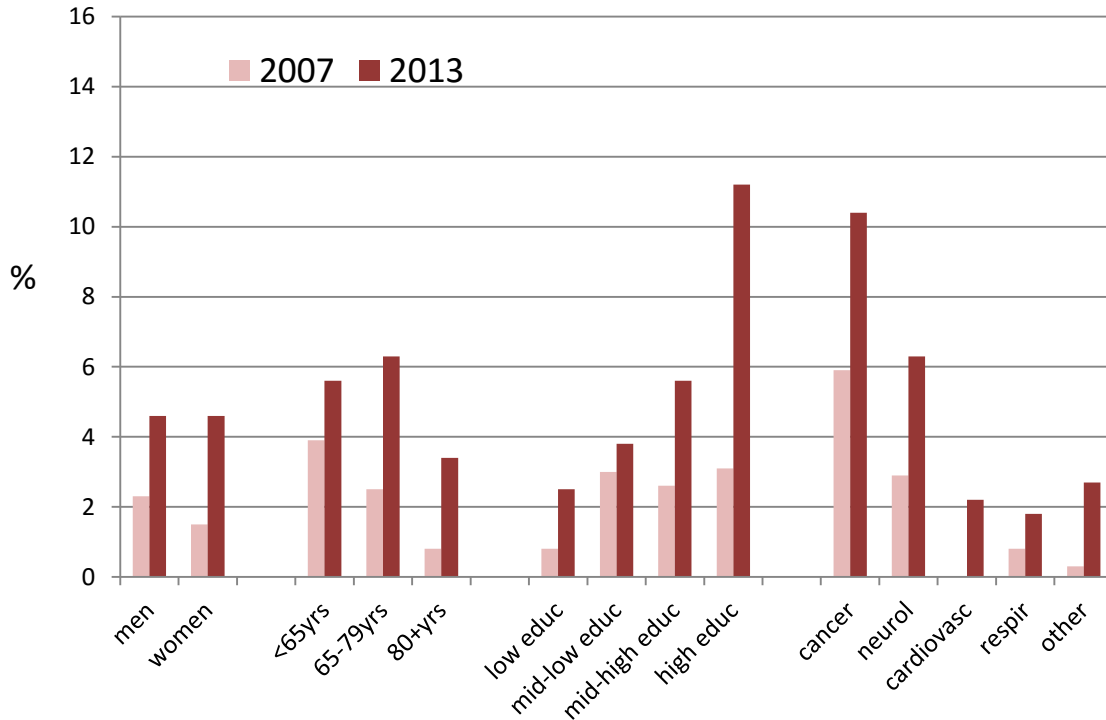
**2007**



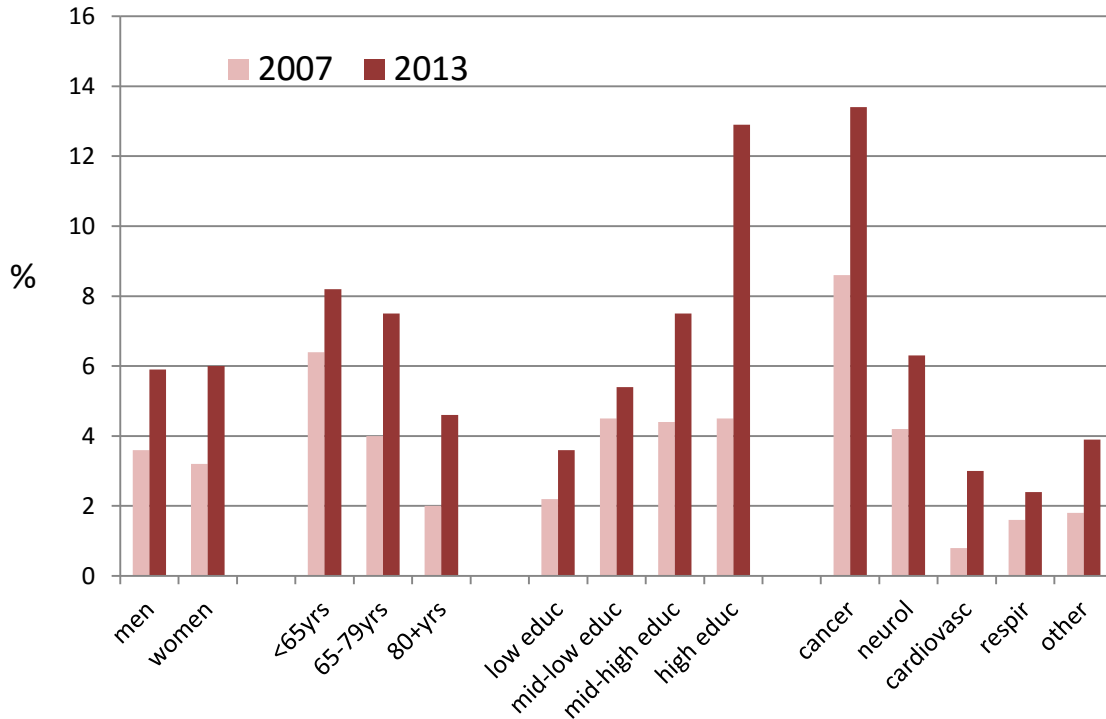
**2013**



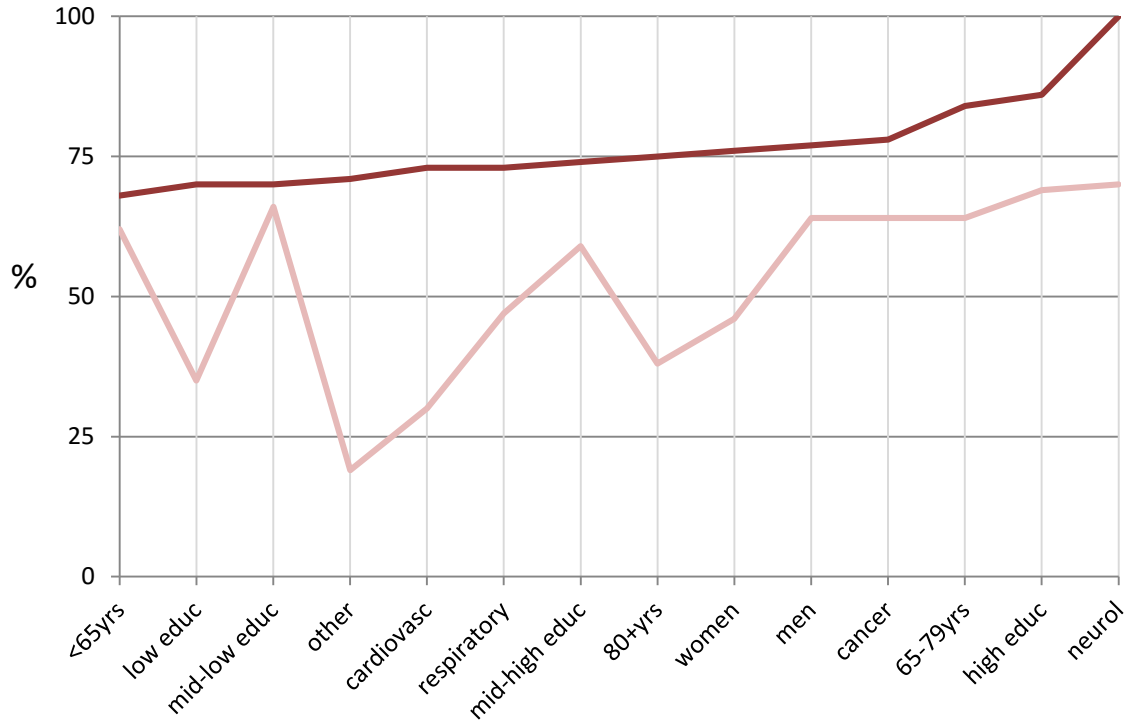
# Euthanasia incidence by group



# Euthanasia requests by group

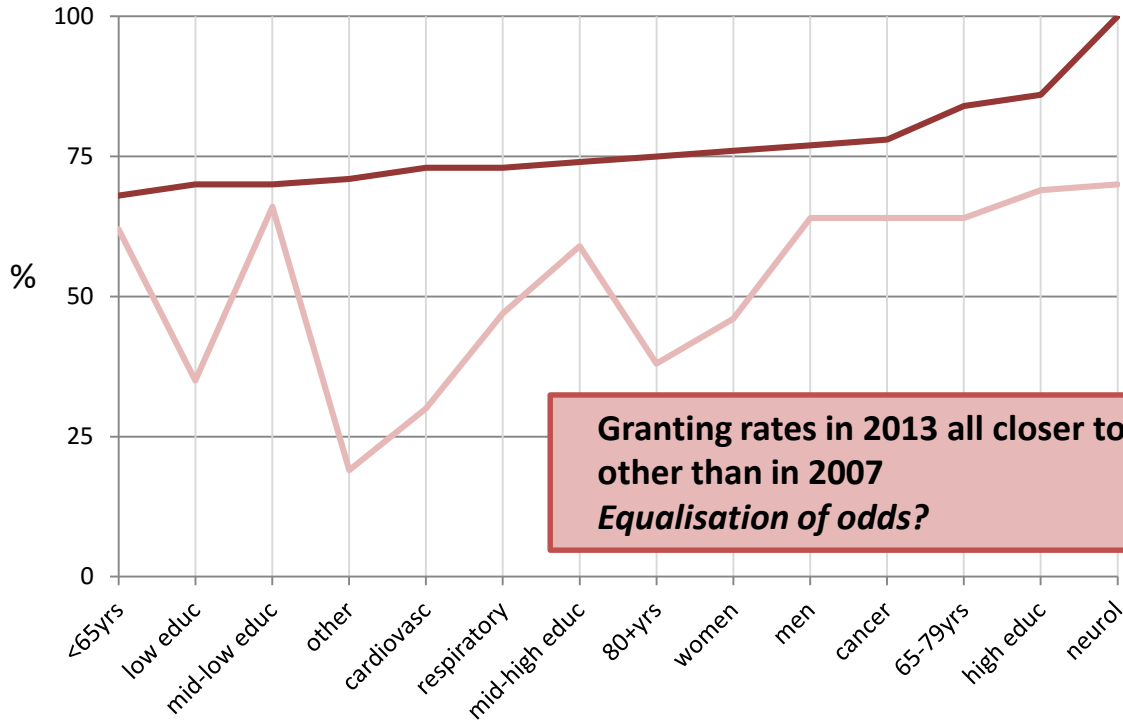


# Granted requests by group





# Granted requests by group



**Granting rates in 2013 all closer to each other than in 2007**  
***Equalisation of odds?***

# Reasons for not granting

	2007	2013
Patient died before final decision	44%	59%
Patient revoked the request	16%	18%
Legal requirements not met	21%	20%
<i>Suffering not unbearable</i>	9%	13%
<i>Patient not terminally ill*</i>	2%	8%
<i>Request not well-considered</i>	10%	10%
<i>Medical situation was not without prospect</i>	6%	5%
<i>Request not voluntary</i>	1%	0%
Reasons external to the patient	<b>23%</b>	<b>2%</b>
<i>Institutional policy</i>	<b>6%</b>	<b>2%</b>
<i>Personal objections</i>	<b>10%</b>	<b>0%</b>
<i>Fear for legal consequences</i>	<b>7%</b>	<b>0%</b>
Other reasons	10%	15%

# Recap of results

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- Euthanasia on the rise in recent years in Belgium
- Increased number of patient requests and higher granting rates of physicians
- “Traditional” groups (cancer, highly educated, age >80) remain the most prominent
- “Non-traditional” groups not staying behind

# Euthanasia on the rise

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## More requests

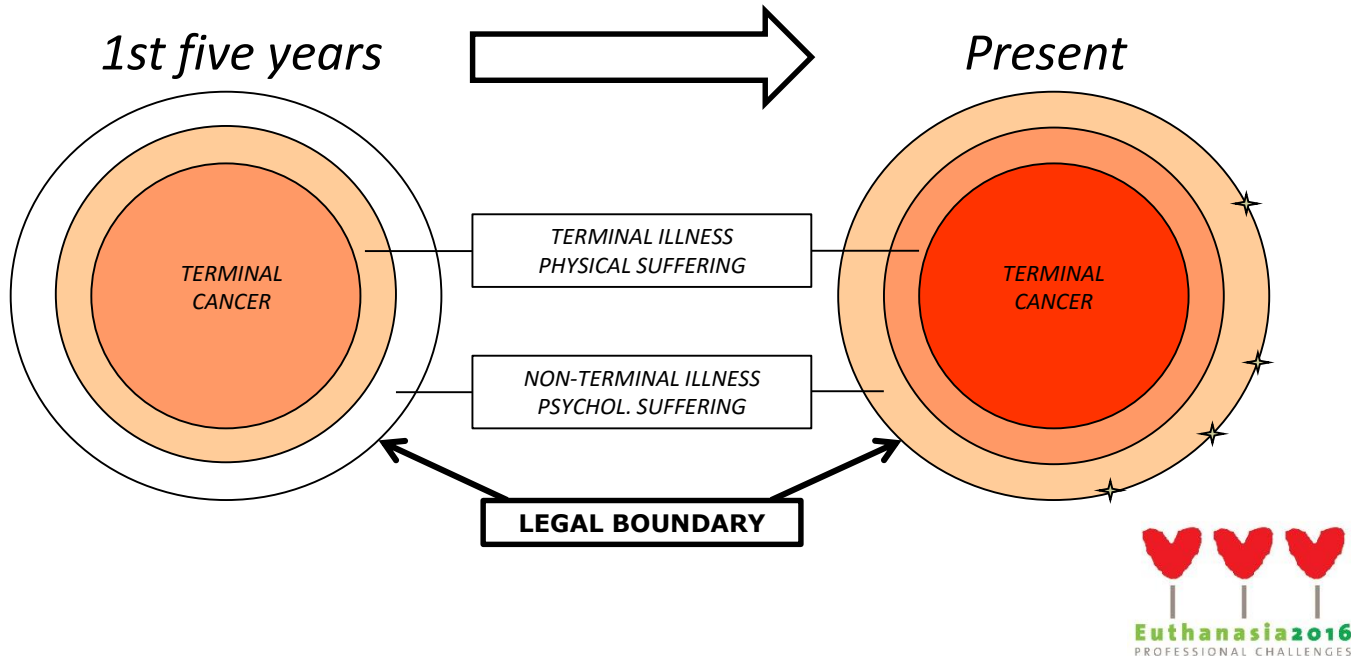
- Higher “visibility” and “positivity” of euthanasia
- Cultural/attitudinal shift? Focus on quality of death, control & self-determination
- Generational shift (secularisation)

## Higher granting rates

- Less reluctance: more trust, positive experiences
- Less resistance in care institutions
- Broadened views on eligibility?

# Euthanasia on the rise

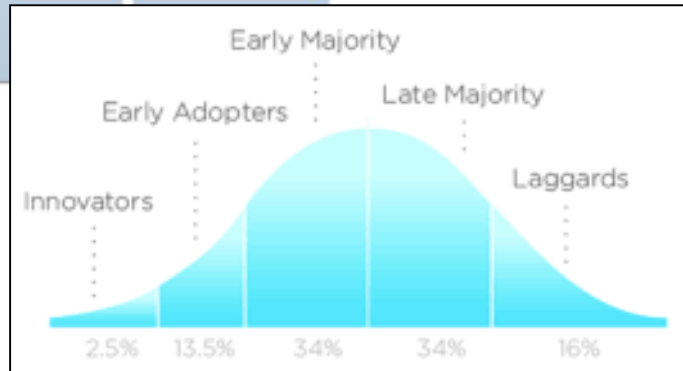
Full scope of euthanasia law now used more often



# What may the future bring?

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Standard Growth Curve

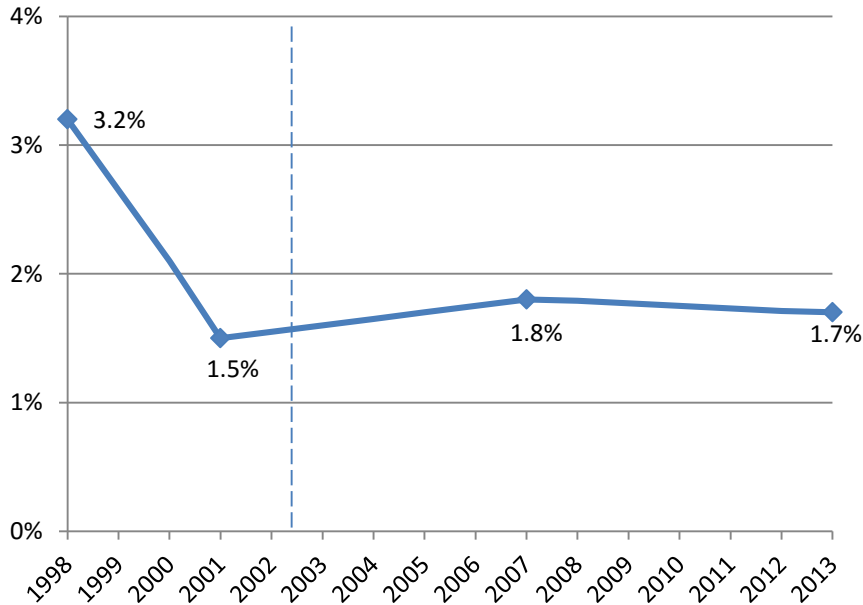


# Euthanasia: shifts in practice

	2007	2013
<b>Request</b>		
Only oral request	50%	31%
Only written/advance directive	7%	7%
Oral and written request	43%	63%
<b>2nd physician consulted</b>	83%	93%
<b>Medication used</b>		
Barbiturate (w/o muscle relaxant)	52%	65%
Benzodiazepine and/or morphine	46%	33%
Other	2%	2%
<b>Estimated life shortening</b>		
Probably none	2%	2%
Less than 24h	10%	13%
Less than 1 week	44%	41%
More than 1 week	44%	45%

Euthanasia  
practice as a  
whole more  
conform to legal  
requirements

# Non-voluntary ending of life



Stagnant rate  
after legalised  
euthanasia

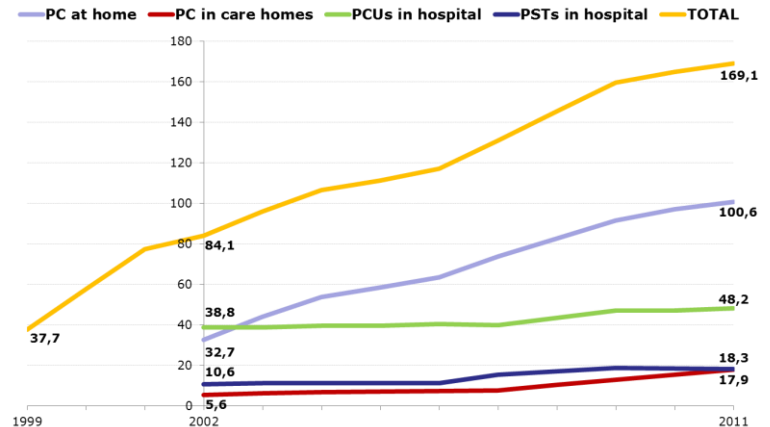
Occurs as well in  
other countries



# Euthanasia & palliative care

Law on palliative care (2002): structural embedding + reimbursement/financing system

	EAPC Atlas Services per mln		
	2005	2012	Δ
Iceland	20.34	21.32	+0.98
Belgium	<b>18.00</b>	<b>18.08</b>	<b>+0.08</b>
UK	14.73	15.43	+0.70
Sweden	11.61	16.64	+5.03
Ireland	10.93	18.12	+7.19
Luxembourg	8.78	19.11	+10.33
Netherlands	8.45	15.32	+6.87



# Euthanasia & palliative care

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Model of integral end-of-life care (Bernheim et al):

- “Euthanasia at the end of a palliative care pathway”
- Synergistic development

Position Federation Palliative Care Flanders

- 2003: “No polarisation”
- 2011: “PC can guarantee that euthanasia requests will be dealt with in a careful and caring way”
- 2013: “Euthanasia embedded in palliative care”



# Euthanasia & palliative care

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In 2013: of all persons receiving euthanasia...

- Referral to specialised PC service in 72%
- PC specialist/team consulted for euthanasia in 52%
- Euthanasia performed by physician working in PC team in 21%
- Euthanasia performed in a palliative care unit in 7%

*Close involvement of PC in euthanasia*

# Euthanasia in Belgium

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Are the concerns corroborated?

- Abuse: ending life without patient request?
- Negative impact on “vulnerable” patients?
- Negative impact on development of palliative care?
- Legal requirements not adhered to?

# Acknowledgments

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Sigrid Dierickx



Prof. Joachim Cohen



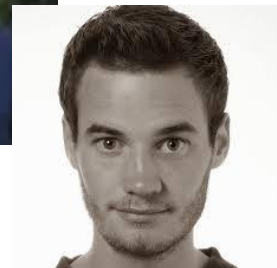
Prof. Luc Deliens



Lenzo Robijn



Jef Deyaert



**Vlaams Agentschap Zorg & Gezondheid**