PHYSICIAN ASSISTED SUICIDE: A ROUND TABLE DEBATE *LEGAL DEVELOPMENTS IN THE NETHERLANDS*

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The legal acceptability of euthanasia and assisted suicide in the Netherlands is based on the legal recognition by the courts, on a case-by-case basis, of the physician's defence of necessity. In order to have this defence accepted the physician who performed euthanasia or assisted with suicide, had to act according to the requirements developed in medical ethics. These requirements have been accepted and specified in case law. Due to its nature application of the defence of necessity is not limited to cases in which the patient's unbearable suffering is of a somatic origin. In actual practice it turns out to be very difficult, if not impossible, to make a distinction between somatic and non-somatic suffering. There are no sharp lines. Suffering itself almost always has a mental component. Dutch courts have accepted the physician's defence of necessity in cases in which the person's suffering was of a non-somatic nature. Nonetheless, in these cases the door is open only a very small crack. Especially the court decisions in the Chabot case have recognized as well as limited physician assisted suicide in psychiatry. In these decisions the requirements for physician assisted suicide in psychiatry have been tightened. This applies specifically to the requirements concerning the availability of treatment alternatives and the consultation of an independent physician. The Dutch Supreme Court requires 'the utmost carefulness' from physicians who consider to go along with a request for assisted suicide in cases of mental suffering. Physician assisted suicide in psychiatry may be justifiable, but only in very exceptional cases. The Dutch attitude is: never say never. At the same time there remains a lot of disagreement. Some key questions have not yet been fully analyzed or answered. Whatever one may feel about the justification of physician assisted suicide in cases in which there is no hopeless somatic illness, it is obvious that the issue will give rise to a lot of debate in the years to come. With regard to physician assisted suicide in psychiatry the Dutch situation seems not to support the slippery slope argument. The issue of physician assisted suicide has been highly publicized in the Netherlands, stimulating both discussion and control. The Chabot-case has triggered a fundamental debate in the Dutch society as to the limits of physician assisted suicide. Case law has resulted in a very restrictive policy, accentuating the respect for human life and the protection of vulnerable patients, without excluding assisted suicide in psychiatry as a last resort in exceptional cases. It seems that, in spite of the imperfections of the Dutch situation, this outcome is a clear result of a policy of openness, accountability and control.

ASSISTED SUICIDE IN PSYCHIATRY: CLINICAL ISSUES

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Although not officially legalized, since the early eighties euthanasia and assisted suicide, under strong conditions, have become allowable in The Netherlands in patients with non-lethal somatic disorders. The conditions or criteria for carefulness are, among others, that the patients are competent and free to express their will, that they do have a longlasting wish to die, and that they suffer unbearably and hopelessly. The latter criterium requires that for their illness no reasonable treatment is available.

Many psychiatric disorders have a chronic or remitting course. Although it is always very difficult to assess, some patients can be considered refractory to treatment. Among them are, for instance, patients with chronic resistant depression, with schizophrenia, and with severe personality disorders. Additionally, it is recognized that also psychiatric patients can be competent to decide to die. Even some patients with psychotic disorders can be competent in this respect. When the above criteria of hopelessness, unbearableness and competence have been fulfilled, it is recognized by many, but not all, Dutch psychiatrists that also psychiatric patients have the right to ask their physician for assistance. Arguments for helping them are the possibilities for a physician to provide them a gentle method (lethal drugs), to support them during the final phase of their life, and to support relatives before and after the suicide. Currently, the Dutch Association of Psychiatry is preparing a document with a protocol and guidelines for their members.

As far as known, only very few patients have actually been assisted: maximally 5–10 per year on a total suicide rate of ± 1.600 per year. On the other hand, it can be argued that the ultimate willingness of a physician to assist a suicidal patient, but only when all treatments have failed, can prevent a 'too early' suicide when this patient consents to treatments in order to fulfill the criterium of hopelessness.

Some cases will be presented for discussion.

S41. Motor disorders in psychiatry

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READINESS POTENTIAL IN CATATONIC SYNDROMES

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Former studies documented alterations of electrophysiologically registered premotor preparation in schizophrenia and other psychiatric diseases. The data were based on the evaluation "readiness-potential"-recording, a negative shift of the cortical DC-potential, which can be seen from 600 up to 1500 msec before voluntary movement onset. Although catatonic patients reveal clinically striking motor disturbances, to our knowledge the "readiness potential" has never been investigated in the catatonic syndrome. Up to now we investigated 5 medicated akinetic catatonic patients (diagnosed according to the criteria of Rosebush (1990) and Lohr (1987) in a postacute state and compared them to 4 healthy controls. Subjects pulled a load of 1000 g by a rapid voluntary flexion of the right index finger. Compared to controls the time onset of the beginning negative deflection of the "readiness potential" measured at Cz was significantly later in patients (-730 ± 206 msec in controls; -479 ± 75 msec in patients; $p < 0.02$). Computing the mean area under the curve from the individual beginning of the "readiness potential" until superficial EMG-onset the patients showed at precentral and central scalp sites the tendency to exhibit a larger negative DC-shift compared to controls, whereas at parietal electrodes the mean negative area was higher in volunteers ($p < 0.02$ at Pz). Our data give evidence that the preparation of self initiated movements at cortical level is functionally altered in catatonic patients. The cortical preparation period is shorter and there seems to be an imbalance of the involved frontocentral cortical regions in relation to the imbalance of the involved frontocentral cortical regions in relation to the parietal areas during the premovement phase although the topographical interpretation of reference dependent has to be done with caution.

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