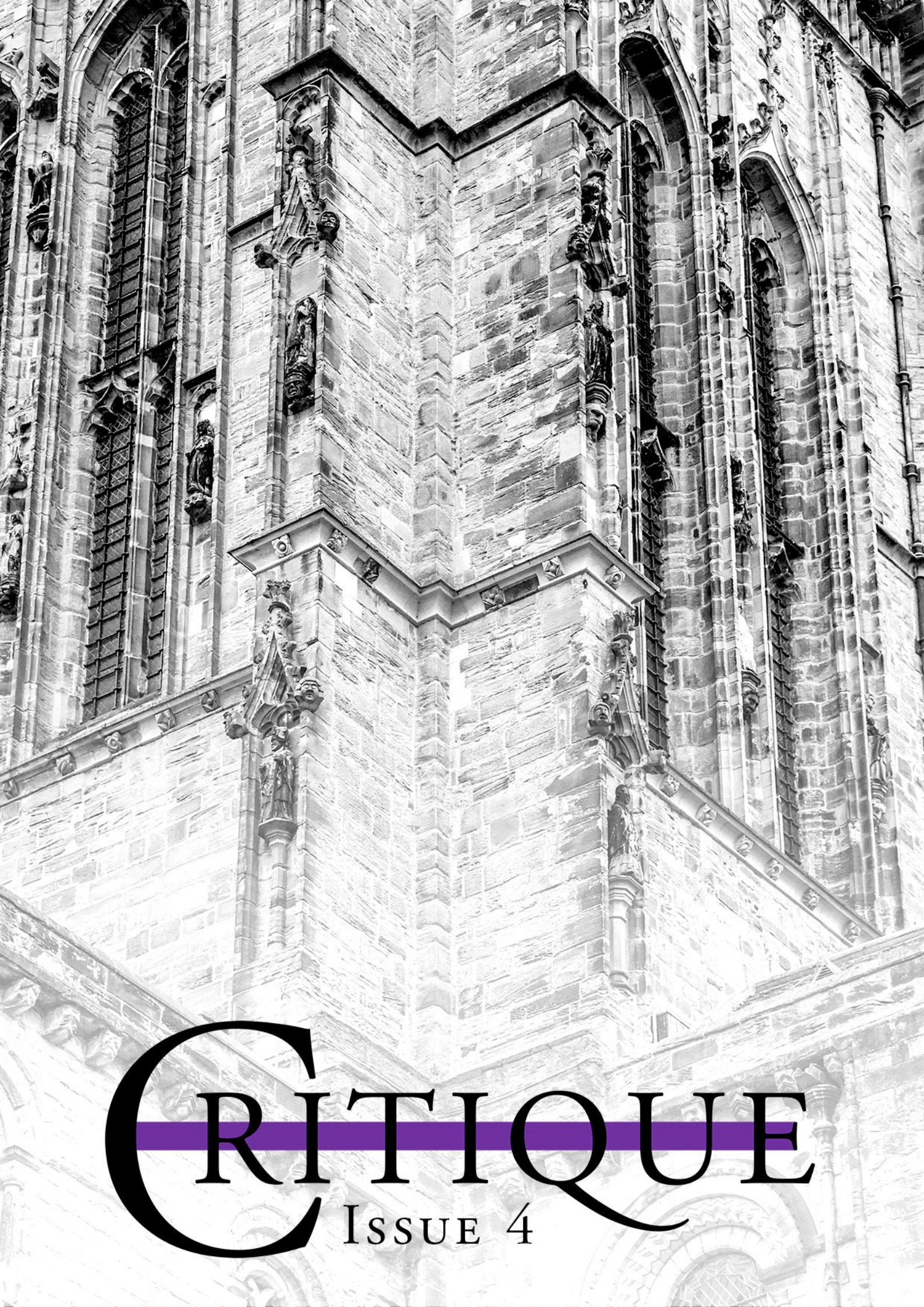

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When, if at all, is assisted dying permissible for psychiatric patients?[1]

Alexandra Pallot (University of Kent)

Introduction

As paths for voluntary euthanasia and assisted dying have opened up in some countries, in recent papers the permissibility of assisted dying in psychiatry has been explored. Yet still our intuitions tell us that there is something irrational about the idea. This is probably because our society is angled to stop people from ending their lives. For example, even in the Netherlands where psychiatric euthanasia is a possibility, the Government of the Netherlands actively tries to prevent people from taking their own lives by suicide, taking measures such as financing helplines and sectioning people at risk of harming themselves (n.d.a., n.d.b.). In the UK, stopping someone from taking their own life is seen as a heroic act – at the 2017 London marathon, two of the most reported and talked-about runners were Jonny Benjamin and Neil Laybourn – two men who met in 2008 when Laybourn saw Benjamin contemplating suicide on a bridge and managed to talk him out of the idea (Furness, 2017). Yet despite our societal views, psychiatric patients being granted permission for assisted suicide is still seen by some individuals and people as morally permissible.

The paper is structured as follows: the first section examines when and why somatic requests are rational, with the second section examining the rationality of psychiatric requests and the third section requests from the chronically ill. Through the course of the paper I argue that assisted dying needs to be treated with great caution due to the treatability of depressive symptoms associated with requests. I argue this despite accepting Hewitt's claim that psychiatric patients can have rational insights into their quality of life. Note that during this paper I do not separate euthanasia from assisted suicide in any way – I use both to represent the process of a physician aiding a patient to die, whether at home or with the physician physically ending the patient's life.

§1 Rationality in Somatic Requests

I start my exploration of the permissibility of psychiatric patient requests for euthanasia by looking at somatic illness and when it is considered rational or irrational for a patient to make a request. Dutch law since 2002 states that for assisted dying to be legal certain requirements must be met. These conditions are that the request is "voluntary, well-considered and durable" and that the patient is in "an unbearable state of suffering for which there is no foreseeable cure" (Janssen, 2002:262). For the patient's request to be voluntary, well-considered and durable, rationality is required. The following case study of a 47-year-old male with AIDS is used by Block and Billings to show an example of a request which would be considered rational:

> He had many discussions with a large network of devoted friends and with his physician about his wishes [for assisted suicide] … he feared loss of control and loss of dignity … [he] had seen a psychiatrist for psychotherapy … medication had not been helpful, but psychotherapy had … Although he did not feel depressed, the constriction of his world and the preoccupation with sickness diminished his sense of meaning and connection (1995:454).

[1] I would like to thank all attendees of the Durham University Philosophy Society's 2017 Undergraduate Conference for their helpful feedback which led to this final edited and improved paper.

In this case the patient's primary care physician and a psychiatrist agreed that the patient had capacity to make an understandable decision and he was assisted by his physician in ending his life. The psychiatrist held an independent evaluation of the patient, concluding that several factors meant the patient was making an autonomous, informed, rational decision (ibid.):

1) The patient did not have major depression
2) His current thinking was not irrationally distorted by the trauma of his lover's death
3) He had a full cognitive and affective understanding of his situation and the implications, for himself and his friends, of hastening his death; and
4) He felt a strong and reassuring connection with his primary care physician.

Point number one, that the patient did not have clinical major depression, is very important for the patient's rationality, although absence of mental illness is not explicitly mentioned in the conditions for euthanasia required by law. Point two is also important, as grief is not mentioned in law either, but is well-known to distort thinking and decision-making. For many years grief was recognised in this way: in the Diagnostic and Statistical Manual of Mental Disorders (DSM), the book clinicians use as a guide to diagnosing mental illnesses, grief is seen as a life process excluding patients from being diagnosed with depression. Although in the new edition of the DSM grief is not mentioned as a life process barring a patient with grief from a diagnosis of depression, bereavement is and has long been recognised to distort thinking and create depression-like symptoms despite being a normal life event rather than a clinically diagnosable illness (Pies, 2014). Mental illness may well also affect point numbers three and four, so it is clear that mental illness is a barrier to rationality in requests.

§2 Rationality in Psychiatric Requests

With this premise that some somatic requests can be rational, provided mental illness is absent, it would seem absurd to consider the idea that a request from a psychiatric patient could ever be rational. To illustrate this, I give the infamous case study of Mrs Boomsma, a patient allowed to die in 1991 under the assistance of physician Dr Chabot. Mrs Boomsma sought out Chabot to ask for his assistance in ending her life as she felt that she was in unbearable psychological pain and suffering after the deaths of her two sons and an otherwise unfortunate life, and her primary care physician had refused to approve her request. She refused psychological treatment with antidepressants and told Chabot that she was "not prepared to undertake the commitment to work with him to change her bleak outlook on life" (Cohen-Almagor, 2002:143). Her reasons for refusing psychological treatments were of the following nature: she felt that by "mourning and by growing" over her losses she would "become a different person" and become "disloyal" to her two sons (ibid.:148). After transcribing all of his sessions with Boomsma, Dr Chabot sent them to "four psychiatrists and a clinical psychiatrist", also consulting "a family physician and a theologian-ethicist" (ibid.:144). "All save one reported that it was unlikely that anything could be done to make Mrs Bosscher's [Mrs Boomsma's] life more bearable" (ibid.). Less than two months later, Boomsma was permitted to end her life with Chabot's assistance:

The short but intense acquaintance with Mrs. Bosscher (from 3 August to 7 September 1991) led Dr. Chabot to conclude that she was a mentally competent person whose freedom of choice was not constricted by mental illness. In his opinion, Mrs. Bosscher had been suffering from a complicated grief process for five years following the suicide of her son, Peter, in 1986 (ibid.:143).

Although Chabot evaluated Boomsma as mentally competent and making a rational decision, the Chabot case, as it has come to be known, is frequently referred to in papers about assisted dying in psychiatric cases. For example, Cowley (2013:228) refers to Mrs Boomsma as having "legal capacity" but suffering from "severe depression", which he describes as "exogenous", "caused not by random transient chemical states in her brain, but by the death of her sons". Mrs Boomsma's second son Peter had died in May 1991, just four months before her own death and although there was "no psychiatric pathology in the strict sense" (Wijsbek, 2010:2), she was in the midst of a grief process, as admitted by Chabot. In fact, Chabot was later found "guilty of professional misconduct" for his actions, including "not *insisting* on therapy as an alternative" (Cohen-Almagor, 2002:146, emphasis mine). This case illustrates the impact of grief and depressive symptoms on rational thinking and capacity, as well as the importance of the psychiatrist's assessment and input in evaluating psychiatric patients.

We have seen that any sign of mental illness or impairment, such as grief, suggests irrationality, given the importance of seeking out these distortions of thinking when being assessed by a psychiatrist. However, some thinkers still argue that patients with psychiatric disorders can still make rational requests. For example, Hewitt points out that patients with a diagnosis of the mental illness schizophrenia are seen with "an assumption of irrationality, which predisposes mental health professionals to view their suicides as the direct result of psychotic phenomena" (2010:26). She believes that this assumption is mistaken and does not recognise "issues of insight and quality of life issues" among people with schizophrenia (ibid.). That is to say, people suffering with an illness such as schizophrenia *can still have rational insight* about their affected quality of life, unprompted and unaffected by occasions of psychosis. Indeed, mental illness can and does cause decreased quality of life for patients, and "hopelessness experienced" as a result of being aware of the "course and consequences of living with schizophrenia" would seem "a reasonable response to the costs of serious mental illness" (ibid.:28). In other words, ideations about ending one's life made difficult by mental illness may well not be derived directly from their diagnosed mental illness. Applied to the Chabot case, perhaps she was experiencing grief but could also see from a non-grief-related, objective point of view that her life had lost meaning and she did not want to live it anymore. I suspect this is the view that Chabot had and which prompted him to accept her request as being from a 'rational' place.

This is not a point to be taken lightly. If requests can be rational and patients are suffering unbearably and without hope for improvement, this would be grounds for a legally approvable euthanasia request. Certainly, there have been other cases of psychiatric euthanasia in the Netherlands, as the way the laws are worded do not rule out assisted suicide in the case of a mentally ill patient. For example, a 34-year-old female with "PTSD, chronic depression and a personality disorder" chose and was assisted to die as well as a "dutch sex abuse victim in her 20s with conditions including "therapy resistant" anorexia and chronic depression" (Boztas, 2016). These are landmark cases as psychiatric euthanasia is still very uncommon across the world. As these cases seem to suggest that assisted dying in psychiatric patients is legally permissible and the patient therefore must be seen to have rationality, this also appears to have implications for the thesis of this paper.

Before continuing I feel it is important to settle a claim which some may make: that schizophrenics are unpredictable and although they may have reported periods of lapse from psychosis, these periods cannot be trusted; therefore Hewitt's results are interesting but perhaps not significant or useable in the framework of something as irrevocable as assisted suicide. However, it is not necessarily true that schizophrenic people are totally unpredictable. It has been found that the perception of unpredictability in schizophrenics is "significantly associated" with "less-educated people" whereas "relatives and professionals are less

convinced that patients with schizophrenia are unpredictable… probably related to their direct experience with these patients" (Magliano et al., 2003:415). Therefore, the arguments following are not about the conduction or reliability of Hewitt's study and participants, but against the implications of its resulting idea: that psychiatric patients can make rational requests for assisted suicide.

§3 Rationality in Chronic Illness Requests

My first argument follows through a thought-experiment:

> Fifty-five-year-old Mrs Arnold suffers with a chronic illness: type one diabetes, which she was diagnosed with thirty years ago. The illness is not terminal because it will not directly cause her death, but it will cause her much suffering over the course of her life. She finds her diabetes difficult to control, and as a result she needs to frequently attend appointments with endocrinologists, diabetes specialist nurses and podiatrists. She also has frequent infections which means she spends much time with a primary care physician, pharmacist and nurse. She needs occasional inpatient stays in hospital as a result of high or low blood sugars. Her daily routine involves finger-pricking, injecting and counting the carbohydrates in the food she eats. Mrs Arnold visits her primary care physician and explains that her daily suffering as a result of her illness has become unbearable and tiring. Her world has been so restricted by the disease that she cannot see a good future ahead. She has considered requesting assisted suicide for the last few years but has been holding out in case of a change of mindset. The primary care physician she presents to assesses her for depression and other mental illnesses but all results are negative. It appears that she is rational and has the capacity to make this decision.

Reading through this case I suspect that many will find it absurd. The fact that she does not have a mental illness does not seem to matter – there is something else in the request which seems irrational. Firstly, Mrs Arnold has time left – she is fifty-five years old, which is definitely not considered an age close to death, especially in the western world. She has had a life of suffering so far but there is still potential for it to change. In short, there are other options available to Mrs Arnold which will probably be successful in changing her suffering. The feelings prompting this patient to seek help in ending her life are complex, for instance: sadness, hopelessness and a negative outlook to the future, which are all symptoms frequently experienced by people with depression (Corruble, et al., 1999:99). From this point onward I will refer to these symptoms as depression-like symptoms. Mrs Arnold's chronic illness is not the direct cause of her desire to hasten death, the feelings associated with her objective view of her situation are the cause: a pessimistic view of the future, hopelessness and sadness. And these are feelings included in the scope of depression-like symptoms I have outlined.

This thought experiment is no different from the Chabot case. Mrs Boomsma's 'illness' was a life full of suffering and the death of close loved ones, but her decision to die was not directly determined by this suffering. It was determined directly by depression-like symptoms, which did stem from the suffering but was n*ot the only option to come from it*. Depression-like symptoms, it appears, are a driving factor for assisted suicide, and for those with a potentially different life ahead of their suffering, such as Mrs Arnold and Mrs Boomsma. Indeed, Beck et al. (1989) have found a strong link between hopelessness and suicidal ideation – in their sample of patients hopelessness was closely related to the likelihood of eventual suicide in patients with recent traumatic brain injury.

These depression-like symptoms are also seen in the terminally ill. Although the permissibility of assisted suicide in somatic patients is not the question at stake, their reason for assisted suicide is usually a loss of hope, that their life will end soon and the last days will be full of unbearable suffering. Despite this

being understandable it is actually *uncommon* for a patient with terminal illness to request euthanasia. For example, Tiernan et al. (2002:389) found that from their sample of 142 terminally ill patients with cancer, "desire for early death was not common", occurring in just two of the patients - that is just 1.4 percent of the sample. Requests being infrequent is also discussed by Block and Billings (1995:447), who state that "most dying patients face their illnesses with remarkable equanimity" and value "whatever time they have left", so "requests to hasten death should be viewed as falling outside the usual spectrum of responses to terminal illness". It seems that even in the terminally ill assisted suicide is not considered unless the patient feels hopeless or has other "significant depressive symptoms" (Tiernan et al., 2002:389). In the terminally ill, the "early recognition and effective treatment of depressive symptoms" is important (ibid.), as they can be reduced: Kugaya, A. et al. gave tricyclic antidepressants to five suicidal patients with terminal cancer and found that just one week later they all "showed marked improvement in their mood, and no further suicidal thoughts, requests for terminal sedation, or desire to hasten death" (1999:433). In other words, patients making requests due to depressive symptoms, without diagnosable depression, can and often do change their mind with psychological treatment.

Just as in the terminally ill, depressive symptoms are separate from the original illness, in the psychiatrically ill these symptoms can exist without stemming directly from psychosis or affective disorders. It would not be unreasonable to say that at least one or some depressive symptoms such as hopelessness *always* exist in those requesting assisted suicide – after all, the reason the patient is asking to end their life is usually because they cannot see a future without their illness or unbearable suffering, and sadness and a negative outlook to the future are included in depressive symptoms. Showing further that Hewitt's psychiatric patients requesting euthanasia from an objective, non-clouded place can still be suffering with separate psychiatric symptoms, Simpson et al. (2011:298) write that "hopelessness can be observed among individuals without enough symptoms to warrant the diagnosis of a depressive disorder". But as Beck et al. (1989:310) write, "hopelessness can be reduced fairly rapidly by specific therapeutic interventions". Indeed, Simpson et al. (ibid.:295) put participants with experience of traumatic brain injury through a programme involving "didactic presentations, group exercises, group discussion" and use of "therapeutic self-rating questions, activity scheduling, and… intersession tasks", with an emphasis on treating "the current issues or challenges that participants were facing". This treatment programme was successful in "producing a strong treatment effect in reducing levels of hopelessness among participants" (Simpson et al., 2011:297). Clearly, the hopelessness directly leading to the request for associated suicide can be treated in all types of patients, whether somatic, chronic or psychiatric. This is a positive sign for people such as Mrs Arnold, who have life left but do not have enough depressive symptoms to warrant a mental illness diagnosis or assessment of irrationality. Given that depressive symptoms without depression can be successfully treated in the same way that depression can, and that patients can change their mind on ending their lives, it seems that more thought may be needed when a psychiatric patient requests assistance to die, even if they are able to step back from their particular diagnosed mental illness.

It is tempting at this point to say that because patients can change their minds on a request to die, the original request must have come from an irrational place. Indeed, peoples' minds can be changed in the reverse direction from a hopeful outlook to a hopeless outlook, yet this does not make their original hopeful outlook irrational. Instead, I make a less bold claim yet a significant one, that often in psychiatric cases our focus is on their wanting to die due to their diagnosed mental illness. This becomes the debate, but feelings and thoughts coming from separate depressive symptoms are overlooked as they do not constitute full, diagnosable depression where the wish to die may be seen as a choice caused by the depression itself.

Instead of questioning whether someone with a mental illness can ever be rational, as with Hewitt, the focus should instead be on the frequent cases where someone does have a mental illness but their 'rational' outlook is directly affected by separate depressive symptoms: mental illnesses each come with different symptoms after all and the negative outlook on life experienced by a schizophrenic may not be directly a result of their schizophrenia but of separate depressive symptoms which could be treated but are overlooked in favour of looking for separation from their original mental illness.

Therefore, any patient presenting with a psychiatric disorder and a wish to hasten their death should be treated with extreme caution. It is all too easy to fall into the trap of thinking that there are only some psychological symptoms in a person and ignoring any symptoms which we deem 'normal' in their situation. Each depressive symptom should be looked into, regardless of whether the symptoms come together to form a diagnosable depression. These thoughts can then be treated: a patient who may have been allowed to die under current considerations due to no diagnosable depression and an 'objective' separation from their original mental illness could change their mind after treatment and go on to live an enjoyable life. And given that the aim of medicine since Hippocrates' time has been to prolong health and life, doing everything to give someone the option of a healthy life should surely be of utmost importance in treatments which we do and do not permit in modern medicine.

Some may argue against the evidence put forward that depressive symptoms can be treated. For example, Simpson et al.'s study refers to patients with traumatic brain injury rather than patients with psychiatric illnesses. Simpson et al. are quick to point out that their results are comparable to similar trials of "CBT programs that treated hopelessness among samples of non- brain-damaged depressed inpatients and outpatients" (2011:297). It appears that no matter the cause of the hopelessness, whether through mental illness, injury or life fatigue, it is treatable and needs to be looked out for and tested by physicians confronted with a patient requesting assistance to die. The sample size with Simpson et al.'s study was also small, but even if the results are not statistically generalisable, they are worth taking very seriously due to the implications for patients suffering with unrecognised depressive symptoms and wishing to hasten death. Whether this particular trial is generalisable or not, taking hopelessness and its treatment seriously cannot have negative results.

Concluding Remarks

In conclusion, depressive symptoms, particularly hopelessness, can be stand-alone and are strongly associated with requests for assisted dying. This may be understandable in cases of terminal illness where the patient's life is very limited, but needs to be treated with caution when potential lifespan stretches ahead. Just as in the case of chronic illness, psychiatric illness can be separated from the depressive symptoms which more often than not come with a request.

Therefore, instead of testing for depression and other mental illnesses it is very important that physicians look at the cognitive roots of the request. As symptoms can be rapidly improved, as shown by Simpson et al. and Beck et al., assisted dying in psychiatric patients cannot be morally permissible without a strong investigation into the patient's state of mind and minor cognitive symptoms leading to the request. To allow a psychiatric patient to die would be to collude with the irrational part of the patient's request, which is not morally acceptable. Instead, physicians need to test for and treat depressive symptoms in these patients, whether their request appears to be separate from their mental illness or not

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