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

Bonnie Steinbock, PhD
University at Albany (emerita)
Distinguished Visiting Professor, CUHK Centre for Bioethics
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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

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

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

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