# When Conscience Wavers. Some Reflections on the Normalization of Euthanasia in Belgium

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*One day when I no doubt needed to have some kind of feedback, I asked a sick person I was accompanying: "What do you expect of me?" He looked at me, then replied: "I expect you to stand firm." The roles were reversed down to the very words that were spoken.*

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## 3.1 The Embarrassment of the Law

The euthanasia law has been established in Belgium since 2002. The law states that a physician does not commit a crime in intentionally ending the patients' life when he meets a number of strict conditions. In certain circles, the euthanasia law is still hailed as a major success story, making Belgium an ethical beacon for the whole world. It is often said that euthanasia has been "accepted" by most of the population and that the so-called opposition, which may have existed initially, has melted away. Euthanasia stands as a figure for the "good death" (eu-thanatos), which more and more people choose every year. In the period 2016–2017, for example, 4337 euthanasia cases were officially registered, 2028 in 2016 and 2309 in 2017 [1]. Officially, about 1 Belgian in

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50 has currently his or her life ended through euthanasia.[1] It is therefore appropriate to speak of a certain normalization of euthanasia as an integral part of the end-of-life care in Belgium. Apparently, the legislative initiative has achieved its goal.

Yet there are also dissonant voices. For example, there is great concern among psychiatrists about euthanasia in cases of mere psychological suffering. Here according to many experts, in recent years there have been avoidable deaths, patients who were obviously not terminally ill and who could have been treated [2–4]. Sometimes these are young women with complex psychiatric problems and a strong persistent wish to die, who are in a socially precarious situation and clash with the limits of inadequately developed care. Their death often causes a shock to the family and the immediate social environment. In one case, this recently led to a criminal prosecution that came before the courts of assize (the criminal court in the Belgian juridical system that treats the most severe crimes), a case which affected society as a whole and enjoyed massive press interest. The doctors involved were in the end acquitted, but the trial revealed severe concerns about the way euthanasia was in this case offered and executed. In fact, during the trial, it became clear that the law on euthanasia was not respected on several fundamental points and that the control commission played an active role in the initial attempts to silence the concerns and questions of the bereaved family. Despite all these worrisome elements, the doctors went free, after a debate behind closed doors of 8 h by the lay jury. Apparently, in the end, the idea that the autonomous wish of the patient was respected and that the physicians had only good intentions overruled the fact that the euthanasia law was interpreted by them in a very lenient way.

Since the trial, a significant group of doctors have argued for a thorough evaluation of the law.[2] Within psychiatric care there has been concern for some time: several stories of problematic euthanasia cases are known, even though some doctors simply deny this. How to deal with that? Even if all these cases would appear to be legally justified, is a law that creates traumas among relatives and causes such discussions in society not intrinsically problematic? And what about the legal certainty of the doctors involved? The law is formulated in such a way that any violation results in a murder charge. Was that the intention of the legislator? Observers note that the acquittal of the doctors sends this signal: do not turn a doctor who tries to help into a murderer. Even though he or she may fail to offer euthanasia on some points in an optimal way, there can be never be spoken of murder in case of

[1] It remains remarkable that in the French speaking part of Belgium there are significantly less euthanasia cases officially declared than in the Dutch speaking Flanders: for 2016 436 cases vs. 1592, in 2017 517 vs. 1792 (roughly 40% of the population in Belgium is French speaking). Moreover, a previous study mentions that the actual number of euthanasia cases in Belgium might be considerably higher than the cases reported to the official Belgian control commission for euthanasia. Despite the fact that the law requires an official report to be submitted to this commission, the study notices that in a sample period of 6 months in 2007 “approximately half (549/1040 (52.8%, 95% CI 43.9% to 60.5%)) of all estimated cases of euthanasia were reported to the Federal Control and Evaluation Committee”. Cf.Smets T, Bilsen J, Cohen J, Rurup ML, Mortier F, Deliens L. Reporting of euthanasia in medical practice in Flanders, Belgium: Cross sectional analysis of reported and unreported cases. *BMJ.* 2010;341(7777):819. https://doi.org/10.1136/bmj.c5174.

[2] According to a poll of the *Artsenkrant/Le journal du Medecin* 70% of the physicians in Flanders and 61.5% in French speaking Belgium insist on an evaluation of the law (*Knack*, 31 January 2020).

euthanasia, because the doctors acted with good intentions or, as one says, "in good faith." This was the official line of argument of the lawyers defending the physicians at the trial on the euthanasia of Tine Nys.

However, as more critical voices remark, these observations raise the thought that the current law looks like a rag of paper, with a purely symbolic function: it cannot really be violated, since it is based on trust in the doctor who commits euthanasia and the belief that nobody asks for euthanasia in a lighthearted way or haphazardly. As long as the doctor follows the correct procedures and faithfully reports every euthanasia case to the monitoring committee, he is fine.

What is the function of the law? Apparently, the law recalls the need for careful handling of something as extremely important and complex as euthanasia, but at the same time, it wants to give doctors legal certainty. In the aftermath of the trial mentioned, the chairman of the audit committee that was created by the law in 2002 unequivocally says that the role of the committee is to act as a buffer between physicians and public prosecutor. This implies that the only possible violations of the law are limited to procedural negligence and carelessness that can be detected by a purely administrative control committee. What action must be taken on infringements, and what exactly those violations could consist of, remains unclear. This may explain why few physicians or law experts are currently willing to sit on this committee. One doctor already resigned in 2018 because it was clear to him after two sessions that manifest violations of the euthanasia law are being ignored by the committee and swept under the carpet. A letter from this doctor to the parliament, to whom the audit committee is accountable, simply remained unanswered.

In what follows I do not want to delve deeper into the controversies and discussions that continue to take place around the euthanasia law in Belgium, nor do I want to comment on problematic cases that keep popping up. Rather, from a philosophical point of view, I want to try to understand why euthanasia, as a symbol of a "good death," but also as a lived reality at the end-of-life, inevitably continues to have something unruly and confronts us with fundamental medical and moral questions and problems, next to personal tragedies and trauma's among families of patients that receive euthanasia. These experiences within the realm of end-of-life care lead to ongoing discussions at the level of civil society, whereby critical voices, asking for a serious and independent evaluation of the euthanasia social experiment, are countered by pro-euthanasia lobbyists who plea for a further extension of the law to people with dementia and a better access for patients with psychiatric afflictions and disorders. These last pleas are fostered by the normalization of euthanasia. However, critics see this as a proof of the slippery slope dynamics that inevitably emerges wherever euthanasia is legally permitted.

Why is the normalization of euthanasia welcomed by some and rather feared by others? Moreover, why should according to the pro-euthanasia experts euthanasia become an integrated part of normal therapeutic practice in the clinic, while others are vehemently opposed to this idea and plea for a more cautious attitude towards the further normalization of the active ending of human life in end-of-life-care? Finally, there is the tricky issue that the *mere possibility* of euthanasia would exert pressure on both the physician and the patient, but also on the whole society as such. Does that pressure indeed exist or does the law, based on self-determination, allows everyone the freedom to choose for euthanasia or not, free from any social pressure?

## 3.2 Euthanasia: Medical Act or Transgression?

The Belgian law describes the act of euthanasia clearly and elegantly. Euthanasia is, we read, "the intentional termination of life by a person other than the person concerned, at his request ..." It is important that this act is performed by a doctor and that specific restrictive conditions are met. In fact, the euthanasia law decriminalizes an act that is subject to a radical prohibition in every legal order: the intentional killing of another, the most severe crime a human being can commit. The law therefore clearly states that the doctor does not commit a crime *if* he complies strictly with the conditions of the law. Moreover, an important clause in the law states that no treating physician can be obliged to "apply euthanasia," although he must explain any refusal and pass on the medical file to a doctor designated by the patient or the confidant (Law on Euthanasia, Chapter VI, Article 14). Apparently, the Belgian law thus respects explicitly the freedom of conscience of the physician, a crucial principle of classical medical deontology.

It is clear the original concept of euthanasia has been considerably curtailed by the legislative initiative: in its original meaning, euthanasia refers to a "good death," and was classically understood to mean the most optimal way in which a person can say goodbye to life, implying among other things a death free from unbearable suffering and pain. In the nineteenth and twentieth centuries this concept evolved: by euthanasia one increasingly understood a medically induced death, initially from the idea that some "unworthy" forms of life may be terminated by a physician based on his medical judgment and skills.[3] In fact, euthanasia in this sense could be offered for a wider range of cases than just unbearable suffering and pain, as the Nazi program Aktion T4 testifies in a gruesome manner, where euthanasia was welcomed as the "good death" for some 200,000 persons with a handicap or a psychiatric affliction [5]. This has also led to the bad connotation that the concept of euthanasia still has in some countries, especially in Germany.

It must be emphasized: crucial in Belgian legislation (such as in the Netherlands and Luxembourg) is the clause that the life-ending act is performed by a doctor *at the explicit request of the patient*. That euthanasia must be the result of an autonomous expression of will, untainted by pressure or occasional emotional distress, is regarded as the moral core of the euthanasia law: thus, the ultimate right to self-determination, and therefore to a dignified, self-chosen death, is honored. Nevertheless, after 18 years and a few thousand euthanasia cases, the alleged transparency of the law seems in practice hardly realized. How come?

There are two ways of looking at euthanasia as it is practiced today in Belgium and the Netherlands (and recently also in Canada, where euthanasia is rather called Medical Assistance in Dying (MAID)): on the one hand, it can be seen as a strictly medical act, contextualized by a procedural framework, which has become integrated into the normal therapeutic realm of end-of-life care and is thus "normalized." In contrast, euthanasia can be understood as an act that presupposes certain

[3] For more on the history of euthanasia cf. the excellent study by Ian Dowbiggin, *A Concise History of Euthanasia. Life, Death, God, and Medecine*, Rowman and Littlefield Publishers, 2007.

medical expertise and takes place in the context of the clinic or medical care *but falls radically outside the normal therapeutic practice*. I think there are good reasons for understanding euthanasia in the second sense. Let me clarify this.

Euthanasia always emerges as an action figure when the curative, healing objective of medicine falls short of a limit. It concerns a weighty, always existentially charged act, in principle performed when a patient is incurably ill and death is imminent, in which a dying process is concluded by a direct intervention. The closer the act is to the moment of a foreseeable death, the more it still seems to fall within the therapeutic space of normal end-of-life care. However, in Belgium euthanasia is also legally possible for nonterminal patients. Euthanasia is then offered to answer the suffering caused by an incurable and untreatable illness or affliction, which is experienced by the patient as a source of unbearable suffering, even at a moment in time where death is not at all imminent or even to be expected. This is especially the case with euthanasia demands for merely psychiatric diseases. Here, the physician leaves the normal therapeutic realm and takes a decision to stop all care and perform a life-ending act based on motives and considerations that are never purely medical. Obviously, if euthanasia is not granted, the patient has all chance to continue his life, while a persistent death wish or suicide threat might still exist. As most psychiatrists admit, at this point the social and existential dimension of euthanasia demands must be highlighted: psychiatric patients that ask for euthanasia do so often under the influence of a detrimental social situation and existential isolation. Significantly, the law in Belgium insists that a physician who considers to positively follow a euthanasia demand should try to consult family members and friends, but only on the condition that the patient gives his or her permission to do so. The law here reveals a possible tension between the *colloque singulier* of doctor and patient and the inevitable social dimension of dying.

## 3.3 Euthanasia as Transgression

Given all these facets I would call euthanasia *a special, transgressive act*, which one cannot reduce to a purely therapeutic option, possibly replaceable by another, technically speaking equivalent medical act. The word *transgression* can make the eyebrows frown. But in several respects, medicine is a practice that involves transgressions. I would like to make a distinction here between transgressions that fall within the normal therapeutic-clinical practice, and transgressions with an existential and therefore deeply moral meaning.

In a way, transgressions belong to the essence of medicine and are a daily practice within the clinic or clinical care: the cutting of the surgeon, but also the physical examination and screening of the body with complicated equipment is inevitably part of good medical practice. This means that the doctor in the clinic or at the bedside comes in specific contact with the most intimate of the human person: his or her body. It is no coincidence that implicitly felt, or sometimes more explicitly formulated rules apply here, which frame the transgressive nature of medical practice and ensure that patients are treated respectfully. Unmistakably, this also means that the

doctor who abuses his transgressive power is expected to perform a morally reprehensible act.

Medically justified transgressions in the clinic and at the sickbed are inextricably intertwined with transgressions with an existential-moral meaning. Here too one can speak of morally acceptable transgressions, which are situated on the borderline of strictly therapeutic and more person-related attitudes and relations between physician and patient. For example, a physician can in the course of a long-term treatment share in a certain way the privacy and intimate personal history of the patient. Empathy is in medicine very important, and always presupposes a person-to-person relationship of a certain sort between physician and patient. In psychiatry, this is the case par excellence, but not only there: in other forms of prolonged medical care the relation between physician and patient has inevitably this more personal dimension. This affects in a fundamental way the medical, moral, and existential impact of euthanasia.

This should not surprise us. Euthanasia concerns one of the two liminal moments by which every human life is structured and affected: birth and death. It is no coincidence that in every culture these moments, of crossing the border between existence and nonexistence as a corporal human being, beget a sacred meaning. Even in our liberal and highly secularized culture, we remain sensitive to this sacred character of life and death. It is no coincidence that the atheistic liberal political philosopher Ronald Dworkin [6] says that when it comes to abortion and euthanasia, the "sanctity of life" is at stake. He calls the moral questions about abortion and euthanasia inevitably *religiously* charged.[4] From this perspective, in all cultures, we find strict rules and taboos that regulate our behavior and attitudes towards birth and death. In fact, the purpose of these rules and taboos is double: on the one hand, they serve to protect the community from transgressions that threaten the sacredness of life and death, on the other hand, they structure and symbolize the way members of a specific community are supposed to behave towards newborn or dying human beings.

From the perspective of the physician, euthanasia should thus be considered a transgression in several respects. Giving a lethal injection to a patient, which results in his or her immediate death, implies an inversion of the attitude a doctor has towards his or her patient in normal therapeutic treatment. Here, the iatrogenic power of the physician reveals itself in a dramatic way.[5] Indeed, the "technical" act of a lethal injection is in the case of euthanasia inevitably loaded with a strong symbolic-existential meaning. This implies that ending a life by euthanasia never

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[4] "We stand on the edge of a new age of religion, though a very different one from the long religious era that history began to leave behind in the eighteenth century." I think Dworkin's conception of an atheistic religious spirit, which sacralizes individual freedom and self-determination is deeply problematic, but it remains significant that he stresses the need to address issues of life and death from a religiously inspired perspective. Cf. also: Dworkin, *Religion without God*, Harvard University Press, 2013.

[5] About the possibility of iatrogenic harm caused by physician, cf. Cavanaugh T. A., *Hippocrates' Oath and Asclepius' Snake. The Birth of the Medical Profession,* Oxford University Press, 2018, pp. 18–22, 108–116.

can become a normal medical act: if something goes "wrong" at the offering of a lethal injection, it is almost impossible to conceive of this as a merely medical-technical issue. Complaints of bereaved families after a botched euthanasia on one of their beloved ones, as in the Tine Nys case, bear testimony to this. Remarkably, some Belgian doctors seem to take their own "technical" mistakes rather lightly and openly avow to consider the offering of a lethal injection a merely neutral medical act.

In fact, when intentionally causing the death of a patient the physician steps outside the normal therapeutic space and his role of healer, who is focused on preserving life and the bodily integrity of his or her patient. When offering euthanasia, the doctor enters the personal existential realm of the patient: he fulfills a deeply expressed wish, without doubt in most cases in good conscience, but also a wish that comes out of tragic and apparently irresolvable dilemma: the patient wants his or her suffering to end and sees no other solution than death. The doctor is therefore addressed also *himself as a person and not merely as a physician.* He must fulfill a most intimate wish of the patient, which is always emotionally charged and expects from the physician to step outside his therapeutic role. The physician is here addressed *as a human being, in his or her own moral integrity*. Obviously, the patient and his or her family expect and hope that the doctor is acting in good conscience when he offers euthanasia and is not merely an executive technician. If this latter is the case, it might make one wonder whether the physician is not causing a deep moral harm, that is hard to discern, let alone to sanction, but that in a way contaminates his whole profession. "It's no small deal, ending a life," a doctor once told me, "It crawls under your skin, it lingers even when it goes well and in a serene way."

Offering or performing a euthanasia act is therefore in the end a deeply morally charged *existential transgression*. It affects the physician inevitably as a human being and gives him or her a power which is from a juridical point of view immense. As the Belgian law on euthanasia indicates, the doctor commits a crime if the prerequisites foreseen by the law are not respected: if so, euthanasia comes down to killing another human being, the gravest sort of transgression that one can commit. No matter how you turn it, the depenalization of euthanasia allows a doctor to break a commandment on which in principle the entire legal order is built. Of course, the aim of the act is in principle humane and shows a deep concern for a crucial goal of medicine as such: the relief of distress and pain. The well-acting doctor is moved here by compassion, he might even see it as his duty to offer euthanasia to a specific patient. However, this does not detract from the charged, weighty nature of the act: euthanasia implies the radical inversion of normal medical therapy.

Because of this transgressive nature, I believe that euthanasia can never be conceived of as a purely procedural act, which follows the logic of supply and demand. Yet, paradoxically, due to its depenalization in the law of 2002 there is a temptation to see euthanasia in this way. In discussions in the civil society in Belgium that view often resonates: "I do what I want with my life, if I ask to die autonomously, no one has business with it, only the doctor I ask. And doctors only have to agree 'yes' or 'no', nobody should further interfere with my demand." This viewpoint implicitly

presupposes a very instrumental relationship between doctor and patient: the offering of euthanasia is seen as a service of a merely contractual nature. But is the reality not more complex? Often doctors in Belgium will confirm this, but it must also be observed that many among them seem to experience a sort of habituation towards the very act of euthanasia. They just follow the public opinion that euthanasia is in fact a sort of right that should be granted by the medical world. But does this normalization not come at a huge price? A doctor who provides euthanasia a dozen times a year or more often, can he still be sensitive to the transgressive nature of euthanasia? One could say: we, as a society have no business with that, we should not be concerned about how a doctor feels about his involvement in the active ending of a human life, nor should we try to estimate the state of his conscience. But is a society conceivable where we become indifferent to the rules and principles that regulate one of the most transgressive acts a citizen can commit? The freedom of conscience of every citizen is of course personal and inalienable, but the rules by which conscience is oriented are collective and should be open to discussion and evaluation.

Pro-euthanasia physicians eagerly defend that in the Belgian medical world euthanasia is always granted and performed with the utmost care and respect for the patient. Moreover, physicians that offer euthanasia always do so in good conscience, so it is said. When one consults physicians and medical experts in Belgium and ask for their experiences with euthanasia in the clinic, they appear to be confident that there is no risk of what Albert Bandura calls "moral disengagement." [7] But at the same time doctors who are willing in principle to offer euthanasia acknowledge that they sometimes struggle with the role they have to fulfill in actively ending a human life. Some awareness of the transgressive nature of euthanasia remains present. Personal differences in attitude and capacity, but also in moral conviction, stand out here: "I can offer euthanasia to conscious patients who are suffering somatically and who are at the end, but do not ask me to euthanize a demented person." Or: "euthanasia on psychiatric patients, one cannot ask this from me. I am unable to do that." "I can only euthanize a patient that I have followed for a long time, and with whom I feel personally connected." We discern the same sensitivity among doctors when they express in specific cases their conscious objection or remain in principle very reluctant or unwilling to commit euthanasia. These attitudes of reluctance and principled opposition should be respected because they exemplify the awareness of the transgressive nature of euthanasia.

## 3.4 Between Law and Conscience: Euthanasia and Moral Integrity

I return to the three questions with which I began this reflection.

1. How should we understand the divergent responses to the so-called normalization of euthanasia? To some in Belgium, it goes without saying that a "right to euthanasia" exists, and could even be derived from human rights, or the right to

self-determination. The disappearance of the taboo around euthanasia is from this perspective a good thing because it seems to make the dying process manageable and death less-threatening. Moreover, it derives from the most intimate wishes of the individual patient and respects his or her right to self-determination by lifting the irrational and paternalistic taboo on death.

However, as I have argued, euthanasia can in my view never be regarded as a purely instrumental transaction in which only the autonomy of the patient and the willingness of the doctor (possibly supported by compassion) are at stake. Euthanasia always has an existential, moral, and even spiritual meaning, from which it is impossible to make abstraction and which affects the collective mind of a whole society and the end-of-life care in general. The fear of normalization among some is a fear that this weighty dimension of euthanasia and its public meaning will no longer be seen. Our collective morality, where self-determination is so central, threatens to expand euthanasia even further beyond the clinic's boundaries: euthanasia becomes a sort of emblem of clean, self-desired death, even for people who are not terminally ill. Remarkably, the law, which in fact should remind us of the great impact of euthanasia, seems to have an eroding effect here. Our moral culture is being thoroughly changed, but there is also much confusion and uncertainty: the transparency the law was promised to offer, remains a far dream.

2. As a transgressive act, so I would defend, euthanasia inevitably falls outside the realm of normal therapeutic action. Yet there is still a debate between those who think that there is a right to euthanasia, and those who dispute this. Until now, the Belgian law recognizes and protects the doctor's freedom of conscience not to commit euthanasia. Claiming that euthanasia should and can therefore become a "normal" therapy ignores this. If euthanasia is just an extension of good medical practice, there would be no reason not to recognize it as a patient right. But that would also mean that a doctor may not refuse euthanasia if in his or her eyes it appears to be the "best option" from a medical point of view.

   But if euthanasia is *a right the patient can claim*, why should it not become an integral part of the medical training? I received the testimony from a young physician whose mentor thought it would be good she would by way of training get involved in a euthanasia case. Happily, this young physician was able to refuse to do so but her attitude becomes less and less accepted by some pro-euthanasia voices. In Canada, bioethicist Udo Schüklenk contends that in a democratic state the doctors' conscience clause must be restricted. "Conscientious objection" should never compromise the patient's rights to have access to certain medical treatments [8]. If euthanasia or MAID is thus considered as a normal medical therapy to which the patient has a right, this would cause an ethical landslide: the freedom of conscience of the physician would be restricted and controlled by the state. Fundamental transgressive acts such as euthanasia and abortion would thus become a public good, available for all. Doctors would turn into a sort of public medical servants.

3. Given the fact that euthanasia is a transgression that affects personal conscience as well as the collective mind of a society, it becomes understandable why it puts,

if legalized, such a pressure on individual doctors, their patients, and the whole medical profession. The proponents of euthanasia in Belgium usually ignore this by stressing that no one is "forced" by the law to ask for euthanasia, one just has the option to do so. The euthanasia law is therefore praised for being very liberal: it leaves maximum space for personal choice, so one contends.

Yet, reality is more complex. Doctors testify they experience conflicts of conscience that lead to disagreement, for example, in a group practice. Sometimes patients seem to be under pressure from the family to ask for euthanasia, however subtle. Or they put pressure on the doctors themselves, often in a state of depression and emotional instability and despair. This proves once again that dying inevitably has a social dimension, but also, and more fundamentally, that it puts a heavy burden on a physician's conscience. He or she is pulled from the strictly therapeutic sphere in the direction of a heavily existentially charged decision and act. Just because the claim to his or her conscience is so great, there is a tendency to hide, as it were, behind the purely procedural requirements of the law. This further promotes the normalization of euthanasia, whereby the active ending of a human life is increasingly considered a purely technical therapeutic intervention.

The normalization of euthanasia is further nourished by the media and influenced by public opinion through lectures, leaflets, moving stories, etc. The message of these public stories is always the same: thanks to the euthanasia law dying has become human, bearable, and serene, and unworthy and inhuman suffering can be avoided. Euthanasia is a gift to the patient and helps the medical profession to deal with the end-of-life in a dignified manner. Euthanasia is presented as a completely neutral act that is independent of any ideology and just meets the patient's right to self-determination. At the same time, any criticism of the way in which euthanasia is applied in practice, or the identification of potential problems or abuses of the law, are rejected or minimized with great persistence. Critics of the euthanasia practice in Belgium are presented as conservative, ideologically biased by religion, and lacking empathy and humanity: their attitude is said to exemplify an obsolete and condescending paternalism.

Such a response shows that the euthanasia law and practice itself is not value-free and is based on an ideology of self-determination and radical autonomy. Moreover, it does not square with the facts: there are also in Belgium staunch non-religious and atheist physicians who share the worries and critique of many colleagues concerning the current euthanasia practice, on legal, medical, and deontological grounds.[6] However, in the mainstream media and increasingly also in the medical world, the normalization of euthanasia goes hand in hand with its sacralization as a symbol of emancipation: euthanasia has become a new way of dealing with human finitude and the mystery of suffering and death. The sacralization of euthanasia in the name of self-determination thus simultaneously makes

[6] There are good arguments to be given against the legalization of euthanasia or assisted suicide from an atheist and liberal point of view. Cf. for this Yuill Kevin, *Assisted Suicide. The Liberal, Humanist Case Against Legalization,* Palgrave MacMillan, 2013.

every reference to the more ancient Hippocratic tradition into a taboo: it can no longer be said or remembered that euthanasia, all things considered, will remain a transgression that is alien to the nature of medicine and the highly ethical calling of the medical profession. Even the doctor who tries to go along with standardization ("I do euthanasia occasionally, but please not too much") might inevitably at some point find himself in a state where he experiences a dilemma or the wavering of conscience. The farther the request for euthanasia—and if granted, the life-ending act—lies from the moment of natural death, the more likely there might arise a struggle of conscience, but also palavers and dissensus between all involved: patients, but also caretakers, physicians, family members. This fatal and never avoidable dynamic is most poignantly exposed in the case of euthanasia for psychiatric patients.

## 3.5 Conclusion

I conclude with three observations.

First of all, the depenalization of euthanasia puts pressure not only on the medical world but also on society at large. This inevitably might trigger a conflict of conscience for the physician and the entire medical team involved in end-of-life care. But the family and wider social environment might also be affected by this process of normalization and experience pressure to choose for euthanasia or to propose it as the most appropriate way to die.

Secondly, the attempt to make active life-ending actions more transparent and unambiguous through the euthanasia law, and to release the doctor from the pressure of legal sanctions, has led to a new kind of uncertainty, now at the level of the freedom of conscience of the physician. Where the Hippocratic oath used to be a benchmark and a guideline, the doctor now has to look for self-invented or very volatile benchmarks for his or her conscience.[7] It is no coincidence that recently in Belgium attempts are being made by groups of doctors—for example, the psychiatrists—to formulate additional rules to somewhat frame the transgressive act of euthanasia and guarantee morally responsible decisions in response to an euthanasia request [9]. At the same time, this creates the temptation, pressured by the culture of normalization, to reduce euthanasia to a procedural act, the result of a merely contractual agreement between doctor and patient. In this way, euthanasia is made morally speaking completely neutral. As a euthanasia prone doctor once declared to a colleague: "who am I not to respect the will of the patient? I am not God!"

Thirdly, I think that there are two ways in which the euthanasia law, and the practice it has created, strengthens problematic coping attitudes on the side of

[7] Arguments in favor of the sustenance of the classical Hippocratic tradition with regard to euthanasia or MAID are given in: Sprung Charles L., Somerville Margaret A., Radbruch Lukas, Steiner Collet Nathalie, Duttge Gunnar, Piva Jefferson, Antonelli Massimo, Sulmasy Daniel P., Lemmens Willem, Ely Wesley, "Physician-assisted suicide and euthanasia: emerging issues from a global perspective" in *Journal of palliative care*, 2018, pp. 197–203.

physicians who welcome the normalization of euthanasia and try to bring their own euthanasia practice in consonance with their conscience. While unconsciously recognizing the vexing and transgressive nature of euthanasia, they at the same time seem to silence possible conflicts of conscience in two ways. Either they hide completely behind the law and let the procedures, provided for by the law, take the place of conscience: "the papers are filled in correctly, everything is fine." Another attitude consists in pretending that one, as a physician, in fact, is motivated by *a pure goodwill*, not contaminated by doubts or afterthoughts: one coincides as it were with one's own conscience and cherishes the illusion that it is impossible to act wrongly. The latter attitude became apparent after the euthanasia trial in Ghent, where the accused psychiatrist, after her acquittal, stated in the press plainly: "Maybe I could have 'saved' Tine if she had come to me 10 years earlier." In other words, the advice pro-euthanasia, and therefore the death of her patient 10 years "too late," is implicitly acknowledged as being somehow a *contingent tragic event*. Unaware of the highly problematic character of her avowal, the psychiatrist openly testifies of her self-indulgence and alleged purity of conscience: she uses her acquittal to openly plea, on television and in newspapers, for an extension of the access to euthanasia for psychiatric patients.

Both the attitude of hiding behind the procedural form of the law and the attitude of self-glorification and alleged purity of conscience ignore in a fundamental way the transgressive nature of euthanasia. Moreover, both attitudes, I contend, derive from the depenalization of euthanasia and the practice inaugurated by this legal regulation. Therefore, it would be highly undesirable to reach as a society a point where doctors are no longer appealed in their conscience—and either reduce euthanasia to a purely procedural semi-therapeutic act or sacralize it as a highly moral intervention. If this point of normalization is ever reached, the freedom of conscience of the doctor evaporates. Perhaps this is the most important lesson to be learned in Belgium after almost 20 years of social experiment on euthanasia: as a transgressive act, euthanasia should always remain controversial and possibly embarrass the doctor's conscience and by extension the entire society. This embarrassment cannot and should not be eliminated by any law or procedural decision. But if this is right, it also cannot be expected that the normalization of euthanasia will ever succeed. The active ending of a human life, even on demand of the patient, will always fall outside the realm of normal medical practice and remain thus the object of possible controversies, clashes of conscience, and deeply felt traumatic experiences, that affect a whole society.

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