# Euthanasia and the Practicing Psychiatrist: Issues in Bioethics

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## Abstract

In recent years, attitudes towards voluntary euthanasia in certain cases such as terminal cancer appear to have become more liberal, and physicians are no longer necessarily expected to undertake all possible measures to sustain life in hopeless situations. At the same time, there has been a contrary trend in psychiatric medicine with an increasing expectation for psychiatrists to prevent morbid self-harm amongst their patients.

The divergence in attitudes regarding voluntary death in physical and psychiatric medicine was demonstrated in 1993 by the case of Dr. Van Gaal, a Belgian psychiatrist, who openly assisted a depressed woman in taking her life. A subsequent court case resulted in considerable publicity and opened up the debate on what has become known as "psychiatric euthanasia."

In this paper, we explore medical ethics by briefly reviewing the historical and cross-cultural aspects of euthanasia to show how attitudes towards this practice have varied over time and place. We first present the case of Dr. Van Gaal, and then focus on three cases from clinical practice in which a psychiatrist had to make difficult decisions when faced with a patient expressing a wish to die. Finally, we consider the bioethical literature concerning voluntary death, which has been developed mainly in respect of physical medicine, and we assess how well its guidance translates to a psychiatric context.

Our conclusions are as follows: the wishes of psychiatric patients toward self-harm are not always the result of an easily treatable and reversible mental illness or necessarily of any mental illness at all. As mental illness is not always curable, there are situations in psychiatry morally comparable in relevant respects to cases of terminal illness in physical medicine. The bioethical literature concerning voluntary death is often not greatly helpful in psychiatry as it focuses on cases of terminal, physical illness. We therefore invite comments from philosophers, lawyers, ethicists, and others concerned with mental health on our three

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Keywords: self-harm, suicide, death

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## Introduction

Euthanasia is a practice whereby a person chooses to end their life. In recent years, popular opinion regarding voluntary euthanasia in cases of serious physical illness has become more liberal, but in the field of mental health, psychiatrists have been met with an increase in expectations to prevent their patients from ending their lives.

Do psychiatrists have a duty to prevent their patients from taking their own lives? Must they always try to prevent it, or are there cases where they should perhaps turn a blind eye or even give assistance to someone who is likely to end their existence? Is there ever a justification for psychiatric euthanasia? In 1993, these issues were brought to attention with the case of Dr. Rinus Van Gaal, a Belgian psychiatrist, who assisted in the death of a woman who was suffering, and in his view suffering hopelessly, from depression.

This paper examines the Van Gaal case with three cases from general psychiatric practice. In each of these cases, dilemmas arose for a psychiatrist regarding the treatment of a patient who wished to end their life. Details of the cases have been altered to preserve confidentiality. The cases will first briefly set up their historical and cultural perspective. This highlights changes in attitudes towards voluntary death and sets the current dilemmas in context. The issues raised by the cases will then be considered and examined in the light of the bioethical literature concerning self-harm and voluntary death.

Our main conclusion is that the bioethical literature, which has been developed largely in reference to terminal physical illness, is often not applicable or particularly helpful in psychiatric practice.

## Historical and Cross-Cultural Perspective

Taking one's life has occurred throughout history, but societies' attitude towards it has changed. In classical literature, ending a life voluntarily at times of adversity or to avoid dishonor was seen as a noble, often heroic, act and an important freedom. Thus, instances of



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voluntary death were common. The prevailing attitude was well illustrated by Seneca, who wrote:

> Foolish man why do you bemoan and what do you fear? Wherever you look there is an end to all evils. You see that yawning precipice? It leads to liberty. You see that flood, that river, that well? Liberty houses within them.....Do you enquire the road to freedom? You shall find it in every vein of your body. (Purdie, 1974) .

In the mediaeval Christian era, taking your own life—morbid self-harm—was seen as a devil-driven sin and a crime deserving of the severest ecclesiastical and secular punishment from the church. The bodies belonging to victims of suicide were subjected to public desecration, and those who had failed attempts could find themselves arrested or even sentenced to death for their actions. This view was hardly challenged until the eighteenth century and the advent of the new schools of philosophy of the Enlightenment. A controversial Liberal view was espoused by the rationalist philosopher David Hume in his essay, *Of Suicide*, published in 1784. He considered man's life to be of no more importance than that of an oyster, and wrote:

> "If it be no crime, both prudence and courage should engage us to rid ourselves at once of existence, when it becomes a burthen."

Certain types of self-death have historically been socially acceptable in other cultures, such as the Hindu practice of suttee in which a widow immolates herself on her husband's funeral pyre, and the Japanese ritual of hara-kiri with a preference for death over dishonor. Both these practices have been slow to die out, if they haven't already died out today.

The concept of ending one's life as a health problem, specifically a mental health problem, is largely a product of the present century. Suicide and attempted suicide were finally de-criminalized in the UK, only as late as 1961. A. Purdie wrote about his own attempt in the 1950's, stating:

> "At some point the police came, as suicide in those days was still a criminal offence. They sat heavily but rather sympathetically by my bed and asked me questions they clearly didn't want me to answer. When I tried to explain they shushed me 'It was an accident, wasn't it sir?' Dimly I agreed. They went away." (Purdie, 1974).



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The decriminalization of suicide consolidated its position as a subject deserving of scientific research and medical endeavor. In 1967, an editorial in the *Journal of The American Medical Association* declared:

> "The contemporary physician sees suicide as a manifestation of emotional illness. Rarely does he see it in any context other than that of psychiatry."

In the same year, the director of the American National Institute of Mental Health called upon public health services to combat "the disease of suicide" (Martinson, 1967). A causal connection between mental illness and suicide was strengthened by a seminal study in 1974 entitled, "One hundred cases of suicide," which retrospectively diagnosed 93 of 100 suicides as suffering from mental illness, mainly depression (St. Amour et al., 1974).

At present, over five thousand suicides occur in England each year, an average of one every two hours (Department of Health, 1993). Overall, rates have been stable in recent decades, but there has been a marked and unexplained increase in the number of young people, particularly young men, who choose to end their lives (Melson, 1995). Suicide is now the second leading cause of death in this sector of the population (Department of Health, 1993). Rates of attempted "deliberate self-harm" have also risen markedly in the second half of this century, and recently, again, particularly amongst young men (Grant and Taylor, 1992).

In recent years, psychiatrists and other mental health workers have increasingly been expected to assume responsibility for preventing their patients from ending their life. In the US, "failure to prevent suicide" is now the leading cause for malpractice lawsuits being brought against mental health workers (Sbrocca, 1986). In Britain, new government "supervision registers" have the effect of making mental-health professionals more guilty for the actions of their patients, and a nationwide confidential enquiry has been set up to investigate death amongst psychiatric patients (Black and Tibbets, 1995; Garrow et al., 1997). A 1992 British Government White Paper titled, *The Health of the Nation*, explicitly



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designates preventing deliberate self-harm as a priority and responsibility of the health and social services and gives quantitative targets for a reduction in suicide rates (Department of Health, 1992).

Likewise, euthanasia has a long history. Culling, or more commonly known as selective slaughter, of the sick and elderly occurred in several primitive societies. In the sixteenth century, Thomas More's "Utopia" advocated adoption of a voluntary euthanasia policy (More, 1516). However, before the development of modern medical techniques and the ability to extend life in the case of chronic or terminal illness, euthanasia was less prominent. Surveys in recent decades have shown a definite trend towards an approval of medical assistance in dying for the chronically ill with support rising from about 50% in the 1960's to 75% or above in recent years (Exit). Almost 50% of doctors in the UK report receiving requests from patients for euthanasia, and a small but significant proportion (12% in one survey) admit to having carried out such requests (Langdone and Konig, 1994). Recent decades have also seen changes in medical practice, with "passive" euthanasia (the withholding of treatments), with hopeless cases being excepted (Galloway, 1995). The legality of this has been upheld in court decisions in the UK most notably those concerning Tony Bland who survived in a persistent vegetative state following the Roseborough football stadium disaster (Sherban, 1992).

Between 1992 and 1994 an all-party Select Committee of the House of Lords met to consider the question of active euthanasia. It advised against making any changes in the law, and the main reason given was fear of a "slippery slope" developing, whereby if euthanasia was legal in any circumstances the boundaries of what is considered lawful death would be stretched ever wider (Kingman, 1994). Other countries have been contending with the same issues. In the US, euthanasia is illegal, and a 1994 referendum by citizens of Oregon which approved assisted suicide was declared unconstitutional by the US district court (Charatan,

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1994). The issue of the right to die has been kept firmly in the public eye by the activities of Dr. Jack Kevorkian, self-styled "obituarist", who has been present at the voluntary deaths of over thirty patients. Despite several indictments, he has so far escaped conviction. In Belgium, euthanasia and assisted suicide remain against the law. However, in recent years, doctors have been protected from prosecution provided they act in accordance with guidelines issued by the Belgian Royal Medical Association and notify the local medical examiner of their actions (Van der Cleef and Claussen, 1994).

Thus, end of life issues are now more pertinent to the medical profession than perhaps at any previous time. These issues are contentious enough in physical medicine, but psychiatrists are being pulled in diametric directions. On the one hand, they are faced with an increasing acceptance of euthanasia and assisted suicide for those who are suffering as a result of physical illness. On the other hand, they are faced with even greater pressures and increasing personal responsibility to prevent voluntary death amongst their patients and affect a decrease in suicide rates generally. If all deliberate self-harm was unambiguously the result of treatable mental illness, there would be no problem here. Wishing one could die could merely be considered as another symptom of mental illness and be treated. However, it is questionable whether all those who consider committing the act of voluntary self-destruction are mentally ill, and mental illness is often not clearly distinguishable from "normal" distress. Mental illness is also frequently difficult to treat and may be intractable.

Consequently, there seems to be no reason why psychiatrists should find themselves bound to try to prevent a patient from taking their own life, or why cases of psychiatric euthanasia, similar in all morally relevant respects to cases of euthanasia in physical medicine, might not occur. This appeared to be the case for a patient under the care of Dr. Van Gaal a few years ago. This case brought problems of requests for euthanasia and assisted suicide by psychiatric patients, and so it is Dr. Van Gaal that we turn to next.

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**The Case of Doctor Van Gaal**

In 1991, Marie-Anne Dutrieux, a physically fit fifty-year-old retired social worker, was referred to Dr. Rinas Van Gaal. Mrs. Dutrieux wanted Dr. Van Gaal's help in taking her own life. She had heard of him through an organization which supported voluntary euthanasia. Dr. Van Gaal had offered his services to the organization when he heard of their problems in finding psychiatrists who were not opposed to a patient's wish to die.

Over the next few months, Dr. Van Gaal had many meetings with Mrs. Dutreiux. He learnt that she was divorced from a physically abusive alcoholic husband and had two sons, both of whom had died—the first, years earlier by auto accident and the second, more recently from cancer. It was after the death of her second son that Mrs. Dutrieux decided she no longer wanted to go on living. She had attempted to take her life the night her son died but had failed. Dr. Van Gaal found her to be a down to earth woman whose "contact with reality was never disturbed." He could find no evidence of psychosis, hysteria, personality disorder or "depression that would have responded to drugs." Nevertheless, he offered her anti-depressant medication and tried to persuade her to enter a therapeutic community. She refused both. She simply did not want to go on living, for life had no purpose without her two sons. She wanted assistance with her suicide so that her death could be peaceful and successful. Dr. Van Gaal discussed her case with several other psychiatrists, a general practitioner, and a psychologist, none of whom saw Mrs. Dutrieux personally. He concluded that Mrs. Dutrieux was competent and her feelings appropriate. In September of 1991, at her home and in the presence of her friend, Mrs. Dutrieux was given a drink containing a lethal dose of sleeping tablets by Dr. Van Gaal. She accepted it, swallowed the draft, and "lay down on her bed, kissed a photograph of her sons, and whilst Bach played on a tape recorder, drifted into death."

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The following day, Dr. Van Gaal reported what had occurred to the local coroner. The case, being unusual as Mrs. Dutrieux had not been suffering from any form of illness, was referred to the local and appeal courts. Both courts dismissed charges brought against Dr. Van Gaal, but as the matter was considered an important test case of psychiatric euthanasia, it was referred to the Belgian Supreme Court. There, it was ruled that Dr. Van Gaal was guilty of unlawful assisted suicide on the grounds that none of the other doctors with whom he had consulted had personally seen or examined Mrs. Dutrieux. However, the court accepted that Dr. Van Gaal had otherwise followed the necessary Belgian Royal Medical Association guidelines on euthanasia and assisted suicide and that Mrs. Dutrieux had been competent with a voluntary and durable wish to die. Due to "the personality of the accused and the circumstances in which what has proved to have happened took place," Dr. Van Gaal was not punished and was allowed to continue practicing medicine. The case and its resolution clarified several issues regarding euthanasia in Belgium. It confirmed that suffering didn't need to be physical and a person didn't need to be terminally ill for euthanasia to be permissible. Thus, despite Dr. Van Gaal being found guilty, the road seemed open for further cases of psychiatric euthanasia.

The Belgian Royal Medical Association welcomed the court's clarification of the above issues and has since tightened up its guidelines on euthanasia to specify that a second opinion doctor must examine the patient and provide a written report before euthanasia takes place. Dr. Van Gaal's own medical board was less supportive of his act. In a disciplinary hearing, they ruled that he had crossed professional boundaries in his treatment of Mrs. Dutrieux. They believed he was wrong in concluding she was untreatable, that her denial of treatment and lack of perspective were typical of depressive illness, and that Dr. Van Gaal should have made a more vigorous attempt to persuade her to try anti-depressant treatment. The doctor was issued with a reprimand, which, although it was the least penalty the board

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could impose, was harsher than had been expected. Dr. Van Gaal himself said, "I do not know if I made the right choice, but I believe I opted for the lesser of two evils" (McPherson, 1994; Nasreddine, 1994; Supreme Court of the Netherlands, 1994). The case of Dr. Van Gaal and his treatment of Mrs. Dutrieux is somewhat unusual, and it received considerable publicity in the medical press. However, difficult issues regarding a psychiatrist's role and their duty to patients who wish to end their lives are not uncommon. These issues are illustrated by the following cases from psychiatric practice.

## Three Cases

### *Case One: Geoffrey*

Geoffrey was a twenty-year-old philosophy student who decided to take his own life when his girlfriend left him after several months of an on-off relationship. He told a friend of his decision, and the friend alerted a general practitioner (GP). Following discussion with Geoffrey, the GP called the local duty psychiatrist for advice as he was unsure of his responsibilities. Geoffrey did not appear to be mentally ill, but there seemed to be a good possibility that he would harm himself. Geoffrey agreed to meet with the psychiatrist, not because he wanted help, but because he wished to prove "a clean bill of mental health" before going ahead with his wish. He said that he was in emotional pain and that he had decided a week beforehand to take his life if his girlfriend left, as life for him would not be worth living without this perfect love. He agreed that other areas of his life were satisfactory and it was likely the pain of losing his girlfriend would ease with time. Nonetheless, he remained fixed in his avowed intention of suicide.

On interviewing Geoffrey, the psychiatrist found him to be in good spirits and was unable to find evidence of pervasive depression or other mental illness. Indeed, aside from his suicidal inclination, there appeared to be nothing wrong with him. The psychiatrist agreed self-harm was a distinct possibility. After much deliberation, it was decided that Geoffrey



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should be admitted to a hospital as an involuntary patient under the Mental Health Act (see Endnote 2, The Mental Health Act). This step was considered to be justified as the possibility that Geoffrey was suffering from mental illness could not be ruled out without a period of assessment that was safely carried out in a hospital. Geoffrey was incredulous and angry that such a thing could be done. However, he agreed to co-operate with the hospital staff (although he would not take medication) and he gave an undertaking not to attempt to harm himself whilst in the hospital. His intention remained to prove himself sane and to take his life once he had been released. Geoffrey remained in the hospital for two months. For the first six weeks, his position remained unchanged. He appeared content, if rather bored, and showed no signs of depression. He discussed his situation at length with doctors, nurses and therapists. No amount of discussion or persuasion appeared to make any difference to Geoffrey's fixed intention.

After six weeks, Geoffrey suddenly announced that he wanted help in changing his mind about dying and he agreed to a trial of antidepressant medication. Two weeks later, he said he had decided to live. He was soon discharged from the hospital and returned to college. Intermittent visits to the psychiatric outpatient clinic over the next few years revealed no return of suicidal ideas or signs of depression, even after stopping the antidepressant medication. Geoffrey was successful in his examinations and began work as a teacher. He met another girl whom he married after a short courtship. He reported that he enjoyed life and had a good relationship with his wife, although not to the intensity that had been present in the previous relationship.

***Case Two: Frank***

Forty-two-year-old Frank had a checkered life history by the time he came to the attention of his local psychiatric services. He had been married and divorced twice following physical abuse of his wives. He thought he had about six children but was not in contact with any of

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them. In his twenties, he had spent some years in the army and had briefly held several jobs, but he had not worked in recent years. He had served several short prison sentences for burglary and violent crime and had intermittently abused drugs and alcohol throughout his adult life.

Recently, Frank had been living with a new girlfriend and her young daughters. After an episode of heavy drinking, Frank violently attacked her, not for the first time. She asked him to leave, but he refused and threatened to harm himself if she insisted. Unsure what to do and unwilling to involve the police, the woman contacted her general practitioner who referred Frank to a psychiatric assessment. The psychiatrist who saw Frank did not consider that he was suffering from an acute mental illness but thought that he probably had antisocial personality disorder (see Endnote 3-Personality Disorder). He believed Frank's threats to take his life were attempts to manipulate his girlfriend into allowing him to stay. Frank himself admitted that this was so. The psychiatrist did not think admission to a psychiatric hospital was indicated. He arranged to see Frank again on the following day with the expectation that the situation would cool down with time.

Frank accepted this arrangement and agreed to stay away from his girlfriend overnight. The doctor privately advised the woman that further violent behavior was possible and suggested that she stay with friends for a while. Unfortunately, she did not heed this advice and in the early hours of the following morning, Frank returned to the house and physically and sexually assaulted her. He was subsequently arrested and held on remand in prison. Over the next few days, he continued to threaten to harm himself. He was seen by a forensic psychiatrist who agreed with the first doctor's assessment that Frank had antisocial personality disorder, and that he could not be helped by treatment in a local psychiatric hospital. The second psychiatrist advised prison officers to observe Frank closely, as self-harm was a possibility. Later that night, Frank cut his throat in his cell and died.

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***Case Three: JoHanna***

JoHanna was a thirty-seven-year-old woman who had been under psychiatric care for over twenty years. She had an unhappy childhood, her mother leaving the family when she was two years old, and her father abandoning the family when she was twelve. She subsequently grew up in the care of social services.

Shortly after her father's death, JoHanna suffered her first psychiatric problems, with school refusal and other anxiety symptoms. Years later, she developed paranoid delusions with auditory hallucinations and was diagnosed with schizophrenia. From this time on, JoHanna had persistent psychotic symptoms, low mood, and recurrent acts of self-mutilation. She had numerous and lengthy admissions to psychiatric hospitals, usually on an involuntary basis under the Mental Health Act. When in the hospital and receiving regular antipsychotic medication, her delusions and hallucinations abated somewhat, although they never completely disappeared. Since she didn't enjoy being an inpatient, her depressive symptoms, overt levels of distress, and self-mutilation increased even as her psychotic symptoms improved. Psychiatric treatment of all forms had no effect on these aspects of her illness. Over the years, she had made many serious attempts to take her life, the two most dangerous occurring whilst she was in the hospital.

When she was not in the hospital, JoHanna lived alone in a run-down apartment, staying mostly in one room with the curtains drawn. She had no interests and no human contact other than visits from her social worker and a community psychiatric nurse. Her nutrition intake and self-care were poor. JoHanna consistently refused all attempts at rehabilitation and improving her socialization. This itself may have been another aspect of her schizophrenic illness. She refused to take medication regularly, and any measures to compel her to do so in the community were ineffective. JoHanna repeatedly said that she would rather be dead and often begged for assistance in killing herself. She saw her life as

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one of continuous, hopeless suffering and her lack of success in ending her life as another indication of her failures.

## The Clinical Dilemmas

Each of these cases concerns a person who has expressed a wish to end their life and has come into contact with psychiatric services. Yet, the wish in each of the cases does not seem to arise directly from the effects of a treatable mental illness, such as acute depression. The cases also illustrate that it is not simply the presence or type of psychiatric diagnosis that has to be considered in planning treatment but the very significant influence of the patient's personality (that is the patient as an individual person) that will affect the appropriateness and success, or otherwise, of any intervention.

In case one, Geoffrey, an intelligent student, did not appear to have a mental illness. He made what he considered to be a rational decision to die. It may be questioned what place a psychiatrist has to intervene in such a case, particularly to detain Geoffrey under the Mental Health Act if he did not appear to be suffering from a mental disorder. However, Geoffrey's wish to die did not appear to be based on hopeless suffering and was not understandable in the way in which it might have been if he were suffering from a terminal illness or even chronically unhappy like Mrs. Dutrieux. Whether or not his proclivity toward self-harm was a result of mental illness cannot be proven either way as there are no laboratory tests for mental illness. The decisions that were made in this case may have prevented a suicide and enabled Geoffrey to go on and lead a successful and contented life. They also avoided the suffering that his family would have undoubtedly endured had he succeeded in harming himself. This outcome, however, could in no way have been guaranteed at the original presentation.

In case two, Frank appeared to have a personality disorder. The place of personality disorder in psychiatry and the extent to which it is treatable have been long disputed. One



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could argue that as of a form of mental disorder, this diagnosis should make Frank and his treatment the responsibility of the psychiatric services. The possibility of further violence towards himself or others was recognized by the doctors who saw him, as indicated by the warnings they gave to his girlfriend and the prison staff. The Mental Health Act includes a treatability clause to prevent the repeated admissions of patients such as Frank to the hospital but in this case, it may be that a period of observation in the hospital would have averted Frank's death. However, he did not receive this, whilst the first case, Geoffrey (who was not given a psychiatric diagnosis), did.

Case three, JoHanna, is perhaps the closest to Dr. Van Gaal's case. JoHanna was suffering and begged to end her life. The lack of efficacy of treatment for her illness, and her own inability to comply with treatment made her illness incurable and her suffering hopeless. A range of clinical responses to JoHanna's predicament are possible, from seeing her in need of prolonged and possibly permanent enforced institutionalization to prevent her from taking her life, to regarding her as a candidate for psychiatric euthanasia. The care plan actually adopted was to offer her as much treatment and care as she would accept whilst continuing to allow her to live independently in the community as she chose. This may have been the best compromise in a difficult situation. It could also be seen as denying JoHanna the maximal medical treatment for her condition and risking a preventable death, whilst at the same time condemning her to a lonely life of suffering and eventual death, should she end her life.

## Can Bioethics Help?

There remains no consensus regarding the morality of voluntary death. Those who end their life voluntarily are now rarely criticized and certainly do not suffer punishment and degradation as in the past, but the major religions of Christianity, Judaism, and Islam remain fundamentally opposed to suicide. Voluntary euthanasia is increasingly accepted but remains illegal (even in Belgium). Most clinicians are aware of a number of bioethical principles and

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distinctions that have been considered of importance in debates concerning voluntary death. We shall now review these principles from the bioethical literature as they occurred to us. We will focus in particular on their application in a psychiatric setting, and to our cases.

***Competence***

When a desire to die is considered, the issue of whether the person making the decision is competent to do so is significant. The principle of autonomy, integral to a free society, requires that a person's decisions regarding their own life should be respected wherever possible. However, only the products of the sound mind of an adult are generally considered competent and given the status of autonomous decisions. If this were not so, the whims of a child, and the ideas of the drunk or delirious, would have to be respected even when they are known to be in opposition to a person's long-term outlook, a state which they may be expected to return to.

The capacity to consent to medical treatment is a function of competence. In British law, capacity is presumed to be present but can be rebutted. The grounds for rebuttal are that the person is incapable of any of the following three things: comprehending and retaining information, believing such information, and weighing such information in the balance and arriving at a choice. The law gives little information as to how these abilities should be assessed, but it is clear that the presence of mental disorder does not in itself imply the absence of capacity, and a recent Court of Appeal Judgement has ruled that irrationality does not amount to incompetence even though it may be evidence of such (Drug and Therapeutics Bulletin, 1997).

However, in bioethical literature, there is no accepted definition of a sound mind. It may be questioned whether a person suffering from a psychiatric disorder, which by definition affects the mind, can ever be considered competent. The existence of this view is evidenced by an opinion that states euthanasia by persons with terminal illnesses should

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never be considered as valid because it is known that a large proportion of the terminally ill suffer from psychiatric illness, namely depression (Ello et al., 1986). The relationship between mental illness and competence is of particular relevance to the person contemplating self-harm as it may occur that hopeless ideas alone are accepted as evidence of mental illness (as in Geoffrey's case). Following this through, if the mentally ill are considered to be always incompetent, and those ideas alone are evidence of mental illness, then wishes toward ending one's life are always incompetent. This refutes the idea of rational self-harm and perhaps imposes an ethical duty on psychiatrists to prevent a patient taking their life whenever possible.

Undoubtedly, in the throes of an acute psychotic disorder, a person may not be rational and their views can often be expected to change when the temporary disturbance of the mind resolves. Such persons may be rightly protected from harming themselves. However, the disturbance of the mind is not always temporary or treatable, and the distortions of thinking and perception of severe mental illness may be chronic or recurrent. If a person experiences such symptoms over many years, it could be argued that decisions based on these symptoms, such as JoHanna's wish to die due to the suffering caused by her schizophrenic illness, or even decisions arising directly under the influence of delusions, should be considered competent. This is because they are based on what is, and will be, that particular person's continuing reality, and would perhaps be shared by anyone else existing in that reality.

Thus, for a person suffering with physical illness wishing to die, the assessment of their competence is something which is distinct and separate from their diagnosis and symptoms, whereas for the mentally ill, the diagnosis and symptomatology may be integral to the assessment of competence. In these circumstances, the very feelings and experiences

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which form the basis of why they wish to die may also be given as the reasons as to why they should not be allowed to do so.

***The Acts and Omissions Doctrine***

This holds that one is more culpable morally for things which one does (acts), rather than things which one fails to do (omissions) even if the end result is the same in both cases (Burleigh 1977). Its application in medical practice is neatly surmised by the well-known maxim:

> "Thou must not kill but need not strive officiously to keep alive."

The acts and omissions doctrine provides a justification for why passive euthanasia (failing to prescribe antibiotics for a patient with terminal cancer who develops a chest infection) might be acceptable whilst active euthanasia (prescribing a deadly dose of a drug for the same patient) might not be. In terminal physical illness, the distinction between acts and omissions is generally clear. The first involves killing the patient whilst the second lets them die by not intervening in an inevitable natural course of events.

In the case of suicide prevention, the moral distinction between acts and omissions breaks down. For a psychiatrist faced with a patient intent on dying, not attempting to prevent that act is surely an omission since the doctor takes no action. The doctor, by the acts and omissions doctrine, is therefore less morally culpable should the patient die. However, as taking one's life itself requires a positive act, failing to intervene is not simply a case of omitting to interfere in an inevitable natural course of events. It is rather allowing (and possibly condoning) an act of killing, which *could* (physically) be prevented. The doctor may thus be more culpable than for a simple omission, as he is actively allowing the patient's life to be extinguished rather than simply failing to prevent them from dying.

***The Doctrine of Double Effect***

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The doctrine of double effect states that it is allowable to take an action that may result in death if procuring death is not the primary intention of that action, but it is not allowable to take the same action with the primary purpose of causing death. For example, in physical illness one can prescribe a large dose of morphine if it is necessary to control a patients pain, even though it may shorten the patient's life, but one cannot prescribe the same dose to the patient with the direct intention of killing them. This doctrine is difficult to assess in practice as the only distinction between an ethical and non-ethical action is in the doctor's mind. It is also difficult for anyone to be absolutely sure of one's own motives for an action.

The doctrine of double effect may not be of particular relevance to current psychiatric practice for, non-withstanding Dr. Van Gaal's actions, taking a direct action intended to kill a patient is unlikely. However, the distinction between the intended outcome of one's actions, and the unintended but foreseeable consequences, is of significance. This is illustrated by the case of Frank. The decision not to institute observation in the hospital to prevent him killing himself was presumably not made with the intention that he should go ahead and end his life, although this possibility was foreseen. Rather, the intention was most likely to prevent reinforcing his threatening and dangerous behavior by giving it excessive attention and possibly to reserve scarce psychiatric resources for patients more likely to benefit from them. In the present increasingly litigious climate of medical practice, it may become more difficult to defend such actions, which although carried out with the best intentions, may have unintended but foreseeable adverse consequences.

***Ordinary Versus Extra-ordinary Measures***

This distinction states that one is expected to take all ordinary measures to preserve a life, whereas extra-ordinary measures are not obligatory (Deschatelts 1986). This can be applied to medical treatments, with ordinary treatments being those which are common, cheap and non-invasive and extra-ordinary treatments being those which are experimental, complex,



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costly or carry a high risk of subsequent adverse effects. In physical illness in an attempt to save a life, one may be obliged to provide simple intravenous fluids but not necessarily to perform major experimental surgery.

Treatments provided by psychiatrists to prevent self-harm could be considered obligatory on these terms as psychiatric treatments by and large are not new, technologically complex or expensive, and sometimes, as in Geoffrey's case, may simply consist of keeping the patient for a while in a safe environment. However, the effects of these seemingly simple treatments may be anything but ordinary, particularly when applied to an unwilling patient over a long period of time. This was expressed by Sbrocca, who wrote:

> "If a psychiatrist is to prevent a person intent on taking his own life from doing so, he clearly cannot, and cannot be expected to accomplish that task unless he can exercise complete control over the capacity of the suicidal person to act." He continues; "But it is either impossible to do this or it may require reducing the patient to a social state below that of a slave; for a slave is compelled only to labor against his will, whereas the person committed to self-harm is compelled to live against his will." (Sbrocca, 1986).

This is illustrated by JoHanna's case. To ensure she does not end her life would entail keeping her under the strictest observation, possibly for the rest of her life. Given the clear evidence from her previous hospital admissions of the distress that this causes her, this treatment would seem inhumane and be seen as a way to decimate any remaining quality of life which she has, even though the actual treatment in itself may be quite simple and ordinary.

The current climate of placing increasing responsibility on mental health professionals for their patients' behavior has resulted in new powers designed to enforce compliance, such as supervision registers and the possibility of community treatment orders. The effect of these measures on a patient's quality of life and civil liberties should be carefully considered. In general, people who have suicidal ideations have committed no crimes and do not pose a threat to anyone other than to themselves.

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***The Terminal Nature of Illness***

Allowing voluntary death may seem less extreme if a person is close to death anyway by fact of suffering from a terminal illness. This is sometimes used as an argument in favor of voluntary euthanasia, that to undertake an action directly intended to cause death of such a patient is not to kill them but merely to not prolong the process of dying. There are problems in determining how close death must be before the provisions of terminal illness apply, and whether the diagnosis of an incurable illness, such as certain cancers, justifies voluntary death on this basis even before a person begins to suffer from any symptoms of the illness.

Psychiatric illnesses are usually not considered to be terminal. Therefore, if voluntary death were only allowable to the terminally ill, mental illness is not a justification for it (and self-harm amongst the mentally ill should thus always be prevented). However, voluntary death rates are much higher amongst those with mental illness than the general population. 15% of persons with major depression eventually end their lives, and 10% of those are diagnosed to have schizophrenia (Woolf and Wagner, 1970). Self-harm could therefore be considered a natural and not uncommon outcome of depression and schizophrenia. In this case, patients with a stated interest in taking their lives who have a serious untreatable mental illness could be considered to have a potentially terminal illness, and euthanasia in these cases akin to the same event in cases of terminal physical illness.

Another position one could argue is that persons suffering severely and hopelessly from conditions which are *not* terminal (such as Mrs. Dutrieux, JoHanna, and persons with chronic painful physical illness like severe rheumatoid arthritis) have more of a justification for seeking voluntary death than those who do have a terminal illness. This is because the suffering of the non-terminally ill may be expected go on for many years without respite, whereas in cases of terminal illness, at least the suffering time is limited .

***The Ability to Act***

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In his book, *Causing Death and Saving Lives*, Jonathan Burleigh puts forth the view that euthanasia should only be an option for those who are physically incapable of carrying out the act of death unaided (Burleigh, 1977). He states that suicide is always preferable to assisted suicide and assisted suicide to euthanasia. This is not due to any absolute moral distinction between the acts, for the intention and outcome may be the same in each case, but because the greater the degree to which a person acts independently, the greater is the certainty that their death is truly voluntary up to the moment of its occurrence. Furthermore, Burleigh suggests that requests for assistance by persons not completely incapacitated may be considered to be cries for help rather than an indication of a serious wish to die.

According to this view, assisted suicide and euthanasia amongst psychiatric patients (who are generally not physically disabled) is unnecessary and morally indefensible. However, although psychiatric illness does not usually result in gross physical incapacitation, symptoms of mental illness may affect planning and executing abilities to the extent to which a successful suicide attempt may be impossible. This could either be considered a good thing or the loss of an important liberty. To say that those who are physically capable should always act alone may also deny the suicidal individual the ability to seek the opinion and advice of others, including their families and their medical advisors. For when does knowing about a potential suicide and not trying to prevent it become assisted suicide? Hence, those seriously intending to end their lives may be condemned to a lonely and violent death or disability from a failed attempt. Mrs. Dutrieux consulted Dr. Van Gaal in order to avoid this, but it remains a possibility for JoHanna.



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## Conclusions

Voluntary death has occurred throughout history and across cultures but it is only relatively recently that it has been seen as a health problem or the business of doctors. Voluntary euthanasia and self-harm are both forms of voluntary death but the bioethical issues they raise have often been considered separately, as if euthanasia concerned solely the physically ill and physicians and suicide the mentally ill and psychiatrists. Attitudes toward euthanasia for the physically ill have become more accepting while psychiatrists have come under increasing expectations to prevent suicide.

In this paper, we have considered the psychiatrist's role and responsibility toward patients who wish to end their lives. The ethical dilemmas that may arise are not merely theoretical but, as our cases show, sometimes require immediate decisions to be made in day-to-day practice. The freedom to end one's own life by choice, something important to Seneca, Hume and other philosophers throughout the ages, is less straightforward now that research has shown that suicide often occurs due to illnesses such as depression and that successful treatment of such disorders can reverse the wish to die. This knowledge may have led to a belief that all suicidal intention is due to psychiatric illness and that suicide can always be prevented by psychiatric treatment. The increasing number of young people who take their lives, paired with a widening scope of life's problems that are now seen as mental health issues, may have led to an increasing awareness of the problem of self-harm and a greater expectation that psychiatrists should be able to do something about it.

The clinical cases we have described demonstrate that the suicidal inclinations of persons whom psychiatrists are called on to treat are not always the result of a recognizable mental illness and that mental illnesses when present are not always easily treatable. They also illustrate the severity and chronicity of suffering that some mentally ill patients undergo. In his treatment of Mrs. Dutrieux, Dr. Van Gaal undertook an unusual approach to a



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psychiatric patient who wished to die by allowing and assisting in her suicide rather than using forceful and coercive measures to prevent it.

There is at present little guidance for practicing psychiatrists faced with ethical dilemmas regarding a patient's wish to die. An examination of the bioethical literature concerning voluntary death shows that the principles and distinctions made are often not easily transferable to a psychiatric context. In particular, competence may be impossible to assess independently from ongoing psychopathology. The acts and omissions doctrine breaks down suicide as an act and not an inevitable process. The distinction between ordinary and extra-ordinary treatments is difficult to apply when psychiatric treatments in themselves may be very ordinary but have the most extra-ordinary effects on patient's lives. Psychiatric illness may not be terminal but this may not justify condemning a person to a prolonged life of severe and hopeless suffering. The mentally ill may not be physically incapacitated from committing suicide but requiring that they should act alone without the implication of others if they wish to die may deny valuable and humane discussion and assistance from others and lead to violent and lonely deaths which, incidentally, may have been preventable.

There is as of yet no consensus regarding issues of voluntary death in the core cases of the terminally physically ill, as the continuing tribulations of Dr. Jack Kevorkian demonstrate. The novelty of the idea of a psychiatric justification for euthanasia or assisted suicide is demonstrated by the repercussions of the Van Gaal case in a country where both practices are not uncommon. To what lengths a psychiatrist should be expected to go in trying to prevent a patient from morbid self-harm, and whether there is ever a justification for allowing or assisting death in psychiatric practice, are questions which are likely to become increasingly acute in the future. The failure of standard bioethical tools to offer assistance indicates an urgent need for wider consideration and discussion of these issues.

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## Notes

1. The Terminology of Voluntary Death

Issues concerning the end of life and medical assistance in dying may be confused by the range of actions with different moral implications which are included under the terms *euthanasia* and *suicide* (Petrucci, 1995). We will define these terms as we understand them.

*Morbid self-harm, Self-harm, and Suicide* are terms defining the action of deliberately taking one's own life. *Assisted suicide* is the deliberate provision of information, the means, and/or help, to enable another person to commit suicide.

*Euthanasia* originates from the Greek, meaning "a good death." In its current usage, euthanasia can be defined as being the bringing about of the death of another person, when death is perceived to be in their best interests. *Voluntary euthanasia* occurs when the person who is to die either requests or gives informed consent to euthanasia. Euthanasia without request has two forms: *Involuntary euthanasia* occurs when euthanasia is performed either against a person's wishes or without those wishes having been ascertained, and *non-voluntary euthanasia* implies that the person who is to die is unable or incompetent to give informed consent. In *active euthanasia*, the perpetrator takes a specific deliberate action to bring about the patient's death (i.e. he or she kills the patient), and in *passive euthanasia* the person deliberately fails to take an action to prevent the patient from dying (i.e. he or she lets the patient die).

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## 2. The Mental Health Act of 1983

In modern Western psychiatric practice, a person likely to commit self-harm is likely to be admitted to a hospital on a voluntary basis if they agree or involuntarily if they do not. In England and Wales, this practice is governed by the Mental Health Act of 1983 which gives doctors certain rights to detain and treat patients with mental disorders without their consent (Department of Health and Welsh Office, 1983). Three conditions must be fulfilled for admission and treatment under the Act: It must be believed that the person to be detained suffers from a mental disorder, that they pose a risk to the health and safety of themself or others, and that alternative methods of treatment are inappropriate. The recommendations of two medical practitioners, one of whom has special experience in mental illness, and an approved social worker (all of whom have examined the patient) are usually required for all but the shortest periods of detention. The act provides only for the treatment of mental disorders. It gives no authority for the treatment of physical disorders without consent, even if they are life threatening. Periods of detention range from four hours to six months in the first instance and are renewable.

## 3. Personality Disorder

The characteristic patterns of behavior and modes of thinking and feeling that make up a person's personality are unique to each individual, and there are no agreed methods of separating personalities into those that are normal and those that are abnormal. However, the study of personality and personality disorders has long been part of the discipline of psychiatry. Despite debate as to its classification, categories of personality disorder continue to appear in all the major classifications of psychiatric illness. In the World Health Organization's International Classification of Diseases (tenth revision), personality disorder is defined as:

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> "A condition comprising of deeply ingrained and enduring behaviour patterns which are inflexible and represent an extreme or significant deviation from the way in which an average individual in a given culture thinks, feels and particularly relates to others." (World Health Organization, 1992).

It is clear from this definition that what is considered a disorder will differ according to culture. It is also true that personalities which vary from population norms are only likely to be labelled disordered if they cause problems, generally to other people and sometimes to the individuals themselves.

It is a matter of long debate whether personality disorder, if it does exist as a medical condition, is treatable. There are certainly no simple remedies and intervention by psychiatric services is often limited to containment and crisis intervention rather than attempting anything curative.

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