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The terminal, the futile, and the psychiatrically disordered

Michael J. Cholbi

California State Polytechnic University, Pomona, 3801 W. Temple Ave., Pomona, CA 91768, United States

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ABSTRACT

The various jurisdictions worldwide that now legally permit assisted suicide (or voluntary euthanasia) vary concerning the medical conditions needed to be legally eligible for assisted suicide. Some jurisdictions require that an individual be suffering from an unbearable and futile medical condition that cannot be alleviated. Others require that individuals must be suffering from a terminal illness that will result in death within a specified timeframe, such as six months.

Popular and academic discourse about assisted suicide paradigmatically focuses on individuals with 'physical,' i.e., non-psychiatric medical conditions, such as cancer or AIDS. Here I defend analyses of the notions of unbearable suffering, futility, and terminality that imply that, regardless of which of these medical conditions is invoked, at least some individuals with severe and persistent psychiatric illnesses satisfy these conditions and ought to be classified as legally eligible for assisted suicide. The legal and moral case for a right to assisted suicide is therefore not in principle weaker for the severely psychiatrically disordered than for those with 'typical' terminal or futile medical conditions.

1. Introduction

The number of jurisdictions worldwide that legally permit assisted suicide (or voluntary euthanasia) continues to grow. The statutes, judicial rulings, and legal practices that authorize assisted suicide do not vary dramatically from jurisdiction to jurisdiction, with one noteworthy exception: what medical conditions an individual must satisfy in order to be legally eligible for assisted suicide.

In the United States for example, those states that have authorized assisted suicide have restricted this right to those with terminal medical conditions, i.e., conditions that are incurable and typically fatal within a defined duration, usually six months. Oregon's Death with Dignity Act, and Washington's Initiative 1000 both limit the 'right to die' to terminally ill patients within six months. The court ruling that legalized assisted suicide in Montana, Baxter v. Montana (2009 MT 449), specifically concluded that the state had no legal right to contravene "the right of a competent terminally ill patient to die with dignity." Outside the U.S., several nations, including Luxembourg, similarly limit the right to assisted suicide to individuals with terminal conditions. In 2010, Colombia's Constitutional Court ruled that individuals cannot be held criminally responsible for aiding a "terminally ill patient" in dying so long as the patient has given "clear authorization" for such aid.

Other jurisdictions adopt the weaker standard that the patient must be suffering from a futile medical condition in order to be legally eligible for assisted suicide, i.e., a condition for which further medical treatment will not improve the underlying condition and will be of little if any benefit to the patient. Belgium's law on voluntary euthanasia, for instance, declares that a patient is eligible for aid in dying only if her situation is "medically hopeless" and "cannot be alleviated." The Netherland's Termination of Life on Request and Assisted Act requires that the patient have a condition "with no prospect of improvement."

A number of jurisdictions add the additional requirement of unbearable suffering. Belgian patients must have a futile condition characterized by "persistent or unbearable physical or mental suffering." The aforementioned Colombian ruling asserted a right to assisted suicide for those with terminal conditions that are "the cause of extreme suffering." Dutch law restricts the right in question to those whose "suffering is unbearable."

With the exception of the Netherlands, where the Supreme Court has ruled that physician assisted suicide can be permitted in cases of unbearable suffering not associated with physical illness, few nations or their courts have thought of psychiatric disorders as plausible bases for a right to assisted suicide. The Colombian Court, for example, explicitly mentions cancer, AIDS, or liver failure as paradigm instances of the terminal conditions that could ground a right to assisted suicide, and in the U.S., patients challenging state laws banning assisted suicide have not suffered from psychiatric disorders (Baxter, the named appellant in the Montana case, suffered from lymphocytic leukemia). Within popular culture, debates about the morality and legality have focused almost exclusively on individuals with conditions such as cancer, organ failure, or the like. Craig Ewert, the patient whose assisted suicide was depicted in an episode of the Public Broadcasting System documentary series Frontline,

E-mail address: mjcholbi@csupomona.edu.

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suffered from ALS. Cody Curtis, the main subject of the award-winning documentary "How to Die in Oregon," had liver cancer.

On the whole then, the possibility that psychiatric disorders might render a person eligible for assisted suicide hardly seems to register in either official or popular consciousness. This (I contend) is a serious omission. For I will argue here that at least some individuals with severe and persistent psychiatric disorders ought to have the legal right to assisted suicide. My strategy will be to show, first, that if futility and unbearable suffering are taken to determine legal eligibility for assisted suicide, then some psychiatrically disordered individuals are no less eligible than those with traditional 'physical' disorders; and second, that if the stronger criterion of having a terminal condition is applied, then some psychiatrically disordered individuals are no less eligible for assisted suicide than those with conditions such as cancer. A central theme in my discussion will be the contested and sometimes contradictory understandings of a medical condition being futile and of its being terminal. I argue that these notions are best understood contextually, in terms of an individual's subjective appraisal of her suffering and her willingness to undergo potential treatments for her conditions, and that so understood, there is not a coherent basis for denying some psychiatrically disordered individuals a legal right to assisted suicide. Attempts to deny such a right can only rest on unjustifiable prejudices that either understand psychiatric disorders as not 'real' disorders or see the psychological distress associated with such disorders as somehow more suspect than the pain associated with 'physical' disorders.

A caveat at the outset: I aim to show only that, whichever of the extant legal standards we adopt for the medical conditions needed to be eligible for assisted suicide, a small handful of psychiatrically disordered persons will satisfy these standards. In essence then, I hope to show that the case for assisted suicide for the psychiatrically disordered is not, in principle, weaker than the case for assisted suicide for those with more 'typical' futile, unbearable, or terminal conditions. But I do not offer a principled argument for a right to assisted suicide. My hope is that those already persuaded of the existence of such a right will be persuaded that it ought to be extended to the psychiatrically disordered. To those skeptical of such a right, I offer no argument to establish its existence.

2. The unbearable

Let us begin with the demand that the individual be undergoing unbearable suffering. Can a case be made that some psychiatrically disordered individuals confront unbearable suffering due to these disorders?

The most straightforward evidence that psychiatric disorders cause unbearable suffering is that many psychiatrically disordered persons prefer not to bear it. As numerous studies have indicated, the presence of psychiatric disorders, in particular the affective disorders such as depression and bipolar disorder, is strongly linked to suicidal behavior. That 90% of suicide attempters are mentally disordered or have substance abuse problems is a widely cited figure (Jamison, 2000, pp. 110–112; Moscicki, 2001; Cavanah et al., 2003; Joiner, 2005, pp. 192–202). We ought not infer from these statistics the simpleminded conclusion that psychiatric disorders cause suicide. For one, though suicide is strongly correlated with these disorders, the correlation is far weaker in the other direction. Tens of millions suffer from depression, but only a fraction of these engages in suicidal conduct, suggesting that for many, such disorders function as a necessary, but not sufficient condition, of suicidal conduct (Joiner, 2005, p. 29).

More crucially for our purposes, however, these psychiatric disorders are more than causes of unbearable suffering. They are symptomatically constituted by these forms of suffering. Consider the criteria for major depression outlined in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000). Patients with major depression have depressed mood, anhedonia, sleep difficulties, fatigue, feelings of worthlessness or guilt, or an inability to concentrate or make decisions, on a daily, or nearly daily, basis. Furthermore, these symptoms "cause clinically significant distress or impairment in social, occupational, or other important areas of functioning." While there is substantial evidence to suggest a neurological basis for disorders such as depression (Johnston et al., 2007), such disorders cannot be reduced to neural anomalies that may predate the onset of symptoms. Rather, such a dysfunction becomes a disorder when it harms the individual in significant ways or impairs her day-to-day living. It need not be the case that the dysfunction or abnormality be such that it would be a harm or an impairment regardless of contingent personal or cultural facts (Wakefield, 1992). Farsightedness is a harm or an impairment in advanced industrial societies in large part because of the central role played by the written word in such societies. A farsighted person might not be similarly disadvantaged (or arguably, might be benefitted) on the African savannah living with other early humans. So too for psychiatric disorders. Social anxiety disorder is debilitating for a salesperson, but the equivalent symptoms may not be sufficiently harmful to constitute a disorder for a cloistered monk.

That suffering is symptomatically constitutive of psychiatric disorder implies that, in one respect, the case for the psychiatrically disordered having a right to assisted suicide is stronger than the case for those with standard 'bodily' illnesses having such a right. For many bodily illnesses are, at certain stages at least, asymptomatic or characterized by little if any suffering. In its earliest stages, cancer is often detectable only through diagnostic testing because the disease is not sufficiently developed to cause symptoms. It is therefore not incoherent for someone to be painlessly afflicted with cancer. It is incoherent, however, for someone to be painlessly afflicted with depression.

Indeed, the unbearable pain associated with psychiatric disorder is in some respects more pervasive and self-defining than 'mere' physical pain. Psychiatric pain and distress manifest not only as suffering, but also as a profound sense of alienation from one's cares and from oneself, a sort of disenchanted listlessness or lethargy. William Styron, perhaps the greatest of contemporary chroniclers of depression, describes the condition as a form of affective paralysis:

> The madness of depression is the antithesis of violence. It is a storm indeed, but a storm of murk. Soon evident are the slowed-down responses, near paralysis, psychic energy throttled back close to zero. Ultimately, the body is affected and feels sapped, drained.

Andrew Solomon, another depression memoirist, describes it as a loveless state, in which a person can neither love nor be loved:

> When it comes, it degrades one's self and ultimately eclipses the capacity to give or receive affection. It is the aloneness within us made manifest, and it destroys not only connection to others but also the ability to be peacefully alone with oneself. …In depression, the meaninglessness of every enterprise and every emotion, becomes self-evident. The only feeling left in this loveless state is insignificance (Solomon, 2002, p. 15).

In the end, Styron saw his illness as culminating in faithlessness:

> In depression…faith in deliverance, in ultimate restoration, is absent. The pain is unrelenting, and what makes the condition intolerable is the foreknowledge that no remedy will come, not in a day, an hour, a month, or a minute. It is hopelessness even more than pain that crushes the soul (Styron, 1990).

The unbearability of psychiatric disorder cannot often not be captured by the language of 'pain' of 'suffering.' Rather, the anguish