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Euthanasia: A Form of Newgenics?

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Abstract

Mentally ill patients' right to "receive" assistance in dying can be defended by the following argument. If people suffering from terminal illness are eligible to receive assistance in dying as long as they are deemed mentally competent to make decisions about their lives, then the justice principle in medical ethics requires that those with mental disorders should also be eligible to receive assistance in dying on the condition that they are mentally competent. In this paper, I argue that two questions must be answered before this argument can be defended. We must first clarify how the terminality of the illness is described and second how the competence of individuals with mental disorders is assessed. To illustrate and defend my argument, I focus on the Netherlands. This is because of their leadership in developing policies to provide euthanasia to not only individuals with physical illnesses, but also mentally ill patients. I argue that the complexity of the answers to these questions warrant skepticism about the defensibility of the argument for assisting mentally ill patients in dying.

Keywords: Mental Illness, Euthanasia, Netherlands

1. Background

Euthanasia and physician assisted suicide have been receiving a lot of attention in medical and legal contexts in the last 50 years around the world. While in some countries such as Netherlands and Belgium assisted suicide is decriminalized, in many parts of the world, including the US, there is resistance against legalizing it. In the US, states such as Oregon, have become more progressive in terms of legalizing euthanasia in 1997, when other states have not followed their lead. The criteria to receive euthanasia in Oregon and the Netherlands vary. In order to meet the criterion to receive euthanasia in Oregon, one must be "diagnosed with a terminal illness that will lead to death within six (6) months."[1] The Netherlands is more open, however, to allowing individuals with mental illness request euthanasia. Historically, most of the debate on the right to receive euthanasia has focused on the rights of individuals suffering from physical illnesses. Within the last decade or so, however, in places like Netherlands there has been a public outcry for equal rights for euthanasia for both physically and mentally ill patients.

The right to receive assistance in dying for the mentally ill patients can be defended by the following argument. If people suffering from terminal illness are eligible to receive assistance in dying as long as they are deemed mentally competent to make decisions about their lives, then the justice principle in medical ethics requires those with mental disorders should also be eligible to receive assistance in dying on the condition that they are mentally competent. According to Robert Munson, the distributive justice principle in medical ethics states, "similar cases ought to be treated in similar ways."[2] Given this, it would be unethical to deny an individual with mental illness the same opportunity to pursue receiving assistance for death if individuals with terminally ill or physical illnesses are given the opportunity.

In this paper, I will first address the complexity of mental illness in regards to its variability among individuals encountering it. I will then address the complications in Dutch Policy in regards to terminability of illness and competency of the patient.

2. Complexities of Mental Disorders

Stigma against people with mental illness is pervasive across cultures, including our own. Considering the extent to which our medical research and clinical practices have grown in the last 200 years, we are still struggling with accepting and understanding mental illnesses. This is mainly because mental illnesses vary greatly from one individual to another. Psychiatric illnesses exist on a spectrum. Even if two individuals both possess the same illness, they may encounter illness in different ways, making it even more difficult to fully comprehend the illness. With the next few examples I will provide, I am assuming that the doctor assessing the patient is a general practitioner (GP), as many individuals with mental disorders may be diagnosed by a GP without having to see a specialist, as to show how difficult it may be to evaluate an individual.

For example, individuals who are diagnosed with depression may possess and experience mild to severe symptoms of depression and may not even experience the same symptoms. There are somatic, cognitive, and behavioral symptoms that may also vary. To qualify for depression diagnosis, or Major Depressive Disorder (MDD), an individual may experience: sleep disturbances, psychomotor agitation or retardation, fatigue or loss of energy, lack of interest in once pleasurable activities, feeling of worthlessness, depressed mood, decline in hygiene, weight change, and loss of reactivity to events. In order to qualify for having depression, an individual must experience five of these symptoms at least twice a week. But, there is still variability with symptoms as well as variances in intensity of experienced symptoms. This creates a subjective picture of what depression is which in turn generates a more difficult disorder to diagnose and treat effectively when the proper training of doctors and practitioners is not in place.

Not only do mental disorders exist on a spectrum, but they can also be episodic. According to Stephen Soreff, " Bipolar Affective Disorder is characterized by periods of deep, prolonged, and profound depression that alternate with periods of an excessively elevated or irritable mood known as mania."[3] But, if a physician were only looking partially at the symptoms or if they weren't taking into consideration the entire image, then an individual who actually has Bipolar Affective Disorder could be falsely diagnosed with Depression Disorder. Because of these nuances between illnesses, we must take careful consideration to look at the entire picture when assessing patients.

Another contributing factor in the complexity of mental disorders is that symptoms patients feel may simultaneously belong to more than one disorder. Guy E. Brannon addresses this complication when discussing Schizoaffective disorder, when he declares, "Schizoaffective disorder is a perplexing mental illness that has both features of schizophrenia and features of a mood disorder. The coupling of symptoms from these divergent conditions makes diagnosing and treating schizoaffective patients difficult."[4] This is challenging in the treatment of mental illness because it increases the difficulty in examining a patient.

Likewise, there may be issues with comorbidity: a patient could simultaneously be diagnosed with PTSD and a psychiatric disorder, such as Major Depression Disorder, "...this high degree of symptom overlap can contribute to diagnostic confusion and, in particular, to the under diagnosis of PTSD when trauma histories are not specifically obtained."[5] A general practitioner must be able to differentiate and diagnose accordingly to aid in treating the patient. But, in any case, the degree to which the general practitioner may correctly diagnose a patient varies significantly. In example, an article written on the misdiagnosis of mental illness was released on July 29th, 2009 by Janis Kelly, a Medscape writer who graduated from Cornell University. In the article, she stated, "A meta-analysis of more than 50,000 patients reported by Alex J. Mitchell, MRCPsych, from Leicestershire Partnership Trust, Leicester General Hospital, in the United Kingdom, and colleagues shows that general practitioners (GPs) correctly identified depression in 47.3% of cases."[6]

If a general practitioner does not recognize when a patient may be suffering from a psychiatric disorder, then they cannot recommend a specialist to aid the individual. These features of mental disorders complicate the assessment of rationality in individuals with mental disorders.

3. Assisted Dying in Netherlands

Since 2002 in the Netherlands the Termination of Life Request and Assisted Suicide Act has directed euthanasia requests. According to this law, the "Dutch Regional Euthanasia Review Committees review all euthanasia and physician assisted suicide reports regarding whether the notifying physicians have conformed to the due care criteria laid out in legislation."[7] The criteria include: "(1) the presence of unbearable suffering without prospect of improvement; (2) a voluntary and well-considered request for EAS (Euthanasia and physician-assisted suicide) from the patient; (3) the patient is informed about the situation and prognosis; (4) the absence of reasonable treatment alternatives; (5) consultation with a second physician; and (6) EAS is performed with due medical care and attention."[8] The due care criteria are steps put in place in order for the counsel and doctors to effectively assess and care for each patient.

Because this act is country wide, there are five regional committees that assess all of the requests. The overall goal is to provide "uniform guidance" while also having a "strong commitment to transparency" with the selection of the cases. The Dutch Psychiatric Association "has published guidelines regarding how to evaluate psychiatric EAS requests… these guidelines are professional practice recommendations (not law) but are frequently referenced" by the Dutch Regional Euthanasia Review Committees.[9] Since the review committees have only submitted "guidelines" and not rules to abide by, this allows physicians to be more subjective with evaluating patients, making the process subjective in different degrees.

The guidelines of the Dutch Act have been broadened in past years regarding how the Dutch Courts and the Royal Dutch Medical Association (KNMG) interpret the Act. For example, in a 1986 court ruling, the court decided that "unbearable pain" was not restricted to physical pain, but can be interpreted as a "psychic suffering" of "the potential disfigurement of personality". In both cases, this now allows individuals to go through with euthanasia whether or not they have a terminal illness, a huge milestone in terms of acquiring rights for individuals with mental illness. Individuals with mental disorders now have the autonomy to pursue a treatment the same as one with a terminal illness would be able to.[10]

One of the biggest arguments in the Netherlands and other states and territories that would like to see physician assisted dying policy pass, is the desire to respect patient autonomy. Respecting patient autonomy is one of the major medical ethics principles that guides how a physician should conduct oneself in a situation dealing with individuals in their care.[11] But, because of the situation of determining how competent an individual is, the determining factor for autonomy could be more power-granting for physicians, rather than patients. In example, "A physician from The Netherlands Cancer Institute told of approximately 30 cases a year where doctors ended patients' lives after the patients intentionally had been put into a coma by means of a morphine injection. The Cancer Institute physician then stated that these deaths were not considered "euthanasia" because they were *not voluntary*, and that to have discussed the plan to end these patients' lives with the patients would have been "rude" since they all knew they had incurable conditions."[12]

Another case in which the autonomy of the individual could potentially become compromised was in a statement released by the Dutch Justice Ministry on February 15th, 1993 that was published within the New York Times a few days later. The article states that the government declared, "…it would consider allowing the killing of patients unable to request it, like severely handicapped newborns and the mentally incompetent."[13] The guidelines for receiving euthanasia are continuously trying to be broadened. Later within the same article, the author declares that, "Under the guidelines passed last week by the lower house of Parliament, euthanasia will be tolerated if a person with unreliable and unbearable pain, confirmed by two doctors, makes repeated request to die."[14]

By including the phrase "unable to request it" now gives the physician in charge more power than any patient would have. Just because a person is incapable of communicating with a physician does not give the physician the power to bestow death upon the individual. This law undoubtedly denies an individual of the principle of autonomy and takes away the right of the patient to decide what treatment option one can receive.

These problems may stem from physicians who are assessing the individuals with psychiatric illnesses instead of directing the patients to a psychiatrist. If the general practitioner misdiagnoses the individual, then the individual would not be receiving the most adequate care in consideration to the mental illness, and therefore, may be exposed. By taking these few examples and background into consideration, we can now address the difficulties involving allowing individuals with mental illnesses receive assistance in dying.

4. Terminal illness and Questioning the Dutch Act

In consideration to the Termination of Life Request and Assisted Suicide Act, the criteria never proclaim whether or not the illness must be physical or mental. This assumes that a physician must be able to address and "treat" an individual with a physical illness in the same sense as an individual with a mental illness, which is undoubtedly false because of the complexity and the numerous differences between both. But, nonetheless, the criteria states there must be a "presence of unbearable suffering" with an "absence of reasonable treatment alternatives".[15]

I find a few things troubling with these two criteria. First, there must be a "presence of unbearable suffering", but, as I've argued above, mental illness lies on a spectrum and no two of the same mental illnesses are alike. The example I used earlier in this paper was depression, but the idea of viewing a mental disorder on a spectrum can be applied to other disorders, in example, Autism Spectrum Disorder (ASD), Obsessive-Compulsive Disorder (OCD), and Anxiety. Because mental disorders lay on a spectrum and every individual experiences mental disorders differently, assessing and evaluating a patient for euthanasia is progressively strenuous because there cannot be an identical comparison. The physician or the psychiatrist must evaluate the patient solely on what the patient is experiencing, and not subjugate the individual to comparability with an individual with the same illness. Therefore, it is much harder to judge what "unbearable suffering" means in accordance to different individuals. Just because a patient claims they are experiencing "unbearable suffering", there is no way to know for sure besides word of mouth. But, I have stated this in the above section, individuals with mental illness may not be able to comprehend their desires because of the illness. If the general practitioners are concluding their diagnosis and treatment based on what they are being told, there becomes an increased chance of false claims made by the patient in order to secure the treatment the individual is eager to receive. For example, Godelieva, a Belgian woman, exercised her right to die in 2012 after a psychologically straining childhood and a breakup that resulted with immense depression. She had to reach out and find a doctor who found her pain unbearable, instead of listening to her psychiatrist who she had been seeing for ten years. Her decision to receive euthanasia, in regards to her son, thought her death was unethical on behalf of the doctor's decisions.[16] It is not uncommon to see an instance in where an individual would do anything to receive euthanasia, including going to multiple doctors.

A review of psychiatric euthanasia/assisted suicide case summaries were analyzed by two senior psychiatrists in the Netherlands between 2011 and 2015 who found that, "Consultation with other physicians was extensive, but 11% of cases had no independent psychiatric input and 24% of cases involved disagreement among consultants."[17] This becomes an issue when there is not only disagreement between consultants, but a percentage of patients who are mentally ill are not even seeing a psychiatrist. Because of these statistics, I believe reform needs to take place in consideration to the process of receiving euthanasia and caring for mentally ill patients.

I propose that individuals must be assessed, not by a general practitioner, which is typically the case, but by an accredited psychiatrist for "unbearable suffering". Individuals are being examined by general practitioners who are being trained in a wide variety of areas, rather than psychiatrists, who specialize specifically in mental illness. Because of an individual's mental state, one's decision may be skewed because they may not be able to coherently decide what treatment option suits best. Psychiatrists would be able to evaluate the patients more thoroughly and accurately than a general practitioner, and therefore, may be able to aid the individual in ways that a general practitioner would not be able to. Likewise, in other professions, one would not go to a general practitioner if they needed open heart surgery. Psychiatrists are professionals in assessing psychiatric illnesses and should be regarded in any case that involves psychiatric illness.

Secondly, the Act declares there must be an "absence of reasonable treatment alternatives", but, how do we know what a "reasonable treatment alternatives," may be if the number of misdiagnoses are astronomically high, and if we still do not know much about psychiatric illnesses? First, we must define the word "treatment". Does the word "treatment" mean, "the techniques of actions customarily applied in a specific situation"[18], or, should we consider an, "action or behavior toward a person, animal, etc.," or even "management in the application of medicines, surgery, etc.,".[19] For most mental illnesses, we have found many "treatment" options that aid in repressing the symptoms of the illness. Whether it be administering Selective Serotonin Reuptake Inhibitors (SSRI's) and cognitive restructuring to individuals suffering from intense OCD[20] or psychotherapy for people with Major Depressive Disorder (MDD).[21] But, how long does an individual have to go through treatment options before they can be considered for euthanasia? This complication may not be an issue for general practitioner or doctors, but a possible change in research or legislation. I believe there has not been enough research done in regards to mental illness that will aid in an individual receiving a "reasonable treatment alternative". If the goal is to "cure" the mental illness, then we, as a society may

never get there, but there are numerous treatment options. Doctors and psychiatrists may be able to suppress some of the symptoms and reactions, but may not ever be able to cure the illness.

I believe that the two criteria, having a "presence of unbearable suffering" with an "absence of reasonable treatment alternatives", must be identified and more closely looked at by doctors an psychiatrists. If we are going to allow patients with mental illness the ability to receive euthanasia, then, the guidelines must be clear in what "unbearable suffering" and "reasonable treatment alternatives" qualify as.

5. Competence Guidelines Between Physical and Mental Illness

The conflict faced by physicians in trying to judge whether or not a person is capable to undergo euthanasia is based on an individual's mental competency. This becomes a challenge when there is not an objective way to measure the level of mania or depth of depression experienced. As with physical illness, there is a more concrete realization of what competence means because the physical illness may not impact an individual's mental capabilities. When addressing mental illness, more care and concentration needs to be taken in order to effectively assess whether or not an individual is competent.

For example, on October 5th, 2007 Linda Bishop, a patient suffering from schizoaffective disorder, had been discharged from the New Hampshire Hospital because she refused treatment and was deemed competent to make such a decision. When Linda was in the hospital and was asked what she would be doing after discharge, she gave no clear indication of what her plan was and because of patient-privacy laws, neither her sister nor her daughter were informed of her discharge. Linda arrived at an old Farmhouse where she slept in the barn for months, kept a daily journal, ate only apples and snow, and waited for her fantasized husband to come and get her. Her sister, Joan Bishop, had finally realized her sister had been discharged when she received a letter she had written to Linda months before that had been returned from the hospital. Linda's last journal entry was January 13th, and her body was found in early May inside the Farmhouse.[22] This case adequately explains why general practitioners and physicians alike need to take due care and diligence when assessing a patient. Linda not only passed because she was discharged when she was in obvious need of help, but she also suffered a slow death because of her poor diet and harsh winter conditions.

The problem of misdiagnosing mental illness is not limited to the United Kingdom, as I've stated earlier in the above section that, "general practitioners (GPs) correctly identified depression in 47.3% of cases."[23] This issue spans globally because of our lack of knowledge and training with psychiatric illnesses. When suffering from Depression, individuals may think they know what they want, or what's best for them, but they may not fully grasp the situation and all of its repercussions. I believe that patients with mental illness should be required to see a psychiatrist before making a final decision on whether or not they would like to receive euthanasia. This way, the psychiatrists will be able to better judge the competency of the individual, correctly diagnose the individual if they had been given a different diagnosis, and assess the individual on how well they comprehend the situation. I do not believe in swaying the individual to not go through with euthanasia, but, rather explain to them all of the options at hand and present them with avenues in which they can find help.

We then must address what "competence" means for individuals who possess mental disorders and how physicians or psychiatrists can measure a patient's competence. There is already a guide used in assessing an individual's competency for both physically and mentally ill patients, the MacArthur Competence Assessment Tool for Treatment (MacCAT-T) written by Thomas Grisso and Paul S. Appelbaum. This competence tool aims to address both physical and mental illness in evaluating patients and is designed to aid physicians in how to conduct a thorough and effective examination. MacArthur Competence Assessment, "is a semi-structured interview that assists clinicians who are conducting assessments of patients' competence to consent to treatment. The process provides a patient with the information about the medical/psychiatric condition that needs intervention, the type of treatment being recommended, its risks and benefits, as well as other possible treatments and their probable consequences."[24]

The MacCAT-T does an effective job at addressing competence in individuals with mental illness, and there are other manuals that aim to assess one's mental state, but, the practice needs to be implemented in order for the assessments to be successful. The MacCAT-T is a guide that attempts to aid the physician in assessing the patient, but there must be more training in order for the assessment to be first nature. Also, just because the MacCAT-T is available, there is no guideline or regulation put in place that forces physicians to assess patients in regards to this manual. Physicians have the opportunity to take advantage of an assessment manual, or they can disregard it and continue evaluating patients with alternative methods. If physicians are going to be assessing patients with mental illnesses, then they must address each individual effectively, thoroughly, and with specific care. There has been

inadequate caution in evaluating patients that has led to unnecessary deaths and discrimination in regards to providing care granting euthanasia requests.

6. Conclusion

The reason why there must be concern for this lack of clarity lies in the fact that eugenics, the "science of improving stock" coined by Sir Francis Galton in a book he released in 1883 titles, *Inquiries into Human Faculty and its Development,* was a widely accepted idea and practice in the early 1900's. [25] The complexity of this subject came to fruition in the late 1930's to mid 1940's that transformed the medical profession immensely. Eugenics was first accepted in Canada and the United States which then traveled to Germany and fueled Nazi Medicine and medical experiments. The use of Nazi medicine and experiments that were conducted against minorities of all types, including the mentally impaired, were a curse to humanity, but a source of knowledge to the medical field. We must not fall back into a faulty power-sharing agreement between physician and patient in which lack of knowledge and due care may critically and detrimentally impact the patient.

When working with individuals who have mental illnesses, doctors must take careful consideration into how they are observing them. The variety of mental illnesses that are recognized today are all complex, and the way in which doctors distinguish between different illnesses is crucial in order for the patient to receive the correct form of treatment. Not only that, but, when individuals request to receive euthanasia, doctors must be diligent in evaluating the individual so they are receiving the best possible treatment.

I argue that doctors must provide due care in assessing the patient. In the medical field, doctors and physicians must effectively identify and define what competence and terminability means in the context of mentally ill patients. Lastly, as a society we need to spend more resources and time into researching mental disorders in order to be able to adequately address and aid the patient in their needs. This is not a declaration for denying mentally ill persons the ability to receive euthanasia, but, for more care and security in the process.

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