

## Correspondence

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### The advocates of euthanasia in patients with mental illness are going in the wrong direction

Shaw *et al* argue that 'it is wrong to assume that patients suffering from mental health issues (including depression) cannot consent to assisted suicide'.<sup>1</sup> But being depressed is the strongest correlate of decision instability, of changing from acceptance of euthanasia to rejecting it at follow-up.<sup>2</sup> As a matter of fact, the rate of psychiatric patients who, after seeking euthanasia or assisted suicide (EAS), no longer wished to die and/or withdrew their requests is quite high.<sup>3</sup> In general, caregivers should be aware of the risks of EAS for patients with a mental health issue.

Beyond the paradox of use of EAS criteria corresponding to clinically targets of therapeutic intervention, available data on psychiatric EAS from Belgium, the Netherlands and Luxembourg highlight real issues of such practice. Even EAS defenders criticise the procedure,<sup>4</sup> agreeing that: (a) a rigorous standardised evaluation involving a biopsychosocial perspective is lacking; and (b) all available treatments are not always tried and access to care not systematically assured. Decision-making capacity evaluation in patients requesting assisted suicide is even more complex in the presence of psychiatric disorder.

Medicine's ongoing assumption that clinicians and patients are rational decision-makers is questionable. All humans (including patients and clinicians) are influenced by seemingly irrational preferences in making choices about risk, time and trade-offs. By extension, the existence of rational suicide is uncertain. Decisions are considered to be rational when they rely on two core dimensions: being realistic and having minimal ambivalence.<sup>5</sup> But how can we rationally consider the options 'to be or not to be'? Suicide is known to be an ambivalent choice. In addition, considering that 'I would be better off dead' is not sensible because there is no knowledge of 'being' after death. The term 'understandability' could thus be rather used than 'rationality' for suicide. However, the ability to understand someone's wish to die does not mean that suicide is for the best.

Moreover, the irremediable dimension of suffering justifying EAS is unclear because suffering may be improved for some patients when they are heard and taken seriously in their death request. Altogether, it suggests that EAS defenders may be misled by personal beliefs, feelings and values. Are EAS advocates reigned caregivers having forgotten the Hippocratic oath '*primum non nocere*'? It is important to note that mental illnesses are now recognised to be chronic and disabling, belonging to a group of serious medical illnesses such as cancer, but do not benefit from the same research

approach. Whereas the goals of biomedical research for severe somatic illnesses are generally cure and prevention, very little research for the mental illnesses has set the bar this high. Thus, to propose an irremediable and definitive solution (death) to a complex and poorly understood phenomenon (suffering) is going in the wrong direction.

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### Capacity is only one aspect of decision-making at life's end

The editorial by Shaw *et al* in the July edition discussing decision-making capacity to request assisted suicide follows on from a previous report from Belgium also published in the journal entitled 'When unbearable suffering incites psychiatric patients to request euthanasia: qualitative study'.<sup>1,2</sup> There seem to have been no balancing editorials or reports on the merits of effective palliative care in individuals who are terminally ill or in those suffering unbearably. This must be the hand of the editor because it definitely is not the hand of God! Assisted suicide and euthanasia are legal in a minority of jurisdictions. They are illegal in the UK. Everyone knows there is a concerted drive by some to foist death by design on those that will not die when they become a nuisance.

The issue of capacity as a stand-alone faculty of itself is a faulty basis for determining a person's true desires. We all know too well that we often do not do the things we should (even though we have capacity) and end up doing the things we do not want to do – such is our state. This is not a lack of capacity but of ability to follow through on what we wish, and it overrides our decision-making capacity. The human will can cloud our cognition/capacity into doing what it wants. Lying, denial, self-delusion, self-justification are among the many ploys the will uses to suppress capacity, and with it the good, the beautiful and the true are suppressed.

Conscience is also active in decision-making. Issues of end-of-life care are laden with conscience issues. 'Should I? Shouldn't I? What do people want me to do? I'm a burden on my family'. People at the last stages of life or who are grievously suffering, are at their most vulnerable and are easily swayed one way or another, and may not have the ability to harness their will power, clarity of thought (capacity) and conscientious understanding of what is at stake. What they are being offered is death by design (assisted suicide/euthanasia) not a new lease of life or some other positive intervention, like effective palliation and hope and support.

Everyone spends their lives living, and their behaviour/body language and drive is to live and make the most of life. Now in

the closing moments should they not be helped to persevere in their lifelong goal, rather than be defrauded in a definitive decision by a faulty concept of decisional ability? Informed consent and freedom from duress or subliminal or liminal influence along with cognition, emotions, conscience and the enormous impact of a life lived over decades all come into play in crucial decision-making at life's closing moment (days, weeks, months). Capacity is only one of these many faculties (and not the most important) involved in late life decision-making.

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## An odd choice for an editorial!

It is puzzling that this article by Shaw *et al* received the mantle of an editorial!<sup>1</sup> The authors express opposition to psychiatric interview and psychological questionnaires in the assessment of individuals seeking assisted suicide. In my opinion the article should have been published for debate, with a contrary view presented.

The authors, ethicists in Switzerland, argue that for medical specialists to cause delay to assisted suicide is unethical, if a person with sound 'decision-making capacity' clearly and repeatedly and without any ambivalence expresses a wish for assisted suicide over a period of time.

One has to wonder why the authors oppose psychiatric assessments and psychological questionnaires. Psychiatrists are generally regarded among the most skilled of medical interviewers. In the opinion of many, untreated depression should be carefully excluded by psychiatric assessment before assisted suicide is supported. Sadly, there are countries where this is not the case.

The article acknowledges that relatives may coerce for financial gain. The person may wish to please relatives, be afraid to speak against them, etc – and still demonstrate sound decision-making capacity. But the article does not deal with how this thorny problem is to be tackled. In fact, examination beyond decision-making capacity is required: the person's motivation must be clearly established.

Psychological questionnaires have long been designed to clarify a respondent's unspoken beliefs and wishes. It is not hard to imagine a case of elder abuse in which a person fears to directly express their situation – and through an indirect questionnaire, followed by skilled interviewing, a wrongful death might be prevented.

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## Physician beneficence: the last stop for patients requesting assisted suicide

In their editorial, Shaw *et al* argue that current medical practice is overly paternalistic towards patients who are mentally competent and who have a terminal illness (including those with psychiatric illness) who request assisted suicide.<sup>1</sup> They base their general argument on the four principles of bioethics with a special emphasis on patient autonomy and end by asserting that, 'any doctor who attempts to prevent a patient who is mentally competent from accessing assisted suicide is adopting an over-paternalistic stance'.<sup>1</sup>

The authors' implicit argument against dissuading a patient from assisted suicide appears to rest on the premise that death is a lesser evil (or a lesser suffering) compared with being alive and suffering. We would hold that this premise merits a closer examination.

Life has always been regarded as the basic right and fundamental good for any human person. Aristotle's distillation of popular wisdom is unequivocal: 'death is the most terrible of all things; for it is the end, and nothing is thought to be any longer either good or bad for the dead'.<sup>2</sup> The person who has lost the desire to live represents the ultimate instance of suffering – existential suffering; and in seeking medical attention, the existential sufferer accepts *de facto* that the physician is the last instance of help. Ultimately a request for suicide is a request for help to relieve existential suffering. It is not a request to annihilate existence.

We would argue that any doctor who unconditionally accedes to assisting his or her patient to die by suicide is abdicating his or her role as a beneficent protector of the sick and suffering and is instead championing absolute patient autonomy.

The Hippocratic dawn of medical practice with its paternalistic physician–patient relationship is thankfully behind us but the beneficent physician is still the necessary companion for the autonomous patient. Indeed, a total abdication of physician beneficence in favour of patient autonomy is neither called for nor is it in the best interests of patients.<sup>3</sup> As Brett & McCullough put it 'if the aim of medicine should be seen as a form of beneficence, then doing harm in the service of autonomy is illogical'.<sup>4</sup>

The authors rightly conclude that 'to impose [one's] values on one's patients is deeply unethical and unprofessional'.<sup>1</sup> Certainly patients must always be free to decide about their own life; but again there is something deeply unethical and unprofessional for a doctor who is traditionally committed to saving life to be instrumental in taking away that very life. The ideal physician–patient relationship should be characterised by the equally important contribution of physician beneficence and patient autonomy operating in a shared environment of justice and non-maleficence. In this regard, an open and sincere shared decision-making process is probably the best context within which a constructive discussion of the meaningful alternatives to suicide for the management of existential suffering can take place.<sup>5</sup> Such alternatives include, but are not necessarily limited to: meaning-centred therapy, hope-centred therapy, dignity therapy and supportive-expressive therapy.

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