



## Cultural differences affecting euthanasia practice in Belgium: One law but different attitudes and practices in Flanders and Wallonia

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### ARTICLE INFO

#### Article history:

Available online 17 May 2012

#### Keywords:

Belgium  
Cross-cultural comparison  
Euthanasia  
Guideline adherence  
Physicians  
Attitudes  
Legal  
Terminal care

### ABSTRACT

Since 2002, Belgium has had a national law legalising euthanasia. The law prescribes several substantive due care requirements and two procedural due care requirements, i.e. consultation with an independent physician and reporting of euthanasia to a Federal Control Committee. A large discrepancy in reporting rates between the Dutch-speaking (Flanders) and the French-speaking (Wallonia) parts of Belgium has led to speculation about cultural differences affecting the practice of euthanasia in both regions. Using Belgian data from the European Values Study conducted in 2008 among a representative sample of the general public and data from a large-scale mail questionnaire survey on euthanasia of 480 physicians from Flanders and 305 from Wallonia (conducted in 2009), this study presents empirical evidence of differences between both regions in attitudes towards and practice of euthanasia. Acceptance of euthanasia by the general population was found to be slightly higher in Flanders than in Wallonia. Compared with their Flemish counterparts, Walloon physicians held more negative attitudes towards performing euthanasia and towards the reporting obligation, less often labelled hypothetical cases correctly as euthanasia, and less often defined a case of euthanasia having to be reported. A higher proportion of Flemish physicians had received a euthanasia request since the introduction of the law. In cases of a euthanasia request, Walloon physicians consulted less often with an independent physician. Requests were more often granted in Flanders than in Wallonia (51% vs 38%), and performed euthanasia cases were more often reported (73% vs 58%). The study points out some significant differences between Flanders and Wallonia in practice, knowledge and attitudes regarding euthanasia and its legal requirements which are likely to explain the discrepancy between Wallonia and Flanders in the number of euthanasia cases reported. Cultural factors seem to play an important role in the practice of (legal) euthanasia and the extent to which legal safeguards are followed.

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### Introduction

Cultural differences can be an important factor explaining differences in the health behaviour of patients as well as of physicians (Kawamura, Honkala, Widstrom, & Komabayashi, 2000; Mitchell, 1998; Perkins, Geppert, Gonzales, Cortez, & Hazuda, 2002; Stromgren et al., 2004; Vincent, 2001). Physicians' compliance with health care guidelines or regulations is for instance susceptible to cultural values. Belgium makes an interesting case in

this respect. The country consists of two culturally different regions: Flanders, the northern Dutch-speaking part making up 56% of Belgium's population, and Wallonia, the southern French-speaking part (33% of Belgium's population), with the first historically more related to the Germanic culture within Europe and the latter more to the Latin culture within Europe. With the political crisis the country has been undergoing for several years in which the political representatives of its two major language communities are failing to achieve political unity, the perception about the significance of these cultural differences is peaking (Arnoudt, 2006; Reigrotski & Anderson, 1959). These stereotypical differences are a lot less pronounced in actual empirical research findings (Billiet, Maddens, & Frogner, 2006; Coffé, 2005; Dobbelaere, 2003).

In the medical field, particularly with regard to end-of-life care, differences between regions have been subject to speculation about

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their relationship to differences between cultures (De Bondt, Englert, Herremans, Matthyss, & Van Neste, 2008; Smets, Bilsen, Cohen, Rurup, & Deliëns, 2010, Smets et al., 2011). This speculation is reinforced by the fact that, while various aspects of health care are a federal i.e. national matter, Wallonia and Flanders have autonomous responsibility for various organisational health care matters such as health promotion and prevention, aspects of care for older people, home care and coordination and collaboration in palliative care (Corens, 2007). The ministries of health of the different regions and communities decide on the amount of subsidy given to home care and services and to health promotion, prevention and education and they also supervise and regulate these matters.

In regard to the practice of euthanasia – which is legal in Belgium and subject to legal safeguards – there are particularly strong reasons to suspect cultural differences between Flanders and Wallonia. The euthanasia law in Belgium specifies several substantial due care criteria (e.g. unbearable suffering without prospect of improvement, explicit and repeated requests) which have to be met in order for euthanasia to take place as well as two procedural due care requirements: a second independent physician has to be consulted beforehand to evaluate whether the euthanasia request of the patient can be granted and, once performed, the euthanasia case has to be reported to the Federal Control and Evaluation Committee for Euthanasia (Smets et al., 2008). It has been found that only 17% of the euthanasia cases reported to the Committee had come from French-speaking physicians (Smets et al., 2010). While some have concluded from this that euthanasia is actually a much more frequent practice in Flanders, it is also often assumed that this very large difference does not, in fact, reflect a very large difference in actual practice but rather a reluctance to report euthanasia cases. However, other studies indicate a tendency towards more performance of euthanasia by Flemish (Dutch-speaking) physicians and more continuous deep sedation by French-speaking physicians (Chambaere, Bilsen, Cohen, Raman, & Deliëns, 2010; Van den Block et al., 2009). Patients in the French-speaking community also receive life-prolonging treatment more often (Van den Block et al., 2009). While the statistical power of some of these studies is insufficient to warrant strong conclusions, they seem to suggest that differences in reporting rates may indeed be due partly to actual differences in the extent to which euthanasia is performed.

It seems interesting, however, to also examine whether different attitudes and approaches between Dutch- and French-speaking physicians exist towards the procedural due care criteria included in the law, such as the mandatory requirement beforehand to involve a second independent consulting physician to ascertain that the substantial due care criteria are met (e.g. request etc), and the mandatory requirement afterwards to report a case of euthanasia to the Committee. The legalisation of euthanasia in 2002 was particularly endorsed in Flanders, which can – speculatively – be attributed to the fact that the Flemish are culturally closer to the Germanic culture of the Dutch making it easier to adopt a similar legalisation. Examining differences in practices and attitudes regarding euthanasia and the euthanasia law between Flanders and Wallonia could therefore also provide useful insights into the question to what extent euthanasia legalisation is culturally transferable.

This article tries to present empirical evidence from several data collections concerning differences in attitudes to and practice of euthanasia. It will address the following questions:

- 1) do attitudes towards euthanasia in the general population differ between Wallonia and Flanders?
- 2) do attitudes towards euthanasia and towards the procedural due care requirements of the euthanasia law differ between physicians from Wallonia and Flanders?

- 3) do Walloon physicians receive fewer euthanasia requests from their patients?
- 4) do Flemish and Walloon physicians deal differently with euthanasia requests, and if they grant a request do they respect the procedural due care requirements (i.e. consulting an independent second physician and reporting the euthanasia case) differently?
- 5) do Walloon and Flemish physicians have a different understanding of euthanasia and of the obligation to report?

## Methods

### Study design

#### European Values Study (research question 1)

Two data sources were used to answer the research questions. To answer the first research question the 2008 Belgian data of the European Values Study were used. This is a large-scale survey held in 2008 in 47 European countries. In each country, a representative multistage or stratified random sample of the adult population 18 years and older was approached for face-to-face interviewing. More detailed information on the scope of the survey, the selection procedure and data collection procedure can be found elsewhere (Cohen et al., 2006a; Halman, 2001). The questionnaire used in the survey includes several questions about respondents' sociodemographic background, their religious values and orientations and several of their attitudes. One question asks about the respondent's acceptance of euthanasia: 'please tell me whether you think euthanasia (terminating the life of the incurably sick) can always be justified, never be justified, or something in between', after which the respondent is asked to answer on a rating scale from 1 to 10. For the purpose of this article we used only the data collected in Belgium and made a distinction between the respondents from Flanders and those from Wallonia.

#### Physician survey (research question 2–5)

To answer the second to the fifth research questions, we used data collected through a large-scale physician survey in Belgium. In March 2009, a mail questionnaire was sent to a sample of 3006 registered medical practitioners working in Belgium, who had graduated in their specialty at least 12 months before the sample was drawn and who, on the basis of their specialty, were likely to be involved in the care of dying patients. As such, a representative sample was drawn from all general practitioners, anaesthesiologists, gynaecologists, internists, neurologists, pulmonologists, gastroenterologists, psychiatrists and neuropsychiatrists, cardiologists, radiotherapists, and surgeons. The sample was proportionally stratified for province and specialty. The sampled physicians received a questionnaire with a unique serial number and were instructed in a covering letter to send it when complete to an independent lawyer, in order to guarantee complete anonymity while allowing for the sending of up to three reminders. The anonymity procedure and study protocol were approved by the Ethical Review Board of the University Hospital of the Vrije Universiteit Brussel. More information about the design, mailing procedure and the non-response survey conducted can be found elsewhere (Smets et al., 2011).

A pre-structured, eight-page questionnaire was developed in Flemish and a forward and backward translation into French was made for use in the French-speaking part of Belgium. The questionnaire was tested with 10 physicians who were experts in palliative care, using cognitive testing. The physicians suggested improved and unambiguous question wording, layout, and routing. Euthanasia was defined in the questionnaire, according to the Belgian legal definition, as 'intentionally ending the patient's life at

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