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Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

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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'.[1] But being depressed is the strongest correlate of decision instability, of changing from acceptance of euthanasia to rejecting it at follow-up.[2] 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.[3] 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,[4] 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.[5] 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 reignited 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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Emilie Olie, MD, PhD, Psychiatrist, Psychiatric Emergency and Post Acute Care, Hospital Lapeyronie, CHU Montpellier / INSERM U1061, Montpellier, France; **Philippe Courtet**, MD, PhD, Psychiatrist, Psychiatric Emergency and Post Acute Care, Hospital Lapeyronie, CHU Montpellier / INSERM U1061, Montpellier, France. Email: e-olie@chu-montpellier.fr

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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.'[1,2] 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