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Correspondence

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Contents

- Unbearable suffering or unbearable deceit?

Unbearable suffering or unbearable deceit?

The series of 26 vignettes[1] with copious surrounding soft speak about how awfully important it is to get it right about euthanising psychiatric patients, looks like poacher becoming game keeper, 'We must really care for our unbearably suffering patients and end their suffering with this new treatment called euthanasia' type of attitude. What is touted is a tick box – let us call it 'unbearable suffering' – that once ticked clears the way for comfortable acceptable and squeaky clean legal euthanasia of vulnerable people. This is pseudoscience all the way with the tacit implication that everyone caring and reasonable agrees that euthanasia is a legitimate respectable pathway for 'care at the end of life'. It is not, and most health professionals strive to palliate suffering and not shoot the patient.

It is ironic that a clinic that supposedly carries out 'end of life care' has such a high mortality figure. Nine of the 26 presenting with letters die by euthanasia. In the rest of the world (except the countries mentioned who euthanise) criminal proceedings would be instigated against such 'clinics'. To embed euthanasia or physician-assisted suicide into the medical world as a standard 'regulated' and supervised procedure is to undermine the doctor–patient relationship. Doctors and patients would now think of cosmetic death as a definite option and societal pressure would torment dependent individuals who are elderly or disabled into requesting it 'because the doctor says it's the right thing to do' (the doctor is not offering hope or any other form of treatment) and 'it would take the burden off my relatives'. These are very vulnerable and easily manipulated people that need our protection and advocacy.

The American College of Physicians have again endorsed their respect for life and opposition to euthanasia and physician-assisted suicide.[2] They mention the reality of the 'slippery slope' (which is occurring in Holland; for example see the report of a Dutch geriatrician on criminal charges for the unlawful death of a 74-year-old woman with dementia).[3] They also cite their opposition to engagement in suicide. Finally, they express the real fear of involuntary euthanasia becoming a reality.

'Unbearable suffering' is a wolf in sheep's clothing. It is impossible to justify killing innocent life.

1 Verhofstadt M, Thienpont L, Peters G-JY. When unbearable suffering incites psychiatric patients to request euthanasia: qualitative study. *Br J Psychiatry* 2017; **211**: 238–45.

2 American College of Physicians Newsroom. *American College of Physicians Reaffirms Opposition to Legalization of Physician-Assisted Suicide*. ACP, 2017 (https://www.acponline.org/acp-newsroom/american-college-of-physicians-reaffirms-oposition-to-legalization-of-physician-assisted-suicide).

3 Sheldon T. Dutch geriatrician faces charges over euthanasia case. *BMJ* 2017; **359**: j4639.

Eugene G. Breen, Adult Psychiatrist, Mater Misericordiae University Hospital, Dublin, Ireland. Email: ebreen@mater.ie

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Authors' reply: In response to our recent paper,[1] Breen expresses two concerns: first, that it may promote degradation of the euthanasia procedure to checking a tick box, justifying bureaucratic approval of death requests; and second, that destigmatising the euthanasia procedure and promoting discussion of patients' desires to die may result in patients feeling pressured by authority or society in general to request euthanasia. Research projects like this might then contribute to sliding down a slippery slope with involuntary euthanasia as the end-point.

Partly, these worries concern not our study, but euthanasia in general. However, we are neither legislators, nor representing the Belgian people. We are researchers/clinicians in a democratic country that has legalised euthanasia, and the considerations underlying this decision go far beyond the scope of an exchange of letters. However, we hope to alleviate the expressed concerns.

First, rising euthanasia rates do not necessarily imply a slippery slope: insufficient research is available to establish whether patients feel pressured or to exclude other causes (for example better registration, patients refraining from suicide). The very example Breen cites[2] evidences the procedures in place to prevent a slippery slope. These legal proceedings are the consequence of taking due care in monitoring and evaluating euthanasia procedures. The fact that euthanasia is 'conditionally decriminalised' means that criminal charges can still be brought in euthanasia cases when legal conditions (for example exclusion of external pressure) are violated. Individual organisations have procedures in place, related to the Dutch and recently published Flemish guidelines on the management of psychiatric euthanasia requests.[3,4] These guidelines emphasise not shying away from patients' death requests while at the same time continuing to explore all potential rehabilitation options (as we reported, some qualitative evidence suggests that paradoxically, the availability of the 'ultimate escape' option to euthanise itself could contribute to rehabilitation).

Given the reality that euthanasia is societally accepted and legal, the conditions under which euthanasia is legal become paramount. Therefore, it is important to carefully monitor this euthanasia decision-making procedure and the outcomes. The practice of euthanasia is anything but a simple tick box exercise, as is depicted by Breen (and to our knowledge, no advocate of euthanasia is in favour of such a tick-box model). Instead, an important step to safeguard a careful and thorough approach is to learn about those requesting euthanasia, and a scientific approach is well suited to do this. Exploring patients' experiences is a necessary step to avoid a procedure simplified to a tick box. Thus, we share Breen's concern, but believe that protection and advocacy of these patients requires taking them seriously. Supporting health professionals in the difficult conversations about their patients' desire to die requires some insight into and respect for these patients' experiences, feelings and beliefs.

We hope to have taken away some concerns regarding this line of research and made clear why this remains such an important matter to study. We thank Breen for his response and this opportunity to better explain the context of our study.

1 Verhofstadt M, Thienpont L, Peters G-JY. When unbearable suffering incites psychiatric patients to request euthanasia: qualitative study. *Br J Psychiatry*. 2017; **211**: 238–45.

2 Sheldon T. Dutch geriatrician faces charges over euthanasia case. *BMJ* 2017; **359**: j4639.

3 Tholen AJ, Berghmans RLP, Huisman J, Legemaate J, Nolen WA, Polak F, Scherders MJWT et al. *Richtlijn Omgaan met het Verzoek om hulp bij Zelfdoding Door Patiënten met een Psychiatrische Stoornis*. [Guideline on How to Deal with Psychiatric Patients' Requests for Assisted Suicide]. De Tijdstroom, 2009.

4 Vlaamse Vereniging voor Psychiatrie VVP [Flemish Association for Psychiatry]. *Hoe Omgaan Met Een Euthanasieverzoek in Psychiatrie Binnen Het Huidig Wettelijk Kader?* [How to Deal with Euthanasia Requests from Psychiatric Patients within the Legal Framework?]. Kortenberg, Leuven; 2017 (http://vvponline.be/uploads/docs/bib/euthanasie_finaal_vvp_1_dec.pdf).

Monica Verhofstadt, **Kenneth Chambaere**, End-of-Life Care Research Group, Vrije Universiteit Brussel (VUB) & Ghent University, Belgium; **Lieve Thienpont**, Co-founder of and psychiatrist at Vonkel (an end-of-life consultation centre in Ghent, East Flanders), Belgium; **Gjalt-Jorn Y. Peters**, Department of Methodology and Statistics, Faculty of Psychology and Education Science, Open University of the Netherlands, Heerlen, the Netherlands. Email: monica.verhofstadt@gmail.com

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