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# Conceiving the unconceivable: ethical and clinical concerns over assisted suicide for people with mental disorders

Bernardo Carpiniello

Department of Medical Sciences and Public Health-Unit of Psychiatry, University of Cagliari, Italy

Bernardo Carpiniello

Euthanasia/Assisted suicide (EAS) for the mentally ill undoubtedly constitutes a hot topic in the field of psychiatry worldwide. However, to date only a few countries including the Netherlands, Belgium, Luxembourg, Switzerland, Canada and some US States have legalized this practice. Indeed, although assisted suicide for people with mental disorders accounts for a very limited number of overall cases of euthanasia, ranging from 1% to 3% [1-3], in recent years it has become one of the most widely debated issues in the field of psychiatry, with two fiercely opposed parties formed of those who are decidedly in favor and those who are firmly against [4-9]. In Italy, public opinion was aroused by the case of Lucio Magri, a leading politician who opted to die by means of assisted suicide in Switzerland several years ago, giving rise to scientific debate [10]. Although EAS is not legal in Italy, the number of patients seeking assisted suicide in Switzerland, a country bordering with Italy, is likely on the rise, although no reliable data are currently available. Indeed, numerous psychiatrists, including the author of the present paper, have received a request from one or more of their patients for a detailed report of their status, including course of their disease and response to previous therapies, as required by some of the Swiss organizations currently practicing EAS. The reasons why psychiatric assisted suicide is considered such a hot topic are very clear, as clearly evidenced by the words of a Dutch psychiatrist: "*apart from controversy about the primary question, whether euthanasia is an option for psychiatric patients, there are medical and ethical dilemmas related to the practical process of decision making and execution*" [11]. Indeed, difficulties encountered by physicians in dealing with euthanasia were revealed in a survey of Dutch general practitioners, revealing how the majority of physicians would grant a request for AS in a patient with cancer or other physical disease (respectively 85% and 82%), whilst less than half deemed this option conceivable in patients with psychiatric disease (34%), early-stage dementia (40%), advanced dementia (29-33%) or those who were "tired of living" (27%) [12]. Qualitative and quantitative data on psychiatric EAS in European Countries in which the practice has been legalized have been reported in a series of papers published in recent years [1-3, 13]. In this paper, using a narrative approach we will aim to address the main concerns relating to the practice of EAS for the mentally ill as emerging from relevant literature in the field.

## Ethical concerns

Still today in western countries thousands upon thousands of physicians embark on their career by citing the Hippocratic Oath, solemnly promising "*I will give no deadly medicine to any one if asked, nor suggest any such counsel"* [14]. Consequently, when faced with a request for euthanasia, psychiatrists may experience "moral distress", as suggested by data from the

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**Correspondence:**
Bernardo Carpiniello
bcarpini@iol.it

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Netherlands, where psychiatrists are facing an increasing number of requests for euthanasia; it would however appear that, over time, they have become more reluctant to grant these requests, with 53% of psychiatrists considering euthanasia unconceivable in 1995, compared to 63% in 2015 [11]. Euthanasia or assisted suicide represents a typical example of a situation in which psychiatrists are faced with the impossibility of having to reconcile two moral obligations, a duty of care and respect of patient autonomy [15]. To put it bluntly, for many psychiatrists euthanasia is ethically unacceptable, particularly as the main aim of psychiatry is to limit patients' suffering [16]. This position is reflected in relevant official documents such as the Position Statement on Medical Euthanasia of The American Psychiatric Association, which states that *"the American Psychiatric Association, in concert with the American Medical Association's position on Medical Euthanasia, holds that a psychiatrist should not prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death"* [17]. As a general rule, Medical and Ethical Codes enforced throughout numerous countries worldwide clearly state that physicians may not facilitate or promote the death of their patients. In Italy, the Ethical Code of the Italian Federation of Physicians and Surgeons with regard to *"Acts aimed at causing death"* state that "*The physician, even at the request of the patient, must not carry out or encourage acts aimed at causing his death" (art. 17)* [18], although very recently the above mentioned Federation issued a redress relating to art. 17. Indeed, the recent ruling of the Constitutional Court (n° 249/19) affirmed that no person may be charged with murder if he/she assists a terminally ill person who wishes to die and is affected by an irreversible medical condition that causes intolerable physical or psychological suffering, is kept alive by life-support treatments, and is still able to make a free and informed decision. Based on this Court ruling, the Italian Federation of Physicians and Surgeons amended art. 17, stating that any doctor who chooses to facilitate suicide would however remain unpunishable from a disciplinary point of view, in which case the conditions laid down by the Constitutional Court would apply [19]. Interestingly, the ruling of the Italian Constitutional Court stemmed from a case that caused quite a stir in Italy, of a famous Disk Jockey known as DJ Fabo, who had been left tetraplegic following a serious car accident and had chosen to commit assisted suicide in Switzerland, with the help of a high-profile politician.

From an ethical viewpoint, another key role is played by the so-called "slippery slope" issue, based on the idea that a particular course of action may lead step by step to unintended and/or undesirable consequences [20]. Euthanasia has been reported as a typical example of the "*slippery slope, down which we have rolled to now allow something that was impossible to conceive as ever being acceptable"* [21]. A series of facts seem to support this concern, including the rate of persons who have died by euthanasia in The Netherlands, corresponding to 3.3% in 2012 - an approximately three-fold rise in the figure reported in 2002, the first year of legalization [22], and the situation in Flanders (Belgium), where euthanasia as a cause of death rose from 1.9% in 2007 to 4.6% in 2013, while the percentage of approval of requests for euthanasia increased from 55% in 2007 to 77% in 2013 [23]

## Public Health Concerns

Suicide rates are deemed to be excessively high in high-income countries, representing the sixth/seventh leading cause of death and the second/third cause of death amongst young people. Taking these data into account, it comes as no surprise that suicide prevention is viewed as a public health priority. The WHO Director-General, Tedros Adhanom Ghebreyesus pointed out recently that *"despite progress, one person still dies every 40 seconds from suicide. Every death is a tragedy for family, friends and colleagues. Yet suicides are preventable. We call on all countries to incorporate proven suicide prevention strategies into national health and education programmes in a sustainable way"* [24]. Indeed, the prevention of suicide is one of the main objectives of both the WHO Mental Health Global Plan 2013-2020 [25] and the European Mental Health Action Plan 2013-2020 [26]. World Suicide Prevention Day has been celebrated every year on September 10th since its establishment in 2003 to remind us of the relevance of the issue. Moreover, guidelines and recommendations for suicide prevention have been developed by outstanding scientific associations, such as the European Psychiatric Association [27]. Indeed, an emphasis on suicide prevention from a public health perspective seems to be somewhat hard to reconcile with the fully implemented or pending legalization of euthanasia or assisted suicide for those countries simultaneously equipped with social and health policies established for the specific purpose of preventing suicide. Considering the specific role of psychiatry in preventing suicide, put in very simple terms the question is: what is the point of psychiatrists trying in every way possible to prevent suicide if the person concerned is entitled by law to seek assistance to commit this action?

## Clinical concerns

Clinical concerns relating to the practice of psychiatric euthanasia or assisted suicide are essentially raised by conditions generally viewed as being necessary requisites: 1. the patient's suffering must be lasting and unbearable; 2. all therapeutic options must have been exhausted, and any further treatment considered futile; 3. the patient's request should be voluntary, enduring and well considered (i.e. the patient should be "competent"). Each of these aspects may represent an intrinsic challenge to psychiatrists, who are largely forced to base their evaluation on subjective, personal criteria, particu-

larly given the lack of objective, reliable criteria. Based on an experience of evaluation of terminally ill patients, McLeod maintained that "*assessments of competency, sustained wish to die prematurely, depressive disorder, demoralization and 'unbearable suffering' in the terminally ill are clinically uncertain and difficult tasks … As yet psychiatry does not have the expertise to 'select' those whose wish for hastened death is rational, humane and 'healthy'* [28]. The same assumptions may also be deemed valid in the case of non-terminally ill psychiatric patients who wish to die due to their mental suffering.

To return to the first condition considered a requisite for EAS, namely that "*suffering must be lasting and unbearable*", the difficulty in evaluating unbearableness is particularly significant due to the lack of related "objective" measures. Physical symptoms such as pain, as well as the entire range of psychopathology, are highly "subjective" experiences, which may be perceived to some extent by others but in no way "measured" with regard to intensity and tolerability. The relevance of this difficulty is highlighted in a survey conducted in 2006 on a sample of 2,100 Dutch physicians, highlighting how of all physicians who had received a request for euthanasia or assisted suicide (75%), 25% had experienced problems in decision-making, mainly in the evaluation of *whether or not the patient's suffering was unbearable and hopeless* (79%) and whether or not the patient's request was voluntary or well considered (58%) [29]. Although the latter study addressed the issue of euthanasia in non-psychiatric populations, it is feasible to imagine that similar issues may also apply to psychiatric cases. Appelbaum, who meticulously addressed concerns arising with regard to assisted suicide in psychiatry [7,8] underlined the potentially scarce reliability of clinical evaluation, reporting how in 24% of cases submitted to further evaluation in the Netherlands for the purpose of obtaining a final judgement, the three independent experts were however in open disagreement.

The evaluation of the *untreatability and futility of treatments* represents another highly challenging task for clinicians. How can we confirm that a single case should definitely be considered untreatable if *"there are no universal standards defining incurability in most cases of mental illness"* [30] and *"there is no reliable mechanism to define incurable disease and determine medical futility for psychiatric care"* [31]. Treatment-resistant depression (TRD) has been described as a typical example of a condition in which the option of assisted suicide should be considered [32]. Unfortunately, the literature yields a series of definitions and staging models for TRD, but no universal definition is available, although some degree of consensus is reached in identifying treatment-resistant depression as failure to respond to two or more antidepressants featuring diverse mechanisms of action [33]. A recent study conducted to identify definitions of treatment-resistant depression confirmed the lack of a universally accepted means of defining the condition, highlighting the presence of a substantial heterogeneity; moreover the study demonstrated a significant discordance between use of the term in research and clinical practice, with several key informants emphasizing that this terminology is rarely used in their clinical experience [34]. In a situation such as this, it could prove an arduous task, even for the most experienced psychiatrist, to confirm that the case undergoing evaluation for assisted suicide is an actual TRD, bearing in mind the need to ensure that all possible therapeutic options besides pharmacological treatments and evidence-based psychotherapies have failed. Accordingly, it should be kept in mind how approx. 20% of Dutch patients requesting euthanasia had never undergone psychiatric hospitalization, 56% had refused some form of recommended treatment, and how in 27% of cases patients had requested assistance with dying from a physician who had not previously been involved in their treatment [7,8]. In other words, they were assessed by a physician with no real direct knowledge of the case. In considering TRD, another pitfall may be represented by the implicit, albeit false, assumption that resistance is equivalent to incurability. To this regard Blikshavn et al. [35] suggests that "*treatment resistant depression, then, is in the current literature not a clinical term but a technical term pertaining to psychopharmacological interventions, applied in retrospect. Crucially, it does not answer the clinically relevant question of whether there is still hope for getting well. Moreover, a predictive use, meaning untreatable depression, is currently precluded by the absence of a valid and reliable way of identifying such patients (assuming that it is a valid concept in the first place)".* A series of questions arise from several studies conducted to investigate treatment resistance. Indeed, data from nine outcome studies for a total of 1279 participants and a duration of follow-up ranging from 1 to 10 years, showed how, in the short term, TRD was highly recurrent, with as many as 80% of those requiring multiple treatments relapsing within a year of achieving remission, while for subjects with a more protracted illness, the probability of recovery within 10 years was about 40% [36]. More recently, 155 TRD patients were evaluated over a 1-7 year (median 36 months) follow-up, revealing how 39.2% of follow-up months were asymptomatic and 21.1% at sub-threshold symptom level, while 15.8% featured a mild, 13.9% moderate, and 10.0% severe depressive episode level, thus demonstrating how the majority of patients with TRD manage to achieve an asymptomatic state [37]. Accordingly, ethical dilemmas in EAS should be perceived in the context of the relationship between patients and their treating clinicians, and in light of the interplay of ethical aspects, countertransference and transference [38].

In relation to the issues whereby *patient's request should be voluntary, enduring and well considered (competency),* a series of doubts have been reported in literature as to whether or not it is truly possible to confirm expression of a desire to die. Indeed, 38% of the Belgian patients

requesting physician assistance withdrew their request to die before assessment could be completed. Moreover, 52% of the Dutch cases and 50% of Belgian cases were related to a diagnosis of personality disorder, a condition often associated with a strong reactivity to environmental and interpersonal stresses, a finding that raised many questions as to the consistency of their desire to die [7,8]. Another challenging issue is represented by the task of assessing whether or not a patient requesting euthanasia is actually capable of expressing "free will". Unfortunately, no standard method is currently available for use in assessing "competence" or "decisional capacity" in patients seeking to hasten their death [30]. A recent study examined a frequently raised concern of how physicians address the issue of the decision-making capacity of persons requesting psychiatric euthanasia/assisted suicide (EAS) in the Netherlands [38]. The study design comprised a review of psychiatric EAS case summaries published by the Dutch Regional Euthanasia Review Committees, on the basis of a directed content analysis performed using a capacity-specific four abilities model (understanding of facts, applying those facts to self, weighing/reasoning, and evidencing choice) to code texts discussing capacity; the main results of the study were as follows: in 55% (36 of 66) of cases, discussion focused solely on global judgments of patients' capacity, even in patients with psychotic disorders, 32% (21 of 66) of cases included evidentiary statements regarding capacity-specific abilities; only in 5 cases (8%) were all four abilities mentioned; moreover, in their evaluations physicians frequently stated that psychosis or depression did (or did not) affect capacity but provided little explanation to corroborate their opinions [38]. The findings of this study once again raised a series of doubts as to the reliability of evaluation of decisional capacity of patients requesting EAS, at least in the Netherlands. Moreover, the presence of a harsh dispute as to whether or not psychopathology itself may obscure the possibility of a rational choice should be taken into account. In this sense, the case of depression is considered emblematic, given that the typical negative attitudes related to the disorder due to cognitive dysfunctions, feelings of guilt, worthlessness, hopelessness and helplessness may fuel a desire to die in order to escape an unbearable condition [10]. Using the words of Blikshavn et al "*considering the emotional pain, avoidance of negative affect, altered cognition, increased recall of negative life events, and failure in role functioning that is part of this disorder, it is not hard to understand how the patient may be drawn towards annihilation rather than growth"* [35].

In addition to the aforementioned clinical problems, one of the most widely debated issues in the decision-making process related to requests for EAS is focused on the role of transference and countertransference. Indeed, Kissane and Kelly pointed out some years ago [39] the critical role of transference and countertransference in the therapeutic relationship with a patient who wishes to die: *"the psychiatrist's therapeutic role is to be a container of anguished, despairing and hopeless emotions of a demoralized or depressed patient. As such, he or she waits for the window of opportunity to instill hope and encouragement back into such a person. Significant transference and countertransference phenomena exist in such a relationship, predicated on power, inequality and charging the psychiatrist with considerable professional responsibility"*. Undeniably, the complex dynamics of a therapeutic relationship in which a physician receives a request for EAS is considered of the utmost importance in this debate. Some authors have criticized the assumption according to which a physician will always act in the interests of their patients, mostly because it fails to consider the doctor's unconscious, and at times conscious, desire for the patient to die and alleviate distress for all concerned, including the physician [40]. Similarly, the implicit assumption that the physician's values and intrapsychic conflicts can be successfully separated from a decision to grant or reject the patient's request has been confuted, particularly in view of the key role these factors may play in such an emotionally-laden decision [41]. Countertransference, the mirror image of transference, has been described as a potential determinant in a physician's choices when faced with patients who wish to die. The assumption that physicians will generally be able to accurately assess patients' requests for EAS, casting aside their own intrapsychic conflicts and personal history, has been confuted, given that countertransference *"can affect doctors' assessments of PAS requests, potentially leading to errors in classifying patients as appropriate or inappropriate for assisted suicide… Doctors who are affected by countertransference or who have psychologically committed themselves to PAS may be prone to accepting patients' reasons for PAS at face value without thorough exploration*" [42]. One of the most frequently cited consequences of countertransference is over-identification with the patient, giving rise to a so-called 'pseudoempathy', a condition resulting in the physician experiencing the feeling that the patient's suicidal wish is 'normal' and that they would feel the same way [43]. Thus, ethical dilemmas in EAS should be perceived in the context of the relationship between patients and their treating clinicians, and in light of the interplay of ethical aspects, countertransference and transference [44]. The impact of transference/countertransference in psychiatrists' decision-making seems to be anything but unusual if we consider data from a Dutch survey of psychiatric consultations related to requests for EAS, showing a reported influence in 24% of cases [45].

## Concerns over the undesirable consequences of EAS

The possibility that EAS may induce treatment nihilism is one of the most frequently reported concerns. To cite the words of Appelbaum: "… *will psychiatrists conclude from the legalization of assisted death that it is acceptable to*

*give up on treating some patients? If so, how far will the influence of that belief spread?"* [7]. To this regard the Author, commenting on data from the Netherlands, reports "*56% of cases in which social isolation or loneliness was important enough to be mentioned in the report",* arguing that *"the latter evokes the concern that physician assisted death served as a substitute for effective psychosocial intervention and support"* [7]. Moreover, Appelbaum evokes the possibility that EAS may induce a sense of hopelessness among other patients in a similar condition to those seeking EAS [7]. Accordingly, Blikshavn et al underline the "*therapeutic role of hope"*, suggesting that "*one of the main tasks of the therapist is not to accept the person's distorted thoughts and their wish to die but instead to keep hope when the patient has lost it. The prognosis is uncertain not only because of the nature of psychiatric diagnoses…but also because the likelihood of improvement is dependent on the hope in improvement*" [30]. Several authors are of the opinion that EAS in psychiatric patients may be detrimental in the advancement of research and implementation of new treatments, given that it "*may reinforce poor expectations of the medical community for mental illness treatment and contribute to a relative lack of progress in developing more effective therapeutic strategies"* [28], contributing towards "*removing pressure on improvement in psychiatric and social services"* [7]. Finally, it has been suggested that EAS is in blatant contrast with the philosophy of recovery, as demonstrated over recent decades in the field of Psychiatry. This position is clearly described by Krumm: *"… how can you live with an official confirmation of your own "unsustainable" and "hopeless" situation? It would have a devastating signal effect if the debate about assisted suicide put mental illnesses in the semantic proximity of incurable diseases and unbearable states of pain. Such a perspective not only obscures the fact that the majority of mental illnesses are easily treatable disorder, it also undermines all hope of a satisfying, meaningful life despite long-term and less or more severe disease courses, as the recovery approach promises …"* [9]. Krumm goes on to express other concerns, including the negative consequences of EAS on the social representation of mental illness and of the psychiatric profession itself: "*What consequences on social representations of mental illnesses, on how to deal with a mental illness and on professional profile if psychiatrists recognize that life with mental illness – even if "only" in individual cases – is not worth living?* [9]

## Conclusions

Dealing with requests for EAS in people with mental disorders is by far one of the most challenging tasks psychiatrists will be called upon to undertake, both on ethical and clinical grounds. Data from studies conducted in countries in which EAS has been approved for people with mental disorders are rather limited and do not allow any firm conclusions to be drawn. However, the data obtained have proved sufficient to give rise to controversy and concerns, all of which should be carefully evaluated by decision makers in countries currently discussing the legalization of EAS.

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