Physician-Assisted Death and the Medical and Philosophical Considerations for Psychiatry

Joseph Emerson Marinas, McMaster University

Word Count: 1316

Date of Submission: March 31, 2016

E-mail: joseph.marinas@medportal.ca

Mailing Address:
682 Eversley Dr
Mississauga, ON

Telephone Number: (647) 882-0491
Physician-assisted death (PAD) is a concept often associated with uncertainty and discomfort in the medical community. With the Supreme Court of Canada ruling that the prohibition of PAD from a competent, consenting adult with intolerable suffering from an irremediable condition as unconstitutional, Canadian medical professionals will have to adapt their attitudes and practices\(^1\). While the medical community as a whole is faced with determining how to implement this ruling and regulate its practice, psychiatrists in particular are presented with philosophical and medical dilemmas\(^2\). How does PAD fit in with the values of the psychiatry community? How does suffering from psychiatric illness differ from somatic illness? How does mental illness affect capacity and comprehension? Although the answers to these questions are still to be determined, it is worth examining why PAD sparks particular interest in psychiatry.

PAD encompasses both euthanasia and physician-assisted suicide and is legal in Belgium, Luxembourg, Switzerland, and certain areas within the United States of America\(^2,3\). Most psychiatric patients who seek PAD are those with treatment resistant depression (TRD)\(^4\). TRD, however, is a term that lacks a clear definition. Some studies utilized definitions including "no response to at least one treatment" and "no response to all reasonably available treatments"\(^5,6,7\). This lack of strict definition in the literature poses issues when making policies for integrating PAD into health care, but common themes usually allow for critical appraisal in order to further the process.

**Traditional Perspectives and Paradigms**

Suicide and the notion of ending one’s own life is a concept that lies at the core of psychiatry. Ideation and attempts at suicide can constitute an emergency situation, serve
as one measure of treatment response, and even provide grounds to suspend patient autonomy. In this traditional view, practitioners work to mitigate the endpoint of suicide and the persistent desire to die signifies inadequate treatment. The concept of psychiatrists facilitating in PAD, then, seems counter to traditional principles, but as we look into the physician’s role in human suffering a more complex situation is uncovered.

**A Holistic View of Suffering**

The concept of suffering is central to the issue of PAD, but there appears to be a dichotomy when addressing concepts such as pain, terminal disease, and refractoriness in the context of physical versus mental illness. Perhaps some of this dilemma stems from how intertwined psychiatric conditions seem to be with personhood and identity. Whereas somatic disease is seen as a discrete entity separate from the patient, mental illness affects defining aspects of existence: thoughts, attitudes, and personality. Because of this difference, it is important to consider suffering in a more holistic sense such as the notion of "existential suffering" where a desire to no longer live may stem from losses at the core of personhood. These losses include the inability to derive a sense of meaning from relationships, emotions, sex and gender, spirituality, and hope for the future. This experience is both difficult to express by those affected and difficult to imagine for those who have not felt “existential suffering”. The resultant disconnect impedes the capacity of practitioners to accurately measure suffering associated with mental illness and appreciate the existential pain of those seeking PAD for psychiatric illness.
Rationality in Suicide

The question of whether suicide can be justifiably rational in the context of psychiatric illness is also important to the issue of PAD. As previously mentioned, suicidal ideation and behaviour can serve as grounds for health care professionals to suspend patient autonomy and have treatment decisions made on his/her behalf. Some view suicidal wishes as inherently irrational and even assert that its presence alone can indicate mental illness. Conversely, Dembo argues that suicidal ideation may be reasonable in certain circumstances. One such case could involve a patient’s accurate appraisal that his/her own life circumstances preclude much hope for a better future (although this concept itself is debatable).\textsuperscript{9} Rationality, capacity, and judgment are further questioned when patients are also psychotic. Schuklenk \textit{et al.}, however, assert that although depression affects a patient’s perception of life, it does not necessarily preclude competent decision-making.\textsuperscript{5} Whether or not suicide in the context of intractable mental illness and suffering can be considered rational is still to be determined, but the answer may lie in the specifics of a patient’s circumstances rather than by the presence of suicidality alone.

Experience in the Netherlands

With the availability of euthanasia and assisted death in the Netherlands, many have looked to the country’s experiences for guidance. In the Netherlands, patients seeking PAD must meet “due care criteria” (Box 1).\textsuperscript{5,7,10} In order to ensure that alternate therapeutic options have been considered and to assess for patient competence, psychiatric patients are evaluated by two psychiatrists and one additional physician, as
outlined in the Dutch Psychiatric Society euthanasia guideline\(^5\). In these cases, the mere presence of psychiatric illness is not enough to preclude an individual's competence and capacity to understand his/her case, awareness of his/her experiences, and evaluation of future prospects (with the exception of psychotic depression)\(^8,11,12\). Recent analysis by Kim et al. found that patients who sought PAD tended to have multiple psychiatric diagnoses, physical problems, and social isolation\(^4\). Further, disagreement was not uncommon between physicians surrounding competence. Although there was in increase in the number of PAD cases in 2013, this may have been due to increased accessibility of services for patients rather than increased demand\(^4,5\). These findings demonstrate the complex circumstances that may lead patients to consider PAD and the challenges that Canada may face as PAD is implemented.

Similarly, euthanasia is also available in Belgium. Thienpont et al. found that most requests for physician assisted death was from those with personality disorders and/or depression. Interestingly, 8 of the 48 participants with approved euthanasia requests either postponed or cancelled the procedure since the option of assisted death “provided enough peace of mind to continue living”\(^16\). This raises the interesting possibility that the choice to end one’s own life in this manner may provide previously unavailable alternative treatment.

**The Psychological Burden of PAD on Physicians**

As the policies surrounding PAD continue to develop, it is also important to consider the psychological toll that these practices also have on physicians. How difficult will it be for psychiatrists to shift from a practice that unilaterally works to prevent
suicide to one that considers PAD as a viable option for the palliation of suffering? There is also the concern that PAD may serve to circumvent proper analysis of factors contributing to TRD or substitute effective psychosocial interventions\textsuperscript{14,17}. Some health care practitioners fear that patients may threaten to continue with suicide if his/her PAD request is denied resulting in the pressure to acquiesce\textsuperscript{18}. Further, concerns of patient family complaints following the completion of PAD may occur. Much of this may stem from a patient’s choice to limit the disclosure of his/her wishes to others and the emotional nature of such decisions. In addition, physicians are limited in what can be disclosed to patient families due to confidentiality\textsuperscript{18}. Indeed, these issues are important to consider for policymaking and educating medical professionals about decisions and consequences surrounding PAD.

**Conclusion**

With the recent ruling of the Supreme Court of Canada, attitudes toward intractable illness are sure to change. Considering the medical and philosophical challenges presented to psychiatrists, further inquiry and education is necessary to equip practitioners with skills to appraise patient capacity and provide just care. It is also important to attend to the concerns of physicians and those who would be affected by a patient’s death. Psychiatry is both an art and a science and drawing upon both aspects of the discipline is important to settle the emotionally-charged and controversial issues of physician-assisted death. Only time will tell how the medical community and society as a whole will integrate the concept of PAD into health care.
Box 1. The due care criteria that must be met in the Netherlands for the consideration of physician-assisted death.

The physician must:

A. be satisfied that the patient's request is voluntary and well-considered;

B. be satisfied that the patient's suffering is unbearable, and with no prospect of improvement;

C. inform the patient about his or her situation and prognosis;

D. have come to the conclusion together with the patient that there is no reasonable alternative in the patient's situation;

E. consult at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled; and

F. exercise due medical care and attention in terminating the patient's life or assisting in suicide.


References


