ARTICLE

Peer Reviewed

Euthanasia in Mental Illness: A Four Part Series

Part IV: Medical Ethics – Autonomy vs Beneficence and Non-Malfeasance

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Abstract

The principles of medical ethics of autonomy, non-malfeasance, beneficence and justice can be used instructively when a patient requests euthanasia. In patients who are terminally ill with an incurable medical condition, these principles align. Not so in patients with mental illness. Mentally ill patients are suffering not dying and the euthanasia request is a nothing else but a concealed request for assistance in committing suicide. Similar to the acutely suicidal psychiatric patient, chronically suicidal psychiatric patients are still mentally ill and the principles of beneficence and non-malfeasance override autonomy.

Keywords: Euthanasia, ethics, autonomy, beneficence, non-malfeasance

For the physician, the request for medical assistance in suicide (MAIS) by psychiatric patients confronts the physician with ethical, moral, and legal questions that are much harder to resolve than the same questions that are raised by the request for medical assistance in dying (MAID) by terminally ill patients who are suffering while in the last few months or weeks of their lives. Medically and terminally ill patients are suffering and dying and seek MAID to bring their life to a peaceful but premature end. Psychiatric patients are suffering but not dying and from an illness that by its very nature compromises the normal workings of the mind. Here the request for euthanasia is clearly a suicidal wish to escape severe and chronic psychological suffering.

The commonly accepted principles of health care ethics can be helpfully applied when grappling with

euthanasia in mental illness. There are four (Beauchamp & Childress, 2001):

1. Principle of respect for autonomy (the right to self determination),
2. Principle of non-malfeasance (do no harm),
3. Principle of beneficence (do good),
4. Principle of justice (fairness-distributing benefits, risks and costs fairly).

How one proceeds depends upon the moral framework, the time frame, and whose perspective is adopted when deciding which principle is accorded precedence. In patients with medical conditions that do not impair brain functions, autonomy is ascendant and treatment will, in the overwhelming majority of circumstances, be dictated by the patient's wishes. The patient is permitted to accept or reject any treatments offered based upon personal preference and this must be allowed with no further justification other than a simple "I don't want any of your treatment" or "I have had enough". Autonomy does not, however, dictate a wanted treatment as this will not be offered if, in the physician's opinion, the treatment requested is not medically justified. Examples would be a patient who insists on a leg amputation to treat a chronic diabetic leg ulcer or high doses of narcotics analgesics to treat chronic low back pain from degenerative joint disease.

In psychiatry, the issue is much more complex. Here, the mind is malfunctioning, impairing insight and generating psychobehavioral responses that may put the patient as well as others at risk of harm. Where the possibility of self harm arises, patients need to be protected from themselves. This is the challenge of the suicidal patient.

A fundamental role of the medical profession is to prevent suicide. We intervene because the wish to die is seen by all reasonable people as utterly abnormal, surfacing only in a diseased mind as an illness manifestation, and not a rational lifestyle choice. Society provides the health profession with a legal framework to do this, allowing for involuntary committal and forcible treatment against the patient's wishes. At first presentation, no psychiatrist would ever consider a patient's suicidal ideation as understandable, sympathize with the patient, and then send the patient on her or his way to die by their own hands. In this circumstance, it would be unthinkable for any psychiatrist to

consider helping the patient implement her or his wish. To do any of this would unleash the fury of family and friends, a review of the psychiatrist's competence, a possible suspension of their license to practice, followed shortly thereafter by a law suit for negligence.

The patient would be considered acutely mentally ill. If the patient's safety is uncertain and the patient is deemed at risk of acting upon her or his suicidal ideation and does not agree to hospitalization and treatment, then the psychiatrist will proceed with committal and involuntary treatment. In this scenario, the principles of beneficence and non-malfeasance always trumps the principle of autonomy. Society expects, demands, and provides a legislative framework for this response from the medical and psychiatric profession.

The hierarchy of principles can arguably shift when the psychiatric condition becomes chronic and attempts at treatment have yielded little, if any, benefit, and the patient accepts a state of chronic depression but is not actively suicidal. In this scenario, the principle of autonomy may be given precedence over beneficence and non-malfeasance. The patient may decline any and all further treatment and this wish will be honoured.

But if the patient is still actively suicidal and is at risk of killing her or himself, can and does the psychiatrist simply walk away justifying the patient's suicidal wish and the intent to act upon it as rational and understandable and sending the patient off to her or his fate?

There are many such patients who are chronically depressed and, in the setting of a biological fluctuation in their mood or a psychosocial crisis, become actively suicidal. They are at imminent risk of carrying through with the self-destructive act and seek help to avoid acting upon these impulses. They cannot stand the psychache but they do not want to die. They know that their brain and thinking are malfunctioning and are turning, yet once again, to be helped and to be saved from themselves. These patients, if agreeable, will be admitted to hospital to ensure safety, to review their medications, and to bolster their community psychosocial system, if this turns out to be deficient and

the precipitant of this particular acute decompensation.

In this setting, if the patient is not agreeable to admission, she or he will be committed to hospital until the acute crisis is over and the self-destructive impulses have abated in response to changed biological and psychosocial interventions. The patient is, after all, mentally ill; suicidality is part of this illness and the duty to save life remains. Beneficence and non-malfeasance still trumps autonomy.

This same patient now remains chronically depressed and suffering from unbearable psychache. The only respite from her or his perspective seems to be suicide. He or she is disillusioned with the helping professions and believes that there is no further help available that will mitigate the psychache. She or he does not wish to have another trial of yet another antidepressant because of anticipated side effects such as weight gain, does not want another course of electroconvulsive therapy (ECT) or to try maintenance ECT, and does not want to have any brain surgeries.

The treatment that he or she wants is death, and they want you, the doctor, to cause this to happen. The patient is not in crisis, seems calm, and presents the request as the outcome of a well-considered introspection of her or his predicament reached after years of suffering. They know they are still depressed as this is obviously the cause of their suffering, but now in their mind, the choice of suicide is a treatment, and the treatment of choice for them given their particular circumstances and history. Suicide is now not the product of their mental illness with disordered thinking, but presented to you as totally rational and a conclusion that any rational human being would reach, and that MAIS should be made available to them in a humane and fair world. In requesting this, they tell you that they are exercising their right of autonomy and this takes precedence over all other ethical principles.

This is not, however, the same circumstance in which a patient, dying from a terminal medical disease, declines further treatment. Both you and they know that medical science cannot save them,

and death is inevitable and imminent. Treatments, if any are available, can extend life by weeks or possibly months. To do this, the patient must be willing to endure another round of toxic chemotherapy (metastatic cancer) or undergo invasive procedures such as mechanical ventilator (end stage motor neuron disease) from which she or he will never be weaned. Some patients may be willing to extend life for as long as possible regardless of the futility of the intervention. This raises its own dilemmas that lie outside the scope of this article, and will not be discussed further. Most wish only to be made comfortable, free from pain or anxiety, or the distress of struggling to breathe.

Here, autonomy is clearly paramount. The patient makes the choice about how they wish to spend their remaining time knowing that no intervention can save them. The patient's choices will be honoured and beneficence and non-malfeasance will align with autonomy. The treating physician will not and should not attempt to force a treatment that reaches or almost reaches the threshold of futility, or that carries significant adverse side effects with minimal predictable gains, or intervene to make a patient machine dependent. Such interventions will only delay but cannot and will not prevent death. The physician knows that life's end approaches and accepts that the patient chooses an earlier death to minimize their suffering.

All physicians will alleviate distress by comforting the patient and provide anxiolytics and analgesics knowing full well that these medications may hasten death by suppressing respiration and increasing the risk of a life terminating aspiration pneumonia and metabolic failure by reducing the drive to drink and eat. On the one hand, suffering is mitigated; on the other hand, death is hastened. This paradox finds an ethical resolution in the rule of double effect (Sulmasy, 2000; Billings, 2011). Here, the intention, with each and every given dose, is to reduce suffering not knowing if this next dose will bring life to an end.

A distinctly different, unique, and now legally sanctioned treatment option now confronts the medical practitioner when some of these patients request direct medical assistance in dying by a single intervention that will immediately bring their life to an end. Here, the physician, and I am not one of them, will administer a lethal dose of medication with the explicit intention of terminating life.

Suffering psychiatric patients are clearly not in this category of patients. They are indeed suffering terribly but they are not dying. They still have a full biological life ahead of them. Their wish to be dead and to hasten its coming is an expression of irrational suicidal ideation, stemming from unbearable psychache. The psychache is central and the result of a biological illness of the brain that we call depression, a mental illness.

But from their subjective perspective, their wish for suicide is rational and that anyone in their situation would come to the same conclusion. I disagree and they will too, but only in hindsight; the outcome of capsulotomy has taught me this. Chronicity has not improved their insight or rationality. They were mentally ill when they were acutely ill and they remain mentally ill now. Their wish to die is still an intrinsic part of their mental illness.

In taking care of such patients, we must continue to do what we have always done. We must do our best to save the mentally ill patient from herself or himself, and beneficence and non-malfeasance must still trump autonomy.

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