Working With Decisionally Capable Patients Who Are Determined to End Their Own Lives

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ABSTRACT

Psychiatrists face complex, vexing, and often conflicting issues in assessing and managing patients with advanced medical illnesses who are determined to end their own lives. Substantial differences of opinion exist among psychiatrists regarding the roles they might take with such patients when the patients are decisionally capable and do not have clear-cut psychiatric disorders. Even those with psychiatric diagnoses often possess rational deliberative abilities and may make decisions to hasten death that are not impacted by their psychiatric disorder. How psychiatrists interact with these patients may be influenced by contradictory and even incompatible ethical, psychological, social, cultural, and professional biases. Tensions often exist between patients' autonomous preferences regarding their wish to die and psychiatrists' usual approaches to suicide prevention. To consider these issues, we review some ethical, legal, psychological, social, and clinical concerns; potential interventions; and support for psychiatrists caring for decisionally capable patients with advanced medical illness who wish to end their own lives. Although psychiatrists' work strongly focuses on suicide prevention, harms might result if suicide prevention becomes the only focus of treatment plans for these patients. We recast benefits and harms in such situations and make suggestions for assessing and managing such patients and for potentially offering assistance to families and other survivors. While psychiatrists should carefully think through each case on its own merits and seek consultation with experts, they should not act reflexively to prevent all deaths at any cost. We argue they may, in some cases, honor patients' and families' wishes and even collaborate with them around decisions to hasten death.

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The 24% increase in US suicide rates from 1999 to 2014[1] has led to greater efforts to identify, prevent, and intervene in situations associated with suicidality.[2] While the desire to kill oneself is not synonymous with a mental illness, 80%–90% of completed suicides are associated with a mental disorder, most commonly depression.[3] Understandably, psychiatrists and other clinicians face strong moral, cultural, and professional pressures to do everything possible to avert suicide.

Hidden within these statistics are unknown numbers of individuals determined to end their lives, often in the context of a life-limiting physical illness, who have no mental disorder or who, despite having a mental disorder, were nevertheless seemingly rational and decisionally capable and in whom the mental disorder did not seem to influence the desire to hasten death.

Since the term *suicide*, referring to the intentional, self-initiated act of ending one's life, may evoke negative emotions, end-of-life scholars have increasingly used the phrases *physician-assisted death* (PAD)[4], "*medical assistance in dying*,[5] or *hastened death*[6] rather than *suicide* to describe acts in which physicians offer aid and active assistance to individuals who wish to die and who fulfill certain criteria such as a limited life expectancy. With PAD now legal in Oregon, Washington, Vermont, California, Montana, and Colorado, over 50 million individuals in the United States live in a jurisdiction allowing this practice. Nuanced discussions of "when suicide is not suicide"[7] continue to evolve across society and the medical profession. For purposes of this discussion, we will simply refer to rationally deliberated acts of self-initiated death as "ending one's own life." Elsewhere, we have also referred to these acts as "pre-planned death."[8]

The existence of laws that legalize PAD underscore that legislatures and voters believe that in some circumstances patients should have the right to end their lives. In reviewing the either sparse or dated literature in this field, surveys from the United States and Canada support that most psychiatrists believe that PAD should be legal and is ethical in some cases and that they might want the option for themselves.[9–13] Studies in Oregon of patients who request PAD indicate that the majority do not have a mental disorder such as depression.[14] Instead, they have long-standing coping traits characterized by determination, persistence, wanting control, and avoiding dependence.[15,16] Accordingly, some individuals who end their own lives might arrive at their decisions only after analyzing costs versus benefits concerning their declining quality of life or anticipating future states worse than death, and estimating odds of improvement. They may value quality of life above a protracted dying. Facing death, they focus on controlling its timing and manner. As one patient stated, "I seem to have the right to choose my profession, my spouse, and my health care plan. I can even put my dog down for a humane death. Why wouldn't I have the right to choose how and when I want to die in a dignified way?" Another said, "I've looked at my future options and conclude that I've been 'check-mated'—it's all downhill from here, and it's only going to get worse. There's no good outcome."

Clinical Points

- Decisionally capable patients with advanced medical illness who wish to die challenge mental health clinicians, who often face conflicting ethical, legal, psychocultural, and professional directives.
- Treatment plans focusing primarily on preventing such patients' hastened deaths may be harmful and deny patients opportunities to maximally benefit from collaborations with clinicians.
- Mental health clinicians should seek and access a variety of professional supports to help navigate this difficult terrain.

Before discussing how psychiatrists might interact with decisionally capable patients who may wish to end their lives, we clarify that we are not making any arguments that psychiatrists should prescribe lethal medications. Although we see "assisted death" as an option of last resort, we instead ask whether on certain occasions psychiatrists might appropriately *not seek* to prevent selected decisionally capable individuals from ending their own lives. As such, they might have a treatment plan that does not focus primarily on preventing death and, in some cases, might actually offer advice and support to these individuals and their families. Without administering or prescribing lethal means, such "unassisted" stances might be termed *physician-unimpeded death* or, to the more extreme extent that a physician might be willing to actively comfort and collaborate with patients and families going through such activities, perhaps *physician acknowledged death*. Since many clinicians react almost reflexively to prevent self-inflicted death under *any* circumstances, raising such questions might be viewed as ethically and professionally risky. Respecting the admonition to "first, do no harm," we encourage clinicians to reconsider harms and what it means to always interfere with patients' plans to end their own lives.

These discussions are of practical significance. With so many jurisdictions now legalizing PAD, mental health clinicians may increasingly interact with patients who have accessed lethal prescriptions legally. Alternatively, in states that have not legalized PAD, patients may access these drugs illicitly from other countries. PAD advocacy organizations may assist persons in obtaining lethal prescriptions. Sympathetic physicians may prescribe these medications illegally.[17] To foster these discussions, this article examines ethical, moral, legal, psychological, social, and clinical concerns; potential interventions; and support for psychiatrists caring for decisionally capable patients who wish to end their own lives.

ETHICAL AND MORAL CONCERNS

There are two categories of ethical arguments against the legalization of PAD and physician prescription of lethal medications. The first argument is that suicide is morally unacceptable. The second is that even if suicide is morally acceptable, physician participation by prescribing lethal medications is not. Surveys of psychiatrists reveal how they may differ in their opposition to PAD based on these beliefs. For example, in a survey of forensic psychiatrists, 20% indicated that suicide is never ethically or morally acceptable, 49% indicated it is ethical under some circumstances, and 32% indicate it is solely the prerogative of a competent individual. Regarding physician-assisted suicide, however, 34% indicated it was never morally acceptable, 55% indicated it is ethical under some circumstances, and only 10% endorsed that it is solely the prerogative of a competent individual.[12] Ethical arguments for and against legalization of PAD and physician prescription of lethal medications balance respect for autonomy and self-determination (and the limits of that respect), beneficence, and nonmaleficence in arguments for and against legalization of PAD and have been extensively debated elsewhere in the medical literature.[18–22]

The ethical arguments around failure to prevent suicide or collaboration with a competent patient who is planning to end his or her life are somewhat different than the arguments around whether a physician should prescribe a lethal medication. Ethical clinicians working with patients who wish to end their own lives are obliged not to coerce competent patients without a mental illness, for example, by holding them involuntarily. For a competent patient without mental disorder, psychiatrists must not violate confidentiality. The psychiatrist should not excessively focus on risk management if it violates the psychiatrist's fiduciary role by putting the clinician's own interests above the patient's. Clinicians who believe that ending one's own life is morally wrong in all cases are still obligated to behave according to these professional ethics. The psychiatrist must be honest with the patient about whether his or her own goals differ from those of the patient. For example, in a survey of Oregon psychiatrists, half of those who opposed PAD would work to prevent the suicide even if the patient was competent and did not have a mental disorder.[9] This position may be consistent with their beliefs, but it would be unethical for the psychiatrist to not reveal his goals to the patient. Even under circumstances in which the psychiatrists might choose to explain their position to patients and withdraw from the case, psychiatrists must always balance their views regarding moral opposition to suicide against patient abandonment regarding a difference in goals.[23]

Although some clinicians oppose ending one's own life under any circumstances on ethical and moral grounds, such positions ultimately rest on personal beliefs, shared by many medical professional groups, but not on universally held codes of conduct. The American Medical Association's current position advises that physician assisted death is fundamentally incompatible with the physician's role as healer,[24] and the American College of Physicians has recently affirmed that it does not support legalization of physician-assisted death.[25] In contrast, the American Association of Hospice and Palliative Medicine has taken a position of "studied neutrality" on whether PAD should be legally permitted or prohibited.[26]

LEGAL CONCERNS

From practical perspectives, since risks for participating might still emerge even where PAD has been legalized, clinicians should be familiar with local laws and institutional risk-management policies most likely to affect them personally. Legalization of PAD offers a safe harbor for involved physicians provided they comply with PAD laws, and psychiatrists in these states would very likely not be under pressure to intervene to prevent death by lethal medication unless the patient lost capacity or was subject to coercion at some point after receiving the prescription. The risks to psychiatrists in states lacking such laws who fail to intervene to prevent self-inflicted death when the patient has decision-making capacity are unknown. Prudent clinicians should always carefully document conversations with patients and family members, limitations in therapeutic options they may encounter, consultations (with physicians, attorneys, ethics committees, risk-management), and rationales for their decisions and actions.

COGNITIVE-EMOTIONAL BIASES DUE TO SOCIAL CONCERNS

Despite hopes that clinicians always act in the best interests of dying patients,[27] medical decisions are often influenced by clinicians' self-protective cognitive biases, including those driven by conflicts of interest that serve to minimize legal and financial risks, interpersonal conflicts, professional shame, and social disapproval.[28] Clinicians are more likely to respect rational patients' plans to end their own lives when patients have full backing of their significant others.

Decision-making becomes more complicated, however, when family members are conflicted or litigious, the clinician has previously been sued for failing to hospitalize a suicidal patient, the employer is a faith-based health care system, risk-aversive institutional risk management inconsistently supports clinicians, or micromanaging supervisors frequently find fault with subordinate clinicians' decisions. In such contexts, clinicians might more readily intervene to prevent death, motivated less by compassion toward the patient than by self-interest.

ASSESSING PATIENTS WHO ARE DETERMINED TO END THEIR OWN LIVES

Clinicians are conventionally trained to assess suicide risks via warning signs—motivations, degree and intensity of ideation, seriousness of intent, presence and lethality of plans and means, anticipated time frames for suicide, and degrees of impulsivity. Psychiatrists rarely allow highly lethal patients to leave their offices, inpatient services, or emergency rooms on their own recognizance. As a result, decisionally capable patients intent on ending their lives, particularly those who live in jurisdictions where physician-assisted death is not legal, may feel compelled to lie.[29]

Integrating suggestions from legal, medical, and mental health literatures, published guidelines for assessing patients requesting PAD offer some direction for evaluating and working with decisionally capable patients determined to end their own lives.[30–32] The clinician's first responsibility is to assess whether previously unrecognized and reversible mental illness is distorting the patient's authentic decision-making. Clinicians should appreciate the need to fully understand patients' cultural and family backgrounds, that the settings and manner in which assessments occur are likely to influence the quality of information obtained, and that collateral information can be invaluable. Clinical interviews and formal mental status examinations should address clinical depression as well as cognitive difficulties related to substance or medication use, trauma, and medical illness; and emotional disturbances affecting patients' judgment or abilities to accept the validity of information concerning diagnosis, prognosis, and risk. The mere presence of such factors, however, should not automatically disqualify a person from PAD. Some suggest administering objective assessment instruments (eg, the MacArthur Competence Assessment Tool-Treatment, which, as reported by Grisso and Appelbaum,[33] organizes 4 aspects of capacity—choice, understanding, appreciation, and reasoning), formal cognitive testing, and ratings of depression and hopelessness.[34]

Assessment of capacities should include the following:

- Ensuring that the patient has an accurate understanding of his or her medical condition and prognosis as well as the limitations and possibility of errors in prognosis.
- Exploring fears and distress, taking opportunities to educate and correct misunderstandings.
- Understanding the nature and extent of current and past psychiatric and medical conditions and treatment history, viable but as yet untried treatment alternatives (including palliative and hospice care for patients meeting criteria) and reasons for rejecting them, and other potential supports for their conditions.
- Understanding alternatives to suicide, including stopping life-sustaining treatment, and interventions such as palliative sedation.
- Understanding the adverse events associated with their contemplated methods of self-termination, including risks of survival with injury and disability, and anticipated impacts of their self-termination on survivors.
- Ensuring that, having weighed this information, patients show the ability to reason and reach a decision.
- Indicating that the decision to end one's life is consistent with his or her long-standing personal values and beliefs.
- Ensuring that the decision to end one's life is voluntary and free of undue influence of family or friends who, for various reasons, might wish the patient dead.

Even when patients are judged to have adequate capacity, the following issues should still be explored:

- Intrapsychic and interpersonal dynamics, including the patient's stated and implied reasons for desiring to die.
  - Could this actually represent a cry for help?
  - Could this be an indirect communication of rage, revenge, loneliness, disappointment, abandonment, loss of control?
  - What modifiable emotions, thoughts, or external circumstances or other factors might be addressed and alleviated?
  - Why have the patient's usual life-sustaining coping strategies failed?
  - What cultural, spiritual, or religious issues promote or detract from intentions to end one's life?
  - How does the decision align with the individual's overall values?
  - Has the patient prepared advance directives or a living will for health care, including durable health-care power of attorney for health care?
  - Are these documents consistent with the patient's intentions?
  - What experiences has the patient had regarding the death of others?
  - What fantasies does the patient harbor regarding an afterlife, discovery and disposal of the body, and funeral arrangements?
  - Regarding interpersonal dynamics, what are the patient's attachments and attachment styles?
  - To what extent has the individual discussed intentions regarding death with significant others, spiritual advisors, and attorneys to put their affairs in order?
  - If they have not had such discussions, why not?
  - How does the patient imagine the death will impact survivors (including future generations)?
  - What prolife or prodeath pressures are others exerting, and how are they affecting the patient's decision-making?
  - To what extent are these other individuals unable to face how much the patient is suffering and the inevitability of further deterioration?
- If at all possible with the patient's permission, learn what are significant others' versions of the patient's history, perceptions, perspectives, and reactions to the patient's intentions to end life.

Clinicians should formulate findings regarding potential impairments of judgment, other pertinent observations, and potential interventions for patients' and significant others' consideration. Ultimately, if patients are judged to possess decisional capacity and are without a treatable mental disorder that impacts the decision, but remain committed to ending their lives despite best efforts at dissuasion, clinicians should consider what additional care they might offer patients and their significant others.

POTENTIAL INTERVENTIONS

Imposing involuntary psychiatric hospitalization on rational patients determined to end their lives ordinarily constitutes a short-term delaying tactic that postpones rather than averts, may burden and shame patients and families already contending with difficult circumstances, and undermines the future relationship with the patient. As such, the clinician's vantage point to promote continued living may be undermined. At times, involuntary hospitalizations in these instances may serve primarily to temporarily assuage clinicians' consciences and address risk management concerns but may put clinicians' interests ahead of patients'.

Under circumstances in which a psychiatrist might be called upon to intervene as a consultant with little or no prior connection to a patient, involuntary hospitalization may be valid when the psychiatrist assesses the patient as rational, but has only recently met the patient and lacks both sufficient information on the patient's history and collateral sources.

Conceivably, additional efforts at motivational interviewing or other therapies developed to improve morale in patients with advanced illness, such as meaning-centered psychotherapy,[35] "dignity therapy,"[36] and other existentially oriented psychotherapies,[37] might actually help some patients change their perspectives. In such instances, unknown numbers of patients might opt to not end their lives. (Many patients, however, will refuse these additional interventions. For example, in the first year of legalization of medical assistance in dying in Canada, the University Health Network in Ottawa offered psychosocial support services to all patients who requested hastened death, but half of the patients declined.[38])

Such detailed assessments and interventions clearly take time, broad-based skills, and willingness on the part of psychiatrists and other mental health clinicians to engage patients in this manner. In instances when the clinician is untrained, uncomfortable, or unwilling to do this type of work, referrals and collaborations should be sought with other qualified clinicians who are capable of addressing these patients' needs, concerns, and requests.

Alternatively, clinicians can acquiesce to the patient's plans and not actively interfere, or discharge these patients from their care without taking further action. But, even when the patient is not detained, treatment plans that focus only on preventing self-initiated death are not ideal and might possibly be counterproductive.

Clinicians have many additional options to help. They can encourage patients to take time—delaying their actions for weeks to months for reflection—to ensure determination without vacillation. Such reflective periods are often mandated for patients requesting legal PAD.[39] When patients are decisionally capable, however, and are not asking clinicians to actively assist in their deaths, patients retain "moral agency."

Clinicians can also offer palliative psychiatric care.[40] When patients are too ill to continue office visits, mental health clinicians might, in collaboration with their hospice and palliative care colleagues, conduct home visits, offer

pre-terminal consultations with family members to assess their attitudes and prepare them emotionally for what is likely to transpire, facilitate reconciliations, assist patients and families to handle unfinished business and say goodbyes, perhaps negotiate the family's presence and participation in the final act, and offer survivors emotional care following the death. Under current circumstances in the United States, few mental health clinicians are likely to be physically present at time of death; understandably, such involvement will not be lightly or frequently undertaken.

PROFESSIONAL SUPPORTS

To assist clinicians, the profession can begin simply by recognizing the legitimacy of conversations concerning these issues, acknowledging that competing value systems exist concerning pertinent ethical and moral considerations, and offering educational and intellectual spaces in which these topics can be openly discussed. Current psychiatric and mental health training programs instruct trainees on suicide assessment and management, virtually always focusing on preventing suicides, but rarely examine broader issues of death and dying.

Seminars addressing suicide might be expanded to consider self-initiated death by decisionally capable individuals, discussing the guidelines mentioned above. The most productive discussions regarding management are likely to focus on specific cases encountered by trainees and faculty, with all their complexities, or on evocative vignettes. Having several faculty participate can generate potentially divergent views provided that all model respectful interactions. To more fully contextualize the social and professional implications, seminar participants might include ethics committee members, risk management representatives, palliative care staff, clergy, and patient advocates. Beyond training settings, clinicians might call upon professional society ethics committees for consultation. Conceivably, in the future, psychiatrists formally trained in palliative care might be more available to assist their peers.

DISCUSSION

Beyond the usual challenges of assessing and managing patients whose suicidality directly results from psychiatric disorders, clinicians are further tested by individuals who, in the context of advanced medical illness, are determined to end their own lives and who either have no clear psychiatric disorder or, despite having diagnosable psychiatric disorders, are nevertheless decisionally capable. Although some of these patients face terminal illnesses and are well served via palliative and hospice care, there are limits in the ability of even excellent palliative care to mitigate all patient concerns. Faced with individuals determined to die, clinicians are pushed to think outside their usual comfort zones and boundaries.

If they are determined to end their own lives, why do such patients even bother telling their psychiatrists? By disclosing these sentiments, such patients are not necessarily asking mental health clinicians to assist in their deaths, nor are they necessarily making a "cry for help"; they might simply wish to confide important decisions to someone they deeply trust, perhaps ask them to not interfere with their plans, and possibly enlist their assistance to help their families and friends better understand and go through the process with them. Indeed, if they do not disclose to their clinicians, such patients might feel deceptive and inauthentic.

Because prevailing psychiatric practices regarding suicidality are almost always highly restrictive, rational patients who are seriously considering ending their lives find themselves in the less-than-ideal position of having to not be totally truthful, honest, or open with their clinicians at the very times that they might most need their emotional support. For the clinician, these same prevailing practices can nudge clinicians to act (out of self-interest) against the patient's clear desires, even when the clinicians might be morally sympathetic to the patient's plight and intentions.

In summary, we are *not* advocating a laissez-faire attitude toward suicide, and we are not advocating that psychiatrists take active roles in administering lethal means. Our arguments apply to patients with limited life expectancy who want to control the timing and manner of their death as an option of last resort. In addition, our arguments are not intended to focus on patients who are decisionally capable, may have substantial suffering, and do not have advanced physical illness—such patients, including patients suffering from chronic intractable psychiatric conditions, are, controversially, accessing PAD in European countries that have legalized PAD.[41,42] We just see problems with knee-jerk reactions that consider all intentions to end one's life as irrational and to be stopped at all costs. Such limited professional reactions undermine our role as psychiatrists.

As described in well-publicized cases, some sections of society have demonstrably acknowledged that organized end-of-life events can provide families and friends opportunities to celebrate and take leave of the individual who is about to die,[43] striving for what has been called "a good death."[44] We believe that psychiatrists can play important roles in enhancing—and not hindering—these important life transitions. Anecdotal reports from physicians who have participated in and attended death-with-dignity activities strongly affirm how powerful and important such experiences can be for all concerned.

ADDENDUM

Immediately before this manuscript was accepted for publication, on October 31, 2017, the American Association of Suicidology published an official position statement entitled, "'Suicide' Is Not the Same as 'Physician Aid in Dying.'"[45] This statement recognizes that, "Although there may be overlap between the two categories, legal physician assisted deaths should not be considered to be cases of suicide and are therefore a matter outside the central focus of the AAS."[45(p1)]

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Editor's Note: We encourage authors to submit papers for consideration as a part of our Focus on Suicide section. Please contact Philippe Courtet, MD, PhD, at pcourtet@psychiatrist.com.