**Gods or Monsters? Non-Explicit Consent and The Role of the Doctor in the hastening of deaths of patients in the Intensive Care Units in the Wallonia Region in Belgium.**

**ABSTRACT**

The Belgian Euthanasia Act of 2002 (The Act), amended in 2014 to include the Minor Act (The Minor Act), has drawn international criticisms for its liberal laws and practices regarding Euthanasia. This research study is a response to allegations that the liberal laws on euthanasia has encouraged doctors to adopt a paternalistic approach towards their patients by terminating their lives without their explicit consent, i.e. engaging in involuntary Euthanasia. Although in theory, only voluntary euthanasia (explicit patient request and therefore consent) is permitted in Belgium, the allegations implied that in practice, involuntary euthanasia (no explicit patient request and therefore no consent) is practiced, especially in the Intensive Care Units (ICUs) in Belgium. One major criticism is that because of its liberal laws, Belgian doctors are killing patients without their non-explicit consent. Specifically, it is alleged that Intensivists are shortening lives or hastening the deaths of their patients without their non-explicit consent in the ICUs in the Wallonia Region in Belgium. This research study conducted an empirical-qualitative study to discover if these allegations were true or false, by interviewing heads of ICUs in five major hospitals in the Wallonia region in Belgium. The research discovered that the allegations are true, but they are also false. The allegations are true because shortening life or hastening the death is sometimes practiced in the ICUs without the patient’s non-explicit consent. The allegations are false because consent is not available due to the patient’s critical condition, and not because it was not asked for. In other words, what is practiced in the ICUs is non-voluntary euthanasia or where patient is unable to request or consent to euthanasia.

**KEYWORDS**

**Intensive Care Units; Intensivists; Non-Explicit Consent; Shortening Lives;**

**Hastening Deaths; Futility; Therapeutic Relentlessness; Voluntary Euthanasia; Involuntary Euthanasia; Non-Voluntary Euthanasia; Terminal Sedation.**

**INTRODUCTION**

**Belgium becomes the most liberal of all countries in the world in its Euthanasia practices.**

The Belgian Euthanasia Act of 2002, (The Act), decriminalizes the practice of voluntary euthanasia in Belgium.[[[1]](#endnote-2)],[[[2]](#endnote-3)] It grants legal authorization to a patient to request and therefore consent to be euthanized by a doctor, if the former is suffering from unbearable mental or physical pain, with no hope of recovery, and where death is imminent, and finally, if certain legal, medical, and ethical requirements are met. Concurrently, it decriminalizes the practice of voluntary euthanasia by a doctor, to depart from the transcendental “for the benefit of the patient” role of the Hippocratic doctor to become a ‘for hire to either cure or to kill’ role of the pre-Hippocratic doctor. [[[3]](#endnote-4)],[[[4]](#endnote-5)]

The Act was amended in 2014 to include the Minor Act (The Minor Act), which removes all age requirements for minors. With this amendment, the Belgian euthanasia law becomes the most liberal law in the world.

Although in legal theory, only voluntary euthanasia (explicit patient request and therefore consent) is permitted in Belgium, media allegations implied that in practice, involuntary euthanasia (no explicit patient request and therefore consent is given) is practiced, especially in the ICUs in Belgium. [[[5]](#endnote-6)] While there were many articles of interest, two articles of interest will be mentioned in this research study. The first article made references to a second article and claimed that The Belgian Society of Intensive Care Council was administering sedative agents with the direct intention of shortening lives or hastening the deaths of patients without their non-explicit consent.

**Articles of Interest**

**First do no harm: Intentionally shortening lives of patients without their explicit request in Belgium. [[[6]](#endnote-7)]**

The first article was published in 2015 in the Journal of Medical Ethics, titled:

First do no harm: Intentionally shortening lives of patients without their explicit request in Belgium. [[[7]](#endnote-8)]

The second article was published in 2014 in the Journal of Critical Care, titled:

“Piece” of mind: End of life in the intensive care unit. Statement of the Belgian Society of Intensive Care Medicine. [[[8]](#endnote-9)]

In the first article, Dr. Almagor made very important observations for this study’s research.

First, only voluntary euthanasia is decriminalized (legal if certain legal guidelines are met) in Belgium. Hence, involuntary euthanasia, or “the deliberate ending of life without the patient’s explicit request” is prohibited. Second, based on research data conducted in the Flanders region in Belgium, he concluded that paternalistic doctors were shortening lives or hastening deaths, of their patients without their explicit request. He made references to specific statements made in the second article, where intensivists Dr. Vincent et al claimed that they do shorten lives or hasten the deaths of patients, without their explicit request, to maintain the quality of the dying process of the patient:

“Shortening the dying process with use of medication, such as analgesics/sedatives, may sometimes be appropriate, even in the absence of discomfort, and can actually improve the quality of dying; this approach can also help relatives accompany their loved one through the dying process—such a decision should be made with due consideration for the wishes of family members.”

**New data**

It is important to mention that in an earlier article, Dr. Almagor noted that while there was an abundance of data in the Flanders region on non-explicit consent and the role of the doctors, in the practice of euthanasia in Belgium, there was “a need for data” in the Wallonia region,[[[9]](#endnote-10)] Hence, this research will be the very first of its kind to have conducted interviews, and to have gathered and compiled responses, from five head intensivists from five major hospitals in the Wallonia region.[[[10]](#endnote-11)]

**RESEARCH OBJECTIVE**

**Are allegations of shortening lives or hastening the deaths of patients without non-explicit consent true or false?**

The research inquiry was unequivocally precise. It was to understand whether allegations of shortening lives or hastening the deaths of patients, without their non-explicit consent, by Intensivists in the ICUs in the Wallonia region in Belgium, true or false.

These allegations, if proven to be true, would mean that doctors in Belgium are killing patients, which is in the eyes of the law, Murder, punishable by life imprisonment.[[11]](#footnote-2)

**RESEARCH METHODOLOGY**

**Empirical Qualitative Approach**

The research was **an empirical-qualitative research**. As such, it conducted interviews with the head intensivists of ICUs across five major hospitals in the Wallonia region in Belgium, namely Hospital Erasmus (Brussels), Chirec (Braine L’Alleud/Waterloo), CHU de Liège (Liège), CHU de Charleroi (Charleroi) and Le CHR de Namur (Namur).

Based on the results of these interviews, this research study made conclusions as to whether the allegations of involuntary euthanasia in Belgium were true or false.

**Sample Size and Data Saturation 2**

As this was a qualitative research, the selection criteria did not depend on the quantity but the quality, i.e., the number of participants needed “to inform fully all-important elements of” the allegations being studied. The sample size here was sufficient as it was representative of an entire medical team in each ICU of the five major hospitals in the Wallonia region, and any additional participant, therefore, would have resulted in data saturation. [[[12]](#endnote-12)]

## The resulting report was the interviewer’s direct observations of the experiences and responses of the Head Intensivists.

## **Geographical Setting**

## The interviews were conducted in five major hospitals’ ICUs in the region of Wallonia, Belgium.

## **Research Tools**

## A Questionnaire consisting of twenty questions, ranging from legislation, ICU Protocol to whether the intensivists practiced non-voluntary euthanasia, was used to determine if the allegations were true or false.

**RESULTS**

**Question regarding media allegations**

The question was whether media articles claiming that doctors in Belgium were killing their patients without non-explicit consent true or false. It was made clear that allegations referred specifically to ICU doctors (or intensivists). The two articles of interest were shown to each intensivist.

**Responses**

According to intensivist A, the allegations were true because consent is unavailable due to the critical condition of the patient. He explained that where patient is capable of giving consent, the medical team will always respect that and will comply with the patient’s wishes.

Intensivist B agreed with intensivist A regarding the willingness of the medical team to consult the patient on consent, where it is available but that in the majority of the cases in the ICU, the unavailability of consent is always an issue.

According to intensivist C**,** consent is a priority as it is about patient autonomy.

According to intensivist D,the media allegations were an accurate portrayal because ICU patients, in the majority of cases, are incapable of consent.

Finally, according to intensivist E**,** the allegations were true because there isno way for the patients in the ICUs to express their wishes to die. Unless there is a will which can be used to express their consent, it is not easy to obtain their consent.

All intensivists agreed that the media allegations were true because in the majority of cases, consent is unavailable.

**Question regarding shortening life or hastening the death of patients**

The question was why a medical team would decide to shorten life or hasten the death of a patient and has this been the only option at times.

**Responses**

According tointensivist A**,** if patient is suffering from unbearable pain, with no hope of recovery, hastening the death is sometimes considered and is in fact practiced through titrated dosages of sedative agents and analgesics, to maintain the quality of the dying process. They cannot keep a patient who is dead artificially alive, according to him. He further clarified that sometimes hastening has been the only option.

Intensivist Bopinionedthat it was where the condition of the patient was hopeless, and all treatments prove to be useless. He was also of the opinion that keeping a patient artificially alive was not beneficial to the patient. Therefore, hastening has sometimes been the only option.

According to intensivist C,when the dignity of the patient is compromised because of futility of treatments, and the patient continues to suffer, hastening the dying process is considered. Hastening is an option when patient suffers unbearable pain with no hope of recovery. Therefore, hastening has sometimes been the only option.

According to intensivist D, painful treatments are considered in determining if hastening the dying process is necessary. For instance, where patient suffers from a treatment such as

Thoracostomy [[13]](#footnote-3), [[14]](#footnote-4) which in itself can be unbearably painful, hastening is considered where the treatment itself does not yield any proportionate benefit. Therefore, hastening has sometimes been the only option.

Finally, according to intensivist E,futility of treatments, unbearable pain and suffering with no hope of recovery, and where the quality of the dying process of the patient is compromised, hastening is considered. Therefore, hastening has been the only option at times, where these factors come into play.

All intensivists were in agreement that futility of treatments, unbearable pain and suffering, with no hope of recovery are the reasons why a medical team would decide to shorten life or hasten the death of a patient. All intensivists were in agreement that shortening life or hastening the death has sometimes been the only option.

**Question regarding consent**

The question was whether all patients are incapable of explicit consent and whether there have been exceptions?

**Responses**

According to intensivist A, most patients are incapable of consent because of   
their critical condition. However, where patient is capable of any communication, the medical team makes a diligent effort to communicate with the patient to procure possible consent to treatment.

This was reiterated by intensivist B, who opined that most patients in the ICUs are unable to communicate and that even if they could, it would normally be very limited communication. It was also made clear by intensivist B that if a patient is able to communicate, and wants a treatment stopped or terminal sedation to alleviate pain and suffering, the medical team must comply with the patient’s wishes, in the name of patient autonomy. However, in the majority of cases, it is not possible to obtain consent from the patient.

According to intensivist C, the medical team will always consult with the patient if the patient is able to communicate. In the majority of cases, however, the ICU patient will not be able to communicate his or her wishes at all. Sometimes, they can “agree” or “disagree” based on symbolic speech such as nodding their heads or squeezing the intensivist’s hand. Limited communication signaling consent is always possible and is considered an exception in the ICU.

According to intensivist D, while patients’ communication certainly depends on the pathology, most patients are incapable of consent in the ICUs.

Finally, according to intensivist E, most patients are incapable of consent. If the patient is able to consent to treatments, the medical team will consult with the patient and will comply with the wishes of the patient. However, the exception, that is, where patient is able to communicate and or consent to treatments, is rare.

All intensivists were in agreement that in the majority of cases, patients in the ICU are incapable of consent. In some exceptional cases, however, they are capable of limited communication to give consent to possible treatments.

**DISCUSSION**

Based on the head intensivists’ responses gathered from questions on media allegations, hastening and consent, this research study concluded that the allegations are true. Shortening life or hastening the death does sometimes occur in the ICUs without the non-explicit consent of the patient. The following reasons were given as reasons for this practice, namely:

1. **Quality of the dying process of the patient is compromised**

Patient’s condition is futile to the point where treatments are not beneficial under the proportionality theory; and too much treatment is not beneficial to the patient and will actually harm the patient under the theory of therapeutic relentlessness. Keeping the patient artificially alive compromises the quality of the dying process of the patient. Hence, shortening life or hastening the death of the patient is only consideredwhen keeping the patient alive compromises the quality of death of the patient.

1. **Consent is unavailable due to patient’s critical condition**

Consent is rendered impossible due to the critical condition of the patient. Where the patient is incapable of explicit consent, the family, or a legal surrogate of the patient is always consulted. In the absence of the family and or legal surrogate, the medical team decides what is in the best interest of the patient and for the benefit of the patient. In arriving at a medical consensus, the medical team consults with specialists trained to treat the patient’s particular condition.

During the interviews, there was no ounce of doubt as to the objective of the medical team, where the final decision is to shorten life or hasten the death of the patient. It was in the best interest of the patient, and for the benefit of the patient, not to keep him or her artificially alive.

In conclusion, therefore it was found that while shortening lives or hastening deaths occurred without the non-explicit consent of the patient, it was not because the medical team did not ask the patient for his or her consent. It was because consent was unavailable due to the patient’s critical condition.

**CONCLUSION**

This research study, through its empirical-qualitative research study, investigated whether allegations that the liberal laws on euthanasia has encouraged doctors to adopt a paternalistic approach towards their patients by terminating their lives without their explicit consent, i.e. engaging in involuntary Euthanasia, were true or false. The research discovered that the allegations are true, but they are also false. The allegations are true because shortening life or hastening the death is sometimes practiced in the ICUs without the patient’s non-explicit consent. The allegations are false because consent is not available due to the patient’s critical condition, and not because it was not asked for. In other words, what is practiced in the ICUs is non-voluntary euthanasia or where patient is unable to request or consent to euthanasia.

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11. Under Article 14 of the Belgian Constitution, Murder, is punishable by life imprisonment.

    2 Please note that this research was approved by the intensivists in Belgium as satisfying "data saturation" because it was conducted specifically in the region of Wallonia, where only five hospitals are considered major hospitals. The head intensivist’s opinion was representative of all the intensivists in that particular hospital’s ICU. Please also note that the author was not allowed to interview any other intensivist due to ICU protocol concerning medical consensus. No other intensivist’s opinions and responses is going to conflict with the head intensivist’s opinion or responses. Finally, the conclusions were made based on the opinions and the responses of the head intensivists, and not based on the author’s opinion. [↑](#footnote-ref-2)
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13. Thoracostomy is a medical procedure, where a tube is inserted in the space between the lungs and chest wall (pleural space) to drain fluid, blood, or air from the area around the lungs. [↑](#footnote-ref-3)
14. Thoracotomy is a surgical procedure, where an incision is made to access the chest area to remove a lung, or a piece of a lung, for tests. It is performed typically in patients suffering from lung cancer. [↑](#footnote-ref-4)