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special articles

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Commentary: suicide prevention and the right to die†

A decision that this patient should be allowed to kill herself is tantamount to voluntary euthanasia, in that prevention interventions viewed as best practice would have to be actively withheld (see Ong & Carter, pp. 435–436, this issue). Thus, the paper highlights the inevitable contradiction between voluntary euthanasia, or doctor-assisted suicide, and suicide prevention. If we wish to retain the public health goal of reducing the suicide rate, can we exempt some people in certain circumstances from this? If so, how are these extenuating circumstances to be agreed on?

Psychiatric illness, especially depression, has a strong influence on the evaluation of quality of life, whether it is life currently, in the past, or in the future. Since advance directives are only valid when the issuer can properly evaluate their options, the pessimism about the future and about the likely effectiveness of treatment that may occur in depression is likely to render an advance directive invalid. The effect of such cognitive distortions and of other psychiatric symptoms on the capacity to state advance preferences, mean that advance directives for both end of life and psychiatric care must be made when the patient is free from these symptoms.

It is quite possible that this patient had capacity to make her living will. Although it is not stated in the paper, it is assumed that the patient made refusals of specified treatments that would otherwise be given to try to prolong her life. These could not have included interventions to try to prevent suicide as these are not covered by living wills in the UK. This is likely to become an issue as the use of crisis plans about which patients have been consulted become standard in mental health care (Department of Health, 2000).

A major stimulus both for the use of living wills and for the movement for doctor-assisted suicide was the feeling in Western countries that technological advances had lead to prolongation of suffering and a quality of life that most would find unacceptable. Two of Age Concern's 'principles of a good death' (1999) reflect the desire to avoid this situation:

- To be able to issue advance directives that ensure wishes are respected.
- To be able to leave when it is time to go, and not to have life prolonged pointlessly.

Both of these principles are problematic in the context of health care rationing as well as psychiatric illness. These two factors influence the decision of 'when it is time to go' by determining respectively what care and support is available and, as discussed above, how this is evaluated. If only some citizens of a country have access to particular health or social care options, this inequity may make suicide relatively more attractive to those with fewer choices. The 'suicide prescription' now is available to Medicaid recipients in Oregon, while other options available to wealthier Americans are not (Farmer & Marusic, 2000).

Culture also influences evaluation of available care. In Western society, fear of dependence and burdening others is strong, particularly among women who have spent much of their lives caring for others. This fear, expressed by the patient in this paper, has been suggested as explaining the disproportionate number of women among Dr Jack Kevorkian's victims, many of whom had disabling but not terminal illnesses (Farmer & Marusic, 2000). Disability rights groups are concerned that if physical dependence on others is accepted as justification for doctor-assisted suicide, insufficient effort will be made to detect and treat cooccurring emotional problems and depression (Farmer & Marusic, 2000). This concern has also been expressed in Hungary, where the high suicide rates among the elderly who felt that their life was not worth living are thought by some to reflect lack of intervention by health professionals.

If we agree with some people that indeed their lives are not worth living, we are sanctioning their suicide. To encourage suicide in some and prevent it in others seems more abhorrent and closer to eugenics than trying to improve the quality of life for all and to prevent any potential suicide, no matter how rational their desire might seem.

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†See pp. 435–436 and p. 438, this issue.

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