

Termination of life on request in patients with a mental disorder

On 28 September 2018 the Netherlands Federation of Medical Specialists [issued](#) a new directive on the **“Termination of life on request in patients with a mental disorder”**.

Noting that the Netherlands euthanasia law allows for the euthanasia of persons with a mental disorder the directive observes that “There is a consensus in the profession that extra caution must be taken into account when the basis of a request” for euthanasia “is primarily a mental disorder”.

The directive also covers persons with a “serious and treatment-resistant addiction”.

The directive aims at outlining “current, careful and useful procedures that are consistent with the ethical standards set out by the medical profession and society and that can be implemented in contemporary practice”.

Euthanasia as the “ultimate and extraordinary treatment” for mental illness

The approach taken by this directive is based firstly on what appears initially at first to be a robust assertion that “Suicidal behavior differs from a request for assistance with termination of life” which later unravels and that the view that “The granting of life termination on request for patients with mental illness is **an ultimate and extraordinary medical treatment** to eliminate suffering, or an ultimate refuge.”

This “extraordinary medical treatment”, that is ending the life of a person with a mental disorder by euthanasia or assisted suicide, may only be done when there is no reasonable prospect of treatment.

“There is a reasonable prospect of treatment when:

- there is a prospect of improvement with adequate treatment;
- within a foreseeable period;
- with a reasonable ratio between the expected results and the burden of treatment the patient.”

“When doctor and patient jointly come to the conviction that neither psychiatric treatment nor recovery support care is sufficient, then it can be said that there is ‘no other reasonable solution’ than terminating the life of the patient.”

Opposition from psychiatrists

The directive does make reference to a survey on the attitudes of psychiatrists in the Netherlands to euthanasia for mental disorders and summarises the responses of those opposed to the practice:

- Considering a euthanasia request conflicts with the goal of ongoing treatment;
- There is a real danger of countertransference which makes objective assessment of a request for the termination of life doubtful;
- There is no ultimate distinction between a desire for euthanasia or assisted suicide and chronic suicidal ideation;
- Hopelessness and unbearable suffering for persons with a mental disorder are elastic, subjective concepts;

- There is a contradiction between “hopelessness” and the relatively long life expectancy of persons with mental disorders; and
- There are many uncertainties in the accurate diagnosis of mental disorders and the assessment of reasonable treatment options.

Is a request for termination of life really different than suicidality?

Those in favour stressed a right to self-determination by the patient and the alleged distinction between “a lonely suicide” and a “dignified” termination of life arranged by the doctor.

The directive does acknowledge that “the distinction between suicidality and a request for termination of life can fade over time or completely disappear. This situation can occur if:

- suicidality is chronically present against the background of a long-standing mental disorder;
- the patient can form a reasoned opinion about his disorder; and
- seeks **professional help with the execution of his death wish.**

Suicidality can then be the expression of a long-standing and autonomous desire not to live anymore, after many episodes of severe suffering. It can be a rational reflection on the lack of future prospects, lack of treatable suicidality and mental disorder and an inability to endure suffering.

Patients can suffer greatly from their own suicidality, for example when there are endless images imposed of their own future suicide on them. **Suffering from one's own suicidality can also be a component form of a considered request for termination of life.”**

Thus in the Netherlands suicidality can in itself be seen as a reason for a doctor to collaborate with the patient’s mentally disordered desire to commit suicide by providing “professional help with the execution of the patient’s death wish”.

Suicide contagion due to the normalisation of euthanasia

The directive even notes that “suicidal behavior is increasingly expressed by the patient as a request for euthanasia or assistance with suicide. After all, the term ‘euthanasia’ is becoming more and more common in the media and patients are increasingly adopting this language in a completely different context.” This observation is consonant with the danger of suicide contagion – in this case from the context of societal approval of euthanasia and assisted suicide to the thinking of persons with a mental disorder.

“The concept of ‘euthanasia’ can be actively used by patients with a borderline personality disorder as an expression of self-destructive tendencies.”

Abandon all hope *except* the hope of termination of life

In an extraordinary statement the directive instructs doctors responding to a person with a mental disorder’s request for euthanasia “not to create any false expectations with regard to the patient’s death wish by offering false hope [that it will be complied with by the doctor] but **he may not deprive the patient of all hope in advance** [that is all hope that the doctor is willing to execute the patient’s death wish].”

Obligation to refer to a doctor willing to kill those with a mental illness

The directive insists on effective referral by any doctor who has an in-principle objection to euthanasing a patient for a mental disorder to a doctor willing to do so despite their being no legal obligation to do so.

Short term doctor patient relationship

The directive deliberately refrains from providing any guidance as the duration and number of contacts between the doctor and the patient before granting a euthanasia request, leaving it to the doctor to decide when he or she has delved into the case and has sufficient insight into the patient's problems before making a decision.

The doctor is directed to obtain a second opinion, usually from a psychiatrist, and to consult with all those who are involved in the current or recent care of the person, before determining whether or not all reasonable treatment options are exhausted.

Role for the family?

Although there is no legal requirement to do so the directive does stress involving the person's family in the discussion about euthanasia and assisted suicide.

"According to the committee, the basic premise is that the termination of life on request can only take place if family members are aware of what is going to happen. If the patient refuses contact with family and relatives the committee believes that the doctor can only continue the process after an extreme effort to motivate the patient for motivate them to be involved. This can only be deviated from in very special circumstances, as with an irreparable break with family and relatives or if family and relatives played an important role in the origin and continuation of the mental disorder. If the patient refuses contact with the family, the doctor can only honor the request after an extreme effort to motivate the patient."

Being a burden to others: a legitimate reason to be euthanased

If the person expresses a desire to no longer be a **burden to others** this could be a sign that the request is not voluntary. However "the experience of being a burden for loved ones due to the dependence as a result of the mental disorder can also actually contribute to the suffering pressing on the patient and in that sense deserves recognition" as a legitimate reason to request euthanasia.

Truly voluntary?

In assessing whether the euthanasia request is truly voluntary the doctor is directed to distinguish "for example, with a depressive disorder" whether the patient's request is made while experiencing "a serious depressive episode merely from the condition indicates that life no longer makes sense" or whether "the patient requests termination of life because he knows about the burden and untreatability of chronic, recurrent and therapy-resistant depression. In a recurrent syndrome there are often periods of remission in which the patient is capable of disease awareness. It is the

physician's job to distinguish these situations and to focus on what the patient says in the periods when he is not controlled by the disease.”

Affirming hopelessness

The directive requires the doctor to decide whether he or she personally considers that the patient has no “reasonable treatment prospect”, inviting the doctor to identify, as it were, with the patient’s feelings of “hopelessness, meaning that there is no longer any prospect of relieving, softening, tolerating or taking away the suffering”.

What a profoundly awful thing for a doctor to agree to say to his or her patient with a mental disorder: “I agree your future is utterly hopeless”.

In assessing the “unbearability” of the patient’s suffering the directive instructs the doctor to take a subjective approach: “An estimate is made of the relationship between the load and the carrying capacity” of this patient.

There is a legal requirement to consult a second doctor before executing a euthanasia request. If the first doctor is not a psychiatrist then the consulted doctor must be one. However, the first doctor is **not formally obliged to follow the (negative) opinion of the consultant**. The doctor can disagree with the consultant disagree and yet proceed to grant euthanasia, but must be able to submit strong arguments to support his intended actions.

Children, intellectually disabled, those with guardianship or custody orders with mental illness also eligible for euthanasia

While expressing the need for “larger restraint” in assessing a euthanasia request from children aged 12 to 17 with a mental disorder, the directive does not absolutely rule out granting such a request.

Nor does the directive rule out granting euthanasia requests from patients with a mild intellectual disability as well as a mental disorder.

Euthanasia requests from patients with mental disorder can still be granted even if the person has a court appointed guardian to look after the patient’s health interests if the doctor nonetheless personally assesses the patient as competent to make the request.

Euthanasia requests can also be granted from patients who have been judicially committed to a psychiatric facility. However in these cases the facility where the person is detained must agree to facilitate the process of euthanasia or assisted suicide on the premises.