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Debate

Debate: Assisted Suicide in Psychiatric Patients

D0001

Pro

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In Belgium, The Netherlands and Luxembourg, euthanasia or physician-assisted dying (PAS) is legally possible under certain conditions. In these legal frameworks, euthanasia is defined as ending the life of a patient through the administration of lethal medication by a physician at the patient's explicit request. In physician-assisted suicide, the only factual difference is that the medication is taken by the patient in the presence of the physician. PAS is only possible for intolerable suffering that cannot be relieved and is due to an incurable medical condition with no therapeutic perspective nor prospect of alleviation. Other legal conditions include an explicit, deliberate, well-considered and repeated request of a competent patient in the absence of external pressure. The physician who considers euthanasia has to consult an independent colleague. Non-terminal illnesses are not excluded, but extra legal criteria apply. The Federal Control and Evaluation Committee reviews and evaluates the euthanasia post factum.

Although the application of these legal criteria poses some problems if the medical condition is a psychiatric illness, I'll defend such a legislation for PAS based not primarily on autonomy, but on irremediable suffering. Furthermore, I'll plea to take lessons from the Belgian and Dutch euthanasia practice that arose from it, arguing for a committee based evaluation before the euthanasia in non-terminal illness, and for stricter legal criteria, guaranteeing more safeguards and due diligence. More legal checks and balances are needed to prevent patients from dying through euthanasia if not all therapeutic options and recovery-oriented approaches have been exhausted.

Disclosure of interest.– The authors have not supplied their declaration of competing interest.

D0002

Con

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The number of psychiatric patients requesting Euthanasia or Assisted Suicide (EAS) is constantly increasing in countries where this procedure is allowed.

Because mental disorders are among the most disabling illnesses, requests for EAS based on unbearable mental suffering caused by severe psychiatric disease may possibly increase. This raises the question: Should the management of patients with psychiatric disorders requesting EAS be considered for suicide prevention?

A systematic literature search allowed to analyse 25 studies from Netherlands and Belgium for the majority, and Switzerland, Germany, Canada, United States. The majority of patients requesting EAS were frequently suffering from both depression and personality disorders, in addition to a comorbid medical condition and other main suicide risk factors (previous history of suicidal act and social isolation). Frequently, evidence-based medical and psychosocial treatments currently are not provided to the majority of patients with psychiatric diseases who would benefit. Interestingly, among psychiatric patients requesting EAS, a considerable percentage no longer wished to die, postpone or withdrew their requests. In the case of patients who received EAS, the consultation with an independent psychiatrist was not an always followed procedure. In conclusion, we believe that the procedures to obtain EAS must be carefully revised, in particular constituting a committee including experts of mental health aimed at evaluating requests before EAS and not only after. Moreover, in the case of psychiatric patients, the waiting period should be longer and standardized treatments should have been formerly administered, particularly aiming at alleviating the enduring of pain suffered by these patients.

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