



# Defending the indefensible? Psychiatry, assisted suicide and human freedom



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## ABSTRACT

The siege guns of the forces for change to euthanasia and assisted suicide laws have been pounding for decades, but the longstanding proscription on these practices has held out in all but a few jurisdictions. A few psychiatrists have enlisted with the challengers, but many remain on the battlements, defending the impermissibility of active assistance in dying. Given the long history of the separation of church and state and the significant secularisation of society; the recognition by the law of both acts and omissions as legal causes; lenient sentences for mercy killers; critiques of the “psychiatrisation” of different aspects of life; and the consistency of public opinion, this recalcitrant stand bespeaks undercurrents and positions that are often by rationalised or camouflaged, and which call for exploration. In this paper, I examine connections between psychiatry and conceptualisations of harm, suffering and natural death; medicalisation, psychiatrisation and medical paternalism; decision-making capacity, rationality and diagnosis; recent legal developments; social pluralism; and religious intuitionism. I conclude that psychiatrists and the psychiatry profession, concerned as they are with enlarging the province of human freedom, should begin a more transparent rapprochement with those they would repel.

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## 1. Introduction

Over recent decades, public support in the west for the legalisation of physician-assisted suicide (PAS) and active voluntary euthanasia (AVE) has reached high levels, while there remain lower, though by no means insignificant levels of support amongst physicians. Some studies report more physicians in favour of legal change than against, and others fewer in favour (Lee, Price, Rayner, & Hotopf, 2009; Miccinesi et al., 2005; Onwuteaka-Philipsen et al., 2006; Parker, Cartwright, & Williams, 2008; Pasterfield, Wilkinson, Finlay, Neal, & Hulbert, 2006). These and other studies show, to some extent at least, that these positions are influenced by factors including medical specialty, the associated factor of whether the doctors worked regularly with the dying (Lee et al., 2009; Parker et al., 2008), and doctors' religious affiliations (Lee et al., 2009).

Psychiatrists are not generally thought of in terms of working regularly with the dying in the same sense as palliative care physicians, oncologists and geriatricians. However, their responsibilities and expertise in the area of cognition, affect, mental disorders and suicide make their attitudes towards PAS and AVE important considerations in the discussions and debates. These attitudes depend on their understandings of decision-making capacity, rationality and diagnosis, but also, in less clear ways, their own moral and religious world

views. Surveys show that as for other specialists, their attitudes are divided (Ganzini, Fenn, Lee, Heintz, & Bloom, 1996; Parker et al., 2008; Shah, Warner, Blizard, & King, 1998), but there seems to be a dissonance between these mixed empirical survey findings and the weight of published, critical *psychiatric* responses to the legalisation issue (Zaubler & Sullivan, 1996). That is to say, there has been a strong defence of the status quo by psychiatrists that has not been matched by a significant groundswell of psychiatrically based argumentation in favour of legalising PAS and AVE.

I have argued previously (Parker, 2000) and more recently (Parker, 2012) that there are good reasons, based on the conflation of imperatives to prevent suicide in the setting of mental disorder and arguments against PAS and AVE, to resist the intuitively attractive proposition that, because psychiatrists are experts in the areas mentioned above, they should be mandated to assess requests for PAS and AVE to ensure valid, competent decisions. In this article I expand on these arguments, and draw them together with those of others, by drawing attention to how many of the critical psychiatric responses to legalising PAS and AVE conceal unstated positions, conflate disparate issues, and rationalise medical incursions on freedom that psychiatry, of all specialties, should be at pains to resist. It is crucial that psychiatrists increase their contributions to the debates (Hotopf, Lee, & Price, 2011), but this must be in an open and honest way. Wherever unjustified medicalisation or an unwillingness to advance the real reasons for ethical positions, are exposed, psychiatrists should lay down these illegitimate arms. These strategies have produced value-driven assessments of decision-making capacity

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and rationality, new diagnostic formulations that serve unstated moral purposes, a continuing but unfounded asymmetry between the requirements imposed on decisions concerning assisted death and those concerning withdrawal or withholding of life-sustaining treatment, and unjustified restrictions applied to the concepts of harm and suffering.

There are four main sections to the paper. In [Section 1](#), I review the vexed question of “psychiatric euthanasia”, i.e. the provision of PAS or AVE for patients with psychiatric conditions. Utilising Fulford’s conception of mental disorder (Fulford, 1989) I show that “psychiatric euthanasia” should be seen as no less permissible than “standard” PAS and AVE, and that psychiatrists should support this position. The discussion of “psychiatric euthanasia” at the outset is deliberate; it is a significant challenge to psychiatrists, other physicians and the public, even some who are generally supportive of liberalising the law. As well as the model of mental disorder that I enlist, its legitimacy depends on the resolution of matters covered in [Sections 2 and 3](#).

In [Section 2](#), I retrace the modern debate over the moral status of the action/omission distinction. Many of the arguments against the legalisation of PAS and AVE fail in light of the now generally accepted moral irrelevance of the bare distinction. While some commentators may claim that the debate over legalisation has moved on to other issues, such as the doctrine of double effect, “slippery slope” concerns, terminal sedation and so on, I argue that resolving these allegedly distinct issues depends on the nature of one’s response to the action/omission distinction. In [Section 3](#), I examine the interrelated issues of the possibility of rational requests for assisted death, the role of psychiatrists *vis a vis* suicide and assisted suicide, psychiatric diagnosis at the end of life, medicalisation and medical paternalism. I show that assessments of decision-making capacity and rationality, as well as diagnostic formulations, can be value-driven rather than evidence-based, and that psychiatrists must avoid these category mistakes.

Finally, in [Section 4](#), I explore the problematic phenomena of pluralism, secularisation and religion in relation to the debates about PAS and AVE. Here, I argue against the generally accepted Rawlsian idea that those who wish to raise religious objections to PAS and AVE should frame their ideas in some common language of “public reason”. I also argue that liberal pluralism deceives, as long as it insists that, to use the example of the current case, the legalisation of PAS and AVE will still provide choice for the opponents of legalisation, on the basis that they are not compelled to participate in the practice. While the question of restricting debate to the language of “public reason” may appear unrelated to the question of psychiatrists’ attitudes to the legalisation of PAS and AVE, I demonstrate links between this issue and the criticisms made in the two previous sections.

I conclude that psychiatrists have clinical and intellectual responsibilities, underpinned by their duty to maximise their patients’ freedom at the end of life, to reconsider how they frame their arguments regarding PAS and AVE, and consequently what their conclusions should be.

## 2. Psychiatry and the scope of suffering

Of all the medical specialties, psychiatry is the one that we might expect to be leading the movement to recognise the legitimacy of so-called psychiatric euthanasia, or at least to be conceding that there is an argument to be made for this category of assisted death, on the basis of defending human freedom and trying to expand it where it is diminished. It is, after all, the disciplines of psychiatry, psychology and psychotherapy that aim to help ameliorate mental symptoms that constrict and restrict patients, that curtail their freedom and autonomy, through exploration, interpretation, support and challenge, in order that patients may make some sense of their predicaments, behaviour and symptoms. Of course the thought of psychiatric euthanasia is intuitively very challenging, due to its rarity, its lack of possible comparison with withdrawal and withholding of treatment that leads to death (and hence the utilisation of criticism of the action/omission distinction), and the appealing claim that someone who has a psychiatric condition so

bad that they would request assistance to die, clearly *demonstrates* a lack of competence or severity of morbidity that should rule out that course of action. This position is strengthened by the conflation of suicide and assisted suicide, discussed in [Section 3.2](#).

For these reasons psychiatric euthanasia has also been seen as an example of the operation of the slippery slope, down which we have rolled to now allow something that was impossible to conceive as ever being acceptable. It is interesting in this regard to note that the Royal Dutch Association of Medicine, for over two decades, has concurred with the Dutch Association of Psychiatrists, that psychiatric suicide should be treated no differently from assisted suicide in medicine generally, and that it maintains that to demand “full rationality” would add even more misery to the life of some patients (Kerckhof, 2000, 456–7). In the mid-1990s, a survey of Dutch psychiatrists demonstrated that 64% considered that euthanasia for a mental disorder could be acceptable, given a standard set of protective conditions such as requests being voluntary and well considered, there being no hope of improvement including with alternative treatments, and suffering being unbearable (Groenewoud et al., 1997).

It was within this medical context that the well known “Chabot” case occurred, involving the assisted suicide of a 50 year old woman whose unbearable suffering stemmed from an early life of being bullied by her mother and subsequently her husband, the birth of two sons whose existence finally gave her a reason to live and the source of her only happiness, then the suicide of her elder son at age 20 and subsequent increased abuse by her husband, divorce and then the death from an aggressive cancer of her second son (Wijsbek, 2012).

Having lost all subjective reason to live and having unsuccessfully attempted suicide, she consulted Dr. Chabot who considered that she was suffering a severe depression as part of a complicated bereavement process, and who proceeded to offer her a variety of treatment approaches which she consistently refused. He also consulted widely, with a consensus from experts that she was suffering unbearably and that there was no prospect of improvement. Dr. Chabot’s assisted suicide of this patient was approved by the lower courts but he was found guilty in the Supreme Court on the grounds that the experts consulted had not themselves interviewed the patient. In every other respect he had complied with the guidelines (Gevers, 1995), and the fact that the Court did not impose punishment confirmed the legal acceptance of this category of PAS in the Netherlands.

Chabot’s patient might well have been thought to have been experiencing, in addition to depression, or perhaps *rather than* depression, a demoralisation syndrome (see [Section 3.4](#)), given that its core construct is hopelessness, with other key features including

“pessimism, stoicism and fatalism; existential despair with loss of purpose, sense of failure or meaninglessness; and the development of social isolation and alienation, the latter being associated with a poor social support network or dysfunctional family”.

[Kissane & Kelly, 2000, 327]

If so, the recommended treatment would consist of psychotherapeutic encouragement of everyday activities, promotion of mourning and facilitation of expressing other feelings, cognitive behaviour therapy for activity scheduling and reframing negative cognitions to counter pessimism, continuing with worthwhile activities that promote meaning, and utilisation of various strategies to promote social and family interactions (Kissane & Kelly, 2000). Many people who have read even a summary of the subjective experience of Chabot’s patient view this kind of treatment response as simply fatuous, as it fails to take into account the singular contexts of patients who experience unbearable suffering, in particular of the mental kind. The experiences of pessimism, despair, loss of purpose, meaninglessness and isolation are appropriate in this case, because they are clearly authentic responses to what Wijsbek describes as the “slings and arrows of outrageous fortune”, because her grief was “the one appropriate

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