PALLIATIVE TREATMENT AND EUTHANASIA FOR PSYCHIATRIC ILLNESSES

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ABSTRACT

When looking at the natural course of life, death is the natural conclusion. Majority of the time, people do not choose when and how they die. Death and dying are topics that are difficult to discuss for many individuals. However, when one decides to choose the context of their death, it raises many ethical considerations. Psychiatry, as a field, looks at the psychodynamics of death and dying for individuals. It is also poised to comment on the growing use of physician-assisted suicide and euthanasia for psychiatric disorders. Through a review of the literature, theories in psychiatry regarding the dying process are used to better understand an individual's choice for choosing euthanasia as a medical intervention to end their suffering from a long-standing psychiatric illness. The use of palliative care in conjunction with psychiatry is also explored.

I WOULD LIKE TO DEDICATE MY WORK TO MY PARENTS: MUTHAIAH CHANDRASEKHARA, MD AND LALITHA CHANDRASEKHARA, MD. THEY ARE MY INSPIRATION FOR EVERYTHING I DO. THEY ARE MY MENTORS, MY CONSULTANTS, AND MY ROLE MODELS.

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CHAPTER 1

INTRODUCTION

Death has been a philosophical dilemma since the dawn of the thinking man, and a bioethical dilemma since the advent of bioethics as an area of study. As medicine continues to progress, death is staved off longer and longer, thus creating a quandary about whether death should be treated less in a philosophical sense, but in a biomedical sense, as a disease, similar to smallpox, and needs to be eradicated. Death, by definition (according to Merriam-Webster) is an "irreversible cessation of all vital functions." This can be expanded upon when looking into the different tiers where death can occur. On a cellular level, death occurs as a programmed response to damage via apoptosis. It is an attempt to prevent damaged material from being replicated in our bodies. When looking at a larger scale, death can occur when a person ceases cardiac and respiratory functioning, or when the brainstem is injured and the brain cannot respond to outside cues. The common theme amongst these definitions is that the damage is "irreversible," accordingly making death absolute. However, these are medical perspectives on a concept that is also socially meaningful. Therefore, it is necessary to look at the social influences at play when discussing death.

Psychiatry is one of the few fields in medicine that takes into account the social and psychological aspects of a person in order to have a better understanding of their disease process. With this, the field of psychiatry has a unique perspective on various life events. Particularly, events that are difficult for many people to discuss, such as major

change or existential issues. One event that encompasses both a major change and existential issue is the idea of death.

Death and medicine have a long history when one looks at the development of "medicine." Procedures that are deemed medical in nature have been around since the Paleolithic era, when proto-men were trephining (making holes) in skulls to ease battle injuries. So, it can be argued that the foundational roots of medicine are easing suffering and delaying death. More recently, many life-prolonging procedures have emerged that prevent individuals from dying. These can include ventilation, LVAD (Left Ventricular Assist Device), organ transplant, and defibrillators, amongst other innovations.

Death is something that we cannot avoid; no matter how much a person tries to resist it. Death is final, or at least a finality of presence on Earth. It is this finality, without concrete knowledge of anything after, which leads to many conflicts within a person around structuring their identity. These internal conflicts with how they understand the world based on previous experiences can lead to anxiety, and possibly, an existential crisis. Thus, psychiatry offers a way to obtain a deeper understanding of an individual's psyche, and how this manifests with regards to their relationship with their own mortality. This can be especially difficult for individuals diagnosed with serious mental illness, as their crises of suffering with a chronic illness can affect their ability to function.

Psychiatry has some unique viewpoints regarding how a person handles their own mortality. A few theories of this will be explored later in the paper. This includes looking at a person's relationship with death and how conflicting beliefs within an individual can lead to anxiety regarding the process of dying. This anxiety can then be further expanded

on through the concept of mental suffering, which may lead to an individual committing suicide.

If death becomes an escape for psychological suffering, then the increase of life-sustaining treatment and delay of death leads to a thought-provoking juxtaposition of medicine prolonging a patient's suffering. To counter this, there has been the development of palliative care, which seeks to relieve symptoms and help aid patients in maintaining dignity at the end of life. Also, this shift has been shown in legislation, with the promotion of advance directives to help patients preserve autonomy. For psychiatric illness, this extends to psychiatric advance directives to help those with mental illness also keep their autonomy.

The exploration of those theories should be used in conjunction with current trends in end-of-life care in order to better understand a person's choice for euthanasia for serious mental illness. It is here that the ethical issues arise. When considering medical assistance with death, it may be our own fear of mortality that prevents us from understanding a person's choice to end their life. If that is the case, we need to explore other options available for intervening with that person's suffering, especially in cases of serious mental illness.

CHAPTER 2

THEORY OF DEATH AND DYING IN PSYCHIATRY

The history of psychiatry has undergone many changes over the years, as it is one of the few medical fields that lend itself to being influenced by cultural and social movements. This is especially interesting when considering the cultural influences that revolve around death across various communities. It is therefore important to consider these influences when approaching the subject with an individual within the realm of psychiatry. Opportunities where this may arise include the psychodynamics of an individual, their relationship with mortality, as well as any suffering they might endure due secondarily to being closer to death. From the advent of psychiatry, death is ever present in the many theories postulated over time for defining the "self." There is a tendency for many people to avoid discussing the process of dying. This taboo on death has prevented many people from not only accepting the natural course of life, but also from openly discuss fears regarding this.

Freud himself wrote that "…in the unconscious every one of us is convinced of his own immortality." (1) Most young people do not think about death unless a parent or friend has died. It is an abstract concept, like time, but an inevitable outcome of the natural progression of life. Therefore, the idea of death and dying is always present, but not always acknowledged by an individual.

How we understand ourselves in relation to the concept of death is another important area of understanding a person's relationship with their mortality. Weisman and Hackett (2), two consult-liaison psychiatrists, developed a "dimensions of death and

dying" framework for working with patients' attitudes towards death. Here, an individual understands death via their relationship with death. For example, working with a cadaver is considered an "impersonal death" because it is removed of any humanistic characteristics. Following this, the other dimensions include "interpersonal death" and "intrapersonal death." The latter being an individual actively and subjectively experiencing the dying process. In this last category, the anxiety an individual feels is due to the impending death, which will result in a dissolution of their previous thoughts and actions. This can lead to panic and/or despair. The process of dying is what evokes anxiety within a person, and may lead to more suffering than their actual death due to the prolonged duration of the dying process in recent years.

Irvin Yalom, MD, a psychiatrist that primarily worked in group therapy with cancer patients, addressed this concern in his book "Existential Psychotherapy." (3) Here, he notes that the fear of death should be considered a primary anxiety due to the conflict that arises in people when they become more aware of their own mortality. The anxiety that develops due to this is known as "death anxiety" and can prevent a person from fully immersing him or herself in the life that they have. It is composed of many different other fears such as: being a burden to others, contemplating an afterlife, or current plans ending. Although it is the primary goal of a therapist to assuage these fears, a therapist may choose not to discuss death in session for their own reasons. Yalom addresses this and notes that death desensitization will help overcome problems regarding the discussion of death and dying and improve an individual's relationship with their transience in life.

Psychiatry is able to offer a unique perspective on an individual's reconciliation with their own mortality, and attempt to integrate this into their final acceptance of death. There has traditionally been little formal attention to considerations of mortality in residency training, with this topic not being addressed through lectures. It is likely assumed that resident physicians will obtain this unique training through rotations in psychosomatic medicine and geriatric psychiatry (4), but that sets an example that this topic is not important for dedicated discussion time, which mimics society's hesitation to discuss death as a normal process for all living beings. Then, death becomes unfamiliar and creates possible anxiety within the therapist if a patient discusses it openly with them.

CHAPTER 3

END-OF-LIFE CARE

There are many thoughts and feelings that get evoked where death is concerned. Not only is it a time of adjustment for the person dying, but it involves the whole family and support systems. Orson Welles famously said that "we are born alone, and we die alone." However, this is not the case for many people. There has been an increase in the number of people dying in nursing homes and acute hospital settings over the past 50 years. (5) People are now being surrounded by hospital staff, not necessarily their family, which would have been the case in the past. This brings with it many bioethical issues regarding a patient's wishes for their care, and where healthcare providers fit into this scope. This will be examined over the course of this paper.

Prior to nursing homes and hospital intensive care units, people would die at home. There were no life-prolonging interventions that would lead to a person living past an infection or a physically traumatic event. Nowadays, many people are living longer lives. The average life expectancy ranges between 70-80 years, depending on gender and race. This is in part to the availability of fresher food, cleaner water and improvement in sanitation. However, this increased longevity also is a result of medical advancements, especially regarding life-prolonging treatment. According to the Centers for Medicare and Medicaid Services, when looking at the health expenditure for medicine, the elderly are considered a small group within the overall population of the United States, but accounted for about one-third of the costs for care. This was mostly due to increased outpatient visits and medication prescriptions. (6)

With regards to end-of-life care, there are many possibilities for medical involvement. This includes life-prolonging treatments/procedures. More recently, a more palliative approach has been utilized in order to prevent unnecessarily prolonged and painful death. The emergence of palliative care, a subspecialty of medicine dedicated to symptom relief and improving quality of life, may be demonstrating a new movement towards focusing on the *quality* of living instead of the *quantity* of years. Palliative care provides a specialty that will consider the patient's wishes, rather than primarily focusing on the physician's recommendations. It is seen as a multidisciplinary approach to end-of-life care and places emphasis on a "whole" approach, which includes pastoral and social services. (7)

Although palliative care represents a progression towards a more accepting viewpoint on end-of-life issues within medical culture, this option does not necessarily extend to those with chronic end stages of psychiatric illness. Currently, dementia is the only psychiatric disorder that can receive palliative care services as well as hospice recommendation. The "FAST" (Functional Assessment Staging Test) is a scale used in order to determine if a patient with dementia meets criteria for hospice placement. (8) The scale relies on a physician evaluating the physical capabilities of the patient and their ability to care for themselves. This includes the inability to feed their self, ambulate, and even speak.

Palliative care also addresses the need to comfort patients. Within medicine, "suffering" is a vague term that is many times used to describe a person dealing with pain. However, there are many categories of suffering that an individual can endure. (9) These categories include physical, psychological, existential, and social. When looking at

the physical category, somatic pain has been more readily accepted as a sole definition of pain. However, there was a study conducted that showed that the descriptions of psychological pain were more intense when compared to descriptions of physical pain. (9) This review also showed that many pathways in the brain connected to physical pain are also implemented when a person undergoes emotional pain.

CHAPTER 4

SUFFERING

Many attempts have been made to define suffering, but the most widely used definition is the one written by Cassel, a critical care physician. In his writing, he defines suffering as "the state of severe distress associated with events that threaten the intactness of the person." (10) As such, the word *suffering*, similarly to the word *terminal*, is vague and not well-defined. The idea of suffering is personal, and because of that, it is difficult to define. Cassel's definition has retained prominence through the years. The idea of suffering was included in both the Belgian and Dutch laws concerning euthanasia. It is also mentioned in Oregon's Death with Dignity act. Although difficult to define, it is an important aspect to bear in mind with regards to end-of-life care. Suffering can envelop many areas of a person's existence. While all areas can contribute to a person's "suffering" and decrease in quality of life, it is usually the psychological and existential aspects that are the most difficult for a person to tolerate, rather than the physical pain associated with their illness.

Besides quality of life, the actual "end" of life has been rising as a point of academic and clinical interest. How a person dies can be very intimate, as it can reflect the themes of control, fantasy, and self-worth. However, it can be taboo at times to discuss a person's desire, wants and wishes, for their own death. Many mental health professionals become uncomfortable with discussing this topic, which may make the person seeking treatment feel that their concerns are abnormal and shameful. This can

continue to contribute to them dealing with their suffering alone, which may lead a person to choose another method to relieve their internal pain.

CHAPTER 5

SUICIDE

A common other method, and a type of death that psychiatrists *are* familiar with handling, is suicide. As posed by Albert Camus, "there is only one really serious philosophical question, and that is suicide." (11) Delving deeper into this quote, Camus is finding absurdity in life by contemplating whether life is worth living. This is an idea that many people struggle with for a variety of reasons. If a person decides that life is not worth living and chooses to commits suicide, there can be many different explanations behind this, ranging from cognitive explanations that focus on reasons to affective explanations that center on feelings. (12)

One cognitive explanation for suicide is the fantasy of taking revenge on the people who have done wrong or caused pain. Another reason for suicide is the vision of being reunited with a loved one. This is especially difficult as it may exists alongside religious beliefs, which are difficult for people to look beyond. Third, the idea of atonement for one's sins through death can provide a compelling rational explanation, especially regarding people that have served in the military and went to war. Lastly, the concept of "retaliatory abandonment" can provide some insight into a person's choice for suicide. In this scenario, a person feels that they were abandoned by someone close to them, and so they are unable to tolerate the emotions associated with this and turn to suicide as a way to maintain control over the perceived loss in their life by leaving first via suicide.

Affective explanations consider the reasons account for strong emotions that an individual may experience that makes life intolerable, and thus, seeking death in order to be free from these feelings. These feelings can range from guilt to rage to despair. The choice between living and dying also allows for more control by an individual. Control can be an enticing reason to decide to commit suicide, as it allows a person the ultimate decision over themselves, particularly if that individual feels that there are many external factors pushing them at that time. (12)

The above mentioned explanations for a person to commit suicide suggest some underlying problems with their ability to perceive the environment or to form stable relationships. Many times, these are suggestive of a psychiatric component that contributes to a person's understanding of the world around them and how their previous experiences and interactions contribute to their current view of the world. If a person is managing symptoms of depression, especially feelings of hopelessness and/or anxiety, it will be difficult for them to be oriented to any future for themselves. They will be focused on their current situation and how intolerable it is, and will seek any means to alleviate the aforementioned feelings. In a similar fashion, a person with the beginning of a psychotic disorder will have difficulty understanding what they understand as real or not, and this loss of self can contribute to feelings of despair leading to a person to wanting to kill themselves, rather than deal with the fear of a progression of their psychotic symptoms. In both of these examples, the underlying psychiatric illness also can affect a person's ability to reach out for support during these difficult times, either through vegetative symptoms or through paranoia, respectively. Hence, suicide has been linked to an underlying psychiatric illness.

However, another opinion of suicide separates it from a person's mental illness. When psychiatric illness is explored compared by Shneidman, he argues that the act of suicide itself is not a mental illness, and in fact can be a rational act. (13) Consequently, this lends some clout to the thought of rational suicide. Rational suicide is the idea that a person willingly chooses to end his/her life, without an underlying psychiatric illness. Many times, this scenario occurs with an elderly patient who reports that "I have lived long enough." In this instance, it is important to question the person's capacity to make this decision and individual factors that could be contributing to this request. One study (14) showed that many times, a person's interest in suicide is not due to a fully diagnosable psychiatric illness, and may be triggered by some recent life event that has occurred. Consequently, the choice to end one's life may not always be secondary to mental defect, and should be considered in context of the individual's experience with their life and, their illnesses, and the treatment of it. Societal acceptance that such considerations should be a key factor at the end of life is a necessary but not sufficient foundation for physician-assisted suicide.

CHAPTER 6

PHYSICIAN-ASSISTED SUICIDE IN THE UNITED STATES

Physician-assisted suicide (PAS) builds from the commonly accepted precept that a patient's autonomy with regards to their health is important to retain, but asks if that principle includes the decision to end their life. This has been an ongoing issue since ancient times. (15, 16) Physicians should "not administer any poison, even if asked to do so" was famously inscribed within the original Hippocratic Oath. Of course, modern views have changed in response to advancements made in medications, especially those for cancer treatment, such as chemotherapy and radiation. For example, cisplatin is a common chemotherapeutic agent that is made from platinum. It is a good agent for targeting tumor cells, but may also lead to neurotoxicity which can evolve into hearing loss for some cases. Hence, our views on medicine and treatment have changed since Hippocrates was practicing medicine.

Similarly, views on physician-assisted suicide and euthanasia have been changing. PAS involves a physician providing a patient with the medication required to have a painless death, but does not administer the medication. In PAS, the patient is the one that administers the medication to himself or herself. Euthanasia requires the physician to be more involved with regards to the procedure and the administration of the medication to the patient for death. About twenty years ago, Dr. Jack Kevorkian was practicing his form of PAS, which eventually turned into euthanasia. He underwent a trial for homicide with regards to those he provided services and was convicted. He ended up losing his medical license, was eventually charged with second-degree murder, and

served prison time. (17) Nevertheless, when looking at the culture of death within medicine, PAS has become an accepted form in the United States in certain states. Oregon's Measure 16, otherwise known as the Death with Dignity Act (1997), became the first legislature that legally allowed physicians to prescribe medication in order for patients to take their own lives. Currently, the only states that legally approve PAS are Oregon, Washington, Vermont, Montana, Colorado, and California. Yet, these states do not allow for euthanasia, and there are strict criteria for people eligible to receive PAS as an option. In the United States, mental health issues are not eligible for PAS, and assessment for PAS eligibility actively screens for any underlying psychiatric illness that may be contributing to a person's request to end their life.

CHAPTER 7

GLOBAL PAS AND EUTHANASIA

Around the world, other countries have legalized PAS and euthanasia. Columbia, Luxemburg, Switzerland and Canada (most recently) are a few of the countries that have passed PAS and euthanasia legislation. Belgium and Netherlands also have PAS and euthanasia laws, but are the only two countries that allow for euthanasia specifically for a psychiatric diagnosis. Although the two countries differ legally (Belgium explicitly allows the practice of euthanasia for serious mental illness, whereas Netherlands does not exclude it), since the enactment of this law, there has been an increase in the number of requests and administrations over the past few years. (18)

In Europe, there has been a fair amount of euthanasia use for serious mental illness. Belgium has seen a rise (9 cases to 58 cases) of deaths by euthanasia for neuropsychiatric illnesses over five years. (18) The Netherlands reported 110 cases that fall into the category of psychiatric illness over five years. (19) Most of the requests are for affective disorders (eg: depression or bipolar disorder), but a good majority of them are also for personality disorders. (18, 19) The process by which a person receives euthanasia is similar between the two countries. The request must be made by the individual without coercion, two physicians (a requesting physician and a consulting physician) are required to evaluate the patient, and then the request is evaluated by a board. In the cases of requests for solely psychiatric illness, a third consulting physician is needed, but there is no requirement of an evaluation by a psychiatrist at any point. Some evaluations do involve the individual's psychiatrist as the requesting physician.

(20) This has set some precedence that psychiatric illness parallels some somatic illnesses, in that they are unbearable for the individual and they need relief, such as the case of a patient with cancer.

CHAPTER 8

FUTILITY AND TERMINALITY

The question of providing PAS or euthanasia to individuals with psychiatric illness also touches the concept of whether psychiatric illnesses can be considered "terminal." Usually, the word "terminal" is reserved for a somatic illness with a prognosis of "six months." However, the definition of "terminal" depends on which institution is defining it. Some definitions do not include a prognostic timeline. So, can mental illness fall into this category? Dementia is currently the only psychiatric illness currently classified as a terminal illness. However, I believe that using the concept of life-sustaining treatment can help elaborate this for other psychiatric illnesses. Life-sustaining treatment, depending on the definition, it is not limited to mechanical ventilation and CPR (cardiopulmonary resuscitation), but can also include the use of medications, which will "forestall the moment of death, whether or not the treatment affects the…biological process," per the definition provided by the Cleveland Clinic.

Due to this, the practice of withholding or withdrawing care has become prevalent in the United States as a form of passive physician-aid in dying. Some cases of withholding/withdrawing care are due to patient refusal. Still, many times, continued care is seen as futile and the recommendation for withholding/withdrawing is presented by the physician caring for the patient. Futility, especially in medicine, is an interesting and not well-defined view on the prognosis of a patient. Medical futility has been defined in either quantitative or qualitative forms. (21) The quantitative form proposes that an intervention in which 100 patients are given a treatment, subjecting 99 individuals to

negative side effects for one positive outcome, is not worth the time. When looking from a qualitative standpoint, futility takes into account the patient's ability to achieve life goals and not be preoccupied by their illness. Regarding mental illness, the latter definition is more applicable. Diagnoses such as borderline personality disorder and anorexia nervosa have been extensively written about and discussed due to their difficult treatment nature and poor prognosis. (22, 23) These illnesses could fall under the category of "futile mental illnesses," as the individual's life becomes consumed by the illness and the overall quality becomes negative. In these cases, what is more appropriate? Is it better for the person to continue their suffering or to have an option available to them to provide relief?

CHAPTER 9

PALLIATIVE TREATMENT

When taking the whole picture into mind, the goal of any medical intervention should be to provide relief of some kind; relief from pain, relief from suffering, relief from symptoms. Following this, it is clear that palliative medicine services can and should be utilized for those diagnosed with chronic psychiatric illness. The use of palliative care for solely psychiatric illness is limited. However, there has been some progression towards "palliative psychiatry." (24) This new model would adapt the framework of palliative care into psychiatry, in order to be applied to those diagnosed with psychiatric illness. When comparing psychiatry and palliative care, there are a great deal of similarities. Both rely on the biopsychosocial model, work with multidisciplinary teams, and manage symptoms due to depression, anxiety and delirium, to name a few.

While the need for palliative care has been recognized in the context of serious illness, the argument it in the context of serious mental illness is lacking. Illnesses such as schizophrenia and treatment-resistant depression also affect the quality of life for the individual, especially if they are unable to receive and/or respond to adequate treatment. (25, 26) Adequate treatment often includes addressing social supports in the treatment plan. This includes the availability of steady housing for a person to keep their medication, a person's education level in order to understand the instructions of care and having the ability to lean on other people in times of need, to name a few. Unfortunately, these social factors are considered outside the scope of the medical profession, despite having a great influence on the overall health outcomes for any individual. For example,

how realistic is it to expect an individual to be adherent to taking medication, if their housing is unstable and they need to move from place to place? It is these social factors that also need to be taken into consideration when medical interventions are recommended.

One aspect of palliative care that has begun to be better incorporated is the advance directive, as this allows for direct wishes from the patient regarding care. Based on the Patient Self-Determination Act, the federal government requires that hospitals receiving Medicaid or Medicare funding inform patients of their right to an advance directive. (27) While most often understood as being related to decisions about bodily medical interventions, this law also extends to mental health decisions. The concept of designating specific wishes while acutely incapacitated can find roots in the story of Ulysses sailing past the sirens. In this part of the Odyssey, he instructs his men to continue rowing, and to not listen to him if he says otherwise. The psychiatric advance directive derives its nickname, a "Ulysses contract," from this mythological perspective. Although the sirens are long gone, selecting certain treatment options and stating one's wishes for future use continues to have much merit. Many states have passed specific laws regarding this with more specific directions than provided in the federal law for overall medical advance directives. The psychiatric advance directive can provide patients with some autonomy over their care, and their use has been shown to increase the therapeutic alliance between patient and practitioner. (28) However, one aspect of psychiatric advance directives that are often criticized is that it can be overridden, especially with regards to involuntary commitment into a psychiatric hospital. In this case, the ideas of "police power" and "parens patriae" come into play. (29) Police power

allows the state to override an individual's autonomy in order to protect the general welfare of the citizens. Parens patriae is a legal term stating "the state as the parent," which grants whichever government the ability to be a guardian for those unable to care for themselves. The ideology underlying these legal premises is the same that obligates mandatory reporting of child and elder abuse.

In order to incorporate this approach, it is important to recognize that the field of psychiatry uses many of these methods when providing care for individuals with psychiatric illness. Some diagnoses (treatment-resistant depression, schizophrenia, anorexia nervosa) have been shown to be chronic in nature with poor response to treatment from a pharmacological standpoint. Most times, individuals with these illnesses have a reduced quality of life from multiple suicide attempts, poor self-care, and/or other comorbidities. As earlier mentioned by Trachsel and colleagues, palliative interventions "…stabilize or improve quality of life without necessarily modifying disease progression in the long-term." Hence, chronic psychiatric illnesses would benefit from this intervention earlier in treatment.

Within outpatient psychiatry, there have been developments in this vein. The increasingly popular recovery model, for example, allows for people with psychiatric illnesses to be integrated into the regular workforce and encourages them to live and function within the general community. The idea of a person being able to function socially within their community is the biggest marker of symptom improvement in psychiatry. Going back to the psychodynamics of being, it provides a purpose for the individual to progress towards possible symptom resolution. There has been some success with this model, but this requires a great deal of social support within the

community in order to have people feel safe and stable enough to thrive. Medications alone are not enough to promote this way of living for people with psychiatric illness.

Conversely, there is some concern that assimilating palliative care into psychiatry may affect the ability of the individual to be able to function within the community. This concern develops out of the idea that using palliative care somehow admits that psychiatric illness is chronic in nature and medication treatment is possibly futile. The field of psychiatry is built on providing hope for individuals through various medical interventions. The fear is that including palliative care methods removes hope from the equation. However, this does not have to be the case. It will be important to recognize that providing some form of palliative care does not signify a loss of hope for the individual's ability to function. It actually can provide more support outside of the hospital setting, especially regarding coordination of care and non-pharmacological interventions including the use of pastoral services.

CHAPTER 10

BIOETHICAL SIGNIFICANCE

Debates over PAS and euthanasia involve all of the key bioethical considerations: the conflicting ideas of patient autonomy (patient's right to choose treatment), beneficence (do good), non-maleficence (do no harm), and justice (equity of resources). Along with these key bioethical pillars, other ideas of ethical concern come into play with end-of life care, particularly regarding PAS and euthanasia for mental health disorders. Capacity, paternalism and informed consent are some of the ethical concepts that need to be addressed when considering end-of-life care.

Regarding autonomy, is our own fear of mortality preventing us, as physicians, from addressing mortality in our patients? Psychiatry strives to not only shine a mirror on a patient's internal biases, but for the psychiatrist to also become more aware of his/her own "blinders" that may prevent deeper exploration of a patient's psyche. With this fear, paternalism likely arises. Paternalism is the idea that a physician will act "as a parent" for the patient, keeping their best interest in mind. However, many times, the physician's and patient's ideas of "best interest" come into conflict. When considering euthanasia for psychiatric illnesses, there are many ethical dilemmas that arise. A major concern is summarized by the phrase "slippery slope," which reflects the consequentialists concern that legalizing PAS and euthanasia would lead to more use of this intervention by poor and marginalized groups. The normalization of this intervention within psychiatric treatment would ultimately change the nature of care provided by mental health services. These services provide hope to many individuals, which has been shown to improve

outcomes for patients. (30) By making this option available, there is a fear of removing hope from people with psychiatric illness, which would likely lead to worse clinical outcomes of symptom control. Another concern here is the idea that certain "unwanted" groups would be coerced into using this intervention more than others. People with the ability to afford medical treatment will be offered that, whereas those that are unable to will be suggested to consider euthanasia.

However, when looking at the deontological view, or view focused on an individual's duty, of euthanasia for psychiatric illness, there is a relief from suffering ultimately being provided to patients requesting this service. As physicians, our duty is to treat out patients and alleviate symptoms that burden them. As previously mentioned before, the idea of suffering is intangible, but ever present in medicine. The suffering of individuals with psychiatric illness is even harder to comprehend. Who is to say that the suffering caused by a somatic illness is more worthy of attention than the suffering secondary to a psychiatric illness?

Following the above question, the principle of justice comes into play when considering the availability of resources for psychiatric illness, especially when compared to psychiatric illness. More specifically, the use of palliative care strictly for psychiatric illness has not received much attention. There has been a lot written regarding providing palliative care for psychiatric patients suffering from somatic illness (eg: a patient with chronic schizophrenia that was recently diagnosed with cancer). This has led to a rise in palliative care psychiatry. However, there has not been much written with regards to providing palliative care solely for psychiatric illness. Justice comes into play due to the importance placed on somatic illnesses over psychiatric illnesses. Providing a certain

treatment option for one type of illness and not for another can be seen as inequality of resources.

CHAPTER 11

CONCLUSION

Based on the above statements, there is a wide area of end-of-life ethics that occurs within psychiatry. It is important to recognize that the field does not exist within a bubble. Psychiatry needs to accept its position as a master in the psychodynamics of death and dying and demand incorporation into clinical care end-of-life discussions. Similarly, palliative care has risen to be a field within medicine that incorporates not only medical issues, but spiritual and psychological as well, and coordinates these amongst various parties such as family and medical services.

Moving forward, psychiatry may be able to benefit from incorporating a palliative care model within its structure. The field of psychiatry already incorporates various social and spiritual aspects into psychodynamic formulations, which then informs clinical treatment for that specific patient. Psychiatry, as a field, also works in multidisciplinary teams more easily than other specialties, so the general organization of it allows for inclusion of other team members commenting on further treatment and/or alternative interventions. Based on this, our view of psychiatric illnesses needs to change with the changing course of medicine. The next step for the field of psychiatry will be incorporating palliative methods, especially for individuals suffering from serious mental illness. Along with this will be the need to address and be comfortable discussing PAS and euthanasia, and possibly redefining futility within psychiatry. Ultimately, it becomes the position of the psychiatrist to be secure with their own relationship with death in order to better serve their patients fully, in all aspects of death and dying.

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