

Euthanasia for detainees in Belgium: the case of Frank Van Den Bleeken

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Abstract

In 2011, Frank Van Den Bleeken became the first detainee to request euthanasia under Belgium's Euthanasia Act of 2002. This article investigates whether it would be lawful and morally permissible for a doctor to accede to this request. Though Van Den Bleeken has not been held accountable for the crimes he committed, he has been detained in an ordinary prison, without appropriate psychiatric care, for more than 30 years. It is first established that VDB's euthanasia request plausibly meets the relevant conditions of the Euthanasia Act and that, consequently, a doctor could lawfully fulfill it. Next, it is argued that autonomy-based reasons *for* euthanizing VDB outweigh complicity-based reasons against doing so, and that, therefore, it is also morally permissible for a doctor to carry out the euthanasia request.

Key words: euthanasia, detainee, psychiatry, autonomy, complicity

The Case of Frank Van Den Bleeken

In the early 1980s, Belgian Frank Van Den Bleeken raped several women, one of whom he murdered. Psychiatrists declared he could not be held accountable for his crimes because they had been motivated by compulsive thoughts resulting from a psychiatric condition. Despite this proclamation, Van Den Bleeken (henceforth VDB) was detained in an ordinary prison, where he has remained for 30 years at the time of this writing.¹ It is extremely unlikely that he will ever be released. Psychiatrists agree that his condition is untreatable, and VDB himself reports that, if released, he would be unable to control his violent sexual impulses. Because he considers himself a threat to society, he has always refused to be considered for temporary leave or parole.

In a documentary televised in 2001, VDB publicly expressed for the first time his wish to receive euthanasia. One year later, in 2002, Belgium legalised euthanasia.² Euthanasia carried out by a doctor would, under certain conditions, no longer be a criminal offence.³ The conditions for lawful euthanasia most relevant to VDB's case can be summarised as follows: (i) the patient is legally competent at the moment the request is made, (ii) the request is voluntary, well-considered and repeated, (iii) the patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident, and (iv) the patient and doctor concur that there is no reasonable alternative to the patient's situation.

In 2011, VDB filed an official request for euthanasia citing as his reason "unbearable psychological suffering." For VDB, this decision was the combination of several factors: (i) feelings of being a prisoner of his deviant sexual fantasies, (ii) conditions in prison, which he perceived to be inhumane, and (iii) the thought that he would (and should) never be released. He reported that his life had become completely meaningless. It is important to recognise at the outset that Belgium has a deplorable reputation regarding the treatment of prisoners and detainees with intellectual disabilities or psychiatric disorders who are held in custody, as a preventative measure. The European Court of Human Rights has condemned Belgium several times for not providing adequate care for prisoners and detainees, even accusing it of falling short of its obligations under the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.⁴

As required by the Euthanasia Act, two psychiatrists were asked to advise on the case. They both deemed that VDB's request met the conditions set out in the Act. The euthanasia request was passed on to an independent doctor outside of the prison system. This doctor believed, however, that there might be a reasonable alternative available for VDB and suggested a transfer to 'De Pompestichting', a forensic psychiatric centre (FPC) in the Netherlands. This high security psychiatric centre is located on 5.5-acre area in the countryside and aims to provide detainees who have committed serious crimes, but who have not been held accountable, with an environment and opportunities that make a meaningful life possible.⁵ VDB was prepared to entertain this option, but, after months of waiting for a decision by the Minister of Justice, it eventuated that no administrative mechanism was in place to transfer a Belgian detainee to a Dutch FPC. In the meantime, two years had passed since VDB had issued his euthanasia request. His lawyer decided to take the case to court to press for a solution. However, while the case was under consideration, another independent doctor agreed to carry out VDB's wishes, whereupon the Minister of Justice gave permission for VDB to be sent from prison to hospital for 48 hours to say goodbye to his family, and to receive euthanasia.

However, recently, the case took an unexpected turn. Six days before VDB's planned euthanasia on 11 January 2015, the doctor withdrew his agreement to the procedure. Due to medical confidentiality, the

reason for this decision was not made public. On the same day, 5 January, the new Minister of Justice announced that a transfer to the FPC in the Netherlands would likely be possible after all. In the meantime, VDB would be transferred to a newly built FPC within Belgium. This FPC currently does not have a long-stay unit for patients who will never be released (so the transfer was initially intended as a temporary solution); however, the government has since announced plans to create a new long-stay unit there. It is not known publicly how VDB has reacted to these recent announcements. He had already written goodbye letters to his family and had prepared his funeral.⁶ After he was informed about the new decisions, he came under special surveillance to prevent him from committing suicide.⁷

Since the initial authorisation of the hospital transfer for VDB came to media attention, twelve detainees, three 'ordinary' prisoners, and one man accused but not yet tried for raping several boys have requested euthanasia.⁸

Aim and Plan

The aim of this paper is to use the case of VDB to explore whether it can be morally permissible for a doctor to fulfil the euthanasia request of a detainee with a psychiatric condition who has not been held accountable for his or her crimes. Although each case will be different, examining this particular case will help to identify the most important ethical issues that arise with such requests. In turn, their analysis will help us deal with other, similar situations.

I begin by briefly considering whether VDB's request meets the relevant conditions of the Belgian Euthanasia Act of 2002. I conclude that it does, and that a doctor could thus lawfully euthanize VDB. Given that would be lawful to do so, I then turn to the question whether it is morally permissible for a doctor to fulfil VDB's request. I argue that autonomy-based reasons *for* euthanizing VDB outweigh concerns regarding doctors' complicity in maintaining immoral detention practices and that it is therefore permissible for a doctor to fulfil his euthanasia request.⁹

Throughout the paper, I assume that euthanasia in Belgium is presumptively morally permissible when it meets the conditions specified in the Euthanasia Act. Thus, in examining the moral permissibility of carrying out euthanasia in VDB's case, I am examining whether there is anything special about this case that renders it morally impermissible, not appraising the moral permissibility of euthanasia in general.

Legal Permissibility

Let us turn, then, to the question whether VDB's request meets the conditions set out in the Belgian Euthanasia Act, specifically, that he is legally competent to request euthanasia, that his request is well-considered and repeated, and that his suffering is unbearable is fairly uncontroversial. What might be more controversial, however, is whether his request is voluntary, whether his suffering is the result of a serious disorder, and whether there is a reasonable alternative to euthanasia available. In the following subsections, I briefly consider whether VDB's request meets these three conditions of the Euthanasia Act.

No reasonable alternative?

According to the Euthanasia Act, it is the patient who determines what is a 'reasonable alternative' to euthanasia, after being informed by the doctor about the alternatives and their costs and benefits.¹⁰ VDB recognises that it is not possible for his suffering to be relieved through a medical treatment: psychiatrists agree that, given the current state of psychiatric care, his condition is untreatable. A

transfer to the FPC in the Netherlands would be a more credible alternative and could provide better living conditions. However, VDB deemed it unreasonable to wait for the regulations to change to make such a transfer possible. At the time this option was initially considered, he had already been waiting for a decision regarding his euthanasia request for more than three years. A further delay would be psychologically unbearable, he said. Thus, for VDB, there was no reasonable alternative to euthanasia, thus satisfying the relevant condition of the Euthanasia Act. The recent unexpected announcements regarding a transfer to the FPC in the Netherlands and the development of a long-stay unit in the FPC in Belgium do not necessarily change this situation. VDB retains the discretion to decide whether such a transfer provides a reasonable alternative to euthanasia. The Act does not require that he try all the proposed alternatives.¹¹

Is the suffering the result of an illness?

The Euthanasia Act stipulates that the patient's suffering (whether psychological or physical) must result from a serious and incurable disorder caused by illness or accident. An obvious ambiguity of this condition is that it is almost always possible to identify an illness that plays some role in motivating a euthanasia request.¹² Furthermore, it is often difficult to specify the causal relation between a certain condition, the patient's social circumstances, and the euthanasia request. Often social circumstances may contribute to one's physical or mental condition (for example, the degree to which a society promotes the use of sign language may determine to what extent deafness is a disability), and a person's condition may influence the circumstances (for example, psychopaths are more likely to be incarcerated than non-psychopaths). This suggests that the Act does not imply that the euthanasia request needs to result *entirely* from suffering caused by an illness or accident. VDB reported that his suffering is largely the result of being a prisoner of his deviant sexual fantasies, which he is unable to control. Psychiatrists who provided advice on the case accept his explanation as likely. This suggests that his euthanasia request results (at least to a significant extent) from an illness. We could, of course, learn more about the cause of VDB's request if he were transferred to the FPC in the Netherlands (or to the long-stay unit in Belgium, once it exists). If, after spending some time in a long-stay unit, he withdraws his request, it would indicate that a contributing factor was the dire nature of the circumstances in which he previously found himself. However, as mentioned earlier, VDB is not required to accept the transfer to such a unit for a doctor to be able to lawfully carry out his euthanasia request. If he does not accept the transfer, and the doctor thinks it is plausible that his request is largely motivated by his illness, the relevant condition of the Act is met.

Is the request voluntary?

It may be argued that VDB's euthanasia request does not meet the conditions of the Euthanasia Act as it is not entirely voluntary. The voluntariness requirement is an important condition of the Act.¹³ It is widely accepted that an involuntary choice is not autonomous. It is also widely accepted that euthanasia in competent patients can only be permissible if it is the patient's autonomous choice.¹⁴

The voluntariness condition is also perhaps the most difficult to interpret. In Belgium, there is no case law regarding the definition or interpretation of voluntariness in the context of euthanasia. Thus, we must turn to arguments of academic experts in law and moral philosophy for interpreting voluntariness in this context. Although a comprehensive analysis of the concept is beyond the scope of this paper, the following considerations may be sufficient to show that the voluntariness condition of the Act is satisfied.

In law, a voluntary decision is usually understood to mean a decision that an agent has reached without having been subjected to coercion, intimidation, deception, fraud or undue influence or inducement.¹⁵ There is no reason to believe that VDB's request was motivated by any of these factors. However, it could be proposed that his decision was in some sense coerced. Unfortunately, coercion is also a disputed concept. Some hold the view that a choice is coerced if the person's options are so restricted that he or she has no reasonable alternative. For example, when discussing the permissibility of offering neurointerventions such as chemical castration to sex offenders as an alternative to further incarceration, Martha Farah writes that "sentencing options are rarely appealing options, introducing implicit coercion."¹⁶ On her view it seems that a choice is coerced if the only alternatives are unappealing.

However, this explanation for when a choice is coerced is unconvincing. It would, for example, imply that a patient whose only alternative to imminent death is to undergo a high-risk operation is coerced to undergo the operation, but this is implausible.¹⁷

A more convincing view, I believe, holds that coercion requires the deliberate control of a person's circumstances or options for the purpose of inducing her to act as the coercer wants. This view is common to several of the most influential accounts of coercion, including those offered by Robert Nozick, Alan Wertheimer, David Zimmerman, Thomas Beauchamp and James Childress.¹⁸

Consider, for example, Zimmerman's Island case¹⁹

A kidnaps Q, brings him to the island where A's factory is located and abandons him on the beach. All the jobs in A's factory are considerably worse than those available to Q on the mainland. The next day A approaches Q with the proposal "Take one of the jobs in my factory and I won't let you starve."

Zimmerman suggests that A's offer should be regarded as coercive. By contrast, when a surgeon offers to perform a high-risk operation in order to save a patient from imminent death, the offer is not, according to Zimmerman, coercive. Zimmerman's explanation for why the kidnapper's offer is coercive but the doctor's is not is that the kidnapper undermines, or limits, Q's freedoms for the purpose of getting him to act in a way that A wants. This explanation seems feasible. It also has the advantage that it offers an explanation for why coercion threatens autonomy: the coerced individual relinquishes some control over her behaviour to the coercer.²⁰

Is it credible that VDB's freedoms and circumstances are being purposefully controlled so as to bring it about that he requests euthanasia? I do not think so. We have no reason to believe that the Belgian state, or anyone else responsible for VDB's conditions of detainment, *wanted* him to request euthanasia. Recall that VDB had been in prison since the early eighties and that euthanasia was decriminalised only in 2002. A more likely explanation for why VDB was detained in problematic circumstances can probably be found in the general shortcomings in mental health care and care for detainees in Belgium.

Thus, if coercion requires purposefully controlling someone's situation to obtain what one wants, it seems that we have no reason to believe that VDB's request was coerced. Moreover, there seems no other reason to suppose that his request is not voluntary. For example, his mental competence is not in question. We may thus tentatively conclude that his choice is as voluntary as a patient's request for a risky operation to avert imminent death. In both cases, a choice is made in order to avoid an unappealing outcome, but this does not make the request involuntary.

Thus, from a legal perspective it would appear that a doctor could lawfully fulfil VDB's request for

euthanasia. However, even if euthanizing VDB would be lawful, there may still be weighty *moral* reasons against doing so. I now turn to consider whether the moral reasons for fulfilling VDB's request defeat the moral reasons against doing so. If so, it is morally permissible for a doctor to fulfil the request.

Let us first look at what reasons there could be *for* a doctor to fulfil VDB's request.

Moral Permissibility

Respect for Autonomy

One possible argument for fulfilling VDB's request is that this would most fully respect his autonomy. This is one of the standard arguments in support of euthanasia in less controversial cases.²¹

We can respect others' autonomy by refraining from interfering with, or attempting to interfere with their autonomous choices and actions, for example by refraining from coercing them. But the requirement to respect autonomy may also have positive implications in the context of certain relationships. For example, in the context of a doctor-patient relationship, it may imply a positive reason to disclose information and foster autonomous decision making, or to assist in realising autonomous decisions of patients that are not in a position to do so themselves.²² However, reasons to positively respect autonomy may be weaker than reasons to negatively respect autonomy. Thus, for example, positive reasons to respect autonomy may be outweighed by costs to the person assisting while reasons to negatively respect autonomy may be decisive regardless of their costs.²³

Carrying out VDB's euthanasia request would not violate the requirement to negatively respect autonomy as it would not interfere with an autonomous decision of VDB. Moreover, refusing to carry out the euthanasia would violate the (weaker) requirement to positively respect his autonomy. Thus, it seems that there are no autonomy-based reasons against a doctor fulfilling VDB's request, and there is at least some reason *for* fulfilling it.

Maintaining unjustified circumstances

An objection may be raised that I am ignoring the most problematic aspect of VDB's case, the fact that he has unjustifiably been placed in bad circumstances. I mentioned earlier that Belgium has been convicted several times by the European Court for Human Rights for not providing adequate care for prisoners, and especially for detainees. At the time of this writing, there are around 1,000 mentally ill individuals in Belgium who have not been held accountable for their crimes but who are nevertheless being held in ordinary prisons where they do not receive appropriate treatment or care. Some measures have recently been taken to improve the situation. For example, the right to adequate healthcare for detainees will become enforceable under the 2014 Law for Internees, which is expected to come into effect in 2016, and two new FPCs were recently built, one in Ghent and one in Antwerp. However, it is widely agreed that much more needs to be done to improve healthcare for detainees.²⁴

Why might VDB's circumstances be relevant to the permissibility of fulfilling his request for euthanasia? After all, I have argued that a doctor who is prepared to fulfil the request not only negatively but also positively respects VDB's autonomy. The problem is that VDB's circumstances cast doubt on this argument from autonomy. Consider the following case:

A kayaker falls in the water and, after being carried along by the strong current, gets stuck

with his arm under a rock. After some time, a team of rescuers arrives. Unfortunately, it is impossible for the rescuers to lift the heavy rock and free the kayaker. The only way to rescue the kayaker is by amputating his arm. The kayaker begs the rescuers to amputate his arm. The rescuers fulfil his request, justifying their actions on the ground that they thereby respect the kayaker's autonomy.

The rescuers' justification is credible. The rescuers have nothing to do with the fact that the kayaker is stuck under the rock, and they provide the kayaker with the only feasible additional option—an option that is of value to the kayaker. There is no reason to think that providing this option unjustifiably harms the kayaker or anyone else.

The Kayaker is analogous in this respect to the patient whose only alternative to imminent death is a risky operation. Just like the rescuers in case of the *Kayaker*, a surgeon could justify performing the operation at the patient's request on the ground that this positively respects her autonomy. The doctor did not contribute to the patient's illness, and there is no reason to believe that offering or performing the operation will unjustifiably harm the patient, or anyone else.

Consider now a modified version of the *Kayaker* story. Suppose the rescuers negligently left something in the water that trapped the kayaker. They could easily move the obstacle but refuse because doing so would cause mild back pain. The kayaker thus begs the rescuers to amputate his arm. The rescuers fulfil this request, justifying their actions on the ground that they thereby positively respect the kayaker's autonomy.

It seems that in this modified scenario, the rescuers' justification for fulfilling the request is more problematic. This has to do with the fact that the kayaker's restrictive circumstances (being stuck under the obstacle) are unjustifiably maintained by the rescuers (mild back pain is not a sufficient reason to refuse to move the obstacle). If the rescuers unjustifiably restrict the kayaker's autonomy by refusing to move the obstacle, they can hardly appeal to a concern for autonomy to justify performing the amputation. To do so would be to inconsistently apply an ethical principle.²⁵ If the rescuers really care about autonomy, they should move the rock, even at the cost of mild back pain.

Similar reasoning could apply to VDB's case. His autonomy is unjustifiably restricted by the state. He should not be in an ordinary prison where he does not, and arguably cannot, receive appropriate care. If the state justifies offering euthanasia to VDB on the ground that this respects his autonomy, we have little reason to accord any weight to this justification, as the state is willing to disregard this value when it comes to VDB's detainment. However, strictly speaking it is not the state who will euthanize VDB if he maintains his euthanasia request; it will be a doctor. Thus, one could argue that though it would be problematic for the state to justify offering euthanasia to VDB by arguing that this best respects his autonomy, this problem does not arise when it is the doctors who are carrying out the euthanasia. Unlike the state, individual doctors do not have the power or responsibility to reform the relevant institutions.

However, one could point out here, that though individual doctors do not have the power or responsibility to directly reform institutions, they can still *influence* their reform reform by others, in this case, the Belgian state. This raises important questions regarding complicity in the wrongdoing of others.

Complicity in immoral practices

Complicity is a disputed concept, but it is generally taken to capture the idea that one may do

wrong by being associated, in a certain way, with the wrongdoing of others. What sort of association is required for complicity is controversial. However, most agree that if one contributes to others' wrongdoing, for example by enabling or encouraging it, one may become complicit in that wrongdoing.²⁶ According to some, contribution to others' wrongdoing is not required for complicity.²⁷ However, the possibility of complicity without contribution is contested and a subject that will not be pursued in this paper.

One possible objection to fulfilling VDB's request is that the Belgian state could welcome this as an easy solution for ongoing problems regarding the treatment of detainees. Fulfilling the request would thus reduce the state's incentive to improve the current situation. In this way, the doctor might help maintain, and thus perhaps become wrongfully complicit in, immoral detention practices.²⁸

Note, however, that complicity is not always wrong, all things considered. If your action makes you complicit in others' wrongdoing, this gives you a moral reason not to undertake that action. However, this reason could be defeated by countervailing considerations. One factor that will influence where the balance of reasons lies is your *degree* of complicity.

It is thus necessary to consider what degree of complicity would be entailed by fulfilling VDB's request. Chiara Lepora and Robert Goodin have developed a useful moral framework for determining an agent's degree of complicity.²⁹ On their account, we must look at several factors: the graveness of the principal wrongdoing in which the agent will become complicit, the extent to which the agent is responsible for her contribution to the wrongdoing, and the centrality of this contribution to the occurrence of the principal wrongdoing. Whether the agent shares the intentions of the principal wrongdoer may also affect the degree of complicity, though as Lepora and Goodin note, one may be heavily complicit in others' wrongdoing without sharing their intentions.

How grave is the wrongdoing in which a doctor may become complicit by fulfilling VDB's request? Detaining VDB in an ordinary prison without appropriate care violates a basic right to healthcare. Thus, most would agree that the wrongdoing is very serious.

To what extent would a doctor carrying out the euthanasia be responsible for her contribution to the wrongdoing, assuming for now that there is such a contribution? It is reasonable to assume that any Belgian doctor who agrees to fulfil VDB's request would do so freely, without significant external pressure.³⁰ The doctor would also likely be aware of the possible impact of her decision on detention practices. Arguably, then, she will be fully responsible for any contribution to maintaining these practices

It is more difficult to determine the centrality of the doctor's contribution to the wrongdoing, if there is such a contribution. It is not at all clear in advance what the expected contribution will be in VDB's case. Perhaps the state will indeed welcome euthanasia as an easy solution to problems with its detention practices, thus reducing its incentive to improve the situation. But the opposite effect could also occur. In fact, as VDB's case continues to unfold, it appears that the growing possibility that he will be euthanized is *increasing* the pressure on the state to improve conditions of detention. After a doctor initially agreed to fulfil VDB's euthanasia request, the case received much national and international attention, causing outrage and igniting a debate. Though we cannot be sure, this is likely to have contributed to the new Minister of Justice's efforts to look for an

alternative institution for VDB and to the government's decision to create a long-stay unit for individuals like VDB.

Thus, though complicity-based reasons are in general important, in this particular case they seem weak. The degree of complicity seems low, as there is no clear reason to believe that the doctor would contribute to the maintenance of immoral detention practices by acceding to VDB's euthanasia request, and indeed there is some reason to think the opposite might be true. Nevertheless, complicity-based concerns would need to be re-evaluated with each new euthanasia request from a detainee or ordinary prisoner.

It should also be noted that, even if euthanizing VDB would contribute to the maintenance of immoral detention practices, the doctor might be able to reduce this complicity by undertaking separate actions that help to improve those practices, for example, by seeking to influence policy decisions in other ways. From a moral point of view, this might be preferable to avoiding all complicity at the cost of the patient's autonomy. After all, one could argue that a doctor's chief responsibilities are to respect her patient's autonomy and act in her patient's best interests, not to influence government institutions. Indeed, if a doctor made her decision about whether to accede to VDB's request solely on the basis of the likely effects on government institutions, it might be argued that she would be using him as a mere means to effecting reform.

Conclusion

I began this article by arguing that VDB's request for euthanasia plausibly meets the relevant conditions of the Belgian Euthanasia Act. Of these conditions, the voluntariness condition is the one most likely to raise legal questions. Some might argue that VDB's request was coerced. However, I disputed this by arguing that the state did not purposefully control his circumstances in the hope he would request euthanasia.

I then turned to the question whether it is morally permissible for a doctor to fulfil VDB's euthanasia request, assuming that it is lawful. The main argument *for* fulfilling the request is that the doctor would thereby positively respect VDB's autonomy. It may be true that the state is unjustifiably restricting VDB's autonomy by detaining him in an ordinary prison without appropriate care. However, this does not threaten the autonomy-based argument, since it is a doctor, and not the state, who must accede to VDB's request.

Nevertheless, by agreeing to euthanize VDB, a doctor may become complicit in the maintenance of immoral detention practices in Belgium. However, I argued that the complicity-based argument against euthanasia is weak in this case. There is no clear reason to believe that by euthanizing VDB, a doctor would contribute to the maintenance of immoral detention practices, and indeed there is some reason to think the opposite might be true. Nevertheless, complicity-based concerns would need to be re-evaluated with each new euthanasia request from a detainee or prisoner.

A further concern that should be considered is the possibility that acceding to VDB's request would set Belgium on a slippery slope towards the routine euthanasia of 'ordinary'—some sort of 'a death sentence on demand'.³¹ As interesting as it would be to investigate this scenario, for now, that must remain a topic for a separate paper.

¹ Under the Belgian Law, mentally ill offenders can be *interned* as a safety measure, to protect society. Vandeveldel S, Soyez V, Vander Beken T, De Smet S, Boers A, Broekaert E. Mentally ill offenders in prison: The Belgian case. *International Journal of Law and Psychiatry* 2011;34(1):71-8.

² The Belgian Act on Euthanasia of May 28 2002. Available (in Dutch and French) at <http://www.ejustice.just.fgov.be> and (in English) at www.kuleuven.ac.be/cbmer (last accessed 20 January 2015).

³ In Section 2 of the Act, euthanasia is defined as intentionally terminating life by someone other than the person concerned, at the latter's request. The doctor who carries out the euthanasia need not be the attending physician, though Section 3 of the Act stipulates that the doctor must have a number of conversations with the patient, spread over a reasonable period of time, to guarantee the durability of the euthanasia request.

⁴ Amnesty International. Public Statement. Belgium falls short of its obligations on torture and ill treatment. Available at <http://www.amnesty.eu/en/news/press-releases/eu/torture/belgium-falls-short-of-its-obligations-on-torture-and-other-ill-treatment-0679/#.VEOSAr4kGS0> (last accessed 20 January 2015). The third ECHR periodic report on Belgium is available at

http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CAT%2FCO%2FBEL%2FCO%2F3&Lang=en (last accessed 20 January 2015).

⁵ For example, the residents can do meaningful work, including repairing bikes, caring for animals, and gardening, and have access to recreational facilities. Their rooms are more spacious than typical prison cells, and each resident has a (highly secured) balcony. More information (in Dutch) is available at <http://www.pompestichting.nl/site/Home/> (last accessed 20 January 2015).

⁶ Leestmans D. Kroniek van een aangekondigde euthanasia. *De Redactie.be* 15/01/2015; available at <http://deredactie.be/cm/vrtnieuws/binnenland/1.2209391> (last accessed 20 January 2015).

⁷ Elb. Frank Van den Bleeken onder verscherpt toezicht. *De Standaard* 8/01/2015; available at http://www.standaard.be/cnt/dmf20150107_01462867 (last accessed 20 January 2015).

⁸ De Redactie. Verkrachter vraagt rechter in Charleroi om euthanasie. *Het Laatste Nieuws* 22 October 2014. Available at <http://www.hln.be/hln/nl/33/Fit-Gezond/article/detail/2097011/2014/10/22/Verkrachter-vraagt-rechter-in-Charleroi-om-euthanasie.dhtml>.

⁹ A further concern is the possibility that acceding to VDB's euthanasia request would set Belgium on a slippery slope towards the routine euthanasia of 'ordinary' prisoners—some sort of 'death sentence on demand'. It would be interesting to investigate this scenario. However, because it is agreed that sufficient empirical evidence is needed to support a slippery slope claim (Douglas T. Intertemporal Disagreement and Empirical Slippery Slope Arguments. *Utilitas* 2010;22(02):184–97), and, at the moment we have little relevant data, I am not investigating this concern now.

¹⁰ See note 2, The Belgian Act on Euthanasia, Ch.2. This provision was included to prevent doctors from imposing their own views as to what counts as a reasonable alternative on the patient.

¹¹ Adams M, Nys H. Comparative reflections on the Belgian euthanasia act 2002. *Medical Law Review* 2003;11(3):353–76.

¹² See note 11, Adams, Nys 2003: 369.

¹³ See note 2, The Belgian Act on Euthanasia, Ch.2, S.3, §1.

¹⁴ See, for example, the first principle of the Nuremberg Code (1947); Convention of Human Rights and Biomedicine, articles 5 and 6; Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*, 5th ed. Oxford University Press; 2001, p. 183.

¹⁵ See, for example, the first principle of the Nuremberg Code (1947).

¹⁶ Farah MJ. Emerging ethical issues in neuroscience. *Nature Neuroscience* 2002;5:1123-9.

¹⁷ See, for example, note 14, Beauchamp, Childress 2001, p. 132-3, and Wertheimer A, Miller FG. Payment for research participation: a coercive offer? *Journal of Medical Ethics* 2008;34(5): 389–92.

¹⁸ Nozick R. Coercion. In Morgenbesser S, Suppes P, White M (eds.). *Philosophy, Science, and Method: Essays in Honor of Ernest Nagel*, New York: St. Martin's Press, 1969:440– 72; Wertheimer A. *Coercion*. Princeton: Princeton University Press, 1989; Zimmerman D. Coercive Wage Offers. *Philosophy & Public Affairs* 1981;10(2):121–45; see note 14, Beauchamp, Childress 2001.

¹⁹ See note 18, Zimmerman, 1981, 133.

²⁰ Taylor JS. Autonomy, duress, and coercion. *Social Philosophy and Policy* 2003;20(2):127–55.

²¹ Another argument in support of euthanasia refers to the interest of the patient. If the patient's quality of life is negative then on a 'whole life' approach to best interests, euthanasia is in the patient's best interests because it increases lifetime wellbeing.

²² Childress JF. The Place of Autonomy in Bioethics. *Hastings Center Report* 1990;20(1):12–17.

²³ This is also reflected in the law. Section 14 of the Euthanasia Act stipulates that a physician is not legally required to fulfil a patient's euthanasia request when it meets the conditions of the Act. She may refuse to do so on grounds of conscious or medical reasons. Thus, in Belgium there is no such thing as a 'right to euthanasia' (though there is a right to *request* euthanasia).

²⁴ Van Mol F. De Gezondheidszorg in de Belgische Gevangenis. 2013.

²⁵ Some would see this as an instance of hypocrisy. Crisp and Cowton, for example, have argued that what runs through paradigm cases of the various kinds of hypocrisy, and what makes hypocrisy problematic, is a failure to take morality seriously. Crisp R, Cowton C. Hypocrisy and Moral Seriousness. *American Philosophical Quarterly* 1994;31(4):343–49. My argument is also related to G. A. Cohen's claim that an argument's persuasive value may depend on who appeals to the argument: Cohen GA. Tanner Lectures 'Incentives, Inequality and Community' (1991). Available at: <http://tannerlectures.utah.edu/lectures/documents/cohen92.pdf>. In his unpublished paper 'What we owe to the hypocrites: Contractualism and the speaker-relativity of justification', Johann Frick has termed this 'speaker relativity of justification'.

²⁶ Gardner J. Complicity and Causality. *Criminal Law and Philosophy* 2006;1(2):127–41; Lepora C, Goodin RE. *On Complicity and Compromise*. Oxford University Press 2013.

²⁷ See, for example, Kutz C. Causeless Complicity. *Criminal Law and Philosophy* 2007;1(3):289–305.

²⁸ It may be wrong on deontological grounds, because complicity is wrong in itself, or on consequentialist grounds, as contributing to others' wrongdoing has bad consequences

²⁹ See note 26. Lepora, Goodin 2013.

³⁰ In fact, as the case unfolded, it became clear that there was some external pressure to *not* carry out the euthanasia: hospitals refused to provide the required facilities for carrying out the procedure.

³¹ Yuill K. Belgium's insane right-to-die law. Available at <http://www.spiked-online.com/newsite/article/belgiums-insane-right-to-die-laws/15899#.VC6JYb4kGfQ> (last accessed 22 January 2015).