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Differences in Performance of Euthanasia and Continuous Deep Sedation by French- and Dutch-Speaking Physicians in Brussels, Belgium

To the Editor:

Belgium consists of two large, geographically divided language communities: the Dutch-speaking community living in the northern region of Flanders and the French-speaking community living in the southern region of Wallonia. Both language communities are represented in the metropolitan Brussels-Capital Region. Its population of more than one million is culturally diverse, with a large proportion of foreign (non-Western) origin.¹

Since 2002, a law legalizing euthanasia has been in effect in Belgium.² Since then, speculation has arisen regarding differences between language communities in end-of-life practices with a possible or certain life-shortening effect. A report by the Belgian Federal Control and

Table 1
End-of-Life Practices According to Physicians' Preferred Language

End-of-life practices	Language		Pvalue ^a
	French (n = 552)	Dutch (n = 149)	
No end-of-life practice	62.0	59.6	
End-of-life practice performed	38.0	40.4	0.637
Intensified alleviation of pain and symptoms	20.1	21.3	0.733
Nontreatment decision	13.1	11.3	0.679
Use of life-ending drugs without explicit patient request	4.2	4.6	0.821
Euthanasia	0.7	2.7	0.069
Continuous deep sedation performed ^b	15.8	9.3	0.049
Life shortening not intended ^c	11.5	6.8	0.129
Life shortening intended ^c	2.4	0.7	0.332

^aCalculated with Fisher's exact test (two-sided).

^bContinuous deep sedation can be performed in combination with other end-of-life practices.

^cExcludes cases of continuous deep sedation until death performed with euthanasia. Information on life-shortening intention was missing in 10 cases (2.0%) for French-speaking physicians and in three cases (1.9%) for Dutch-speaking physicians; percentages of life-shortening intention were not adjusted.

Evaluation Committee for Euthanasia revealed proportionally more euthanasia cases reported in the Dutch than in the French communities.³ It is not clear whether this reflects a difference in willingness to notify authorities about euthanasia cases or a difference in actual performance of euthanasia. A nationwide mortality follow-back study by means of a sentinel network of general practitioners found a tendency toward more euthanasia in Flanders but more continuous deep sedation in the Walloon region.⁴ However, the question remained whether these differences reflect a cultural disparity between language communities rather than mere geographical differentiation. Examining differences in the occurrence of these and other end-of-life practices between language communities within the same geographical area of Brussels could more decisively inform us regarding these issues.

In 2007, we performed a retrospective survey among the reporting physicians of a representative sample of death certificates in the Brussels-Capital Region. We sent questionnaires in French and Dutch to enable physicians to answer in their preferred language. Of 1,701 sampled eligible cases, we received 701 answers

(response 41%), 552 from French-speaking physicians and 149 from Dutch-speaking physicians. The response sample was adjusted to be representative of all deaths in Brussels in 2007. Patients treated by French- and Dutch-speaking physicians did not differ significantly regarding age, sex, cause of death, living situation, or place of death. However, French-speaking physicians tended to have more non-Belgian patients (11.3% vs. 6.0%, $P = 0.055$), which is not surprising, considering that most of the Brussels-Capital Region's inhabitants of foreign origin speak French as a second language rather than Dutch.

French- and Dutch-speaking physicians did not differ in rates of intensification of pain and symptom alleviation, nontreatment decisions, or life-ending drug use without explicit patient request, whereas there was a higher rate of euthanasia by Dutch-speaking physicians (2.7% vs. 0.7%, $P = 0.069$). Continuous deep sedation until death was performed more often by French-speaking physicians (15.8% vs. 9.3%, $P = 0.049$). We observed a higher prevalence of sedation with a life-shortening intention by French-speaking physicians than by Dutch-speaking physicians (2.4% vs. 0.7%, $P = 0.332$), though not significantly (Table 1). Additional analysis showed no influence of patient characteristics on these results (data not shown).

These results support earlier findings of differences in end-of-life care between the French- and Dutch-speaking communities. Furthermore, our results demonstrate that these differences are present irrespective of geographical separation. Medical (end-of-life) culture seems to differ between language communities in Belgium.⁵ Although euthanasia is more often performed in the Dutch-speaking community, its performance in the French-speaking community is possibly met with more reluctance. This may be because of a lesser degree of familiarity with euthanasia in the latter community, as after the euthanasia law, the issue did not pervade the social and medical arena as much as in the Dutch-speaking community. Also, since the euthanasia law, Life End Information Forum, a voluntary association, was established in the Dutch-speaking community to provide physicians with information and assist in issues concerning (predominantly) euthanasia. This kind of initiative arose considerably later in the French-speaking community and is less

developed. As a result, more uncertainty regarding the performance of euthanasia may exist among French-speaking physicians.

Alternatively, French-speaking physicians perform continuous deep sedation until death more often than their Dutch-speaking colleagues. This practice, better known as palliative or terminal sedation, has enjoyed growing acceptance among medical professionals but has also been criticized for its potential use in hastening death.⁶ Our study shows that a life-shortening intention was present in some instances: in 2.4% of French-speaking physicians and in 0.7% of Dutch-speaking physicians. The criticism, thus, seems to hold. These findings, however, also raise the question whether less inclination to perform euthanasia leads to more continuous deep sedation with a life-shortening intention. Our data are inconclusive, and further research on this matter is needed.

We conclude that French-speaking physicians in Brussels seem more reluctant to perform euthanasia than their Dutch-speaking colleagues; the former more often opt for continuous deep sedation until death, which, in some cases, is carried out with a life-shortening intention.

Kenneth Chambaere, MA
 Johan Bilsen, PhD
 Joachim Cohen, PhD
 Evelien Raman, MA
 Luc Deliens, PhD
 End-of-Life Care Research Group,
 Vrije Universiteit Brussel
 Brussels, Belgium

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Targeting Diuretic Use for Malignant Ascites—Two Case Reports Highlighting the Value of the Serum-Ascites Albumin Gradient in a Palliative Setting

To the Editor:

Malignant ascites is a distressing, debilitating, and common complication occurring in up to half of all malignancies.^{1,2} Repeated paracentesis is widely recognized as the mainstay of treatment but benefits tend to be short-lived and the procedure can be associated with fatigue and hypotension.² Studies have shown that patients with ascites formed because of liver metastases, termed central ascites, tend to respond to diuretics and that identification of such patients can allow targeted diuretic use.² The serum-ascites albumin gradient (SAAG) is a simple test that can accurately distinguish the mechanism of formation of malignant ascites.³ Two cases are described where the SAAG was successfully used to guide the use of diuretics in the control of ascites.

Case 1

An 84-year-old woman with pancreatic cancer was referred with progressive symptomatic ascites. She also had marked peripheral edema with lymphorrhea. The patient had been on spironolactone 50 mg for four weeks, increased from the 25 mg that she had been taking for