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Euthanasia: should psychiatric patients be systematically excluded ?

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Euthanasia or Assisted Suicide (EAS) can be legally practiced in the Netherlands, Belgium, Luxembourg, Switzerland, Colombia, Canada, as well as in six United States states (Oregon, Washington, Montana, Vermont, California, Colorado) and Australian states of Victoria and Western Australia. EAS includes : 1) euthanasia consisting of ending a person's life at her/his own express request; 2) physician-assisted suicide consisting of helping a person, at her/his own express request, to end her/his life (e.g., providing prescription or medications). As medical assistance in dying might be legalized in additional countries, we suggest that psychiatrists should engage in the debate because EAS will represent ethical and clinical challenges to face. If euthanasia for patients with unbearable somatic suffering is the subject of fierce ethical debate, the debate is even fiercer in cases of unbearable psychiatric suffering [1]. An increase of the number of psychiatric patients requesting EAS has been reported in countries practicing EAS [2]. The Benelux countries have enlarged EAS to unbearable suffering caused by a psychiatric disorder (psychiatric EAS, or pEAS). We thus propose to discuss 3 of the issues raised by pEAS.

1) Psychiatric disorder :an irreversible condition associated to medical futility ?

In general, the law requires irreversibility of the condition to grant EAS. Mental disorders have a negative functional impact on daily life and are the most globally disabling disorders in comparison to somatic illnesses. Based on the literature [3, 4], most of the pEAS patients suffered from a treatment-resistant mood disorder and/or severe personality disorder. It is admitted that one third of depressed patients are treatment resistant and no pharmacological treatment has been yet developed to specifically treat personality disorders. Unfortunately, some patients do not have access to or benefit from non-pharmacological interventions such as psychotherapy or electroconvulsive therapy or newer brain stimulation techniques. Psychiatry should thus recognize its therapeutic limits and recognize that there are situations where available treatments are very limited in their ability to alleviate suffering.

Nevertheless, the definition of treatment resistant depression vary across clinicians. Moreover, there is no or few evidence for a specific psychopathological or neurobiological profile defining precisely treatment resistant psychiatric disorders [5]. Psychiatrists do not have yet robust prognostic factors to predict quality of outcome and thus no consensual definition of psychiatric incurability. ~~Interestingly, recovery may in severe and chronic cases, even after several years and lines of treatments.~~ The issue of medical futility (i.e., uncertain available data on improvements with a specific therapy [6]) is particularly difficult to

determine in psychiatry. ~~and needs~~ Perhaps the development of evidence-based disease staging for mental illness, similar to those in cancer care would be helpful. In addition, the point on the outcome probability at which futility occurs is still inherently arbitrary and is determined differently among physicians and patients [6]. Studies are needed to determine clinical and biological factors that may help to better predict disease evolution and therapeutic response.

2) Capacity to make informed decisions ?

According to Appelbaum's criteria [7], capacity relates to the abilities to understand relevant facts, apply those facts to oneself (appreciating the consequences of those facts), reason and weigh the facts, and evidence a stable choice. When considering whether individuals have a right to choose when and how to die, suicidal ideation may be viewed as well-considered, deliberate choice but not a psychiatric symptom, i.e. 'rational suicide' [8]. People suffering from medical illnesses who receive EAS tend to be empowered people who value self-determination and control. It thus may be distinguished from 'traditional suicides' [9]. Similarly, autonomy, empowerment and destigmatization are at core of psychiatric care. Mental illness and cognitive impairments may be compatible with having decision-making capacity . Psychiatric diagnoses should thus not be equated with incapacity. It might be expected that some patients with a psychiatric illness may have sufficient decision-making capacity to request euthanasia in a well-considerate way, as an existential choice.

Nevertheless, this point is particularly controversial in psychiatric patients because mental disease may alter patient's judgment. Patients requesting EAS may have limited ability to foresee alternatives and long-term perspectives to select adequate choices. Cognitive impairments raise the question of ability to decide for ending life, and may also alter the stability of such "choices". Existence of "rational suicide" may be also debated. Decisions are considered to be rational when they rely on two core dimensions : being realistic and having minimal ambivalence- But suicide is known to often be an ambivalent choice and there is no knowledge of "being" after death.

3) pEAS, a copycat of traditional suicide or a therapeutic alternative ?

Suicidal acts and pEAS are both motivated by the will to escape from psychological suffering. Psychiatric illness is the interaction between biological and environmental processes. Whereas a euthanasia request and the reactions it encounters do not influence the prognostic of a severe somatic illness, it might influence the course of a psychiatric illness. Some patients describe the process of EAS request as helpful to get relief from suicidal thoughts. Some patients testify that the possibility of EAS being made concrete is helpful to continue living: the knowledge of an escape route, an emergency exit being prepared, alleviates their suffering and makes life more bearable. A large subgroup of patients requesting pEAS – and in some psychiatrists' experience, a large majority – finally do not choose euthanasia but life.

~~It is important to recognize that~~ Even speculative, legalization of pEAS may weaken societal efforts to fight suicide. Moreover, individuals seeking pEAS are remarkably similar to individual who die by 'traditional' suicide. Psychopathologies, particularly depression and personality disorders, concurrent physical illnesses, and social isolation are among shared factors. Moreover, higher psychological pain levels are associated with suicidal ideation and attempts. According to Dierrickx et al. (2017) describing euthanasia cases for people suffering from psychiatric disorder or dementia, psychological pain is the main motivation of EAS up to 70% of cases. As patients requesting pEAS seem to have clinical features that overlap with those of patients committing suicide, the current risk could be to convert "traditional" suicides into pEAS or to increase suicide mortality by giving access to lethal methods to suicidal patients. It is a paradox that unbearable psychological suffering is a target for suicide prevention in daily practice and also a required criterion for pEAS. On the one hand, pEAS acceptance may be a solution to cope with suffering give them courage to continue living. Indeed, suicidal ideation (but not act) could be a mechanism to cope with psychological pain in depressed patients having intact decision making performances [10]. On the other hand, pEAS might reinforce loss of hope and demoralization for others.

Conclusion

EAS is driven by unbearable suffering with no prospect of improvement. Both suffering and incurability rely on subjective assessment and deserve to be better defined. Physicians should hope further advances in psychiatry to promote new alternatives to get relief from pain and suffering which may motivate pEAS requests. Psychiatrists should also produce practice guidelines to be involved in pEAS debate : to propose standardized assessments to detect

untreated or pseudo-resistant depression, to determine decision capacity, to develop specific therapeutic options. Finally, psychiatrists should develop research programs in order to compare the clinical characteristics of suicidal patients and those requesting pEAS as well as follow the number of deaths by pEAS vs. suicide in countries where EAS is legally practiced.

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