

Euthanasia, assisted suicide and psychiatry: a Pandora's box

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Euthanasia has been defined as 'the bringing about of a gentle and easy death for someone suffering from an incurable and painful disease or in an irreversible coma' (Pearsall & Trumble, 1996). It accounts for nearly 2% of all deaths in The Netherlands, where the indications include intractable suffering (Huyse & van Tilburg, 1993), and in April 2001 that country became the first to legalise the practice fully. Since approval of the Death with Dignity Act, initially in 1994 and again in 1997, the state of Oregon in the USA has allowed medically assisted suicide, where the physician may provide a patient with lethal drugs but may not actually administer them. The US Attorney General has recently attempted to stop this practice – a move opposed by the Oregon Medical Association. Laws permitting euthanasia were introduced in Australia's Northern Territory in 1995 but were overturned by the Australian senate 2 years later. Increasingly, mental health professionals are being challenged to consider their role in end-of-life decisions.

Several critical issues for psychiatrists have been raised with the advent of 'physician-assisted suicide' (PAS), which is the deliberate prescription of medication to or counselling of ill patients so that such patients may use this medication or information to end their own life (Cohen *et al*, 1994).

While psychiatrists specialising in old age or liaison psychiatry may have regular experience in the management of patients in the end stages of dementia or other terminal conditions, most general psychiatrists have little experience of euthanasia-related issues.

MANDATORY PSYCHIATRIC ASSESSMENT

Psychiatric assessment is mandatory for patients who request PAS in some

jurisdictions, but not in others. Between 1995 and 1997, each patient in Australia's Northern Territory requesting PAS underwent mandatory psychiatric assessment (Kissane *et al*, 1998). In Oregon, a physician refers the patient to a psychiatrist or psychologist only if the physician believes a psychiatric disorder may be present. A similar situation applies in The Netherlands, where psychiatric assessment is requested for only 3% of patients who request PAS (Groenewoud *et al*, 1997), raising the possibility that psychiatric disorder may be underdiagnosed in this population.

In assessing patients requesting PAS, the primary role of the psychiatrist is to identify and treat psychiatric illness. The psychiatrist may also be expected to provide an assessment of the patient's decision-making ability and to support staff in their own decision-making process (Bannink *et al*, 2000). These are all important issues in light of the prevalence of depression in this patient group (Chochinov *et al*, 1995) and also the potential for distress and division among staff members.

The various roles of the psychiatrist in this situation, however, may not rest easily with each other. Notably, the concept of assisting – rather than preventing – suicide counters the core aims of psychiatric practice. The shift of therapeutic role from alleviating psychic despair to facilitating suicide would be anathema to many psychiatrists. The psychiatrist may be drawn into the position of mediator between patient, family and medical staff.

Mandatory psychiatric assessment also places the psychiatrist in the problematic position of 'gatekeeper' for PAS. There is evidence that some psychiatrists would allow their own attitudes to influence their recommendations, and only 6% of psychiatrists are confident that a single assessment could enable them to decide whether or not mental illness is influencing a person's

request for PAS (Ganzini *et al*, 1996). Indeed, while some 64% of British psychiatrists agree that psychiatric assessment is important, only 35% would be willing to carry out such assessments (Shah *et al*, 1998).

PHYSICIAN-ASSISTED SUICIDE FOR PSYCHIATRIC ILLNESS

Most jurisdictions are reluctant to authorise PAS for patients with severe psychiatric illness in the absence of physical illness. None the less, the Dutch Supreme Court has ruled that PAS may be justifiable in certain cases in which there is unbearable mental suffering in the absence of physical illness. In 1994, the Court indicated that extreme care should be taken if PAS is considered in the absence of physical illness, and that the request should not be granted if the patient has deliberately refused a realistic alternative treatment. The advice of an independent expert is also required.

In Dutch psychiatric practice only about 2% of requests for PAS are finally granted – compared with 37% of requests granted in Dutch medical practice as a whole (Groenewoud *et al*, 1997). In The Netherlands, PAS occurs in current psychiatric practice no more than five times per year, and most of these patients have both physical and mental illness. It could be argued that to deny a person PAS on the grounds that the illness is psychiatric rather than physical would be discriminatory. Is this the 'slippery slope' that opponents of PAS have always feared? Moreover, in an increasingly consumer-led society, could it become incumbent upon psychiatrists to provide such services?

Requests for PAS on the basis of psychiatric illness alone stem from the provision of PAS for physical illness and from our growing understanding of the biological basis of certain mental illnesses. However, the similarities between physical and mental illness, though strong, are not complete. There is still a limited understanding of the underlying causes of common mental illnesses, including depression and schizophrenia. In the case of an individual patient, it remains extremely difficult to predict whether therapy will produce an early response, a delayed response or no response (Schoevers *et al*, 1998). It is impossible to predict which patients will

undergo spontaneous remission and when this will happen. These uncertainties are far more pronounced in psychiatric practice than in medical practice, to the extent that it is essentially impossible to describe any psychiatric illness as incurable, with the exception of advanced brain damage as occurs in progressive neurodegenerative disorders such as Alzheimer's disease and Huntington's disease.

There are further clinical, ethical and legal issues that complicate the issue of PAS in psychiatric rather than medical practice. Terminally ill patients with depression are more likely to change their minds about PAS than patients without depression (Emanuel *et al*, 2000). This raises questions about the usefulness of advance directives or 'living wills' for PAS in the event of developing psychiatric illness and deteriorating quality of life. From an ethical standpoint, the doctrine of double effect will not apply to most psychiatric disorders, for example the administration of drugs to relieve not only physical pain but also associated mental distress, even if this might hasten death. From a legal standpoint suicide is no longer a crime in the UK, but assisting in the suicide of another person still carries a jail sentence of up to 14 years.

RECOMMENDATIONS

Recent legislative changes in The Netherlands are indicative of changes in attitudes in a number of other countries. Belgium is actively changing its legislation to increase the availability of PAS. In the UK, there is renewed professional and public interest in PAS following the case of a terminally ill 42-year-old woman whose request that her husband be allowed to assist her suicide was turned down by the House of Lords (Dyer, 2001).

Some psychiatrists feel that they should have no role at all in PAS. None the less, there is certainly an important role for psychiatrists in the identification and treatment of mental illness in patients with terminal disease, including those who request PAS. There is continuing debate, however, about whether all patients who request PAS should have psychiatric assessment, and whether PAS should be provided

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for psychiatric illness in the absence of physical illness.

There is a marked lack of clarity about the goals of mandatory psychiatric assessment in all patients requesting PAS. More worryingly, there are no clinical criteria to guide such an assessment – just as there are no criteria to assess the rationality of any person's decision to commit suicide. The development of standardised criteria is difficult owing to varying definitions of mental illness across cultures, ongoing debate about the possibility of rational suicide, and the inevitable complexity of each individual case. In the context of terminal illness, a patient's capacity to make decisions may be affected by both mental and physical illness, including chronic pain.

There is a strong need for the provision of psychiatric training and support for physicians who routinely treat patients with terminal illness. In the cases of patients who request PAS, increased awareness of psychological issues helps physicians appreciate the psychological underpinnings of the patient's distress and can also prompt the instigation of appropriate referral for psychiatric assessment. When psychological issues are explored, the request for PAS may be withdrawn (Bannink *et al*, 2000). The presence of psychiatric illness in addition to physical illness should not necessarily represent grounds for denying PAS. However, the provision of PAS for psychiatric illness alone would be unwise.

DECLARATION OF INTEREST

None. The views expressed in this editorial do not necessarily reflect those of the Stanley Research Foundation.

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