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Letter to the Editor

The "Inevitable Suicide Paradigm" and the Notion of "Lasting and Unbearable Mental Suffering which Cannot Be Alleviated" under the Belgian Euthanasia Act (2002)

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We would like to contribute to the discussion (Sadock, 2013; Voracek & Niederkrothenthaler, 2013) regarding the proposed paradigm of "inevitable suicide" in psychiatry (Sadock, 2012). According to Dr Sadock (2012), some suicides in the psychiatric practice "even under the best of circumstances (…) might not have been preventable" and patients dying such death might have a "unique biopsychosocial profile" (p. 221). This profile might include a diagnosis of a psychiatric disorder (mostly, depression, bipolar disorder, and schizophrenia), heavy genetic loading for psychopathology/suicide, severe past and current psychosocial stressors, and chronic suicidal ideation. Although the paradigm of "inevitable suicide" seems a novelty in the field of psychiatric practice and suicide prevention, Dr Sadock points out that similar concepts have been already mentioned in the literature.

Reading the article and the subsequent discussion in Suicidology Online (Sadock, 2013; Voracek & Niederkrothenthaler, 2013) we were reminded of the concept of "lasting and unbearable mental suffering which cannot be alleviated" recognized under the Belgian Euthanasia Act (Ministry of Justice, 2002). Belgium is one of three countries in the world (together with the Netherlands and Luxembourg), which allow euthanasia in cases of exclusive mental disorder in the absence of physical illness given certain conditions are met (McCormack & Fléchais, 2012). According to the Belgian law, euthanasia can be allowed if a) the patient is of legal age and is conscious at the time of the request, b) the euthanasia request is voluntary, well-considered, repeated, and is not a result of an outside pressure, and c) the patient is suffering from a medically hopeless condition involving lasting and intolerable physical or mental suffering which cannot be alleviated, and which is due to a serious and incurable condition caused by an accident or an illness (Ministry of Justice, 2002). In case of a euthanasia request from a patient suffering from a psychiatric condition, a psychiatrist can be the referring doctor or the second (or third) opinion consulting doctor, who is required to confirm the lasting and unbearable character of the patient's suffering, and the voluntary, well-considered and repeated character of the request.

According to the official Belgian government data, reported in biannual reports by the Federal Control and Evaluation Commission (http://www.health.belgium.be/euthanasie), there

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have been 3,451 cases of euthanasia between 2002 and 2009. Among these euthanasia cases there have been 52 cases of euthanasia due to "neuropsychiatric disorders" (Callebert, 2012). These included mostly patients suffering from the Alzheimers disease (n=17) and the Huntington disease (n=10), and there have been individual cases related to the Creutzfeldt-Jacob disease, encephalopathy and vascular dementia. Of interest for this discussion, the category of euthanasia due to "neuropsychiatric disorders" included also cases of depression (n=11), autism (n=3), anorexia/anxiety (n=2), psychosis with repeated suicide attempts (n=1), bipolar disorder (n=1), obsessive-compulsive disorder with a history of suicidality (n=1), and post-traumatic stress disorder (n=1). In 2008-2009 two cases of euthanasia due to an unspecified psychiatric diagnosis in relation to psychological sequeale of a physical disorder with a history of six suicide attempts and untreatable psychological pain were recorded (Callebert, 2012).

The question arises whether the biopsychosocial profiles of (at least some of) the Belgian patients who died as a result of euthanasia due to psychiatric disorders causing lasting and intolerable suffering could overlap with the suggested profile of the "inevitable suicides". No detailed information regarding the course of the psychiatric illness, family history, psychosocial stressors, or history of suicidal ideation and behavior of individuals who died by euthanasia in Belgium is available. On the other hand, there are no established "diagnostic criteria" for "inevitable suicide", and this question shall remain unanswered.

However, of interest for the current discussion is the similarity between some of the ethical considerations raised in regards to the assessment of psychiatric patients requesting euthanasia in Belgium (Vandenberghe, 2011) and the arguments in favor and against the concept of "inevitable suicide" (Sadock, 2012; 1013; Voracek & Niederkrothenthaler, 2013). For example, there is an uncertainty considering the evolution and prognosis of a psychiatric condition along with the possibility of future recovery and relief. There is a paradox between the practice of involuntary psychiatric hospitalization of suicidal patients and, in case of the Belgian law, the permission to help a patient die. Another paradox lies between the expectation that a psychiatrist can recognize and acknowledge the patient's hopelessness, and consequently, his/her right to die, and the psychiatrist's inherent belief in the (unconditional) value of life and the (ever present) hope. There is also a need to distinguish between a death wish, which is a symptom of a psychiatric illness, such as depression, and a death wish which is a well-considered and deliberate choice.

Neither "euthanasia due to lasting and unbearable mental suffering" nor the "inevitable suicide" should ever become an alternative for the best available treatment. Sadock (2012) cautions that the paradigm of "inevitable suicide" should "not be misconstrued as therapeutic nihilism. To the contrary, it should serve to stimulate efforts to treat this patient population more effectively" (p. 221). According to a Belgian psychiatrist, Vandenberghe (2011), "(…) at a societal level euthanasia cannot be more than the last option in the health care system, which first has exhausted all [other] resources" (p. 553). Both Sadock and Vandenberghe observe that the acknowledgement of the (intolerable) suffering and the death wish of a patient suffering from a psychiatric condition can lead to the deeper understanding and better communication between both parties. Paradoxically, it can even result in an improved quality of patient's life and prevent a suicide.

In conclusion, we hope that the discussion around the "inevitability" (or "preventability") of suicide will contribute to a better understanding of the suicidal wish in the context of psychiatric conditions or otherwise, and to the further development of effective psychotherapeutic interventions for this highly vulnerable group of patients.

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