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Euthanasia and psychiatry

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Having analysed the circumstances of physician-assisted suicides, the author indicates temporary depressive states as an important cause of the patient's wish to die. Numerous patients demanding this kind of "aid" are not able to express their will in a fully conscious way. In the author's opinion participation of physicians, and especially of psychiatrists, in this particular form of euthanasia is inadmissible. Moreover, euthanasia itself is a manifestation of

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Following a period of silence in the post-war years the problem of euthanasia has been a systematically recurrent issue not only in mass media, but also in professional journals since the early 1980s. The problem, initially a theoretical one, in recent years has become practical, as in some countries euthanasia is a real fact. In the Netherlands it is accepted and widely applied, moreover, steps have been taken there toward the formal legalization of euthanasia.

In Poland, the first large wave of publications on euthanasia appeared in 1996. Then, after a three-year interval of relative silence the next series of interviews and articles on the subject (including some translations from foreign press) followed. In August 1999, results were published of a survey carried out in July by CEBOS (a major Polish opinion poll agency) on a random sample of 1055 adults. The survey shows that 42% of respondents would approve of a physician's intervention leading to the death of a terminally ill patient, and 41% are for providing the patient with a means to end his or her own life painlessly. Moreover, 45% would agree that the doctor could painlessly terminate his patient's life when consciously asked by the patient to do so. Besides, 55% of respondents believe that life-sustaining medical devices should be stopped if the patient himself – being still conscious and aware – asks for it. As compared to the 1988 survey data, the number of those who endorse the view that physicians should comply with the wish of terminal patients demanding a lethal agent increased by 10%. Surveys conducted among medical students in 1992 and 1994 also indicate the future Polish doctors' very permissive attitude toward euthanasia: while euthanasia was viewed as acceptable by 56.9% in 1992, their number rose to 64.7% in 1994 [7].

A serious debate on euthanasia cannot be avoided in our country, as evidenced not only by these research findings, but also by the recent publications on the problem in newspapers and magazines (cf. "Tygodnik Powszechny" No. 36, 45; "Gazeta

Wyborcza" 10-11.04.1999, 9.09.1999, and other titles). My presentation is based on a paper delivered at a meeting of the Warsaw Scientific Society on June 14, 1999, and at a conference of the Polish-German Association for Mental Health, held in Cracow on August 25, 1999.

Euthanasia advocates and propagators (including the well-known heart surgeon C. Barnard) [1] adduce three major premises for its legalization, namely:

- Euthanasia is to be a sign of compassion and striving to relieve the suffering of incurably ill terminal patients;
- The patient has a right to decide about his treatment and his fate, which includes the administration of life-terminating drugs;
- If the patient's suffering is intolerable and we are unable to help him, it is permissible to let him die.

As I have already mentioned, in the Netherlands euthanasia is accepted and widely applied [14, 21, 23, 24, 25, 26], although not recognized as legal yet. In other countries, e.g. in Australia, the U.S., or Great Britain, its legal permissibility is still being discussed [11, 12, 13, 27]. The univocally negative viewpoint of the American Medical Association in this matter [5] is shared by some German psychiatrists [16].

Opponents of euthanasia set forth several groups of important arguments, including:

- Ethical and moral objections, i.a., these pertaining to medical ethics (cf. The Medical Ethics Code passed at the II Special Meeting of Polish Physicians in 1991).
- Legal objections (cf. The Medical Profession Act of 5 December 1996).
- Objections stemming from historical premises, and especially from experiences of the not too distant past (in the years 1939-1945, 170 thousand of mentally ill or mentally handicapped people were murdered in the III Reich (Nazi Germany) for "eugenic" reasons or because of their "low quality of life").
- Objections stemming from medical knowledge.

In the following part of my presentation I would like to focus mainly on the fourth group of these premises, i.e. on the **clinical aspect of the problem.** More strictly, I will be talking about euthanasia and mental disorders (especially depression), leaving aside the obvious ethical and moral implications. I am fully aware that such an approach is artificial, since it is impossible to separate ethical and moral issues from strictly medical premises and practice. However, I have chosen this kind of approach being convinced that strictly medical arguments are sufficient to prove inadmissibility of the "Dutch cure" as a method of helping the incurably ill.

The legalization and application of euthanasia in medical practice involve physicians in the process of ending the patient's life:

Passive euthanasia – is a conscious withholding further help to the incurably ill patients or to those in a very severe general condition, although not always irreversibly so.

Active euthanasia is conducted without the consent of people put to death – the physician administers a lethal agent to the patient. Psychiatrists sometimes participate in the decision-making process, especially in cases when the patient is not able

to express his or her wish, but euthanasia is demanded by the family, or by caregivers to the disabled suffering from dementive disorders in the course of degenerative diseases of the brain (e.g. Alzheimer's disease). The main premise for the decision about euthanasia (as in such cases it is difficult to speak about any form of suicide) is the so-called low quality of life, and as a matter of fact – economic reasons (costs of caring for the handicapped people). This tragic problem will not be analyzed in my presentation. It should be noted only that authoritative international bodies recognized it in the past as a criminal activity [16].

"Physician-assisted suicide" - on the patient's demand the physician provides him or her with a means to end life (usually it is not a poison, but a drug that kills when taken in a lethal dose). The so-called "physician-assisted suicide" evokes a rising interest and anxiety among psychiatrists, since they are directly concerned there. The psychiatrist more and more often becomes an active participant of the drama and begins to be directly co-responsible for decisions made in this form of putting to death (the same pertains to many situations involving active euthanasia).

The so-called "physician-assisted suicide" was responsible for 4.5% of all deaths in the Netherlands in 1995. In the light of legal regulations obligatory in that country, a physician may participate in the patient's suicide if the person desiring to die meets the following criteria [10]:

- has been demanding death long enough and his desire to die is expressed in a fully conscious and voluntary way;
- his or her suffering is intolerable, incurable, and with no real prospects of an effective improvement.

Several physicians should personally examine the patient during an independent consultation before the decision about euthanasia can be made. The whole procedure should be carefully documented, with special emphasis on reporting the motives underlying the patient's request. The document should also include a detailed interview with the patient, a report of the discussion among the consultants, and justification of their opinion.

The Dutch criteria that must be fulfilled by a person demanding physician-assisted suicide were formulated for the physically ill. However, they may apply as well to people in a good physical condition suffering from chronic depression – in their case a persistent desire for death, intolerable suffering and the lack of prospects of an effective relief in a foreseeable future are not particularly rare features.

In 1994 the Supreme Court in the Netherlands considered a case of Dr. Boudewijn Chabot, a psychiatrist who had participated in the suicide of a 50-year-old female patient (with depression following the loss of her two sons). In this case the judicial decision was that in exceptional situations not only incurable physical illness, but also intolerable psychical sufferings might entitle the physician to assist his patient in committing suicide. So it is severity of suffering rather than its cause that justifies such a decision. The Supreme Court restricted the implementation of such an action in practice by imposing the following safeguards [10]:

- the patient should be provided with the maximum help available to relieve his suffering,

- if the patient refuses alternative forms of treatment, then physician-assisted suicide should not be allowed,
- expert consultants who had examined the patient personally should participate in the decision making.

The Supreme Court decision briefly presented here is in agreement with the standpoint of the Dutch Royal Medical Association holding that the presence of psychopathological symptoms does not automatically deprive the patient of the right to the "blessing" of physician-assisted suicide. This became a kind of legalization of such "suicide" as regards some mentally ill people, particularly patients with depression. The viewpoint is shared by a majority of surveyed Dutch psychiatrists [10]. Out of 552 respondents, 64% believe that under particular circumstances the mentally ill have the right to physician-assisted suicide. In this group, 205 psychiatrists (35%) participated in the preliminary qualifying procedure and gave their consent to this type of suicide in 12 cases. It should be noted that in the opinion of a majority of respondents it is the primary care physician that should assess the patient's clinical status and decide about a possible need for an expert (psychiatric) evaluation of his or her mental status.

Also a survey conducted a year earlier among 321 psychiatrists in Oregon (USA) (8,9] indicates their considerable permissiveness toward physician-assisted suicide. Namely, 68% of respondents regard the latter as permissible and are for its legalization, as well as - among other things – for providing the incurably ill in particular situations with drugs enabling them to commit suicide. The authors of the survey – Ganzini et al. [8,9] are astonished with their research findings showing a gross discrepancy between their colleagues' opinions and the contemporary knowledge about causes and determinants of suicide as well as about the specific role of depression in this dramatic phenomenon.

It seems worthwhile for our further considerations to recall a few basic clinical facts concerning depressive disorders [20].

Depression (in the sense of a Major Affective Disorder) is a mental illness involving not only the feelings of sadness, depressed mood and despondency, fatigability and a loss of ability of action, insomnia and numerous somatic complaints, but also a severe impairment of cognition. The latter is manifested by a depressive, pessimistic and permeated with a sense of hopelessness evaluation of the present, future, and often – also of the past. This pattern of thinking may be called a "depressive outlook". Remission of depression is frequently accompanied by a change in the patient's evaluation of his or her personal situation, i.e. by a more realistic perception, acceptance of the actually existing problems, and sometimes – even with attempts at their resolving.

Desire for death is a common feature of depressive states. In many cases it is manifested in the form of attempted suicide, completed by some patients (suicide is the cause of death in 15 to 25% of people with affective disorders). The reasons for depressive patients' suicidal attempts are complex and related not only to mood and thinking disorders, but often also to their difficult, unsolvable life problems. There is no simple relation between suicide risk and depression severity assessed in terms of the number and intensity of particular signs and symptoms of this disorder.

Depression as a full syndrome or a trait is present in a vast majority of suicides (some

studies report that this is the case in 90% of completed suicides) [15, 20]. A growing body of evidence suggests that early diagnosis and appropriate treatment of depression together with prevention of relapse may contribute to a marked decline in suicide rates among people suffering from affective disorders. Numerous data indicate also that effective therapeutic interventions in depressive patients contribute to a decline in the suicide rate in the general population.

Epidemiological studies indicate that ca. 10% of adults have at least once in a lifetime experienced mood and affective disorders meeting the diagnostic criteria for depression in terms of severity and duration (i.e. attaining the level of illness). The prevalence of depressive disorders increases with age, being twice as high in the elderly as compared to middle-aged people. Depressive disorders frequently occur in the population of the physically ill. In some conditions their prevalence rate amounts to 50%, being even higher in incurable diseases; it should also be noted that the presence of depression makes prognosis markedly worse [20]. More and more numerous data indicate that a desire for death and suicidal thoughts in the severely ill (especially those suffering from an incurable disease) are associated with clinical depression. In the study by Brown et al. [2], among 44 incurable terminal patients 34 did not express either suicidal thoughts or desire for death, while the remaining 10 did so – and a depressive state of clinical severity was found in all of them. The authors point to a close relationship between suicidal thoughts and depression. Among those without depressive disorders none had suicidal thoughts or revealed expectations of hastening their death. Also among hospice patients manifesting suicidal tendencies clinical depression was found in almost 59% of cases, while among those without such tendencies – in 7.7% of cases only [4].

It is very difficult and often unfeasible to evaluate the nature of mood and thinking disorders in terminal states. It is even harder to decide whether the patient's depressed mood, feelings that life is not worth living or desire for death are an adequate response to his or her incurable disease (and thus whether they may be regarded as fitting the so-called "normal" range). Maybe, they should rather be categorized as pathological mood disorders of depressive type [2, 3, 4]. From the clinical viewpoint the question is rather unimportant – in both cases the patient should be provided with help.

In contemporary psychiatry a variety of antidepressants are available to depressed patients. New antidepressants are more and more widely accessible, make the treatment safer (lower risk of complications and side effects), and may be administered to those patients with depression and physical diseases in whom older antidepressants are contraindicated. We may expect further development in the pharmacological treatment of depression in the near future. It should be noted that in a considerable group of patients with depression the treatment must not be limited to pharmacotherapy. Some patients require psychotherapy to improve the effects of antidepressant treatment [19, 20]. Moreover, in some patients community-based interventions are necessary.

Long-term, persistent depressive disorders resistant to standard treatment methods are a serious clinical and social problem. Patients with chronic depression, usually of moderate severity, but often disappointed with life and suffering from suicidal thoughts constitute from 15 to 25% of the population of people with affective disorders.

Many of them are elderly. Despite the common conviction (held also by psychiatrists) that such a condition is incurable – some patients do get better (sometimes to the point of a full remission) in response to therapeutic interventions and improvement of their living conditions. In some cases spontaneous amelioration or remission is noted even though their depression persisted for a few years.

In many countries, including Poland, the presence of an imminent danger to life due to mental illness warrants treatment without the patient's consent (Art. 23 Par. 1 of the Mental Health Act). In the case of depression, suicidal tendencies posing a risk to life are an indication to such action. In the light of this legal regulation the depressed patient's request to end his or her life (or asking for physician-assisted suicide) should be considered as invalid. Also from the clinical viewpoint considerations concerning validity (informed consent) of this kind of request seem to be pointless.

In debates on the position of psychiatry and the role of psychiatrists regarding the legalization of "physician-assisted suicide" the problem of **their competence** cannot be neglected. Strictly speaking, it is the problem of their knowledge and experience in helping the incurably ill. With the rare exception of psychiatrists working in hospices or as consultants to oncology departments, psychiatrists very seldom meet incurable terminal patients in their practice. Thus, **most psychiatrists have a limited competence** in this respect, and their expert opinions on incurable terminal patients' wishes frequently reflect the expert's views rather than the actual clinical status of the patient [9]. As regards some participants of the dramatic process of "legitimate" putting the patient to death, a peculiar "psychological infection" should be taken into account. The phenomenon, described by suicidologists, consists in that people helping those at risk for suicide take over their "suicidal image of the reality", with pessimism and a sense of hopelessness predominating [9].

* * *

An analysis of the current knowledge about causes and prevalence of depressive disorders, as well as of circumstances under which decisions about so-called physician-assisted suicide are made allow us to formulate the following conclusions:

- Decisions of persons requesting the physician's assistance with taking their own life frequently result from their specific affective state that in many cases meets the diagnostic criteria of depression or can hardly be differentiated from depression.
- It is often difficult or even impossible to assess whether the patient's expecting or requesting the doctor's assistance in suicide is fully conscious and "rational" or rather that such a request constitutes a symptom of depressive disorder.
- The feelings that life is not worth living and the desire for death are not stable traits and they disappear in many people [17].
- The notion of "incurability" does not apply to many mental disorders, including depression.
- Even if "strict criteria" are observed in qualification of patients to the particular form of euthanasia discussed in this presentation, the process is to a considerable extent affected by subjective factors, especially by the consultants' views on euthanasia and permissibility of "physician-assisted suicide" [29].

Literature as well as press publications on euthanasia and the so-called physician-

assisted suicide induce us to a sad reflection. Namely, the majority of authors presenting their views on this dramatic issue produce arguments of philosophical, ethical and legal nature. Publications dealing with the problem of helping the incurably ill in the terminal stage of their life can be regarded as an exception. There are even fewer studies concerning the treatment of depressive disorders in the incurably ill. I believe that euthanasia, and its specific form – physician-assisted suicide – are a symptom of a **crisis of the contemporary medicine** and social policy in developed countries:

- The crisis in medicine results from the fact that it has not yet worked out effective ways of helping people who live longer than formerly, due to developments in medical knowledge. The implementation of new, effective treatment methods is not accompanied by an adequate development of palliative medicine and of a system of effective care for terminal patients.
- Increasing costs of health services provision reduce the range of their accessibility to all in need. This pertains especially to expensive treatments accessible only to selected groups of the population, with an evident discrimination of the elderly and the incurably ill.
- Euthanasia is also a symptom of a crisis of the family, where provision of care to an incurably or chronically ill father, mother, spouse or child is "overburdening" in the psychological or material sense.
- Admissibility of euthanasia, including "physician-assisted suicide", infringes on the crucial standards of medical practice such as the principle of life protection, or the principle of trust in the patient-doctor relation, and blurs the border between treating and killing [22]. I am convinced that a physician, especially a psychiatrist, has a right and obligation of refusing to participate in any stage of practice aimed at taking the patient's life.

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