vascular dementia (VaD) cases. ($p < 0.001$). Not only are psychotic symptoms more frequent, they are also more persistent over time. Hallucinating DLB cases have reductions in choline acetyltransferase in temporal and parietal cortex, to 20% or less of age matched controls, with relatively preserved indices of monoaminergic function. Promising pharmacological strategies in DLB should therefore include cholinergic enhancement and serotoninergic/dopaminergic antagonism.

Severe adverse reactions occur in 50% of DLB patients prescribed standard doses of typical neuroleptics. This has generated a "neuroleptic sensitivity" hypothesis, which is supported by a review of the clinical literature. We have postmortem evidence of a critical vulnerability to striatal D2 receptor blockade in neuroleptic sensitive DLB patients, associated with a 40–50% loss of dopaminergic neurones in the substantia nigra.

The first step in managing psychosis in DLB should be a reduction in any anti-Parkinsonian agents, the preferred order being L-deprenyl, anticholinergics, followed by direct, then indirect, dopamine agonists. If psychosis persists despite withdrawal of anti-Parkinsonians to a point where further motor impairment becomes unacceptable, an antipsychotic agent should be cautiously prescribed during inpatient admission, observing carefully for serious adverse effects. Atypical neuroleptics, particularly those with neither D2 or muscarinic receptor antagonism, should be particularly suited to the neurochemical profile of patients with DLB.

S40. Physician assisted suicide

Chairmen: P Cosyns, F Beyaert

PHYSICIAN ASSISTED SUICIDE: A ROUND TABLE DEBATE

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In this paper some arguments against physician assisted suicide in case of mental suffering will be evaluated.

A first argument contends that physician assisted suicide violates the moral integrity of medicine, psychiatry and the physician-patient relationship. Physician assisted suicide would undermine trust in the physician and undermines the goals of medicine and psychiatry. Elements of this argument are:

- the inalienability of life
- the sanctity of life
- the absolute prohibition against killing, and
- healing as the single goal of medicine

A second argument against physician assisted suicide in mental health care is that it inevitably leads to the so-called "slippery slope". By some it is even claimed that "the Dutch experience" — i.e. the legal ruling in the Chabot case — already shows that slippery slope effects in fact are taking place in the Netherlands.

The third claim that will be evaluated concerns the argument that if a person wants to die (i.e. to commit suicide) he can do it himself. Upon this claim there is no justified reason why a third person/physician ought to provide assistance.

Critical normative and empirical evaluation of these three arguments leads to the conclusion that they do not justify an absolute prohibition against physician-assisted suicide in case of mental suffering.

PHYSICIAN ASSISTED SUICIDE: A ROUND TABLE DISCUSSION

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The main responsibility of physicians is to use medical expertise to respond to the patient's need for help in order to improve his health or functional status. Psychiatrists are sometimes, as any other physician, confronted with the limits of their scientific knowledge. What can a psychiatrist do when he no longer can meet the medical needs of his patient, requesting physician assisted suicide, when medical treatment is futile and has nothing to offer to improve the quality of life? There is a difference between the medical needs of a patient, his wishes and desires.

The current societal emphasis in our culture of the principle of autonomy means a shift of the responsibility of health from the physician to the patient. This principle of autonomy is not absolute and has also limitations. Respect for patients as autonomous persons is distinct from complying with their individual choices concerning life and death.

Physicians have a specific role in society, but should assisting suicide be a part of that role? Is assisting suicide a true medical act? Exceptional cases do indeed exist in medical practice, but they must remain exceptional, so not put forward as exemplary for a larger group of more common cases. Negative changes would enter into the relationship of the physician with the public and his patients, should the practice of physician assisted suicide become common. Moreover every one of us has the factual possibility to commit suicide without physicians help. In some individual cases nonintervention may be appropriate and characterize "allowed" suicide rather than "assisted" suicide, which implies aid in implementing a decision.

We take notice of a still expanding intrusion of the legal model and thinking in the field of medicine. Is it opportune or beneficial for society to make laws or official regulations on physician assisted suicide? The question is if such laws improve the quality of care provided by psychiatrists.

PHYSICIAN ASSISTED SUICIDE: A ROUND TABLE DISCUSSION

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Suicide may be active or passive, voluntary or involuntary. Suicide and attempted suicide were decriminalised in France at the Revolution, in the U.K. in 1961 and in Ireland in 1993. Britain and Ireland regard assisted suicide as a crime. Physician assisted suicide carries the further penalty of erasure from the medical register. In euthanasia, the patient is passive and the doctor is the active agent. In assisted suicide, these roles are reversed with the doctor providing the drugs, instruments or necessary advice. In some European countries and, in most states in the U.S., the physician may give advice or drugs but cannot be present at the death. If he was, he would have a professional responsibility to resuscitate. A distinction must be made between assisted suicide and fatal terminal illness and assisted suicide in functional illness. Pre-emptive suicide, i.e. suicide in anticipation of illness, must also be distinguished.

The "slippery slope" appellation is usually used in a pejorative sense. Society is fragile however and intended restrictive practices may easily become general rules. Hard cases make bad law. Dissonants in Nero's day were asked had they considered suicide. If not, of if they hesitated, the Emperor was wont to send his physician to call.

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