

Ethics policies on euthanasia in hospitals—A survey in Flanders (Belgium)

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Abstract

Objective: To determine the prevalence, development, stance, and communication of written institutional ethics policies on euthanasia in Flemish hospitals.

Methods: Cross-sectional mail survey of general directors of all hospitals ($n = 81$) in Flanders, Belgium.

Results: Of the 81 hospitals invited to participate, 71 (88%) completed the questionnaire. Of these, 45 (63%) had a written ethics policy on euthanasia. The Belgian Act on Euthanasia and centrally developed guidelines of professional organisations were the most frequently mentioned reasons for and sources used in developing ethics policies on euthanasia in hospitals. Up to one-third of hospitals reported that they developed the policy upon request from physicians or nurses, or after being confronted with a euthanasia request. Development and approval of institutional ethics policies occurred within a multidisciplinary context involving clinicians, ethicists, and hospital administrators. The majority of hospitals restrictively applied the euthanasia law by introducing palliative procedures in addition to legal due care criteria. Private Catholic hospitals, in particular, were more likely to be restrictive: euthanasia is not permitted or is permitted only in exceptional cases (in accordance with legal due care criteria and additional palliative care procedures). The majority of hospitals took the initiative to communicate the policy to hospital physicians and nurses.

Conclusions: Since the enactment of the Belgian Act on Euthanasia in 2002, the debate on how to deal with euthanasia requests has intensified in Flemish hospitals. The high prevalence of written institutional ethics policies on euthanasia and other medical end-of-life decisions is one possible outcome of this debate.

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1. Introduction

In 2002, Belgium became the second country after the Netherlands to enact a law on euthanasia. This

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law allows euthanasia only under strict conditions and to be performed only by physicians [1]. Euthanasia-related mortality rates in Belgium and the Netherlands are low, ranging from 0.30 to 1.20% for Belgium and from 1.70 to 2.59% for The Netherlands [2–4]. Although euthanasia rarely occurs, the complexity of the clinical–ethical decision-making processes surrounding euthanasia requests and the need for adequate support and guidance of physicians [5,6] and nurses [7,8] require that healthcare institutions take responsibility for handling euthanasia requests within the institution.

Hence, to develop written institutional ethics policies on euthanasia represents one possible option to guarantee and maintain the quality of care for patients requesting euthanasia. Such a policy might also clarify for caregivers, patients, and their relatives a hospital's stance on handling euthanasia requests. Between January 2004 and December 2005, 54% of all registered cases of euthanasia in Belgium were performed in hospitals [9]. Research about written institutional ethics policies on euthanasia in hospitals has thus far been carried out only in Dutch [10] and in Flemish Catholic hospitals [11], revealing that of surveyed hospitals 69–79% have such policies in place.

Primary research aims of the study are: to determine the prevalence of ethics policy on euthanasia in comparison with other medical end-of-life decisions (MELDs) (1), to describe how policies on euthanasia have been developed (involved parties, reasons to develop or not to develop a policy) (2), to describe hospitals' stance on euthanasia (3), and to describe the communication of these policies (4). Secondary research aim of the study is to describe which hospital characteristics (religious affiliation, size, etc.) influence the prevalence of policies and the stance on euthanasia.

2. Methods

2.1. Study population and data collection

A cross-sectional descriptive mail survey was used. The study was carried out from November 15, 2005 to February 28, 2006, in Flanders, the Dutch-speaking state of Belgium, where 60% (5.9 million) of the nation's population lives. Questionnaires were mailed to the general directors of all hospitals in Flanders

($n = 81$). The list of the Flemish hospitals was obtained from databases of the Flemish Ministry of Health, the list included addresses and institutional characteristics such as type of institution, province, ownership, and size [12]. All non-responders were mailed a reminder together with a new questionnaire 6 and 10 weeks after the first mailing.

2.2. Questionnaire

The 20-item questionnaire was based on the one used in our pilot study [11]. This pilot questionnaire was based on a Dutch semi-structured questionnaire [10] that was adapted to the Belgian context. To optimise the validity of the questionnaire, first a thorough literature review was performed. Second, 12 experts critiqued the relevance and clearness of each item in a standardised way [13]. These experts had broad experience in ethics committees and/or ethics policymaking, or had pertinent knowledge relating to the euthanasia issue. We made small adjustments based on their comments. Lastly, the questionnaire was adapted according to the comments of six general directors to ensure that the questionnaire was clearly written and constructed for the targeted subjects of the study.

The revised questionnaire consisted of 20 questions, organized into five major parts. The first part contained questions about hospital characteristics (type, province, ownership, religious affiliation, size, membership in umbrella organisation). The second part contained on the one hand questions whether and in which year an ethics policy on euthanasia, withholding and/or withdrawing life-sustaining treatment, pain and symptom control with possible death hastening side effects, or palliative sedation has been developed, and contained on the other hand questions about the development of ethics policies on euthanasia (reasons, sources, involved parties). The third part contained questions about the stance on euthanasia for three patient categories (competent terminally ill, incompetent terminally ill, and non-terminally ill patients) described in the policy: euthanasia is permitted according to due care criteria outlined in the law, or euthanasia is permitted only in exceptional cases: according to legal due care criteria and additional palliative care procedures, or euthanasia is not permitted. The fourth part contained questions about the communication of the policy to professional caregivers, patients and rel-

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