

Euthanizing People Who Are ‘Tired of Life’ in Belgium

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Introduction

In Belgium and in The Netherlands, a debate is developing about people who express a desire to end their lives although they do not suffer from an incurable, life-threatening disease. In 2000, a court in Haarlem in The Netherlands considered the case of 86-year-old Edward Brongersma who had expressed his wish to die to his general practitioner, Dr Philip Sutorius, claiming that death had ‘forgotten’ him, his friends and relatives were dead, and he experienced ‘a pointless and empty existence’ (Sheldon 2000). After repeated requests, Dr Sutorius euthanized his insisting patient and was then put on trial. The public prosecution recognized that Dr Sutorius fulfilled all the legal criteria but one: ‘hopeless and unbearable suffering.’ Therefore, the patient’s request should have been refused. The court did not discipline Dr Sutorius, saying that the patient was obsessed with his ‘physical decline’ and ‘hopeless existence’ and therefore was suffering ‘hopelessly and unbearably’. A spokesman for the Royal Dutch Medical Association reacted to the court judgment by saying that the definition of ‘unbearable suffering’ had been stretched too far and that ‘what is new is that it goes beyond physical or psychiatric illness to include social decline’ (Cohen-Almagor 2004). The then Justice Minister Benk Korthals said that being ‘tired of life’ is not sufficient reason for euthanasia (Sheldon 2000). Since then, the debate as to whether physicians should comply with euthanasia requests of people who are ‘tired of life’ has been widened

¹ I am grateful to Chris Gastmans, David Albert Jones, Calum MacKellar, Bert Keizer and Sigrid Sterckx for their comments on a previous draft of this paper.

and many people in Belgium and in The Netherlands are calling for the law to be expanded in order to include similar patients (Van Wijngaarden *et al.* 2014).

The methodology of this research is based on a critical review of the literature supplemented by communications with leading scholars and practitioners. First, concerns are raised about euthanizing people who say that they are 'tired of life'. Some suggestions designed to improve the situation are offered. The Belgian legislators and medical establishment are invited to reflect and ponder so as to prevent potential abuse.

People Who Are 'Tired of Living'

Studies have shown that age-related losses, inability to carry out daily activities, decreasing sociality, lack of valuable relations and companionship, low self-esteem, self-withdrawal that leads to depressive feelings, personal characteristics and beliefs are associated with euthanasia requests (Rurup *et al.* 2005a; Rurup *et al.* 2011; Van Wijngaarden *et al.* 2014, 2015). Elderly people face the diminution of their family and social circles as they withstand life hardships while their loved ones pass away. Sometimes they suffer a string of bereavements in succession. A Belgian study from 2013 showed that being tired of life was a relatively common reason for physicians to grant euthanasia requests. In declining order, the most important reasons were the patient's request (88.3%), physical and/or mental suffering (87.1%), no prospect of improvement (77.7%), expected further suffering (48.3%), low expected quality of life (45.1%), loss of dignity (52.1%), thinking that life should not be needlessly prolonged (30.7%), being 'tired of life' (25.3%), family's request (23.4%), situation was unbearable for the family (13.8%), and other reasons (0.4%) (Dierickx *et al.* 2015). I have dealt with the problematic involvement of the family in decision-making processes at the end of life elsewhere (Cohen-Almagor 1996, 2011). Here I wish to focus attention on one

controversial reason for euthanasia: being “tired of life”. Such cases concern people who do not suffer from a physical or medically defined psychiatric disease yet they are unhappy with their lives and wish to terminate them. These cases are not unique to Belgium (Calman 2004; Pike 2010; Withnall 2014; Van Wijngaarden *et al.* 2014). They are, however, salient in Belgium and in The Netherlands because of their respective euthanasia laws and the slow process by which both societies are broadening the situations in which euthanasia can be considered, such as for mental suffering and children. Debates are taking place concerning people who are ‘tired of life’, psychiatric patients and patients with dementia.² In The Netherlands, it is estimated that requests for euthanasia on the grounds of being ‘tired of life’ are made approximately 400 times a year (Rurup *et al.* 2005a). These requests pose a delicate moral dilemma that deserves close consideration. According to the Dutch physicians, being tired of living was one of the important reasons for the request for euthanasia and assisted suicide in 14% of patients suffering from cancer (282/2056), 30% of patients with another severe disease (81/271), and for 74% of patients who had no severe physical or psychiatric disease (45/61) (Rurup *et al.* 2005a).

Euthanizing People Who Are ‘Tired of Life’

The Oxford Dictionary defines ‘tired’ as ‘In need of sleep or rest; weary’ or ‘Bored or impatient with’. People who are tired go to rest, rejuvenate, collect themselves and return to their daily routine. People who are ‘tired of life’ presumably do not wish to rejuvenate, collect themselves and return to their daily routine.

² For discussion, see Thienpont *et al* 2015; Moonen *et al* 2015; Claes *et al* 2015; Cohen-Almagor 2016.

In 2009, Amelie Van Esbeen asked her doctors for euthanasia after she indicated that she had ceased appreciating her life. Her physicians did not believe that she was suffering from a 'serious terminal illness' and 'constant and unbearable pain that cannot be relieved' as the law stipulates, hence they refused her request. The 93-year-old woman began a hunger strike and after ten days a different physician helped her die.³ The controversial case re-launched the debate as to how life should end; about quality of life, and whether such requests should be honoured. Wim Distelmans, who heads the Belgian Federal Control and Evaluation Commission for Euthanasia, said that euthanasia can only be performed when there is a question of 'unbearable suffering' ('93-year-old Belgian Woman on Hunger Strike' 2009; 'Belgian Woman Dead after Fighting for Assisted Suicide' 2009; '*Amelie Van Esbeen est décédée par euthanasia*' 2009; 'Belgian Euthanasia, Controversy Is Served Again' 2009; 'Belgian Woman, 93, Gets the Help to Die that She Wanted' 2009). This sounds like a restrictive view of euthanasia. But Distelmans maintained that older persons often suffer from many illnesses: poor sight, poor hearing, poor verbal skills and dependence on others:⁴ 'Put together this could amount to unbearable suffering. I don't believe it's wrong to request euthanasia in such situations' ('93-year-old Belgian Woman on Hunger Strike' 2009).⁵ Distelmans voiced his belief that the Belgian *Euthanasia Act* should be changed to

³ In her comments on an early draft of this paper (13 March 2011), Professor Sterckx noted: 'This is a rogue doctor and this should be condemned and many have done so; but it is only ONE case.'

⁴ One referee noted the increasing number of euthanasia deaths for 'multiple pathologies' in Belgium. This may suggest increasing euthanasia not for terminal illness but for the many illnesses of old age. Some of them are conducted on the basis of being 'tired of life'.

⁵ Dr Keizer remarked on a draft of this paper that in the Netherlands there is also much pressure to outline a new law under which frail, tired, elderly persons can ask for an overdose.

enable seniors who are 'tired of life' to be able to request euthanasia ('93-year-old Belgian Woman on Hunger Strike' 2009).⁶ But Distelmans' view is contested. Research has shown that a significant number of physicians interpret 'unbearable suffering' to require serious physical symptoms (Van Tolet al 2010; Pasman et al 2009; Bolt et al 2015).

A 2015 study by Bolt et al shows that 3% of all euthanasia and physician-assisted suicide requests in the Netherlands are from people who are 'tired of life' and that only a minority of physicians find it conceivable that they would grant such a request. Bolt et al (2015) think that legal arguments and moral objections deter most physicians from complying with such requests.

In 2014, a British woman who was neither terminally ill nor seriously handicapped but who had become fed up with the modern world of emails, TVs, computers and supermarket ready meals wished to end her life. As no physician in Britain would help her, she travelled to Switzerland where her wish was granted by the Dignitas assisted suicide clinic (Withnall 2014).⁷

Relevant Considerations

The *raison d'être* of medicine and health care is to relieve suffering, to assist patients in coping with their particular ailments, and to seek to treat or heal. Physicians are there to serve the best interests of their patients on matters that concern their health. Does

⁶ Professor Sterckx doubted that Distelmans said this and suggested to check with him whether the press release is accurate. I wrote to Distelmans but received no reply.

⁷ See also 'Second British woman "tired of life" helped to die by Swiss suicide clinic aged 99' 2014.

terminating the lives of people (I refer to them as 'people' not 'patients') who are 'tired of life' fall within this *raison d'être*? I believe the following considerations should be included.

Autonomy: People have the right to control what happens to their bodies. The central idea of autonomy is self-rule, or self-direction. Accordingly, the view is that individuals should be left to govern their business without being overwhelmingly subject to external forces. We are said to be free when our acts are not dominated by external impediments, thus enabling us to form judgment, to decide between alternatives, and to act in accordance with the action-commitments implied by our beliefs. Thus autonomy means that an informed, competent adult can refuse or accept treatments, drugs, and surgeries according to his or her wishes. The autonomy argument is weak because these people suffer, and they are dependent on others. They may consider themselves to be autonomous, self-determined people who make a rational choice to end their lives but in effect their self-rule is impaired. They are vulnerable, needy and depend on others, including their doctors. Thus we are considering a restricted sense of autonomy and deficient capacity for self-rule.⁸

Furthermore, the issue is not denying individuals to exercise what they perceive as their right. Granted that some people may believe that death serves their best interest. But they do not commit suicide. They want the physician to help them. Respecting the autonomy of the person would require changing the scope of medicine and healthcare to include providing aid-in-dying to people rather than to patients.

Neil Calman (2004) tells the heart-wrenching story of 'Sarah Brownstein' (this is a fictitious name), 92-year-old New Yorker lady of sound mind who was 'tired of life' and asked his

⁸ One referee noted that people who are tired of life do not always have a diminished autonomy capacity.

assistance to die. Sarah was lonely. She had difficulties hearing and reading. She had difficulties thinking. She felt unworthy, of no use to anyone, not even to herself. She wanted the doctor to end her misery. At the same time, Sarah's medical condition was stable. She lacked most signs of depression. She was eating and sleeping well. She dressed up and put on make up every morning. She also obediently took her many medications. The doctor could not come to her aid as Sarah requested; such act was against New York law. He did tell Sarah that it was her right to end her life if she so chooses. As Sarah continued to insist, he finally told her she can stop taking all her medication. This was completely within her control. This way she could exercise her autonomy without compelling the physician to violate the law.

Nonmaleficence: 'First, do no harm' is the bedrock of medical ethics, *sine qua non* that guides the work of all healthcare providers. In every situation, healthcare providers should avoid causing harm to their patients (Beauchamp and Childress 2013). Granted that some treatments may cause some harm thus the requirement is that the treatment should not be disproportionate to the benefits of treatment. We assume that people who are 'tired of life' are suffering. But is their suffering so unbearable that death is the solution? Even if there are situations in which some people suffer a lot because they are neglected and have no hope to improve their abysmal situation, enlarging the scope of medicine to end the life of such people may entail disproportionate harms.

Beneficence: The autonomy of the person is important. Not harming others is a professional value of medicine. Beneficence dictates that health providers contribute positively to the welfare of their patients. Beneficence connotes acts of kindness, charity, mercy and

friendship (Beauchamp and Childress 2013). Healthcare providers should take into account the benefits and risks of their decisions. They should act in a way that benefits the patient. They must strive to improve their patient's health, to do the most good for the patient in every situation. Granted that what is good for one patient may not be good for another, thus each situation should be considered individually. Those who are 'tired of life' are not interested in efforts to improve their health condition. But beneficence requires that physicians will exhaust all treatment options which do not impose disproportionate burden and which have not been refused by the patient. Beneficence requires to positively come to those people aid. Whether kindness and mercy require ending the lives of those who are 'tired' of living is an open question but this conduct should always be the last resort.

Dignity: The term 'dignity' is derived from the Latin noun *dignitas*, which means: (a) worthiness, merit; (b) greatness, authority; and (c) value, excellence. The noun is cognate with the adjective *dignus* (worthy), from the Sanskrit root *dic* and the Greek root *deik*, which have the sense of 'bringing to light,' 'showing,' or 'pointing out' (Lowental 1984; Bayertz 1996; Velleman 1999; Cohen-Almagor 2001).

When using the phrase 'death-with-dignity,' we refer to the timing and setting of death, i.e., patients should be allowed, whenever possible, to choose the time and setting of their departure. With the help of medical professionals, patients should be able to control the process of dying, maintaining autonomy at the end of life, not being humiliated, perceiving themselves with honour. The concept of dignity refers to a worth or value that flows from an inner source. In this context I wish to distinguish between *dignity as recognition* and *dignity as liability*.

Dignity as recognition is about us recognizing the inner spark of the soul that we all possess, the inherent quality of the person. It is not given from the outside but rather is intrinsic to the bearer of dignity. As Lawrence Ulrich (1999) notes, a painting may have value but it does not have dignity. The value is placed upon it by the members of the artistic community in light of the skill of the artist and the aesthetic priorities of the community. The value does not derive from the painting itself. Persons, on the other hand, can be said to possess dignity as an inner source of worth. Inherent dignity should be recognised by oneself and also by others. If this were not the case, people would simply be the bearers of instrumental value like all other objects in the world. Instead, human beings are set apart and treated in special ways. Human beings are precious; their lives are appreciated and should be protected.⁹

Because the concept of dignity also relates to the inner self, it involves not only *objective* but also *subjective* notions. It is the source from which human rights are derived, and it also refers to one's own feelings about oneself. To have dignity means to look at oneself with self-respect, with some sort of satisfaction. It means to feel human, not degraded.

Subjective concept of the self refers to how a person perceives of his or her life, achievements, and place in the world. The subjective evaluation is affected by the individual's self-respect, relative to the abilities he or she believes he or she possesses relative to peers and surroundings.

⁹ Contra Peter Singer 1993, I am a 'speciesist'. I believe first of all of my own species, the human race. Contrary to Singer, I believe that the very birth of human life is morally significant, something of great importance. Contrary to Singer, I believe that it is only a humane and preferable inclination to think first about our fellow humans.

I have argued that we all have a right to dignity (Cohen-Almagor 2001, 2013). *Dignity as liability* requires that we all respect persons *qua* persons. People deserve to be accorded a certain treatment from birth. We are endowed with dignity and have the right to be treated with dignity. While people cannot expect concern from fellow humans, we can expect respect from others.

More specifically and with reference to the role of physicians, preserving dignity means helping patients to feel valuable. The preservation of one's dignity involves, *inter alia*, listening to the patients' complaints, helping patients cure their diseases, or at least assisting them in controlling pain, responding to their distress and anxieties, making an effort to relieve them, demonstrating sensitivity to the physical indignities that occur in severe illnesses, making the patient sense that he or she is a human being and not an infant, a case study, or worse, a body that occupies a bed and consumes resources. Maintaining the patients' dignity requires physicians as well as the patients' families to help the patients retain at least some of their self-respect. The aim is to secure dignified living in severe health conditions.

The subjective feeling of loss of dignity is a significant consideration for those who request euthanasia and assisted suicide in the Netherlands (Rurup et al 2005b). People who are 'tired of living' come to believe death is their preferred option. They wait for death because they have nothing to live for. Patients who suffer from incurable deadly disease have little or no hope because present medicine cannot provide suitable answers. But people who 'are tired of life' are not in the same position. They do not suffer from such life-threatening diseases. There is some hope for them and they can regain self-worth and value.

My research in eight countries (Australia, Belgium, Canada, Israel, New Zealand, The Netherlands, United Kingdom, United States) has shown that most patients find some

meaning in their lives even when they are severely impaired, bed-ridden, limited in movement, and in constant need of help (Cohen-Almagor 2001, 2004). We are talking about a very small number of people who are 'tired of living' and who come to entertain the option of shortening their lives. Many of these people who are 'tired of living' were independent, active and energetic. They become in their own eyes dependent upon others. They reach the conclusion that their lives have become a burden to them and to the people they love. They might lose their sense of humanity as well as their self-respect, and this might lead them to lose interest in life and to choose death. The challenge is to make them resume the zeal for life. The challenge is to make them acknowledge the richness of life even when the alternatives presented before them are more restricted compared to what they used to have. Death awaits all of us. The medical profession should exhaust all avenues of helping those people, aiming to accommodate their needs and to refill the void in their lives before opting for euthanasia.

Compassion: But what about those people whom we cannot help? We have tried everything. Nothing helps. They suffer from some medical conditions that are not life-threatening. They may be old and lonely. We are unable to arrange sufficient company for them and to garner enough points of interest to make their lives worthy of living. Should we just ignore these people?

The virtue of compassion combines active regard for another's welfare with an emotional response of sympathy, tenderness, and discomfort at the other's misfortune or suffering. It is expressed in acts of beneficence that aim to alleviate suffering. Indeed, the principles of respect for autonomy and beneficence, and the virtues of care and compassion offer solid

reasons for recognizing the legitimacy of physician-assisted death (Beauchamp and Childress 2013).

Calman (2004) was unable to assist Sarah. As he advised her to stop taking her medication he reassured her that, should she become uncomfortable or filled with fluid from heart failure, he would prescribe a pain medication to take away the sensation of being out of breath, without treating her heart failure. He promised to come to see her any time day or night. Sarah followed his advice but continued living for a few more months, and became more agitated as death failed to visit her instantly. She was angry with her physician who felt deep remorse for his inability to help her as she wished. Calman (2004) concluded with the hope that when his own time will come, his physician will have a good understanding of palliative care and end-of-life options, will have the courage to act on his behalf, and that the legal situation will be such as to facilitate more merciful assistance at the end of life. The issue of people who are 'tired of life' is a 'hard case'. The moral dilemma is real and significant. I can think of situations in which strong-willed people who lost some of their capabilities, who are lonely, and who are trapped in their own comparative memories, recall their previous times of life when they were active, social beings, when they had led meaningful life with significant others whom they loved; these people lost the zeal for life, do not see a way out of their situation and prefer death. We should help them to the best of our abilities but I think we should be very careful in providing a licence to physicians to aid their dying. Such people, in such condition are exceptional. The Belgian *Euthanasia Act* should not be expanded to cater for them.

Having said that, I believe medicine should try to help *all* people, not only the majority of them. The rule should be to exclude people 'who are tired of life' from the rule that permits euthanasia. Thus contra-Distelmans, while I am against enlarging the scope of the

Euthanasia Act yet again (in 2014, the *Act* was amended to include children), I do recognize that exceptions can be made.

In the next section below I will make some suggestions as to how to accommodate exceptions. I oppose expanding the law yet again because it is impossible to build a policy that will keep shifting as individual situations present themselves. Furthermore, to honour death requests because people are 'fed up with life' is a dangerous move. People who experience mental, physical or existential tiredness and who request death should receive proper psychological counselling, not lethal medication. They should receive recognition, a caring treatment, respect and concern that could potentially renew their zeal for life.

Judging from past experience, and observing the Belgian tendency to widen the circle of eligibility of euthanasia beyond the 2002 *Euthanasia Act*, there is a considerable danger that if being fed up with life becomes a legitimate consideration for ending life, otherwise healthy people who have just been separated from their spouses, married people who are grieving over the death of their spouse and find it difficult to carry on, people who lost their jobs, parents who have lost a child, among others, may appeal to have euthanasia. Debate will ensue, pressure will mount on Parliament, some legislatures and physicians will argue for listening to such appeals, and the permissive euthanasia culture in Belgium might seriously entertain further expansion of the *Euthanasia Act*. Society and end-of-life practitioners are better off refraining from engagement with such requests.

Professional Integrity: All the above considerations directly relate to those who are 'tired of life' and ask physician's aid-in-dying. However, I wish to highlight another consideration that seems to be of important relevance. This consideration refers to the coherent integration of the moral characteristics of the field of medicine. It is about maintaining certain professional

standards that are essential for maintaining trust between physicians and those who are dependent on them.

The relationships between physician and patient are not equal. The physician is usually situated in a power position above the patient. The physician has authority and a position to decide the fate of the patient. Thus power should be exercised judicially and carefully. We know that power can be used and abused. While most physicians will use the power granted to them sensibly, some might either lack the necessary discretion or would not always act with utmost caution. Physicians should be the first to acknowledge this possibility.

Therefore, it is in their best interests not to open the door to procedures that might increase the likelihood of abuse. Enlarging the scope of the law to include euthanasia for people who are 'tired of life' might pejoratively affect the integrity of the medical profession. This might 'rock the boat' and undermine trust between physicians and others. The sensible thing is to continue speaking about 'patients' than about 'people' at large.

Moral dilemmas are difficult to resolve. Often their solution is not perfect. Compromises are sought where we weigh each option's benefits and risks. Here the risks are too weighty.

Medical professionals must set a certain level of risk that they are expected to assume.

Beyond that level, decisions should be optional rather than obligatory. This 'level drawing' is difficult and it may be contested as societal norms are different from one country to another (for instance, Dutch and Belgian societal norms regarding euthanasia are different from the norms in Britain and in Israel), societal and medical-professional norms are in flux and they do not always exist in harmony (in Britain, polls show that 82% of the public back assisted dying but the British Medical Association opposes all forms of assisted dying),¹⁰ and

¹⁰ See Gallagher and RoxbyHealth 2015; 'Assisted dying debate: The key questions' 2015; Walsh 2015.

technology may introduce new standards. At present, medical professional standards should not include euthanasia for people who are 'tired of life'. If physicians did terminate lives of people who are not suffering from a life-threatening disease, this would change the *raison d'être* of the profession and might endanger lives of many more elderly (or younger), vulnerable people who wish to live. *The culture of medicine and the principle of beneficence should not include death as a way for improving people's health.*

Suggestions for Improvement

The legal guidelines are there to protect and to provide control. The Van Esbeen case was used by euthanasia supporters in Belgium to undermine the guidelines and to enlarge the scope of euthanasia. This enthusiasm opens the door wider for abuse. A fine line distinguishes between ethical decisions regarding a specific case, and policy making. The law is not designed to tailor each and every scenario and incident. We have courts to decide on specific cases, whether they have standing and whether they are justified. However, courts are often slow and expensive. Thus, it is suggested to address this moral dilemma by putting in place specific regulations. The regulations would require the establishment of an ad hoc committee for each and every euthanasia request made by people who are 'tired of life'. The ad hoc committee would include three senior experts in the relevant fields of medicine that concern the 'tired of life' applicant. The committee should also include a lawyer and a public representative, possibly an ethicist. The ad hoc committee will consider all the aspects of the petition, meet with the applicant twice in a span of several weeks, and make a decision whether an exception to the law should be made. This procedure of allowing exceptions rather than enlarging the law seems to me more sensible and signals that the role of medicine is still to heal. Only as a last recourse, after exhausting all other options, the

autonomy of the person, beneficence, the dignity of the person, care or compassion may persuade physicians to provide aid in dying.

In September 2014, an elderly husband and wife from Brussels Francis, 89, and Anne, 86 revealed their plans to die by assisted suicide. Both were not terminally ill, but they feared loneliness if one died before the other. Francis said: 'We want to go together because we both fear for the future... It is as simple as this – we are afraid of what lies ahead' (Roberts 2014).¹¹

Fearing for the future is natural. We all have some fears regarding the future. Fearing for the future in an old age is understandable. Old people are more vulnerable, less secure. They feel that their journey has come to an end, and that their lives matter less. Some of them lost their viability, their energy. Some feel their contribution to society and to their loved ones is diminished. But if they are provided with the assurance that their lives do matter, that people around them are still enjoying their company, that they are important to them, then they may reconsider their position. As most people wish to continue living, my assumption is that it is possible to rekindle the urge to live. What we need is to reassure old people that they are appreciated, and that it is time for payback: it is time for their loved ones to reward them for many years of caring that they gave for their family. If elderly people do not receive this kind of support from their family, then we as a society should strive to grant them such support, making them feel valuable not vulnerable, precious not obsolete. With the supporting environment, the attraction of death would cease to exist.

¹¹ One editor remarked: The issue of a double assisted suicide/euthanasia raises questions of coercion or influence. In the case of double suicides it seems that, typically, it is the man who takes the lead. Where one has a terminal illness and the other does not (but is 'tired of life' – or afraid of bereavement) the question of influence is even more difficult.

Some people are feeling trapped in their present situation. They no longer see the candle that lights their lives. Life lost its meaning for them. They want a way out. Offering death as solace is relatively easy and far less demanding than investing in patients' time and resources. Such an investment is what we should opt for as warranted by humane and compassionate medicine that endorses the values of beneficence, justice, non-maleficence, and enabling patients to make reasoned informed choices (Beauchamp and Childress 2013) where death might be only one of the available choices, and the very last act after carefully exhausting all other alternatives.

There is a need to involve palliative care consultants to treat people who find life too difficult to bear (Bernheim et al 2008; Kuin et al 2004; Cohen-Almagor 2002, 2004, 2015). Being "tired of life" is not a disease. It is a mental state. It can be addressed with comprehensive care that seeks to improve the patient's mental, spiritual and physical condition. What is suggested is combined efforts of palliative care and involving the patient's loved ones in treatment. Palliative care means a holistic treatment that is designed to help individuals resume their will to live, helping them to rediscover meaning in life. Palliative care aims to relieve suffering and improve the quality of life through specific knowledge and skills, including communication skills; management of pain and other symptoms; psychosocial, spiritual, and bereavement support; and coordination of an array of medical and social services (Morrison & Meier 2004; Sampson et al 2014).¹² It is suggested that all general practitioners in Belgium should all undergo such training.

¹² For further discussion, see Schenker and Arnold 2015; Leemans 2014.

Conclusions

More than a decade ago, the Dutch Supreme Court considered the 'tired of life' reasoning for euthanasia. The Netherlands has had long experience with the practice of euthanasia and in many respects paved the way for those who pushed for such legislation in Belgium. In a landmark decision, the Court ruled that physicians may not perform euthanasia or help with suicide unless the request comes from a patient suffering from a medically classifiable physical or psychiatric sickness or disorder. Merely being 'tired of life' cannot serve as a basis for physicians to grant euthanasia (Sheldon 2003).

The liberal state has an obligation to protect the vulnerable. Protecting the vulnerable means caring for them. The Belgians are researching the way their dying patients are being handled in a medical context. Their culture of self-searching is certainly necessary. This issue should be put on public agenda and open for debate, examining the pros and cons of each and every choice of conduct.

The Belgian *Euthanasia Act* was passed only in 2002, and the country is still in the early learning stages (Cohen-Almagor 2009). We can hope that the Belgians learn from their experience and will devise ways to address the concerns. Having said that, looking at the short history of the euthanasia laws, policy and practice, in Belgium and also in the Netherlands may lead us to think that there is something intoxicating about the practice that blinds the eyes of decision-makers, leading them to press forward towards further end-of-life practices without paying ample attention to caution. The scope of tolerance towards the practice of euthanasia is thereby enlarged so that yesterday's red light becomes obsolete today. As the restrictions are removed, practitioners and law-makers are already debating the next step and the additional groups to be included within the more liberal euthanasia policy. This is quite astonishing as human lives are at stake. What is required is a

careful study, together with an accumulation of knowledge and data, addressing the above concerns, thereby learning from mistakes and attempting to correct them before rushing to introduce more liberal ways to euthanize people.

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