SUICIDE, EUTHANASIA, AND THE PSYCHIATRIST

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ABSTRACT

Recently, attitudes toward voluntary euthanasia appear to have become more liberal, and physicians are no longer expected to undertake all possible measures to sustain life in hopeless situations. There has also been a contrary trend in psychiatric medicine, with an increasing expectation for psychiatrists to prevent suicide.

This divergence in attitudes regarding voluntary death was evidenced in 1993 by Dr. Chabot, who assisted a depressed woman in committing suicide. A subsequent court case opened the debate on psychiatric euthanasia.

In this paper, we review the historical aspects of suicide and euthanasia to show how attitudes toward these practices have varied. We present the case of Dr. Chabot, then focus on three cases from clinical practice in which a psychiatrist had to make difficult decisions when a patient expressed a wish to die. Finally, we consider the bioethical literature concerning voluntary death and assess how well its guidance translates to a psychiatric context.

Our conclusions are: that suicidal wishes of psychiatric patients are not always the result of a mental illness; that mental illness is not always curable; that there are situations in psychiatry comparable in respect to cases of terminal illness in physical medicine; and that the bioethical literature concerning voluntary death is often not greatly helpful in psychiatry.

We invite comment from those concerned with mental health, focusing on the practical issue of management. We believe our cases are not atypical, and that the dilemmas they represent will be faced with increasing frequency in years to come.
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INTRODUCTION

Suicide, assisted suicide, and voluntary euthanasia are all practices in which a person chooses to end their life. In recent years, popular opinion regarding assisted suicide and voluntary euthanasia in cases of serious physical illness has become more liberal; but in the field of mental health, psychiatrists are increasingly expected to prevent their patients from ending their lives by committing suicide.

Do psychiatrists have a duty to prevent suicides? Must they always try to prevent it, or are there cases where they should perhaps turn a blind eye, or even give assistance to a likely suicide? Is there indeed ever a justification for psychiatric euthanasia? In 1993, these issues were brought to attention with the case of Dr. Boudewijn Chabot, a Dutch psychiatrist who assisted in the suicide of a woman who was not terminally ill, but in his view, suffering hopelessly from depression.

This paper examines the Chabot case and 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.1 The cases will be briefly set in their historical and cultural perspective to highlight changes in attitudes toward voluntary death, and set 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 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.

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1 Details of the cases have been altered to preserve confidentiality
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HISTORICAL AND CROSS-CULTURAL PERSPECTIVE

Suicide has occurred throughout the history of mankind, but society’s attitude toward it has changed. In the classical world, suicide at times of adversity or to avoid dishonor was seen as a noble, often heroic act, and an important freedom. Instances of suicide are common in classical literature. 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 medieval Christian world, suicide was a devil-driven sin, and a crime deserving of the severest ecclesiastical and secular punishment. The bodies of those who committed suicide were subjected to public desecration, and those who attempted suicide could find themselves arrested, and even sentenced to death for their actions. This view was hardly challenged until the eighteenth century, with the advent of the new schools of philosophy during 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.”

Historically, certain types of suicide have 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, or the Japanese ritual of hara-kiri with a preference for death over dishonor. Both these practices have been slow to die out, if they have yet.

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

“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).

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, Galas, & Phillips, 1974).

At present, over 5,000 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 kill themselves (Melson, 1995). Suicide is now the second leading cause of death in this sector of the population (Department of Health, 1993). Rates of attempted suicide, or deliberate self-harm, have also risen markedly in the second half of this century, and recently, again, particularly among young men (Grant & Taylor, 1992).

In recent years, psychiatrists and other mental health workers have increasingly been expected to assume responsibility for preventing their patients from committing suicide. In
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the United States, “failure to prevent suicide” is now the leading reason for malpractice suits being brought against mental health workers (Sbrocca, 1986). In Britain, new government “supervision registers” have the effect of making mental health professionals more culpable for the actions of their patients (Black & Tibbets, 1995), and a nation-wide confidential inquiry has been set up to investigate suicides and homicides among psychiatric patients (Garrow, Crochtiere, & Ahmedson, 1997). A 1992 British government white paper, “The Health of the Nation,” explicitly designates suicide prevention 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 usually abandonment, of the sick and elderly occurred in a number of 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 of an issue than it is today. As medicine advances in its abilities to prolong life, the public acceptability of euthanasia appears to be growing. Surveys in recent decades have shown a definite trend toward an approval of medical assistance in dying for the hopelessly 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 & Konig, 1994). Recent decades have also seen changes in medical practice, with passive euthanasia (the withholding of treatments) occurring in hopeless cases (Galloway, 1995). The legality of this has been upheld in court decisions in the UK, most notably that concerning Anthony Bland, who survived in a persistent vegetative state following the Hillsborough football stadium disaster (Sherban, 1992).
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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. The main reason given was fear of a slippery slope developing, in which if euthanasia was deemed legal in any circumstances, the boundaries of what is considered lawful killing would be stretched ever wider (Kingman, 1994). Other countries have been contending with the same issues. In the United States, euthanasia is illegal, and a 1994 referendum by citizens of Oregon, which approved assisted suicide, was declared unconstitutional by the US District Court (Charatan, 1994). In the US, the issue of a right to die has been kept firmly in the public eye by the activities of Dr. Jack Kevorkian, self-styled “obitiatrist,” who has been present at the suicides of over thirty patients. Despite several indictments, he has so far escaped conviction. In the Netherlands, euthanasia and assisted suicide remain against the law. However, in recent years, doctors have been protected from prosecution for either act, provided they act in accordance with guidelines issued by the Dutch Royal Medical Association and notify the local medical examiner of their actions (Van der Cleef & 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 diametrically opposite directions. On one hand, they are faced with an increasing acceptance of euthanasia and assisted suicide for those who are suffering unbearably as a result of physical illness; on the other, they are faced with ever greater pressures and increasing personal responsibility to prevent suicide among their own patients, and also to generally affect a decrease in suicide rates. If all suicides were unambiguously the result of treatable mental illness, there would be no problem here. Suicidal wishes could be considered as merely another symptom of mental illness and reversed, to the relief of all, by the institution of a simple treatment. However, it is
questionable whether all those who consider committing suicide are indeed mentally ill, as 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 a priori reason why psychiatrists should always find themselves bound to try to prevent suicide, or why cases of psychiatric euthanasia, similar in all morally relevant respects to cases of euthanasia in physical medicine, might not occur. This indeed appeared to be the case for a patient under the care of Dr. Chabot a few years ago. This case brought the problems of these requests for euthanasia and assisted suicide by psychiatric patients into the open, and so it is to Dr. Chabot that we turn next.
THE CASE OF DOCTOR CHABOT

In 1991, a physically fit fifty-year-old retired social worker, Mrs. Melsony Bosscher, was referred to Dr. Boudewijn Chabot, a specialist psychiatrist. Mrs. Bosscher wanted Dr. Chabot’s help in committing suicide. She had heard of him through an organization which supported voluntary euthanasia. Dr. Chabot had offered his services to the organization when he had heard of their problems finding psychiatrists who were not utterly opposed to a patient’s wish to die.

Over the next few months, Dr. Chabot had many meetings with Mrs. Bosscher. He learned that she was divorced from a physically abusive and alcoholic husband, and had two sons, both of whom had died; the first died some years earlier by suicide, and the second more recently from cancer. It was after the death of her second son that Mrs. Bosscher decided she no longer wanted to go on living. She had attempted suicide the night her son died, but had failed. Dr. Chabot 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 wanted to die, for life had no purpose without her sons. She wanted assistance in suicide so that her death could be peaceful and nonviolent, and so that she could be sure of success. Dr. Chabot discussed her case with several other psychiatrists, a general practitioner, and a psychologist, none of whom saw Mrs. Bosscher personally. He came to the conclusion that Mrs. Bosscher was competent and her feelings appropriate. In September 1991, at her home and in the presence of her friend, Dr. Chabot gave Mrs. Bosscher a drink containing a lethal dose of sleeping tablets. She accepted it, swallowed the mixture, 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. Chabot reported what had occurred to the local coroner. The case, being unusual as Mrs. Bosscher had not been suffering from terminal or physical illness, was referred to the local court. Both the local and an appeal court dismissed charges brought against Dr. Chabot, but as the matter was considered an important test case of psychiatric euthanasia, it was referred on to the Dutch Supreme Court. There, it was ruled that Dr. Chabot 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. Bosscher. However, the court accepted that Dr. Chabot had otherwise followed the necessary Dutch Royal Medical Association guidelines on euthanasia and assisted suicide, and that Mrs. Bosscher had been competent, suffering unbearably, and had possessed 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. Chabot was not punished and was allowed to continue practicing medicine.

The case and its resolution clarified several issues regarding euthanasia in the Netherlands. It confirmed that suffering need not be physical, and a person need not be terminally ill for euthanasia to be permissible. Thus, despite Dr. Chabot’s being found guilty, the road seemed opened for further cases of psychiatric euthanasia. The Dutch 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 themselves examine the patient and provide a written report before euthanasia takes place. Dr. Chabot’s own medical board were less supportive of his act. In a disciplinary hearing, they ruled that he had crossed professional boundaries in his treatment of Mrs. Bosscher. 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. Chabot should have made a more vigorous attempt to persuade her to try anti-depressant treatment. The doctor was issued a reprimand.
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which, although it was the least penalty the board could impose, was harsher than had been expected. Dr. Chabot 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, 1995; Nasreddine, 1994; Supreme Court of the Netherlands, 1994).

The case of Dr. Chabot and his treatment of Mrs. Bosscher is somewhat unusual, and it received considerable publicity in the medical press. However, difficult issues regarding a psychiatrist’s role and 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: “Robin”- Suicidal intent in the (apparent) absence of mental illness

Robin was a twenty-year-old philosophy student who decided to commit suicide 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. Following discussion with Robin, the GP called the local duty psychiatrist for advice, as he was unsure of his responsibilities. Robin did not appear to be mentally ill, but there seemed to be a good possibility that he would kill himself. Robin 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 suicide. He said that he was in “emotional pain,” and that he had decided a week beforehand to kill himself 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 that it was likely that the pain of losing his girlfriend would ease with time. Nonetheless, he remained fixed in his avowed intention of suicide.

On interviewing Robin, 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 suicide was a distinct possibility. After much deliberation, it was decided that Robin 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 Robin was suffering from mental illness could not be ruled out without a period of assessment, and assessment could only be safely carried out in a hospital. Robin was incredulous and angry that such a thing could be done. However, he agreed to cooperate with the hospital staff, although he would not take medication, and gave an undertaking not to abscond or to attempt suicide while in the hospital. His intention remained to prove himself
Sane and kill himself once he had been released. Robin 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 biological or other 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 Robin’s fixed suicidal intention.

After six weeks, Robin suddenly announced that he wanted “help in changing his mind” about suicide, and he agreed to a trial of antidepressant medication. Two weeks later, he said he had decided to live. He was soon discharged from 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 on stopping the antidepressant medication. Robin 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 of the intensity that had been present in the previous relationship.

Case two: “Alastair” - a violent and suicidal man

Alastair, forty-two years old, 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 the physical abuse of his wives. He thought he had about six children, but was not in contact with any of them. In his twenties, he had spent some years in the army and had briefly held several unskilled jobs, although 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, Alastair had been living with a new girlfriend and her young daughters. After an episode of heavy drinking, Alastair violently attacked her, not for the first time. She
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asked him to leave, but he refused and threatened to commit suicide if she insisted. Unsure what to do, and unwilling to involve the police, the woman contacted her general practitioner who referred Alastair for psychiatric assessment. The psychiatrist who saw Alastair did not consider that he was suffering from an acute mental illness, but thought that he probably had a psychopathic personality disorder (see Endnote 3 -Personality Disorder). He believed Alastair’s suicidal threats had the primary purpose of attempting to manipulate his girlfriend into allowing him to stay. Alastair himself admitted that this was so. The psychiatrist did not think admission to psychiatric hospital was indicated. He arranged to see Alastair again on the following day with the expectation that the situation would cool down with time.

Alastair accepted this arrangement and agreed to do this and 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, Alastair returned to the house, physically and sexually assaulting her. He was subsequently arrested and held in prison. Over the next few days, he continued threatening to commit suicide. He was seen by a forensic psychiatrist who agreed with the first doctor’s assessment, that Alastair had a psychopathic personality disorder, and that he could not be helped by treatment in a local psychiatric hospital. The second psychiatrist advised prison officers to observe Alastair closely, as suicide was a possibility. Later that night, Alastair cut his throat in his cell and died.

Case three: “Edwina” - an enduring wish to die

Edwina 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
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was two years old, and her father committing suicide when she was twelve. She subsequently grew up in the care of social services.

Shortly after her father’s death, Edwina suffered her first psychiatric problems, such as refusing school, along with other anxiety symptoms. Some years later, she developed bizarre paranoid delusions, along with auditory hallucinations, and was diagnosed as having schizophrenia. From this time on, Edwina remained continuously mentally unwell, with 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. While in the hospital and receiving regular antipsychotic medication, her delusions and hallucinations abated somewhat, although they never completely disappeared. Edwina hated the hospital; when she was 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 suicide attempts, the two most dangerous occurring while she was a hospital inpatient.

When not in the hospital, Edwina lived alone in a run-down flat, 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 state of nutrition and self care was poor. Edwina consistently refused all attempts at rehabilitation or improving her socialization. This itself may well 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. Edwina repeatedly said that she would rather be dead and often begged for assistance in killing herself. She saw her life as one of continuous, hopeless suffering, and her lack of success in committing suicide 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 have met with psychiatric services; yet the suicidal wish in each of the cases does not seem to arise directly from the effects of a treatable mental illness, which may be the case, for example, in acute depression. The cases also illustrate that it is not simply the presence or type of psychiatric diagnosis that should be considered in planning treatment, but also the very significant influence of the patient’s personality (that is, the patient as an individual person) that will affect the appropriateness and success of any intervention.

In case one, Robin, 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 when a psychiatrist should intervene in such a case, particularly to detain Robin under the Mental Health Act if he did not appear to be suffering from a mental disorder. However, Robin’s wish to die did not appear to be enduring or based on hopeless suffering, and was thus not understandable in the way it might have been were he suffering from a painful terminal illness, or even chronically unhappy with good reason like Mrs. Bosscher. Whether or not his suicidal ideas were 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 perhaps prevented a suicide, and perhaps enabled Robin to go on and lead a successful and contented life; they also avoided the suffering that his family would undoubtedly have endured had he committed suicide. This outcome, however, could in no way have been guaranteed at the original presentation.

In case two, Alastair clearly appeared to have a personality disorder. The place of personality disorder in psychiatry, and the extent to which it is treatable, has been long disputed. One could argue that as a form of mental disorder, this diagnosis should make Alastair and his treatment the responsibility of the psychiatric services. The possibility of
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further violence toward 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 pointless admissions of patients such as Alastair to the hospital, but it may be that in this case, a period of observation in the hospital would have averted Alastair’s suicide. However, he did not receive this, while the first case, Robin, who was not given a psychiatric diagnosis, did.

In case three, Edwina, is perhaps the closest to Dr. Chabot’s case. Edwina was suffering, and begged to be allowed to die. The lack of efficacy of treatment for her illness, and her own inability to comply with treatment, made her illness incurable and her suffering apparently hopeless. A range of clinical responses to Edwina’s predicament is possible, from seeing her in need of prolonged, and possibly permanent, enforced institutionalization, to prevent her from committing suicide, 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, while 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 Edwina the maximal medical treatment for her condition and risking a preventable death, while at the same time condemning her to a lonely life of suffering and death, alone and unsupported.
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**CAN BIOETHICS HELP?**

There remains no consensus regarding the morality of voluntary death. Those who commit suicide are rarely morally castigated and certainly do not suffer punishment and degradation as in the past, even as the major religions of Christianity, Judaism, and Islam remain fundamentally opposed to suicide. Voluntary euthanasia is increasingly accepted, but remains technically illegal, even in the Netherlands. Most clinicians are probably aware of a number of bioethical principles and 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, as well as to our cases.

**Competence**

When a desire to die is considered, the issue of whether the person making the decision is competent enough 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, or the crazy ideas of the drunk and 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 confidently be expected to soon return.

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 balance and arriving at a choice. The law gives little information as to how these abilities should be
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assessed, but it is clear that the presence of mental disorder does not in itself imply the absence of capacity. A recent Court of Appeal judgment has ruled that irrationality does not amount to incompetence, even though it may be evidence of such (Drug and Therapeutics Bulletin, 1997).

However, in the bioethical literature, there is no accepted definition of a sound mind. It may be questioned whether a person suffering from psychiatric disorder, which by definition affects the mind, can ever be considered competent. This existence of this view is evidenced by the opinion in which requests for euthanasia by persons with terminal illnesses should never be considered as valid, because it is known that a large proportion of the terminally ill suffer from psychiatric illness, namely depression (Ello, 1986). The relationship between mental illness and competence is of particular relevance to the suicidal, as it may occur that suicidal ideas alone are accepted as evidence of mental illness (as in case 1, Robin). Following this through, if the mentally ill are always considered to be incompetent, and suicidal ideas alone are evidence of mental illness, then suicidal wishes are always incompetent. This refutes the idea of rational suicide, and perhaps imposes an ethical duty on psychiatrists to prevent suicide whenever possible.

Undoubtedly, in the throes of an acute psychotic illness, a person may not be rational, and their views can often be expected to change when the temporary disturbance of mind resolves. Such persons may be rightly protected from harming themselves. However, such disturbance of 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 Edwina’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.
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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 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 which form the basis of why they wish to die may also be given as the reasons 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 why passive euthanasia (failing to prescribe antibiotics for a patient with terminal cancer who develops a chest infection) might be acceptable, while 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, while 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 suicidal patient, not to attempt to prevent suicide is surely an omission as the doctor takes no action. The doctor, by the acts and omissions doctrine, is therefore less morally culpable should the patient die. However, as suicide itself requires a positive act, failing to intervene is not simply a case of omitting to interfere in an
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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 allowing the patient to be killed rather than simply failing to prevent them from dying.

The double effect doctrine

The double effect doctrine 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 patient’s 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. Chabot’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 Alastair. The decision not to institute observation in a hospital to prevent him killing himself was presumably not made with the intention that he should therefore go ahead and commit suicide, although this possibility was foreseen. Rather, the intention was probably to prevent reinforcing of 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
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become more difficult to defend such actions, which although carried out with the best intentions, may have unintended but foreseeable adverse consequences.

Ordinary versus extraordinary measures

This distinction states that one is expected to take all ordinary measures to preserve a life, whereas extraordinary measures are not obligatory (Deschatelts, 1986). This can be applied to medical treatments, with ordinary treatments being those which are common, cheap, and noninvasive, and extraordinary treatments being those which are experimental, complex, costly, or carry a high risk of subsequent, adverse effects. In physical illness, in an attempt to save a life, one may thus be obliged to provide simple intravenous fluids, but not necessarily to perform major experimental surgery.

Treatments provided by psychiatrists to prevent suicide could be considered obligatory on these terms, as psychiatric treatments by and large are not new, technologically complex, or expensive, and sometimes, as in Robin’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 killing himself 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 suicidal person is compelled to live against his will” (Sbrocca, 1986).

This is illustrated by Edwina’s case. To ensure she does not kill herself would entail keeping her under the strictest of observation, possibly for the rest of her life. Given the clear
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evidence from her previous hospital admissions of the distress that this causes her, this treatment would seem inhumane and entirely 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. If not reducing the patient to the level of a slave, they could be said to be subjecting them to the treatment of a criminal; and in general, the suicidal have committed no crime and do not pose a threat to anyone other than to themselves.

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 not to 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 AIDS or 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 suicide among the mentally ill should thus always be prevented). However, suicide rates are much higher among those with mental illness than the general population. 15% of persons with major depression eventually end their lives by suicide (Woolf & Wagner, 1970), as well
as 10% of those diagnosed to have schizophrenia. Suicide could therefore be considered a natural and not uncommon outcome of depression and schizophrenia. In this case, suicidal persons with serious untreatable mental illness could be considered to have a potentially terminal illness, and euthanasia in these cases is 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. Bosscher, Edwina, and persons with chronic painful physical illness such as severe rheumatoid arthritis) have in fact 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 to go on for many years without respite, whereas in cases of terminal illness at least the suffering is time limited.

**The ability to act**

In his book, *Causing Death and Saving Lives*, Jonathan Burleigh puts forth the view that assisted suicide and euthanasia should only be an option for those who are physically incapable of carrying out the act of suicide 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 cries for help rather than an indication of a serious wish to die.

According to this view, assisted suicide and euthanasia among psychiatric patients (who are generally not physically disabled) is unnecessary and morally indefensible.
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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 that a successful suicide attempt may be impossible. This could be considered either 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 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? Thus, those seriously intending to end their lives may be condemned to a lonely and violent death, or worse, disability from a failed attempt. Mrs. Bosscher consulted Dr. Chabot in order to avoid this, although it remains a possibility for Edwina.
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 suicide 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 at the same time as 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, so 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 numbers of suicides among young people, together with a widening of the scope of life’s problems now seen as mental health issues, may have led to an increasing awareness of the “problem” of suicide, 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. Bosscher, Dr. Chabot undertook an unusual approach to a psychiatric
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patient who wished to die by allowing and assisting in her suicide, rather than using forceful and coercive measures to prevent it.

At present, there is 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 as suicide itself is an act, not an inevitable process. The distinction between ordinary and extraordinary treatments is difficult to apply when psychiatric treatments in themselves may be very ordinary, but have the most extraordinary 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 lead to violent and lonely deaths which, incidentally, may have been preventable.

As of yet, there is 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 Chabot case in a country where both practices are not uncommon. To what lengths a psychiatrist should be expected to go in trying to prevent suicide, and whether there is ever a justification for allowing or assisting suicide 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.
END 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.

Suicide is 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 literally “a good death.” In its current usage, euthanasia can be defined as 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. Non-voluntary euthanasia implies that the person who is to die is incompetent or unable to give informed consent. In active euthanasia, the perpetrator takes a specific deliberate action to bring about the patient’s death (i.e., they kill the patient). In passive euthanasia the person deliberately fails to take an action to prevent the patient from dying (i.e., they let the patient die).

2. The Mental Health Act 1983

In modern western psychiatric practice, a highly suicidal person 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 (1983) which gives doctors certain rights to detain and treat patients with mental disorders without their consent (Department of Health & 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 he poses a risk to the health and safety of himself 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 modes of thinking and feeling and patterns of behavior 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 nosological status, 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 “a condition comprising of deeply ingrained and enduring behavior 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
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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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