PSYCHIATRY AND PHYSICIAN-ASSISTED SUICIDE

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Interest in physician-assisted suicide among the American public has grown in recent years. Population surveys now reveal that most support legalization of physician assistance in suicide for terminally ill patients. Physician response to this interest has ranged from unconditional rejection to qualified acceptance, with internists dominating the medical commentary on this issue. Psychiatric response has been almost uniformly critical of the rationality of suicide. This criticism seems to grow out of the tradition of suicide prevention that is well established in our speciality. There is, however, little available information on the association between suicide, mental illness, and rationality in the terminally ill. Rather, psychiatric opposition to physician-assisted suicide has been grounded on information about suicide in patients without medical illness. This article examines the validity of the extension of the psychiatric view of suicide in the medically well to the terminally ill. The principal arguments advanced in the psychiatric literature against the legalization of physician-assisted suicide are discussed, and recommendations are made concerning the role the psychiatrist could play in the physician-assisted suicide process.

THE MOVEMENT TOWARD LEGALIZING PHYSICIAN-ASSISTED SUICIDE

Public opinion, in the United States and elsewhere, is generally in favor of legalizing physician-assisted suicide. A 1991 poll of Americans
revealed that 64% of those polled favored legalizing physician-assisted suicide, almost twice the number of those who favored its legalization in 1950. In 1994, Oregon voters narrowly approved an initiative legalizing assisted suicide. A federal court judge recently struck down the law, in part because the law did not require evaluation by a mental health professional. That decision is now on appeal before the same court that is reviewing Washington state's ban on physician-assisted suicide. Australia's Northern Territory recently enacted the Rights of the Terminally Ill Act of 1995 legalizing physician-assisted suicide. Assisted suicide is widely practiced in The Netherlands, although it technically remains illegal.

The Oregon and Australian laws concerning physician-assisted suicide delineate specific requirements that must be met before an individual's request for assistance in dying is honored. A patient must be terminally ill, which is generally defined as having a disease that leads to death within 6 months. A minimum period of time, 15 days under the Oregon law and 48 hours under the Australian law, must elapse between an initial request for assistance in dying and its implementation, to ensure that an individual's decision is stable and consistent over time. Finally, the individual's primary physician and a second consulting physician must confirm that the patient has a terminal illness; is acting voluntarily; and is informed about the diagnosis and prognosis of his or her illness, the potential risks of taking the medication to induce death, and the alternatives to suicide, such as hospice care. These physicians must also evaluate a patient for decision-making capacity to make an informed decision. The Australian law also mandates that a physician "who holds a diploma of psychological medicine or its equivalent" has confirmed that "the patient is not suffering from a treatable clinical depression in respect of the illness." Because such competency assessments and clinical evaluations are typically performed by psychiatrists, our profession will almost inevitably participate in the physician-assisted suicide process. Indeed, some commentators have gone so far as to argue for mandatory psychiatric evaluations for anyone requesting assisted suicide. The Oregon court held that such a safeguard is necessary to uphold the law.

THE PSYCHIATRIC PERSPECTIVE ON SUICIDE

Psychiatric opposition to physician-assisted suicide is rooted in the view that suicide is a symptom of psychopathology. It is, therefore, an outcome of illness that must be prevented through psychiatric treatment. The belief that suicidal ideation is a sign of psychopathology stems from the high correlation between suicide and mental illness. Postmortem psychological autopsies reveal that in more than 90% of suicides, individuals suffered from a psychiatric disorder at the time of suicide, typically depression, substance abuse, or psychosis. There
is also some evidence establishing an association between depression and the desire for death in the terminally ill.\textsuperscript{14, 20} Psychiatry, moreover, is the only discipline in medicine that defines suicidal ideation as a criterion of illness.\textsuperscript{2} Many psychiatrists, therefore, have traditionally believed that a request for death, coupled as it must be with psychopathology, cannot represent a rational decision. By treating the mental illness, the conventional wisdom goes, rationality is restored and the patient will no longer have a desire for death.

Given this formulation of suicide as a fatal symptom of mental illness, its prevention is of paramount concern to psychiatrists. Indeed, the psychiatric literature suggests that to some extent suicide prevention takes priority over attempts to treat the underlying psychopathology.\textsuperscript{31} For example, many psychiatric interventions on inpatient settings are geared physically or chemically to restraining or isolating a patient to prevent suicide. Commentators have suggested that this emphasis can be ultimately countertherapeutic for patients in terms of treating their underlying psychopathology.\textsuperscript{31} A patient whose privacy and autonomy are sacrificed through interventions, such as constant observation or protracted hospitalizations, to ensure his or her safety can become overly regressed and dependent, thus compromising his or her overall mental health. Psychiatrists, therefore, may often confuse suicide prevention as the goal of treatment rather than as a means of keeping a patient alive to treat his or her mental illness. This confusion may lead to interventions with paradoxical, countertherapeutic consequences.

The context in which a psychiatric patient commits suicide helps explain psychiatrists' attitude toward suicide and the attendant emphasis on prevention. A psychiatric patient's suicide is almost universally followed by a series of institutional reviews of the quality of care the patient received. This underscores the fact that institutions typically define suicide as a failure of psychiatric care. Family members, moreover, in what may reflect feelings of displaced anger and guilt toward their deceased relative, may perceive the psychiatrist as responsible for the suicide, or at a minimum for the inability to prevent it. In short, the psychiatrist treats patients in a culture where there is an expectation that suicide should be prevented.

Psychiatrists, however, impose this construct of suicide—arguably appropriate for the medically well—onto the terminally medically ill, insisting that suicidality among such patients is treatable, preventable, and certainly a sign of psychiatric disorder.\textsuperscript{58} In contrast, most physicians in other disciplines perceive a terminally ill patient's refusal of lifesustaining treatment and, by extension, expression of suicide as understandable responses to his or her medical condition, and not necessarily an indication of psychopathology. In this perspective, death is seen as "nature taking its course," an outcome that need not be shunned at all costs. This follows from the well-established clinical (and legal) tradition of accepting a terminally ill patient's "right to die" in the context of refusing lifesaving treatment.\textsuperscript{45}
THE PSYCHIATRIC DEBATE ON PHYSICIAN-ASSISTED SUICIDE

Given this perspective on suicide, it is not surprising that almost all of the psychiatric literature on physician-assisted suicide is opposed to its legalization; however, the principal argument made in opposition to assisted suicide—that suicide is almost always a symptom of mental illness—may not apply to terminally ill patients requesting physician's assistance in suicide. The postmortem studies showing a prevalence of psychiatric disorder in excess of 90% of suicides in the general population often do not include, or mention, individuals with terminal illness. Even those studies that did consider the prevalence of suicide among the terminally ill are inconclusive because of the low number of terminally ill patients, only 6% of cases in one study and 4% in another. The statistics frequently cited in opposition to the legalization of physician-assisted suicide must be extrapolated to provide information about the prevalence of psychiatric disorder specifically among terminally ill patients who are suicidal. The studies that do address the prevalence of psychiatric disorder among terminally ill patients are inconsistent. Some studies suggest that as many as 77% of late-stage cancer patients suffer from major depression. Most studies, however, show that only a minority of terminally ill patients suffer from either major or minor depression, with figures ranging from 13% to 26%. This is nonetheless higher than the prevalence of depression in the general population.

When focusing more specifically on the prevalence of depression or other psychiatric disorders among terminally ill, suicidal patients, there is a dearth of information. A 1986 study by Brown et al conducted at St. Boniface Hospital concluded that those terminally ill patients who had suicidal ideation—3 out of 44—all suffered from severe depression. Most (75%) of the patients, however, did not suffer from depression and never wished for death or suicide. A more recent study by Chochinov et al at two Canadian hospitals showed that only 17 out of 199 terminally ill patients (i.e., 8.5%) had "a serious and pervasive desire" for death. Notably, of these 17 patients, 7 (i.e., 42.2%) did not meet criteria for a diagnosis of depression. This study also indicated that of these 17 patients, only 1 had actually requested assistance in dying. The authors, however, speculate that in a culture more accepting of assisted suicide, all of the terminally ill patients who had a desire for death might have requested assisted suicide. Chochinov et al note that in their study the percentage of terminally ill patients with a pervasive desire to die (i.e., 8.5%) is consistent with research in The Netherlands showing that 6% to 7% of terminally ill patients request assisted suicide.

The studies by Brown et al and Chochinov et al provide inconclusive results concerning the importance of depression among the terminally ill who desire death. One would ultimately want to know not just that the desire to die is associated with other depressive symptoms, but
that treatment of depression reverses this desire. There is some evidence that challenges the basic assumption that there is a strong association between depression and the desire for death among the terminally ill. One study showed that depression accounted for very little of the variance in decisions about forgoing lifesaving treatment, and that quality-of-life assessments were more closely associated with the desire for lifesaving treatment.\textsuperscript{43} Quality of life, which is often a measure of a patient's functional status, was measured in this study by four variables correlated with a patient's satisfaction with life: (1) zest, (2) resolution and fortitude, (3) congruence between desired and achieved goals, and (4) mood tone. Another study by the same authors showed little change in the wish for life-sustaining therapy following depression treatment.\textsuperscript{29}

Additional research is clearly needed to clarify the prevalence of suicidal thoughts, both persistent and transient, among terminally ill patients, and the association between suicidality, psychiatric illness, and competence in this population. The evidence that nearly 50\% of terminally ill patients with a pervasive desire to die are not depressed\textsuperscript{20} can be interpreted as a glass half full or half empty. It certainly means that it is appropriate to assess for depression in those who seek to hasten their deaths. But it does not justify a blanket disqualification of these desires as symptoms of mental illness.

Some psychiatrists argue that even in the absence of a major depression, suicidality among the terminally ill reflects an inability to cope adaptively with the prospect of an imminent death. According to Herbert Hendin,\textsuperscript{34} one of the leading psychiatric opponents of the legalization of physician-assisted suicide, individuals "displace anxieties about death onto the circumstances of dying—pain, dependence, loss of dignity, the unpleasant side effects resulting from medical assistance." Indeed, some hospice directors have commented that patients with strong needs for control and independence may, in particular, have extreme difficulty accepting the deterioration of their bodies and are likely to attempt to establish control over their situation by seeking assistance in suicide.\textsuperscript{10} A desire for suicide may possibly subside when the terminally ill patient, through psychotherapeutic intervention, comes to terms with death. For example, Hendin\textsuperscript{34} describes patients requesting assisted suicide who are terrified about losing their independence and experiencing extreme pain and indignities from their illnesses and the side effects of their treatment. By talking about the prospect of dying with a psychiatrist, their desperation about the "circumstances of dying" and desire for assisted suicide subsided, and they were able to achieve a "loving" parting with family and friends that they otherwise would have missed.

In the experience of some psychiatrists working with the terminally ill, patients who are especially self-reliant, perfectionistic, and judgmental with narcissistic and obsessive-compulsive traits, may have difficulty coping with severe medical illness.\textsuperscript{10} Psychotherapy may help such patients reconceptualize their experience of dying in terms that are less frightening and more acceptable. For example, a patient may be
helped to satisfy a need to be in control by construing his or her experience of dying as perseverance in the face of adversity and uncertainty. It is possible that where issues of control are paramount in determining a patient's desire for death, accepting suicide as a possibly rational decision may facilitate a therapeutic relationship with a patient and paradoxically lead to a decrease of suicidal thoughts. Nonetheless, it remains unclear precisely how malleable decisions about suicide are, and to what extent they reflect unresolved conflicts about death. There are no studies, other than isolated case reports, examining the likelihood of terminally ill, suicidal patients changing their minds about suicide after receiving psychotherapy.

In addition to arguments concerning the relationship between psychopathology and suicide, some psychiatrists advance a slippery-slope argument against physician-assisted suicide. This is premised on the theory that legalization is likely to lead to a slippery slope of potential abuses of vulnerable, marginalized patients. For example, family members may cause a terminally ill relative to feel pressured or coerced to hasten death. This dynamic may stem from the difficulty family members have coping with the emotional or financial stress of caring for a dying relative. Even in the absence of family pressures, a patient may experience financial pressures as a significant determinant in choosing to seek an early death. This concern is particularly acute in the United States, where more than 37 million people are uninsured and insurance carriers routinely cap coverage. By contrast, several Dutch physicians comment that this is much less of a concern in The Netherlands, where there is universal health insurance.

Psychiatric opponents of assisted suicide also argue that the safeguards intended to protect individuals from abuse may be gradually relaxed in a culture more accepting of suicide and assisted death. Legalization of physician-assisted suicide for the terminally ill may lead to physicians assisting in the death of patients with chronic but not terminal illness, of mentally ill patients without medical illness, and ultimately to physicians making decisions to end the life of competent patients without first consulting them. Psychiatrists point to case reports of each of these scenarios in The Netherlands. Dutch studies indicate that medical decisions that hasten death occur in 38% of all deaths, with 2.1% of these including either assisted suicide or voluntary active euthanasia (when the physician, as opposed to the patient, medicates the patient) and 0.8% including euthanasia without the patient's consent. Dutch studies indicate that medical decisions that hasten death occur in 38% of all deaths, with 2.1% of these including either assisted suicide or voluntary active euthanasia (when the physician, as opposed to the patient, medicates the patient) and 0.8% including euthanasia without the patient's consent. This final category, resulting in about 1000 deaths per year, occurred in instances where physicians felt that they were not able to control pain effectively, their patient's quality of life was very low, and often life would be shortened by only a few hours or days. For example, describes the case of a physician who terminated the life of a nun several days before she would have otherwise died, because the physician felt that the nun's religious beliefs would have prevented her from asking for assistance in dying despite the fact that she was suffering from severe pain. Opponents of legalization argue that legalizing as-
sisted suicide will not result in greater respect for patient autonomy but rather will lead to a pernicious paternalism with physicians deciding unilaterally when it is in their patients' best interest to die.39

Other commentators suggest that when physicians clandestinely assist in their patient’s death more abuses are likely to occur than would occur in a legalized system with built-in procedural safeguards.8, 53 Today, there are approximately 6000 deaths per day in the United States that are either planned or indirectly assisted,45 most of which are performed legally with the ostensible goal of pain management. This practice has been historically justified by the principle of *double effect*, which holds that a premature death is morally justified so long as it is an unintended consequence, not the goal, of the physician’s intention to treat a patient’s pain. This controversial distinction between intended and unintended consequences has been the ethical basis for the implementation of such death-hastening practices as morphine drips or barbiturate sedation.52 These practices have become commonplace and widely accepted as a method of pain management. In the confusion between intended and unintended consequences of comfort care, physicians may become lax about the necessity of full disclosure concerning the potentially lethal consequences of these practices with the patient and family. Advocates of legalization, therefore, argue that by legalizing assisted suicide, with procedural safeguards, fewer abuses are likely to occur than under the present system.

Opponents of physician-assisted suicide also caution that assisted suicide is a violation of a physician’s professional responsibility and integrity. In other words, physicians have a duty to respect the health of the living, such that they are prohibited from any actions that assist death.40 Some contend that physician-assisted suicide may lead to an erosion of the public’s trust in, and perception of, physicians as protectors of life. If physicians are to respect not only the human body but also the person suffering from exquisite pain or indignities from a terminal illness, however, then assisting in death could take precedence over preserving bodily life. This need not necessarily compromise professional integrity.50 Moreover, some have argued that physicians have an affirmative responsibility to assist in death at a patient’s competent request in the context of unremediable pain and suffering. To do otherwise is thought to be equivalent to abandonment of the patient at a time of great need and vulnerability.13

In contrast to the dominance of arguments against physician-assisted suicide in the psychiatric literature, several surveys show that many psychiatrists may be more tolerant of physician-assisted suicide than other physicians. One survey assessed geriatric psychiatrists’ attitudes toward physician-assisted suicide given several vignettes.37 Seventy-two percent said that they would counsel a competent patient with severe depression refractory to all treatments against suicide, whereas only 32% would counsel a competent patient terminally ill with pancreatic cancer against suicide. In this instance, 22% said they would actually assist in the suicide. In another survey distributed to physicians (both
psychiatrists and nonpsychiatrists) in the state of Washington, slightly more than half the physicians favored legalizing physician-assisted suicide, with psychiatrists the strongest supporters of these practices. Although the psychiatric and medical literature regarding assisted suicide suggests a divergence between the perspectives of psychiatrists and other physicians, this is not borne out in surveys of physicians' attitudes. It is possible that those psychiatrists who are more tolerant of physician-assisted suicide have chosen not to express their opinions, perhaps because arguments in support of physician-assisted suicide are well documented in the medical and bioethics literature.

THE ROLE OF THE PSYCHIATRIST IN PHYSICIAN-ASSISTED SUICIDE

Standing in contrast to the psychiatric literature opposing physician-assisted suicide is public and judicial opinion in favor of psychiatrist involvement in assisted suicide. Indeed, psychiatric evaluations are mandatory in the Northern Territory of Australia's Rights of the Terminally Ill Act of 1995, were deemed necessary by the judge reviewing Oregon's Death with Dignity Act, and typically occur in The Netherlands. Set forth next are issues of clinical significance for psychiatrists participating in the physician-assisted suicide process.

Competency Assessment

For a terminally ill patient's request for death to be deemed competent, the patient's decision-making capacity must be assessed according to one or more of four legal standards commonly used for competency determinations. As applied to the context of a terminally ill patient requesting assistance in dying, they are the following: (1) A patient's ability to communicate a stable and consistent desire for assisted suicide. (2) A patient's ability to understand the purpose and nature of the treatment that will be provided to induce death, the risks of this treatment (i.e., if death is not induced), and the alternatives to assisted suicide, such as comfort or hospice care. (3) A patient's ability to appreciate the personal relevance of assisted suicide. This is distinct from the ability to understand, which can be achieved through an abstract cognitive awareness of the facts of treatment without appreciating how the treatment will affect one's life. (4) A patient's ability to think rationally about assisted suicide, which entails having logical, sequential, goal-directed thought processes.

These standards have traditionally been thought to range from the least stringent (i.e., allowing some incompetent refusals) to the most stringent (i.e., overruling some competent refusals). The standards are variously used, depending on the context in which a competency evaluation is being made. In other words, the standard chosen to determine competency varies with the risks, benefits, and consequences of treat-
ment being proposed. In the case of assisted suicide, where the risks can be severe (i.e., a botched attempt may leave the patient in a persistent vegetative state), and the benefits and consequences of assisted suicide irreversible, a stringent standard to assess decision-making capacity should be used. Thus, a patient should have a rational explanation for why he or she is requesting assistance in dying and probably should meet several or all of the other standards. Indeed, because of recent evidence suggesting that these standards cannot be hierarchically ranked according to their level of stringency but are more stringent in combination,\(^5\) it may be essential that a patient meet all of the standards before the patient’s decision-making capacity is deemed competent.

It is essential that when assessing decision-making capacity psychiatrists not fall prey to the antiquated notion that mental illness is synonymous with incompetency. It is possible, for example, that even a psychotic individual may be able to make a competent decision about his or her treatment. Moreover, affective illness also may not necessarily interfere with decision-making capacity. There is evidence that mild-to-moderate depressions do not alter a patient’s ability to make competent decisions about lifesaving or life-ending treatment.\(^20\), \(^43\) When evaluating decision-making capacity in a depressed patient, it is important to identify symptoms, such as anhedonia, hopelessness, helplessness, or worthlessness, which may distort a patient’s perception of self, the future, and the world in general. Vegetative symptoms of depression, on the other hand, are less likely to impair decision-making capacity. It is also important not to focus exclusively on cognitive elements of the mental status examination. Depression is likely to leave intact the cognitive ability to understand facts about treatment, while impairing the ability to appreciate the impact a treatment may have on one’s life.\(^18\) Familiarity with these issues is crucial to assess competency among the terminally ill requesting assisted suicide because the prevalence of depression among terminally ill patients is, as discussed previously, higher than in the general population.

Although psychiatrists (as well as courts and legislators) generally assume that it is necessary to assess a terminally ill patient’s decision-making capacity, there are other measures that can be used to assess a patient’s decision to seek aid in dying. Determining the authenticity of a patient’s request is equally, if not more, compelling. This concerns whether a patient’s decision is consistent with a well-established, time-honored, personal value system. Authenticity can be evaluated by talking to the patient’s friends and family to determine the patient’s past thoughts about assisted suicide, the importance accorded to the dignity versus the sanctity of life, or the ability to tolerate pain. Unlike competency evaluations that involve a dynamic assessment of a patient’s current mental functioning, assessing the authenticity of a decision involves the retrospective determination of its continuity with a personal value system. When friends and family are available for consultation, authenticity may often be confirmed with greater speed and objectivity than competency. It is possible, however, that a patient confronted with
the reality of a terminal illness may feel differently about decisions, such as whether to seek aid in dying, than he or she did when previously contemplating such issues while in good health. Measuring the quality of a patient’s decisions by authenticity alone may not sufficiently respect a patient’s prerogative to change his or her mind about treatment decisions at the end of life.

It may be useful, therefore, to combine assessments of authenticity with competency to honor decisions that may be competent, although not necessarily authentic. Combining these measures would also help minimize the risk that a physician deem a patient incompetent because he or she disagrees with the reasonableness of a patient’s decision to seek assistance in dying. Respect for authenticity ensures that judgments about the reasonableness of a patient’s decision are measured against the patient’s own value system and not the physician’s. Advance directives and proxy decision makers with durable power of attorney may also serve to protect the integrity of a patient’s value system. Although such measures would not obviate the need to evaluate the competency of a patient’s decision to seek aid in dying, they would at a minimum help to place the decision in an historical context and clarify its authenticity.

In sum, the competency of a patient’s decision to seek physician-assisted suicide may be difficult to assess. Although a high threshold should be set to determine a patient’s competency, it should not be set so high as to make it virtually impossible to honor the request. It is difficult in some cases to apply a truly independent standard of competence that amounts to something more impartial than the psychiatrist’s own belief about the reasonableness of a patient’s decision. Assistance may be obtained by looking to other measures to assess the quality of a patient’s decision, such as authenticity, advanced directives, or proxy decision makers.

**Clinical Aspects of Patient Care in Assisted Suicide**

In addition to competency assessments, psychiatrists can make other meaningful contributions to the management of terminally ill patients requesting aid in dying. A major contribution psychiatrists can make is screening patients for treatable neuropsychiatric disorders, which is a distinct inquiry from competency assessment. Studies of terminally ill patients suggest that the prevalence of neuropsychiatric disorders among such patients is higher than in the general population. Psychiatrists need to consider whether a patient suffers from depression, anxiety, and organic mental disorders, such as delirium. These disorders are widely underdiagnosed in the medical setting and extremely prevalent. For example, the prevalence of delirium among cancer patients, which is often misdiagnosed or unrecognized by nonpsychiatric physicians, has been shown to range from 25% to 40% and as high as 85% during the final stages of illness. Depression, with a prevalence as high as 77%
in cancer patients with advanced disease, must be screened for given
the frequency with which it is underdiagnosed in the medical setting
in general. Moreover, depressive symptoms in the terminally ill, in
particular, are often viewed as reasonable, normal responses to severe
medical illness and not necessarily a sign of psychiatric illness. Diagno-
sis of major depression among the severely medically ill, however, can
be extremely challenging given the overlap of symptoms owing to
medical illness and depression. In the evaluation of patients requesting
physician-assisted suicide, it is wise to err on the side of overinclusiv-
ness, considering any signs and symptoms diagnostic of depression
regardless of whether or not they may be caused by the medical illness.
This is especially important because depression can often be successfully
treated in the setting of severe medical illness with antidepressants,
psychostimulants, and electroconvulsive therapy. Although there is
no conclusive evidence of its effectiveness, psychotherapy, as discussed
previously, may also be helpful for terminally ill patients attempting to
come to terms with death and the attendant fears of losing independence
and control over one’s life.

The Psychiatrist as Gatekeeper

Many psychiatrists and legislators argue that psychiatrists should
have a mandatory role in evaluating patients requesting assistance in
suicide. Legally requiring psychiatric evaluations for all patients
requesting physician-assisted suicide may seem wise given the preva-
ience of depression among the terminally ill and the difficulty of depres-
sion diagnosis in these patients; however, this gatekeeping role is prob-
lematic for psychiatrists and psychiatry. At its most basic level, the
decision to seek aid in dying is deeply personal and subjective. If society
decides that citizens have a right to request a physician’s assistance in
dying when they are terminally ill, citizens should not need psychiatric
validation to exercise that right. The burden of proof should be on those
who seek to deny citizens their rights. Medicalizing access to this prac-
tice obscures the fundamental value choices being made by society
in legalizing this practice. Psychiatrists are physicians, not policemen.
Psychiatric evaluation should be done primarily to point toward effec-
tive therapies, not universally to adjudicate the appropriateness of a
patient’s exercise of his or her rights.

The absence of a systematic, impartial method to assess the compe-
tency of a patient’s decision to seek aid in dying further complicates the
role of psychiatrist as gatekeeper. There is relatively little information
about the influence of psychiatric disorders on decision-making capacity.
Moreover, diagnosis of depression in the terminally ill can be extremely
difficult and imprecise. In the absence of an impartial and precise
method, psychiatrists’ judgments are likely to reflect their own personal
views about assisted suicide. Something similar happened in the late
1960s when, in most states, abortion was illegal and psychiatrists were
frequently consulted to demonstrate that a woman was at risk for developing a mental illness unless the pregnancy was terminated, despite the fact that there was no conclusive research on the psychiatric consequences of denied abortions. Psychiatric certification for abortion was grounded on a psychiatrist’s perspective on abortion as social policy rather than on expert knowledge.3

Finally, if psychiatrists are perceived as gatekeepers, patients may view their interactions with the psychiatrist as adversarial. This may inhibit free discussion of thoughts and feelings about suicide. More generally, public trust and confidence in the profession may be eroded if psychiatrists are perceived as making little more than personal judgments in the guise of medical science. Given these problems with establishing psychiatrists as gatekeepers, it is not surprising that in The Netherlands, where there is no requirement for a mandatory psychiatric evaluation, most Dutch psychiatrists are opposed to any efforts to institute mandatory psychiatric consultations.38

PALLIATIVE CARE AND ASSISTED SUICIDE

Psychiatrists can also provide palliative care to terminally ill, suicidal patients, both by identifying psychosocial sources of unnecessary suffering and using psychopharmacology to relieve suffering. Pain is very common among terminally ill patients. Studies have shown, for example, that 70% of cancer patients experience severe pain at some point in the course of their illness.27 Despite its prevalence, pain is often underdiagnosed and poorly treated.46 Psychiatrists can help to identify sources of pain and suffering and recommend methods of symptom control, such as augmentation of other pain medications with antidepressants and psychostimulants, hypnosis for nausea, and behavioral treatments for anxiety.10

In addition, psychiatrists can help other physicians caring for terminally ill patients deal with their own conflicts about death. Given the traditional focus on curing illness and preventing death, physicians are generally not well suited to help the dying patient and often have little training in palliative care. The emphasis many physicians place on providing elaborate, expensive, high-tech treatments for terminally ill patients facing an imminent and unavoidable death may reflect a defense against their own difficulties in working with dying patients and coming to terms with death. Indeed, there is some evidence that physicians may have a greater fear of death than nonphysicians, and consequently are predisposed to treating patients’ diseases and symptom complexes without paying adequate attention to the psychological, social, and spiritual dimensions of dying that their patients are experiencing.57 Some commentators argue that physicians have rejected the “naturalness” of dying from old age or chronic disease in favor of a highly medicalized perspective of death.48

Despite the contributions psychiatrists can make to palliative treat-
ment for the terminally ill, we are also typically not well versed in issues of death and dying and receive very little education about this in our training. One survey, which assessed the teaching of death and dying in psychiatric residencies, reported that 74% of residents attended no lectures or didactics on death and dying, and 44% of the residency training programs (according to residency training directors) offered no such teaching at all.23

Further research is needed to clarify the extent to which pain influences patient's decisions to request assisted suicide. There is evidence that medically ill patients experiencing painful symptoms have a higher frequency of psychiatric disorders and are at greater risk of committing suicide.12 In The Netherlands, one study showed a clear association between pain and requests for assisted suicide, with approximately 85% of patients withdrawing their requests with improved pain control.59 Some recent evidence challenging this association, however, showed that the determinants of the desire for death among terminally ill patients are multifactorial, with pain and family support having a less direct influence on this desire than depression.20

CONCLUSION

Psychiatrists have long equated suicide and the desire to die with psychopathology. As we come to evaluate and treat those at the end of life, it would serve us well to re-examine this time-honored perspective on suicide. Internal medicine gradually has come to realize that there comes a point in clinical care when death is the appropriate outcome. Psychiatry, too, may find the desire for death or the intentional hastening of death to be reasonable sometimes. At times this desire should be treated as a symptom; at other times it should be respected as a decision. Sorting these cases out clinically will be very difficult. Designing policies and laws to separate appropriate from inappropriate requests for suicide assistance may not be possible, however, before we have a better understanding of the context in which such decisions are made and patients have universal access to hospice and palliative care. Psychiatrists have much to learn about palliative care and the treatment of the terminally ill if we are to help reduce suffering at the end of life.

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