

A Psychiatrist Visits Belgium: The Epicenter of Psychiatric Euthanasia

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On Sept 8, 2017 I was invited to give the opening lecture in a fairly remarkable symposium in Belgium on their 15-year-old practice of the voluntarily euthanasia of psychiatric patients. I spoke to an audience of Belgian mental health professionals and administrators. My charge was to present to them something of “the outside world’s view” of this issue, and touch on the APA’s recently issued Position Statement regarding medical euthanasia:

APA Position Statement: “... *a psychiatrist should not prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death.*”

I had helped to craft this statement, and shepherd it through the APA Assembly (where it was approved unanimously) and ultimately to the Board of Trustees, who approved it as the official APA position in December 2016. That is one of the reasons I was invited to Belgium.

In 2002 Belgium legalized euthanasia by physician (typically by injection) at the request of patients, and removed any distinctions between terminal vs. nonterminal illness, and physical vs. psychological suffering. As long as the condition is deemed “untreatable” and “insufferable,” a psychiatric patient can be potentially eligible for euthanasia. There is a consultative process that basically needs a minimum of two doctors to agree about the patient’s eligibility. Also, the patient gets to weigh-in on whether their condition is “treatable.” Since the patient has the option to refuse treatments, this refusal may create an “untreatable” situation. The evaluation pathway even makes it possible for a psychiatric patient to be euthanized with only a single psychiatrist in support. Once approved, some patients are euthanized by their own treating psychiatrist. Alternatively, there are other physicians who will perform euthanasia; though the number of such euthanizers is small (in fact, 70% of psychiatric euthanasias are performed by one particularly zealous Belgian psychiatrist, Dr. Lieve Thienpont).

About 500 inpatient psychiatric beds and a number of outpatient clinics in Belgium are run by the Catholic Order, The Brothers of Charity. Since the 2002 Belgian law was passed permitting psychiatric patients to access euthanasia, like those with other qualifying medical conditions, the Brothers would not allow the procedure or evaluation process in their facilities. However, earlier this year they announced a change in policy: they would be providing euthanasia consultations and lethal injections for their psychiatric patients, much to the chagrin of Rome and the entire Catholic world. In fact, the Pope has warned them to stand down or risk possible excommunication. Since the hospital sponsoring this symposium, the Alexianan Institute, in Tienen, is one of the Brothers’ hospitals, many members of the Board of the Brothers of Charity were present at the symposium. They were imminently preparing a response to the Pope’s objection. They had engaged a professional ethicist, who spoke on the

program with me, who had helped them develop the theologically based ethical rationale for their astonishing shift in policy. He explained that their approach now is to strongly encourage the patient to live and engage in treatment, but the Brothers are now open to providing euthanasia as a “last resort.” A lecturer who was a Jesuit priest and an oncologist made reference to Jesus’ example of choosing his own death for the greater good of mankind.

It was made clear to me on my arrival that the majority of Belgians and their mass media support this practice. I learned that although a number of psychiatrists feel very negatively about this, they are reluctant to speak out for fear of being vilified in the press. Though back in 2002 several individual psychiatrists lobbied against the proposed law, medical organizations did not, and have not expressed objections. Organized medicine has not articulated a stance on this because there isn’t a strong enough consensus among doctors, not even psychiatrists, I was told. Also, I learned there isn’t a strong tradition of ethics activities at the organizational level, or significant focus on an ethics code. The Belgian professionals were quite aware that the majority of the world (many medical associations) disagrees with the euthanasia of psychiatric patients. It seemed almost a point of honor that they differed in this way, as if they are on higher moral ground in a bold new era of medical ethics. Someone pointed to the fact that Belgium and the Netherlands (which also has a robust program of psychiatric euthanasia) after all, were the first nations to legalize gay marriage. They are claiming a similar, higher moral ground in the matter of psychiatric euthanasia.

I ascertained that the background of religion is vital to understanding some of the vectors influencing the development of euthanasia in Belgium, and its slipping down the slope from terminal medical patients to psychiatric patients, and even those not medically ill at all, but simply “tired of living.” [In the Netherlands, the Minister of Justice and Minister of Health are pushing to expand voluntary euthanasia to those who claim to have a “completed life.”] For centuries Belgium has been a deeply Catholic culture. However, in the latter part of the 20th century, the country became extremely secularized. They refer to their culture now as “post-Catholic.” In that sense, there is a pushback (conscious and unconscious) against values for which the Catholic Church traditionally stands. One of those core values is the *absolute* value of life. “Post-Catholic” Belgians, rather see the value of upholding life as something to be balanced against other values, which sometimes might supersede it (e.g. autonomy, compassion, etc). Indeed, I heard that when a Belgian person asserts negative feelings about euthanasia, they are sometimes assumed to be “Catholic,” and that is used to invalidate their opinion. It will be interesting to see how that kind of *ad hominem* invalidation might change if The Brothers continue to sustain their position in defiance of Rome.

My presentation was entitled “Voluntary Euthanasia of Patients with Mental Illnesses: An Inversion of Psychiatry’s Fundamental Clinical and Ethical Values.” I reviewed a great deal of data about psychiatric euthanasias in The Netherlands and Belgium, demonstrating how there has been a profound “mission creep” in both countries, with an ever widening diameter of eligibility, leading to an appalling slippery slope. I did make mention of the ways that the leading and most celebrated psychiatrists in Nazi Germany lost their ethical moorings, swept along by a powerful social movement, and participated with dedication and relish in the “T4”

program to exterminate the mentally ill. Yes, that was involuntary euthanasia, but the lesson is how psychiatry is vulnerable to a social tsunami, and can detach from core medical ethics with enthusiasm, convinced they are pioneering a virtuous new moral frontier. I reviewed the positions of several international medical and psychiatric bodies that are against some of these practices, including that of the APA. I then addressed a variety of social, clinical, financial, and ethical concerns about psychiatric euthanasia. I particularly emphasized what I called the “fundamental ethos of psychiatry” to prevent suicide and its special skill set to address hopelessness, helplessness, desire to die, and inability to see a better future. Human suffering is our core focus, no matter what the diagnosis, and our approach is to address that suffering in various ways, but not by snuffing out the life of the sufferer. I wouldn’t say it was a hostile audience; just a largely skeptical one.

I went with an open mind to try and grasp the arguments in support of psychiatric euthanasia from the people and clinicians immersed in it as a “treatment” option for 15 years. What I heard from several other speakers (philosopher, psychiatrist, psychologist, Jesuit priest who was also a physician) was actually very disturbing to me. I was powerfully struck that these people, who had been living with this as the law of the land, *a fait accompli*, were starting with the accepted conclusion that it was OK, and reasoning backwards to create an *a posteriori* justification. The conclusions are a given, so arguments were sought specifically to justify the conclusion, and ideas that would lead to a contradictory conclusion were filtered out. It was a powerful kind of sophistry. Indeed, there was even an apologetic tone by some speakers; they seemed to be apologizing to themselves as many were uncomfortable with the conclusion. The speaker who represented the new ethical stance of The Brothers seemed particularly fraught, with a strong sense of forcing an argument which, between the lines which virtually shouted, “we really don’t want to do this, but the society we live in wants it.” They were justifying literally killing (on request) the very kinds of patients to whose hopelessness and helplessness I am devoted to address as a psychiatrist. My reaction was visceral; I found myself eyeing the exits to bolt out and get some fresh air. It wasn’t hard to imagine that I was at a psychiatric conference in pre-war Germany, listening to learned speakers intellectualize uses of psychiatry that were trying to topple the millenia-old gyroscope of medical ethics in service of radical progressive shifts in social mores.

Euphemisms abounded that permitted a disengagement from the prior, traditional moral baseline. There was talk of “compassion,” “listening to and respecting the patient’s wishes,” “the end of doctor-knows best,” and an apotheosis of autonomy to the point where it actually seemed fetishized. It was certainly easy to follow the arguments for compassion, not abandoning the patient, taking the patient’s suicidal wishes seriously, exploring the extensive underlying reasons for wanting to die, etc. All of these penultimate approaches sounded like good, solid psychiatry. What was not presented at all was justification for taking the very last step— killing the patient, for the physician him or herself to engage in killing. I had hoped at the very least to hear the Belgian health-care establishment support psychiatric euthanasia, but protest that it should not be occurring in the House of Medicine, by the hand of a physician, and unhappiness that society had come to expect that of them. It was quite clear to me that these professionals who spoke have been living with this for far too long. They are too far

down the rabbit hole at this point. Those who became mental health professionals since 15 years ago were professionally born into this paradigm, and it's all they have known their entire careers.

I don't want to say that nobody had problems with it. There were some calls for modification of the law, for example mandating a minimum of at least a year or more to pass between approval and administration of euthanasia for psychiatric patients. The sense was the system needed some "fine tuning" but was fundamentally acceptable. Outrageous cases are "exceptions to an otherwise good system." There was, however, a small group of professionals who saw the whole situation as very negative, dire, and deeply disturbing. On two different nights they invited me to dinner and wanted to ventilate their concerns in a more private setting as well as to seek advice about how they might better organize the professional opposition. They are particularly concerned that the mainstream press has a robust buy-in for psychiatric euthanasia. With the help of some wine over dinner, their agita about the situation became more expressive.

It turns out that there have been a couple of positive consequences of legalizing psychiatric euthanasia. One speaker, a psychologist, showed how she used the euthanasia law to introduce to Belgium the "Recovery" concept. She was able to build a peer-support-Recovery-oriented group of patients who have been approved for euthanasia but haven't yet implemented it. The purpose of the group is to use the Recovery model to help build more momentum, meaning, and support to *live*, an alternative to proceeding with the approved euthanasia. One of the most common motivations for psychiatric euthanasia in Belgium, according to data reported to review commissions, is being "tired of living" or "loneliness." So that gives a compelling focus for a Recovery group. Another interesting development is a new speciality —psychiatric palliative care. The criteria for euthanasia— a condition that is "insufferable and untreatable"— has called into existence a new category for the mentally ill who have those characteristics. I found it particularly interesting to contemplate that the idea of an "untreatable" condition in psychiatry really didn't exist until legislatures in the Benelux countries conjured it into legal existence, to be congruent with such a concept in somatic medicine, particularly terminal somatic conditions with which physician administered euthanasia originally began. Once the law was struck, this categorization became an official clinical reality in psychiatry, and suddenly "palliative care" for psychiatric patients began to make sense. Without euthanasia, "palliative psychiatry" doesn't seem much different than ordinary psychiatry practiced with excellence (probably much more intensive than average). This new psychiatric speciality provides for the "hopeless and insufferable" cases a level of service intensity that can mitigate the need many patients feel to have euthanasia. Indeed, one of the psychiatric patients who attended this symposium told me that it is said in Belgium, "if you want better and more intensive psychiatric care, just say you want euthanasia." In this way it reminds me of the U.S. discussion around outpatient civil commitment—it is a path to more intensive services, which probably were needed all along, and could have prevented the need for outpatient commitment.

Sadly, I left without much hope for Belgium to reverse its stance on psychiatric euthanasia. It has been too many years, there is too much widespread buy-in, the professional societies cannot get sufficient coherence to express a viewpoint or take a stand, and psychiatrists fear being seen as cruel, or retrogressive, or “crypto-Catholic” if they speak out too loudly as individuals. The press will flock to their door with unpleasantly critical, challenging interviews.

The APA’s position has taken on a critical importance for those in Belgium who are seeking clear declarations of the unethical nature of psychiatric euthanasia. As of this writing, the World Psychiatric Association is one month away from voting on the following new ethics statement: *“Psychiatrists should not be involved in actions that are intended to lead to the death of patients.”* The influences of the APA and WPA as prominent voices of organized psychiatry are important. But, unless the medical and psychiatric establishment in Belgium can get its act together and speak coherently against this appalling practice, objecting psychiatrists will have to continue to be whisper their worries to each other, and little Belgium will likely continue to convince themselves that they are virtuously righteous in letting their doctors provide suicide to certain non-terminal suicidal patients who are “untreatable” and request death.

PostScript:

Two days after my lecture an article about the symposium appeared in Belgium’s leading newspaper De Standaard. The journalist Veerle Beel wrote (in Dutch translated by Google Translate):

“American psychiatrist Mark Komrad gave a fierce argument against euthanasia in psychiatric patients. ‘The core task of psychiatry is to prevent suicide,’ said Komrad. There was an ugly comparison with eradication programs in Nazi Germany. It is not uncommon for psychiatrists in Anglo-Saxon countries to rule out euthanasia in psychiatric suffering. . . .The presence of an American at a symposium of an institution affiliated with The Brothers of Charity could easily be seen as a criticism within the organization, by people who agree with Komrad . . . It was also highly uncomfortable for Flemish psychiatrist Joris Vandenberghe [who has performed euthanasia on psychiatric patients]. He said, “We know that what we do is provoking fierce reactions internationally, and at times I felt outraged by what our American colleague said.”

So, I stirred a hornet’s nest. Once someone (or a culture) has taken a life by euthanasia, it’s difficult to go back and say that the law or policy that allowed it was mistaken. That would create profound cognitive dissonance.

Finally, three days after the symposium, the Board of The Brothers of Charity in Belgium, voted to SUSTAIN their decision to provide euthanasia services to eligible psychiatric patients in their facilities, against the objection of the Pope. Though disappointed, I am not

surprised. I certainly had no pretensions that my one lecture could influence the course of a determined Catholic battleship that is prepared to engage in battle with Rome.

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