Published:
Y. Cho, L. Caruana, 'Ethics: Euthanasia – Questions concerning Depression', *Cambridge Medicine* 11, 3 (1995), pp. 35-36.

EUTHANASIA: CONSIDERATIONS REGARDING DEPRESSION AND ETHICS.

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In the previous issue, SR Sinclair presented the important topic of the right to die and discussed the legislation of euthanasia.[1] Although many points were mentioned, it seems that some further discussion can be helpful, especially as regards some important facts from the clinical perspective.

Important distinctions

Some preliminary distinctions are important. There is *euthanasia* when medical professionals, or any others, act in such a way that they *deliberately* bring about the death of a patient with the intention of putting an end to a life marked with suffering. Two types of euthanasia are often distinguished. *Active* euthanasia happens when death is produced by a *deliberate act* of someone caring for the patient. A special case of active euthanasia occurs in *assisted suicide*, in which case it is the patient who brings about his or her own death with the help of someone else. *Passive* euthanasia occurs when death is produced deliberately by the *omission* of treatment which would have prolonged the life of the patient.

Euthanasia should not be confused with palliative care, like that practiced by the Hospice Movement. Practically everyone today, including the Roman Catholic Church, accepts that one can justifiably cease to strive to prolong a person's life. Practically no one requires that one should always preserve and prolong life as far as possible. According to those who uphold the sanctity of life, the sorts of omission (or refusal) of treatment which are justifiable for a competent patient are, for example, when the burdens attendant on treatment are more than a patient can be expected to bear; when these burdens are too great to be warranted by the expected benefits of treatment; when life-saving treatment, in the case of a dying patient, does not seem worthwhile since the patient has reason to think he or she no longer has any obligation to prolong his or her life.[2]

The case for legalising euthanasia is crucially dependent on what may be called the *autonomy argument*. This has it that a dying patient should be free to choose euthanasia, or reject it, as a matter of personal freedom. Such a free choice is allegedly justified because society should not interfere with the liberty of any person

as long as that person is not harming others. There is however a serious problem with this argument.

Depression: the major weak point of the autonomy argument

In June 1994, the Dutch supreme court convicted but declined to punish a psychiatrist, Boudewijin Chabot, for assisting the suicide of a physically healthy 50-year-old woman who was stated by the court to have had a depressive disorder.[3] The court explicitly accepted that euthanasia or assisted suicide might be justifiable for a patient with severe mental suffering without a physical disorder or a terminal condition, under the condition that an independent expert actually examines the patient and agrees with the decision. (In the case of Chabot, he was convicted because his procedure had not met this condition.)

This Dutch judgement was criticised because: (a) Depression is curable and treatable despite recurrence. Patients can live a good life between episodes of depression. (b) Hopelessness and suicidal thoughts are core features of depression. (c) The expression of suicidal thoughts is often, consciously or unconsciously, used by the patient as a substitute for a cry for help. (d) Relatives, friends and even medical staff may manifest ambivalence and aggressiveness towards suicidal patients and their suicidal communication. They may easily accept the patients' request of death. (e) Distortions of thinking and judgement falling short of delusions commonly occur in depression. Thus, the Dutch judgement *goes against accumulated psychiatric knowledge*. It is worth knowing that Britain has two major movements to reduce mental suffering and death caused by it. One is the *Defeat Depression Campaign*, and the other is the *Health of the Nation White Paper* with targets to improve significantly the health and social functioning of mentally ill people, to reduce the overall suicide rate by at least 15% by the year 2000, and to reduce the suicide rate of severely mentally ill people by at least 33% by the year 2000.[4]

Consequently, when we think about the autonomy argument, we should bear in mind at least two important clinical facts. First, the disease of depression usually yields the symptom of a wish to die. Secondly, depression affects rational decision making.[5,6] This implies that a depressive individual is not fully competent. Therefore, we must not be simplistic about patients' autonomy. A subclinical depressive state is also an object of treatment, and safeguards are necessary lest it should be an object of euthanasia or assisted suicide. One striking case is that of Alison Davis, who, because euthanasia was not legalised, fortunately accepted to be cured of her depression instead of committing suicide.[7]

Serious basic problems with the legalisation of euthanasia

So, in the majority of cases, a wish to die is a symptom of depression. One may insist that there may be some cases of patients who wish to die but are not suffering from depression. In these situations, the case for euthanasia is weak because of three main reasons.

(1) If euthanasia is legalised, the one committing the killing would be a member of the medical profession. This situation entails a *serious deformation* of

what the medical profession legitimately represents in our society because the one who heals becomes also the one who kills.

(2) Legalising euthanasia would very probably bring about a social order in which great social pressure will be exerted on those members of our society who will start to feel themselves useless or even a burden to those around them and to society at large. The handicapped, the old, and the incurably sick have not lost their desire to live. But after such a legalisation, they will start perceiving negatively the burden that they represent for those who care for them.

(3) If euthanasia were legally permitted, it would lead to a slippery slope — a general decline in respect for human life. For example, if voluntary euthanasia were legalised there is good reason to believe that at a later date another bill for *compulsory* euthanasia would be legalised. Dutch law allows euthanasia and assisted suicide but the danger of misinterpretation of the rules and of the extrapolation to other exceptional cases is great.[8] Assisted suicide for depression in the Netherlands is the first sign of the slippery slope in action.[9] In the case discussed above, the meaning of '*suffering'* in the original rules of euthanasia or assisted suicide has been extended to the mental field. Ironically, one month before the historic judgement, a medical inspector and a secretary of medical affairs of the Royal Dutch Medical Association emphasised that the Dutch practice of euthanasia was not leading down the slippery slope.[10] Moreover the Dutch experiment already shows that there are cases of ending of life without an explicit request. It is estimated that such ending of life without an explicit request has occurred in about 1000 cases a year.[11]

The debate for or against euthanasia makes us reflect on some fundamental traditional values usually implicitly passed on from one generation to the next by the great religions. The 'slippery slope' strongly suggests that such values should not be irresponsibly abandoned without cogent and serious reasons, or just in the name of a distorted view of progress. The intrinsic value of life is one example. In the Christian tradition, and also in others, one lives with the assumption that nobody can pass comprehensive judgements on the value of another person's life. A person can either consent to or rebel against God. The contest between good and evil in a person's life is something ultimately beyond human judgement. So the value of any part of that life cannot be known by others. Though this valuation of human life is clearly religious, some religious sense of the mystery of human life is quite accessible to anyone. It must be recalled that a basically religious valuation of human life underpins many of our laws, for example our homicide laws, which have hitherto preserved civilised life as we know it.

The atrocities committed in Germany during the Nazi era to eliminate undesirables should not be forgotten. Nowadays, some are sceptical about the relevance of the Nazi era to the understanding of the possible implications of the contemporary movement for euthanasia.[12] They say that the Nazi concept of euthanasia was different from ours today. This is misguided. The motivation behind terrible crimes does not fall from the sky without a history. At the early stage, in the 1920's, the central Nazi argument for euthanasia was clearly the concept of 'a life not worth living'.[13] Claiming that we cannot learn anything from the mistakes committed by Nazis is very dangerous. Society seems to be led towards inhumanity at first by thin, inconspicuous strings. One of the lessons to be learnt from the World War II atrocities is to keep watch for the strings, since the chains will be much harder to break.

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