

EXCLUDING PSYCHIATRIC CONDITIONS FROM PAD: HAS THE CASE BEEN MADE?

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Dying Well Workshop 2
2nd December, 2015

PHYSICIAN-ASSISTED DEATH (PAD)

- ▶ Includes both physician-assisted suicide (PAS) and euthanasia
- ▶ In this talk, I bracket the moral acceptability of PAD
 - What limits are justifiable if it is acceptable?
- ▶ Allowing PAD for psychiatric conditions not an issue for its opponents, nor for supporters who reject any restrictions
- ▶ A serious issue for those who support PAD but think there should be restrictions

THE LEGAL SITUATION

▶ USA

- Euthanasia illegal everywhere; aid-in-dying (PAS) legal in 5 states (OR, WA, VT, CA and MT)

▶ Canada

- Supreme Court held PAS to be fundamental right; will be implemented in 2016

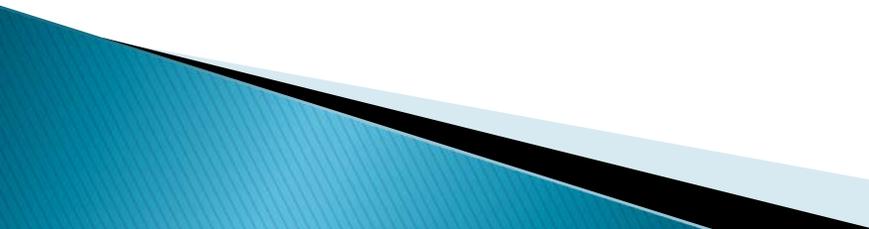
▶ The Netherlands and Belgium

- Both euthanasia and PAS are legal when carried out as prescribed by law

▶ Switzerland

- Assisted suicide is legal if not done from self-interested motives

IS THERE A MORAL DIFFERENCE BETWEEN PAS AND EUTHANASIA?

- ▶ Pragmatic reasons for PAS
 - Voluntariness may be more assured
 - PAS may allow more for last-minute change of mind than euthanasia
 - Only half of patients requesting pills in OR actually took them
 - ▶ Pragmatic reason against
 - Arbitrarily rules out those who cannot swallow
 - ▶ No intrinsic moral difference
 - Physician agency/responsibility is the same in PAS and euthanasia
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1st ARGUMENT AGAINST EXPANSION: ROLE RESPONSIBILITY

- ▶ Facilitating suicide would be anathema to psychiatrists
- ▶ Assisting suicide counters core aims of psychiatry
 - to alleviate psychic despair and prevent suicide

RESPONSES TO 1ST ARGUMENT

- ▶ 1. Same claim made by many physicians about physical illness
 - “Physicians should be healers, not killers”
- ▶ Does not distinguish psychiatric illness in particular
- ▶ 2. Not everyone agrees that assisting death is inconsistent with physician’s role
 - Remains to be shown that assisting death is incompatible with *psychiatrist’s* role

2ND ARGUMENT: PAD SHOULD BE LIMITED TO TERMINAL ILLNESS

- ▶ Terminal illness (prognosis of death within 6 months) required for aid-in-dying in US
- ▶ Not required in Netherlands, Belgium, or Canada
- ▶ The argument for terminal illness
 - Nothing more can be done for a dying patient, except provide a “good death”
 - Prevents a slippery slope who are not dying, or even ill, but have other reasons for wanting to die

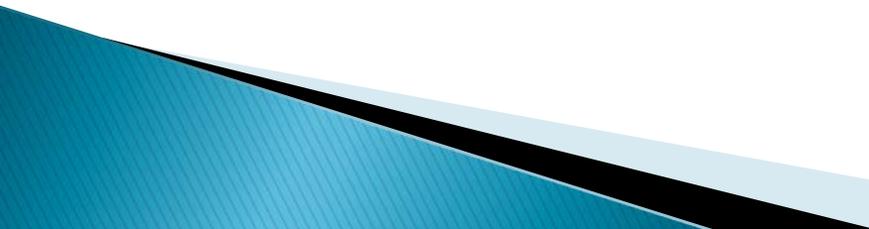
RESPONSE TO 2ND ARGUMENT

- ▶ Those suffering from incurable, progressive illnesses like ALS, MS, Parkinson's seem as good candidates for PAD as terminally ill
- ▶ Argument from suffering applies even more strongly in case of those who won't die within 6 months
- ▶ OR data reveal that suffering is not a primary reason why people seek aid-in-dying
 - Autonomy, dignity, loss of valuable things in life
 - These are also concerns for those not terminally ill
- ▶ Morally relevant features are incurable conditions that cause severe, unrelenting, unrelievable suffering, not terminal illness

3rd ARGUMENT: PSYCHIATRIC CONDITIONS CAN BE TREATED

- ▶ Wrong to offer PAD when treatment is possible
- ▶ Psychiatrists disagree on whether treatment is always possible
- ▶ Some say it is
- ▶ Others say there are cases of incurable depression
 - Roughly 20–30% of clinically depressed patients suffer from treatment-resistant depression (TRD)
 - Significant number of them have little hope of recovery
 - Will suffer for the rest of their lives
- ▶ Still others say we can't know which cases are incurable
- ▶ Psychiatry different from the rest of medicine

RESPONSE TO 3RD ARGUMENT

- ▶ May overstate the difference between medicine and psychiatry
 - ▶ Notoriously difficult to determine death within 6 months
 - Some “terminally ill” patients live longer; some go into remission
 - ▶ Difficult to predict individual outcomes in many areas of medicine
 - Premature babies
 - ▶ Unclear that psychiatry is unique in terms of prognosis
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4TH ARGUMENT: IMPAIRMENT OF DECISION-MAKING CAPACITY

- ▶ Respect for patient autonomy a foundation of contemporary biomedical ethics
- ▶ But some conditions impair decision-making, rendering choices less than truly voluntary
- ▶ Severe depression can impair decision-making
 - Not necessarily in understanding or reasoning
 - Profound effect on attitude
 - Chances of remission/recovery may be impossible for severely depressed patient to appreciate

RESPONSE TO 4TH ARGUMENT

- ▶ Effect of TRD on decision-making clearly relevant to assessing request for PAD
- ▶ But does not justify an absolute ban, any more than it would justify depriving severely depressed patients of all say in their medical treatment
- ▶ Standards of decisional capacity should be very high when the outcome is patient's death
- ▶ But if patient has undergone all available therapy for years, to no avail, and has such severe suffering that death is preferable, seems a legitimate ground for PAD
- ▶ Why must a compassionate physician refuse this request?
- ▶ Laura, 24-year-old Belgian woman with TRD

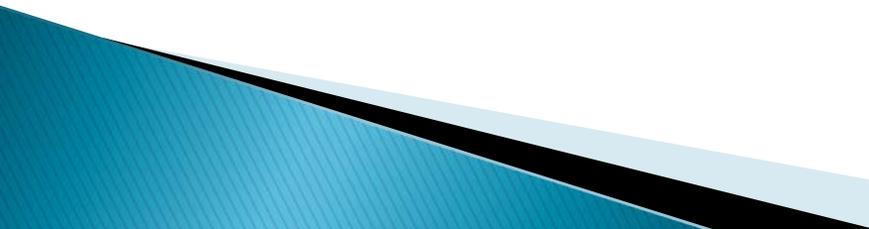
5th ARGUMENT: SLIPPERY SLOPE TO EXISTENTIAL SUFFERING

- ▶ If psychiatric illness is a grounds for PAD, it will likely expand to “existential suffering” or being “tired of life”
- ▶ The case of Edward Brongersma
 - 86-year-old Dutch patient who wanted to die because of physical decline and a “pointless existence”
 - The doctor who helped him to die initially acquitted, then found guilty of assisting a suicide
 - Dutch Supreme Court (2002): for legal euthanasia, patient must have “classifiable physical or mental condition”
- ▶ Rejected by Royal Dutch Medical Association (2005)
 - PAD not limited to physical or mental illness; can be legal for those who are “tired of life”
- ▶ 2012: opening of End of Life clinic in the Netherlands

RESPONSE TO 5TH ARGUMENT

- ▶ Slippery slope concerns not unique to psychiatric conditions
 - Cited as a reason against PAD generally
- ▶ Slippery slope not in evidence in OR
 - Not being used against vulnerable people
 - Not being used instead of palliative care
 - No evidence of coercion or subtle pressure
- ▶ But OR limits PAS to physical illness

IS INCLUSION OF EXISTENTIAL SUFFERING EVER JUSTIFIABLE?

- ▶ Depends on whether being tired of life can be seen as severe, intolerable suffering that can't be addressed any other way
 - ▶ RDMA's report advised caution against expansion of PAD beyond illness, recommending:
 - Protocols be created for judging "suffering through living"
 - Therapeutic and social solutions to existential suffering be tried first
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CONCLUSIONS

- ▶ PAD should be the last response to intolerable suffering, whether caused by physical illness, psychiatric disease, or existential suffering
- ▶ Safeguards essential to prevent mistake/abuse
 - Is the request voluntary? Is there outside pressure/coercion?
 - Is the patient competent to make the decision?
- ▶ But focus on the source of suffering seems misplaced
- ▶ Salient factor is severe, unrelenting suffering that cannot be alleviated any other way
- ▶ Assuming that PAD is in principle acceptable, the case for absolute exclusion of psychiatric causes of suffering has not been made