

## Addressing Treatment Futility and Assisted Suicide in Psychiatry

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In psychiatric residency training, as well as in practice, we work under the assumption that all mental illness is treatable, and that treatment never becomes futile. Meanwhile, in somatic medicine, there is a subspecialty, palliative care, devoted to improving the quality of life for those who are dying of an incurable illness. In somatic medicine, increasingly, physicians and the public are discussing the questions of legalizing terminal sedation, assisted suicide, and euthanasia for suffering related to refractory, incurable illness. As a resident in psychiatry, I struggle to understand the discrepancies in this regard between psychiatry and other medical specialties. After discussion with several advisors and bioethicists, I have come to believe that several questions should be open for discussion: what are the ethical issues we must address in psychiatry when considering how to help patients with unbearable, prolonged treatment-refractory suffering? Why is it that we are more comfortable with the notions of “refractoriness” and “terminality” in physical illness than in mental illness? What would “palliative psychiatry” look like, and when – if ever – might assisted suicide be a reasonable course of action in mental health care? In addressing these issues here, I intend to open a critical discussion, but not to argue an opinion. Given the tragedies that have historically ensued in the field of medicine as a result of refusal to discuss ethically contentious issues, and given the increasing publicity regarding assisted suicide in the western world, it seems pertinent to address this as it may apply to psychiatry.

In the Netherlands and Oregon, and most recently Washington and Montana, assisted suicide for terminal somatic illness is legal, or has been decriminalized, under very specific conditions. Only in the Netherlands, thus far, have these conditions been extended to include patients suffering from refractory mental illness in the absence of somatic disease, and within this category the conditions are more stringent. This development in the Netherlands began in 1991 following a case in which a psychiatrist, Dr. B. Chabot, assisted in the suicide of a 50-year-old woman with chronic depression.<sup>1,2,3,4</sup> Dr. Chabot was charged by the Dutch Supreme Court and suffered a minor penalty because he had not provided the patient with an “independent expert consultation.” That said, this case set a precedent in which the courts stated that physician assisted suicide “may be justifiable for a patient with severe psychic suffering due to a depressive illness and in the absence of a physical disorder or terminal condition.”<sup>1</sup>

Following this case, the Royal Dutch Medical Association adapted its guidelines for assisted suicide from somatic to psychiatric illness.<sup>1</sup> The next publicized case occurred in 1997 and involved a 48-year-old woman with chronic, severe, and treatment-refractory major depression and anorexia nervosa. Due to her psychiatrist’s compliance with the new guidelines, no charges were pressed. In 1995, it was estimated that two to five patients per year receive assisted suicide in the Netherlands for exclusively psychiatric illness.<sup>1</sup> This same research indicated that 37% of Dutch psychiatrists had at least once received an explicit request for physician assisted suicide for psychiatric reasons, the most common of which was depression. These findings beg the question of whether North American physicians receive similar requests; they also indicate that this is a highly relevant discussion in psychiatry.

Multiple ethical, legal, and philosophical principles must be considered in order to acquire a balanced perspective on what ethicist Eric Matthews describes as “an abstract idea that has non-abstract consequences.”<sup>5</sup> I will attempt to address the most pertinent of these here.

### Suffering and Personhood

How, as physicians, are we to diagnose suffering? The diagnosis is murky at best in somatic medicine, but in psychiatry is at times completely bewildering. Ethicist Eric Cassell reminds us that suffering is an affliction in which the intactness of not only the body, but also the *self* or person, is threatened.<sup>6</sup> Suffering is therefore suffering, whether it is physical or psychological. Where terminal sedation or physician assisted suicide are legal and are in consideration for a particular patient, physicians consider both physical suffering and the existential pain related to that suffering in their decision-making process. Is it, then, inconceivable that severe existential pain in the absence of physical illness could ever be a rational reason to consider ending one’s life? What if we relate the notion of “existential pain” to that of personhood, and loss of personhood through mental illness? Cassell lists multiple components of “personhood,”<sup>7</sup> including one’s valued social roles and relationships, the uniqueness of emotional expression, the experience of gender and sexuality, the joy of having a rich spiritual and fantasy life, and the perception of having a meaningful future. Serious mental

illness interferes with – and I might argue detracts from – multiple aspects of personhood, the loss of which in turn leads to suffering. I would ask of the reader to consider the following: how many, and which, aspects of your own personhood would you be willing to lose, before you would no longer want to live?

## Rational Suicide and Capacity

The above questions lend themselves to a discussion of rationality and capacity in decision-making about suicide. In psychiatry, we often assess capacity for treatment decisions, place of residence, and financial decisions; an individual is considered capable if she understands the nature of the issue at hand, as well as the likely consequences, and potential risks, harms, and benefits, of pursuing one decision over another. Interestingly, we do not assess capacity in this way for a decision to suicide. Furthermore, in somatic medicine, when a patient is deemed capable with respect to treatment decisions, she is allowed to refuse life-saving treatment; in psychiatry, however, we can certify a suicidal individual without formally assessing that person's capacity to decide upon suicide.

There is actually a significant body of literature devoted to addressing the question of whether suicide can be a rational decision. Many argue that suicide is rational if the despair prompting the suicidal wish is rational: that surely despair can be justified if there is, realistically, very little hope for a better future.<sup>1,3,8,9,10</sup> Who has the right to determine what constitutes a “better future” is in itself sometimes debatable. In the context of mental illness, this debate is extraordinarily complex. Some mental health professionals believe that suicidality alone is an indicator of mental illness, whether or not other DSM-IV criteria are met for a mental disorder. There are also those who believe that in the presence of a mental illness – no matter which illness – suicidality is automatically irrational. Furthermore, some professionals question whether rationality can be maintained in psychotic versus nonpsychotic illnesses.<sup>2,11</sup> It seems that the boundaries between a realistic appraisal of a difficult and deteriorating life course, a cognitive distortion, and further, of a delusion, are frighteningly ill-defined. One philosopher, Jeannette Hewitt, reminds us that human beings are frequently irrational, but their irrationality “rarely interferes with their rights or freedom unless accompanied by a diagnosis of mental illness.”<sup>8</sup> She asks whether hopelessness is ever a realistic appraisal of life circumstances and illness course in schizophrenia and other mental illnesses, rather than just a “symptom of psychopathology.”<sup>8</sup>

## Treatment Futility

It would be wrongful to assume that all suicidal individuals, psychotic or not, can realistically appraise their likelihood of having a better future. Having entered the profession of psychiatry for the purpose of helping people to achieve improved futures, I find it dreadful, as do many of my colleagues, to contemplate the possibility that there are some people I cannot help. We do, however, live in a universe of likely infinite possibilities, and therefore it is plausible that in some cases mental illness and its resultant unbearable psychic pain can indeed be refractory to treatment. Surely this is the case in psychiatry, as it is in the rest of medicine. Ethically speaking, how do we manage these situations? At what level of probability of no improvement or no cure, can we deem treatment “futile?” Whose role is it to determine what constitutes “futility” for any specific patient? How many treatments should we attempt,

and what should the duration of each treatment be? How many side effects should we expect our patients to tolerate in the name of treatment? And, at what point do we allow our patients to give up on treatment, and on life itself? At what point are we, as physicians, entitled to “give up?” Once we have given up, what kinds of palliation can we then provide?

This discussion highlights not only the importance of the patient's autonomy, but also of the physician's: there is, after all, in medical and ethical literature, a consensus that there are limitations to a physician's obligation to provide care that she believes has no benefit.<sup>12</sup> I would ask also whether acknowledging futility could ever be helpful for the patient, for the physician, and for the therapeutic alliance, and whether refusing to acknowledge futility could ever be harmful. According to the Hippocratic Oath, I have sworn both to “do no harm or injustice to my patients” and “not to give a lethal drug to anyone if I am asked.”<sup>13</sup> I wonder if it is possible that by refusing at all costs to provide a lethal drug, I would ever be doing the “harm” of prolonging intractable suffering? I understand that current best psychiatric practice in North America eschews even non-intervention in suicide, and so the idea of assisted suicide is further afield. However, I wonder how this might apply to situations in which a failed suicide attempt has left an individual with permanent debilitation or chronic pain that has worsened what was already intolerable suffering. Furthermore, I cringe to imagine that after a lifetime of suffering, an individual with refractory mental illness would have to die in solitude and fear, and that if the attempt fails this may result in worsened suffering. Some practitioners argue that many individuals who survive a suicide attempt later express gratitude that they are alive and that therefore suicide should be prevented in all cases; there is, however, a significant response bias here as we cannot inquire as to the feelings of those who have succeeded in ending their lives. Could assisted suicide ever, therefore, be considered a “harm reduction” approach in refractory mental illness?

## The Slippery Slope

There are many valid counterarguments to the notion of legalizing treatment cessation, palliative sedation, assisted suicide, and euthanasia in somatic medicine, let alone in psychiatry. One of the prominent writers in this area, Herbert Hendin, argues passionately that if we legalize physician assisted suicide in any field of medicine, there is a risk that patients will lose autonomy through coercion, for example related to caregiver burnout, family attitudes toward the given illness, or financial stress.<sup>2,14</sup> Other slippery-slope advocates warn that legalization of physician assisted suicide would prevent us from working harder to improve the standard of care, including social supports and medical resources (including palliative care providers and facilities), that would enhance a patient's quality of life and thereby prevent the distress leading to suicidality.<sup>11,12</sup> What if the perpetuating factors for an individual's suicidality are isolation, stigma, and the structure of society itself, as opposed to her mental illness? Until we can improve social supports, ameliorate isolation, and decrease stigma, are we simply avoiding addressing the greater social factors at hand, by allowing for or assisting in suicide?<sup>11,14</sup> Multitudes of other questions abound: what if the suicidal patient's psychiatrist is over-invested or suffers from her own biases related to suicide? How does one avoid solely protecting the psychiatrist's need to see an end to a patient's suffering, in lieu of protecting the patient's right to continued treatment? And, how would society

perceive psychiatry – and the field of medicine itself – if some or all of the above concepts were legalized?

Given the new, and often murky, legal status of assisted suicide in somatic medicine, let alone psychiatry, there is thus far little data that addresses the above questions. However, due to the high documentation and reporting standards in Oregon following the Death With Dignity Act, some outcome data are available.<sup>16</sup> Contrary to the “slippery slope” concerns, the data indicate that between 1998-2003, those who died under the Act had the following characteristics: 80% were enrolled in hospice care, which is the gold standard of palliative care; 98% had health insurance, and over 60% had private health insurance; 97% were white, middle-class, and had a college degree; physicians’ unanimous response to the initial request for assisted suicide was to put more supports in place to enhance quality of life; only 50% of patients who received a lethal prescription chose to use the given medication to end their lives; and finally, the deaths under the Act in Oregon accounted for less than 0.5% of total deaths in the state during this time period. These data indicate that contrary to our fears, those who request and undergo physician-assisted suicide for terminal somatic illness neither lack an appropriate standard of medical care, nor belong to marginalized groups. It goes without saying, however, that further research is required in order to generalize these conclusions to individuals suffering from refractory psychic pain due to mental illness.

**Conclusions**

Although exceedingly complex and painful, this discussion is necessary, and possibly increasingly so as the debates about palliative sedation, assisted suicide, and euthanasia become more heated in North American medical circles. Psychiatry, as medical profession, has an important role to play. I would like to address fairly, and from all possible angles, the original question: how can I help my patients with prolonged, treatment-refractory illness, in the most ethical ways? How do I most effectively reduce my patients’ suffering while preserving their autonomy and personhood? Is the prolongation of life in psychiatric illness, with or without a somatic illness, always the best choice? Is it possible, or ethical, to assess capacity for a decision to commit suicide? What would be the psychiatric equivalent of palliative care? Given the above countless questions, debates, and unresolved ethical quandaries, it has become increasingly clear to me that this must be a subject open to discussion. Avoiding it is not only detrimental to the well-being of our patients, but also to that of our profession and its place within medicine.

**References:**

1. Groenwald JH, Van der Maas PJ, van der Wal G. Physician-assisted death in psychiatric practice in the Netherlands. *NEJM* 1995; 336: 1795-1801.
2. Ogilvie AD, Potts SG. Assisted suicide for depression: the slippery slope in action? *BMJ* 1994; 309:492.
3. Hawton K, Burgess S. Suicide, euthanasia, and the psychiatrist. *Philosophy, Psychiatry, & Psychology* 1998; 5.2: 113-26.
4. Berghmans R. Physician-assisted suicide and mental illness. *Philosophy, Psychiatry, & Psychology* 1998; 5.2: 131-5.
5. Matthews E. Choosing death: Philosophical observations on suicide and euthanasia. *Philosophy, Psychiatry, & Psychology* 1998; 5.2: 107-11.

6. Cassell E. Diagnosing suffering: A perspective. *Annals of Internal Medicine* 1999; 131: 531-4.
7. Cassell E. The nature of suffering and the goals of medicine. *New England Journal of Medicine* 1982; 306 (11): 639-45.
8. Hewitt J. Rational suicide: philosophical perspectives on schizophrenia. *Med Health Care and Philosophy* 2009; 13: 25-31.
9. Ganzini L et al. Attitudes of Oregon psychiatrists toward physician-assisted suicide. *American Journal of Psychiatry* 1996; 1469-73.
10. Matthews E. Choosing death: Philosophical observations on suicide and euthanasia. *Philosophy, Psychiatry, & Psychology* 1998; 5.2: 107-11.
11. Sakinofsky I, Swart GT. Suicidal patients and the ethics of medicine. *Canadian Journal of Psychiatry* 1986; 31: 91-6.
12. Hendin H, Foley K. Physician-assisted suicide in Oregon: A medical perspective. *Michigan Law Review* 2008;106: 1613-39.
13. From NIH internet site: [http://www.nlm.nih.gov/hmd/greek/greek\\_oath.html](http://www.nlm.nih.gov/hmd/greek/greek_oath.html)
14. Sakinofsky I. Rational suicide and the older adult: A humane experiment gone adrift. *Crosscurrents (CAMH publication)* 2008; summer: 18.
15. Helft PR, Siegler M, Lantos J. The Rise and Fall of the Futility Movement. *NEJM*, 2000; 343: 293-296.
16. Werth JL, Wineberg H. A critical analysis of criticisms of the Oregon Death With Dignity Act. *Death Studies* 2005; 29(1):1-27.

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