

Etica e psichiatria

Euthanasia and physician-assisted suicide for patients with depression: thought-provoking remarks

Eutanasia e aiuto al suicidio dei pazienti depressi: spunti di riflessione

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SUMMARY. Euthanasia and medical assistance in dying entail daunting ethical and moral challenges, in addition to a host of medical and clinical issues, which are further complicated in cases of patients whose decision-making skills have been negatively affected or even impaired by psychiatric disorders. The authors closely focus on clinical depression and relevant European laws that have over the years set firm standards in such a complex field. Pertaining to the mental health realm specifically, patients are required to undergo a mental competence assessment in order to request aid in dying. The way psychiatrists deal and interact with decisionally capable patients who have decided to end their own lives, on account of sufferings which they find to be unbearable, may be influenced by subjective elements such as ethical and cultural biases on the part of the doctors involved. Moreover, critics of medical aid in dying claim that acceptance of such practices might gradually lead to the acceptance or practice of involuntary euthanasia for those deemed to be nothing more than a burden to society, a concept currently unacceptable to the vast majority of observers. Ultimately, the authors conclude, the key role of clinicians should be to provide alternatives to those who feel so hopeless as to request assistance in dying, through palliative care and effective social and health care policies for the weakest among patients: lonely, depressed or ill-advised people.

KEY WORDS: assisted suicide, euthanasia, depression, mental capacity.

RIASSUNTO. L'eutanasia e l'assistenza medica nella morte comportano spaventose sfide etiche e morali, oltre a una serie di problemi medici e clinici, che sono ulteriormente complicati in casi di pazienti le cui capacità decisionali sono state influenzate negativamente o addirittura compromesse da disturbi psichiatrici. Gli autori si concentrano sulla depressione clinica e sulla legislazione europea che nel corso degli anni ha fissato standard fermi in un campo così complesso. Per quanto riguarda in particolare la salute mentale, i pazienti sono tenuti a sottoporsi a una valutazione della competenza mentale al fine di richiedere aiuto nella morte. Il modo in cui gli psichiatri affrontano e interagiscono con pazienti capaci che hanno deciso di porre fine alla propria vita, a causa delle sofferenze che ritengono insopportabili, può essere influenzato da elementi soggettivi come pregiudizi etici e culturali da parte dei medici coinvolti. Inoltre, i critici dell'aiuto al suicidio affermano che l'accettazione di tali pratiche potrebbe gradualmente portare ad ammettere la pratica dell'eutanasia involontaria per coloro che sono considerati un peso per la società, il che è un concetto attualmente inaccettabile per la stragrande maggioranza degli osservatori. In definitiva, concludono gli autori, il ruolo chiave dei clinici dovrebbe essere quello di fornire alternative a coloro che si sentono così senza speranza da chiedere assistenza nella morte, attraverso cure palliative e politiche socio-sanitarie efficaci per i più deboli tra i pazienti: soli, depressi o malconsigliati.

PAROLE CHIAVE: suicidio assistito, eutanasia, depressione, capacità di autodeterminazione.

INTRODUCTION

Contemporary bioethics is characterized by a bioethical dichotomy between catholic and secular bioethics precepts. According to Sgreccia, the rift between catholic and secular bioethics has been for the most part artificially developed. It is a contrast, in some centers and scholars, meant to juxtapose an “open” and “respectful” view of everyone’s choices – such as the secular ones – with a catholic approach, labeled “narrow” and “intolerant” in pluralistic and diverse societies such as ours.

The conflict between “catholic bioethics” and “secular bioethics” is therefore misleading and disingenuous¹. Catholic bioethics is grounded in principles such as dignity, sanctity of human life from conception to the fateful time of natural death. The core principle is centered around God, who wants and designs the birth of every human being; by virtue of that dynamic, human life has immense, incalculable value, which remains intact even in cases of individuals who have come to consider their lives unworthy of being lived. Hence, human life, by virtue of its “undisposable” essence, may never be suppressed, whether

that be in its beginning, through abortion, or in its final stages through euthanasia or medically-assisted death.

Conversely, secular doctrine draws a distinction between “biological life” and “human life”. The latter presents peculiar traits that set it apart from mere survival “as in vegetative states) or from situations of unremitting and unbearable suffering. Life in and of itself is not what matters the most, since the “quality of life” indicator outweighs it and determines its actual worth. If the quality of life element subsides to intolerably low levels, then life may conceivably be ended. That philosophical approach in turn makes it so that human life may indeed be “disposed of” by each individual. Given that the “disposability” of human life has to be assessed based on quality of life standards, it is each individual’s right to choose how to live and how to die, which translates into the right to decide whether to accept or refuse life-saving treatments based on thorough information. The sacredness of human life according to catholic doctrine does not mean, however, that such an approach disregards or discounts the importance of life quality. It only means that unlike the secular approach to bioethics, catholic doctrine views the sanctity of human life as the foremost and decisive standard, which outweighs any quality of life consideration. As a consequence of that, it cannot be countenanced to provide aid in dying to patients who deem their lives no longer worth living. According to catholic bioethical principles, in fact, it is essential to make an assessment of life in and of itself by evaluating its “transcendent” value. Only after such assessments have been formulated can the quality of life be addressed and possibly improved both socially and therapeutically, through pain management procedures, for instance.

As far as the secular bioethics’ realm is concerned, a distinction needs to be drawn between a utilitarian-collectivist conception and the utilitarian-individualistic one. The former only deems morally acceptable any choice aimed at pursuing the collective good, even if it should come at the expense of the individual’s interests. The latter philosophical approach, on the other hand, puts a premium on individual self-determination, including the right to end one’s own life². Both criteria inform moral judgement taking into account, first and foremost, life quality. Still, in the utilitarian-collectivist view, life may be deemed “unworthy” when it starts compromising the collective interest, i.e. when it makes it impossible for any individual to actively contribute to the common good. Hence, someone may possibly have become a “burden” to society, being unable to make any contribution, but still view his or her life as worthy of being lived. Conversely, according to the utilitarian-individualistic school of thought, life is no longer worth living when it loses its fundamental functions, such as conscience, feelings, retention of memories, sensitiveness, sexuality, the ability to relate to others and make decisions, which according to the patient are key-elements when judging whether life is worthy or unworthy of being lived any further.

EUTHANASIA AND ASSISTED SUICIDE WITHIN THE ITALIAN AND EUROPEAN LEGAL CONTEXT: THE CRITICAL ELEMENT ARISING FROM CLINICALLY DEPRESSED PATIENTS

As the concept based on self-determination has gained a foothold, physician-assisted suicide has come to outweigh eu-

thanasia. While the two practices may appear fairly similar to each other, there are fundamental differences: physician-assisted suicide in fact puts the individual front and center, a lot more than euthanasia does: the patient’s decision to die and the self-determination element are in fact not enough (both elements also occur in cases of “consensual euthanasia”, when the request is not made by others on behalf of incapacitated patients), since patients are required to self-administer the lethal drugs that are medically prescribed at the end of the process.

In terms of comparative law, European countries have opted for disparate sets of norms in order to regulate such a controversial and utterly sensitive issue. Italian statutes do not allow any medical procedure to be aimed at causing any patient’s death. Euthanasia is therefore a criminal offence in Italy, punishable as “consensual homicide” (under article 579 of criminal statutes) or first-degree murder (article 575), which charges may be partially mitigated in cases of proven reasons of “high moral value”, such as piety and compassion for the patient’s unbearable suffering. Assisted suicide is also banned by Italian criminal codes, being punishable with a 5 to twelve years prison sentence, provided that the suicide has been achieved. Article 580 of Italian criminal codes makes no distinction between suicide requests made on the basis of psychiatric illnesses or somatic diseases, whether terminal or not. The Italian Constitutional Court, in its ruling issued on 25th September 2019 at the end of the Marco Cappato trial, which saw the defendant charged with providing assistance in dying to an incurable patient, Fabiano Antoniani³, has declared Cappato not guilty under article 580 provisions; according to the Court’s rationale, in fact, those who provide assistance in dying are not punishable under specific conditions: if the suicidal intention is autonomously and freely developed by mentally capable patients who have been kept alive artificially and suffering from an incurable disease causing physical or psychological suffering that the patients themselves consider unbearable⁴.

Several other European nations have already enacted fairly permissive laws on the subject.

In June 2014, Quebec’s National Assembly passed Bill 52, An Act respecting end-of-life care, which came into force on 10 December 2015⁵. Canada has also legalized euthanasia⁶.

Among US states, Oregon has been the first one to decriminalize assisted suicide through the 1994 Death with Dignity Act⁷. Later on, Washington state has passed the Washington Death with Dignity Act⁸, Vermont passed its own legislation in 2013, the Patient Choice and Control at the End of Life Act⁹. In California the End of Life Option Act¹⁰ has been in force since 9th June 2016; Colorado passed the Colorado End of Life Option Act following approval of Proposition 106 by popular vote on 8th November 2016¹¹.

South American countries themselves, traditionally opposed to such practices, are apparently beginning to reconsider their positions. Colombia’s Constitutional Court issued a ruling in 1997¹², in addition to the 2015 Ministry of Health Resolution 1216 regulating access to euthanasia¹³.

In Europe, among the countries where euthanasia has been legalized there are Holland, via the 2002 Termination of Life on Request and Assisted Suicide (Review Procedures) Act, Belgium, with its *Loi relative à l’euthanasie* from the same year and Luxembourg, by the 2008 *Loi sur l’euthanasie et l’assistance au suicide*; all 3 countries have set conditions that need to be met in order for euthanasia practices to be

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legally sound¹⁴. Holland and Belgium are however the only countries in the world to have legalized euthanasia for minors, with Belgium setting no age limit whatsoever. Patients may legally apply on mental disease grounds as well. Nonetheless, in cases of non-terminally ill patients, a psychiatric evaluation is required or a specialist in the patient's specific illness category. An assessment from a general practitioner is not enough, given the risk that he or she may misjudge the patient's mental capabilities; moreover, in cases of family doctors, a sort of personal involvement with the patients might occur, due to long familiarity, that could prejudice the doctor's ability to objectively formulate an evaluation. According to the Royal Dutch Medical Association, psychiatric counseling is essential¹⁵ for the purpose of establishing whether the patient is actually making an autonomous, well-informed request, whether he or she is really experiencing intractable and unbearable pain and whether they have changed their minds¹⁶. A 1998 set of guidelines released by the Dutch Association for Psychiatry¹⁷ clearly assert the need for counseling from an additional psychiatrist as well, meant to confirm or debunk the assessment from the first professional. Psychiatric counseling constitutes a crucial stage, still it is not conclusive: the final decision has to be made by the regional review committees.

In Switzerland, assisted suicide constitutes a crime only if it is provided in order to pursue a personal interest (as stated in article 115 of the criminal code)¹⁸. Guidelines outlined and released by the Swiss Medical Academy of Sciences (SAMS) make it legal to prescribe the deadly drug pentobarbital only to terminally ill patients¹⁹. Psychiatric euthanasia is therefore illegal in the country. The Swiss Federal Court, however, in an apparent departure from such guidelines, has issued ruling 2A.48, which states that the right to apply for physician-assisted suicide be extended to non-terminally ill patients, provided that they find themselves in a situation of unbearable suffering, not necessarily physical, but psychological as well²⁰. Apparently, that has brought back to the forefront end-of-life issues and assistance in dying for psychiatric patients, particularly those with severe depression. Due to a lack of clarity in end-of-life regulations, the European Court of Human Rights has ruled against Switzerland for the Gros case, for the alleged violation of Article 8. As a matter of fact, by virtue of the Swiss Court decision 2A.48, associations such as Exit and Dignitas have started offering logistic support (within the medical setting) and lethal drugs to patients seeking assistance in dying, not limited to Swiss nationals but for foreigners as well.

The requirements that must be met in order to qualify for euthanasia or assisted suicide procedures are quite uniform overall in every national set of legislation: patients are required to be mentally competent and over the age of 18, must state and reiterate their free will to have their own lives ended. All national statutes mandate that prior to the assisted suicide process begins, doctors should verify the patient's competence, the intolerable and irreversible degree of his or her suffering and lastly, ask for a second opinion from at least another physician. A substantial difference among national statutes has to do with the patient's clinical conditions. In Switzerland, in fact, only terminally ill patients are deemed eligible for physician-assisted suicide, whereas in Holland and Belgium, the presence of intractable pain is enough. Nevertheless, such legal standards are not easy to objectively determine in cases of psychiatric euthanasia requests. It may prove hard, for instance, to verify whether a request for assisted suicide is "voluntary and well-considered": psychiatric condition could have in fact compromised the patient's decision-making capabilities. Furthermore, patients in a state of objective vulnerability may have been pressured or coerced, possibly by family members, into making such a choice. Not even the criteria that entail "no prospect of improvement" and "no reasonable alternative in the patient's situation" are easily verifiable^{21,22}. Undoubtedly, the evolution of psychiatric disorders is elusive and unpredictable, as is the possibility for remission, or even spontaneous recovery, in the long term²³. In light of the broad range of therapeutic option currently available to treat mental disorders, conclusively establishing that there are "reasonable alternatives" may well be a complicated, highly-subjective process, depending upon what the psychiatrist in charge of the decision considers a reasonable and effective therapeutic option. In addition, several psychiatrists have argued that persons suffering from severe mental illnesses are mentally incompetent by definition, thus incapable of making end-of-life decisions, although such a view is not universally acknowledged, given the absolute need to assess individual patients on a case-by-case basis²⁴. Taking into account such medical and ethical challenges, some psychiatrists may deem mental patient's ineligible to access physician-assisted suicide. In 2012, the End-of-Life Clinic²⁵ was founded in the Netherlands for the purpose of providing assistance in dying services to patients who are declared legally eligible but are denied the assistance because of a negative assessment of mental competence by a psychiatrist²⁶.

Some analysts have pointed to the abuse potential that could arise from a broad legalization of euthanasia or assist-

Statutory due care criteria Netherlands

Physicians who carry out an euthanasia or assisted suicide request must:

- a. be satisfied that the patient's request is voluntary and well-considered;
- b. be satisfied that the patient's suffering is unbearable, with no prospect of improvement;
- c. have informed the patient about his situation and prognosis;
- d. have come to the conclusion, together with the patient, that there is no reasonable alternative in the patient's situation;
- e. have consulted at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled.

ed suicide, even to the point of allowing euthanasia for patients whose life is not deemed worth living (e.g. newborn babies with severe disabilities, mentally impaired individuals). A 2017 Belgian study²⁷ centered around euthanasia requests has detected 179 cases in which the sole motives for euthanasia were psychiatric disorders or dementia diagnosis. Out of that pool, 83 cases were mood disorders, 6 dementia patients, 22 psychiatric patients and 12 mood disorders coupled with other psychiatric disorders. It has been found that .5% of euthanasia cases in the 2002-2007 time span occurred with a diagnosis of psychiatric disorders or dementia; from 2008 to 2013, that rate had grown to 3%. The net increase is particularly conspicuous in patients with a diagnosis of mood disorders. Female patients made up for most cases (58.1% with dementia and 77.1% with mood disorders). As far as psychiatric patients are concerned, statistical data reflect that 61 assisted suicides were carried out in 2014, with a modest growth to 63 in 2015, which confirms the “slippery slope” scenario²⁸ (Table 1).

The above-cited statistical data seem to point to a “slippery slope” scenario in the making, which might well lead to a transition from assisted suicide/euthanasia based on patient autonomy and self-determination to situations where such measures may be applied according to utilitarian-collectivist standards and logic. As a matter of fact, back in 1991, Boudewijn Chabot, the Dutch psychiatrist viewed as the “father of euthanasia”, had denounced an alarming loosening of the legal standards, which would bring about uncontrollable consequences²⁹. As recently as two years ago, in September 2017, Ludo Vanopdenbosch, neurologist member of the Belgian federal oversight commission on euthanasia, resigned citing the commission’s failure to report to the authorities a case of a dementia patient who had been killed against his

will, and on his family’s request, without any advanced directive signed by him concerning euthanasia³⁰. Such a case certainly speaks volumes, in that it proves how legal oversight and control mechanisms can be circumvented, and that mental, depressed patients with dubious or limited decision-making capabilities could be euthanized against their will³¹.

Data on the Dutch scenario released by the Regional Euthanasia Review Committees in 2013³² show that the highest percentage of patients for whom euthanasia is requested is made up by cancer patients (3588 cases, or 72.6% of the 4829 cases recorded), followed by patients with neurological conditions (6%), multiple geriatric syndromes (5.2%), severe cardiovascular diseases (4.6%), respiratory diseases (3.6%), dementia (2%) and mental illnesses (.9%). As it can be noticed from parsing those numbers, patients with dementia or mental conditions that have received assistance in dying or euthanasia are relatively few compared to the overall number of patients, which has risen over the years.

In 2013, a research study undertaken by SAMS and centered on Swiss physicians and titled “Physicians’ attitudes to assisted suicide”³³, has highlighted how most doctors tend to turn down requests for assisted suicide or euthanasia from patients whose suffering stem from mental illnesses (Table 2).

The area where most physicians have been found to be in favor of assisted suicide is for terminal ill patients, roughly 80%; the rate is substantially lower in cases of mentally ill patients: 41% of doctors have declared their opposition to providing assistance in dying to dementia patients (with only 10% in favor), 37% opposed to it for patients with severe mental illnesses (as opposed to a mere 10% in favor). Although most assisted suicide or euthanasia procedures are carried out on cancer patients, in 1994 the Dutch Supreme Court ruled (in the Chabot case) that “the degree

Table 1. Reported cases of euthanasia with a diagnosis of psychiatric disorder or dementia, 2002-2013.

	2002-2007	2008	2009	2010	2011	2012	2013
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Psychiatric disorder or dementia No. (% of all reported cases)	10 (0.5)	9 (1.3)	16 (1.9)	19 (2.0)	29 (2.6)	42 (2.9)	54 (3.0)
Mood disorder No. (% of all psychiatric and dementia cases)	4 (40.0)	4 (44.4)	3 (18.8)	7 (36.8)	13 (44.8)	22 (52.4)	30 (55.6)
Mood disorder accompanied by another psychiatric disorder ^a No. (% of all psychiatric and dementia cases)	1 (10.0)	0 (0.0)	0 (0.0)	1 (5.3)	1 (3.4)	4 (9.5)	5 (9.3)
Other psychiatric disorder ^b No. (% of all psychiatric and dementia cases)	0 (0.0)	0 (0.0)	6 (37.5)	3 (15.8)	2 (6.9)	6 (14.3)	5 (9.1)
Dementia No. (% of all psychiatric and dementia cases)	5 (50.0)	5 (55.6)	7 (43.8)	8 (42.1)	13 (44.8)	10 (23.8)	14 (25.9)

^a Mood disorder accompanied by unspecified personality disorder (5), borderline personality disorder (4), autism (1), anorexia nervosa (1), psychotic personality (1)

^b Other psychiatric disorders were autism (6), borderline (3), posttraumatic stress disorder (2), anorexia nervosa (3), dissociative disorder (1), immature personality disorder (1), psychosis (1), anxiety disorder (1), compulsive disorder (1), paranoid schizophrenia (1), unspecified personality disorder (1), unspecified psychiatric disorder (1).

Modificato da: Dierick et al.²⁷

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Table 2. Doctor availability.

Diagnosis	In favor	Mostly in favor
Terminal illness	58%	20%
Neurological or muscular diseases	29%	32%
Progressive chronic pain	23%	36%
Multiple age-related illnesses	21%	27%
Dementia	10%	
Mental illnesses	10%	
Being tired of life	8%	

of severity of the patient’s suffering does not depend upon the cause of such suffering”, thus rejecting the differentiation between physical pain and psychological or mental pain. Lastly, only 8% of Swiss doctors would be in favor of assisted suicide for very old, but otherwise healthy patients³¹. That scenario has been termed *being tired of life*, a state of mind that involves mostly elderly patients; although it has not yet been listed as an illness, such a mindset is caused by the awareness of having to go on living with a lower level of life quality than one had grown accustomed to³⁴. The Dutch Supreme Court, while adjudicating on the Brongersma case³⁵, has set forth a somewhat restrictive interpretation of the concept of “unbearable suffering”. The Court has in fact ruled that in order to be recognized as such, physical or mental suffering must be caused by a medically-acknowledged disease. Hence, the condition of “feeling tired of living” is not enough to back up a voluntary euthanasia or assisted suicide request^{36,37}.

Later research studies have proven that medical professionals generally deem euthanasia or assisted suicide much less acceptable for psychiatric or demented patients than they do for individuals with extremely severe and debilitating somatic illnesses such as cancer³⁸. Data from a 2015 study³⁹ have shown that the vast majority of doctors surveyed were in favor of providing assistance in dying to patients with cancer (85%) or another severe somatic illness (82%), but even those afflicted with mental disease (34%) or merely “tired of living” (27%). The study’s authors have set up interviews with doctors and found that many of them would be willing to provide assistance in dying only if the request did not conflict with their deeply-held ethical principles; each patient’s basic living conditions would have to be taken into account as well, according to those surveyed. What seems to surface in no uncertain terms is that the request for assistance in dying from same patient could be assessed differently by two or more doctors, since each one of them would act and judge according to science, conscience and a personal set of ethical and moral values, in addition to possibly different evaluations of the patient’s decision-making capabilities and competence, if such faculties have not been objectively compromised by the mental illness⁴⁰.

DEPRESSION: THE INNATE DEATH WISH WITHIN A PSYCHOPATHOLOGICAL FRAMEWORK

A high number of patients who request assistance in dying are afflicted with depression, or present depression-related symptoms. A 2011 study has found that roughly 25-50% of patients seeking assistance in dying had shown signs of depression, while 2-10% of those who received such assistance were clinically depressed⁴¹.

The clinical traits of depression, in the definition associated with the diagnostic criteria of major depressive disorder, both single episodes or recurring ones, and within the context and development of bipolar disorder, are polymorphic and present extremely diverse symptomatology, which need to be traced back to each patient’s personal history and life conditions. That background is substantially complicated in case of additional severe somatic diseases, which may worsen, both physically and mentally, the general picture. After all, the wide-ranging clinical classification of adjustment disorders, either in presence of depressed mood or mixed emotional features, comprises a rather broad presentation, with manifestations typically related to depression and with significant potential for comorbidities or transition from one form into another⁴².

Depression as a psychopathology is characterized by feelings of intense sadness, which may gradually transition into melancholy and the very loss of feelings, the inability to gain an interest or feel pleasure in daily life experiences, to see a future and project oneself into it; in addition, overwhelming desperation may set in, along with a sense of being doomed, of powerlessness and often incurability of somatic diseases, among other noxious manifestations. The degree of emotional and affective suffering in depressed patients is extremely high, and often times, it cannot even be expressed by the ordinary words used to describe other forms of suffering. Under such conditions, patients are bound to be overwhelmed by a sense of loss of interest in any activity and even in life itself, which could ultimately lead to desiring death and suicidal ideation.

In similar circumstances, the request from the depressed patient for assistance in dying is very much akin to an autonomous suicide attempt, which many severely depressed patients do make or consider on their own.

Furthermore, a critical element should not be overlooked: any consideration of requests for assistance in dying from depressed patients needs to take into account that depression typically presents a phasic development, which is spontaneously liable to remit or even recover, despite risks of relapse. Depression is well-known as a treatable condition, even in its most acute and critical manifestations. The notion of “persistent depressive disorder” does not appear to be clearly definable, being often assessed with reference to each patient’s peculiarities and the degree of response to a given treatment, the proper implementation of such a treatment and the patient’s psychosocial background. The already mentioned feelings of powerlessness, hopelessness and perceived lack of any future prospect constitute an integral part of the depressed patient’s daily living, but those are clinically viewed as elements that speak in favor of undertaking therapeutic interventions, not of their discontinuation. A sense of hope, which is typically not found or pathologically lacking in depressed patients, has an innate therapeutic value, and

when doctors agree to provide assistance in dying they implicitly validate their patient's loss of hope, thus contributing to depriving him or her of an important potential chance to retrieve a measure of vital momentum⁴³.

Such dynamics are even more relevant in cases where depressive syndromes have set in as a result of severe somatic, disabling illnesses, causing intolerable pain, as in cases of cancer and several neurological conditions.

On the other hand, depression coupled with a major somatic disease often misleads doctors into underestimating it as an autonomous disease; that in turn may lead to a failure to properly assess and treat depression, while also evaluating an assistance in dying request⁴⁴.

DOES DEPRESSION COMPROMISE DECISION-MAKING SKILLS?

Whenever doctors are called upon to assess requests for voluntary euthanasia from patients afflicted with depression, they find themselves facing clinical and ethical issues. Firstly, it is difficult to objectively prove the existence of unbearable sufferings and the lack of recovery prospects in depressed patients. Nor is it easy to demonstrate the free and fully aware nature of the patient's request: a comprehensive view of the disease is in fact required for patients to ask for assistance in dying, in addition to solid decision-making skills with respect to all therapeutic options available. Such abilities may be impaired or compromised in clinically depressed patients: depression is potentially capable of warping and altering the individual's judgement capacity. Moreover, the irreversible nature of depressive disorders is a highly debatable notion, in light of the high diversity and variability of such conditions, which greatly influence the prognosis⁴⁵, both in relation to single episodes and to generalized disease progression. Realistically, it is possible that the wish to end one's own life may in fact arise from experiencing the disease's symptomatology⁴⁵.

The onset and progression of the depressive condition does not necessarily entail the loss of self-determination, although such pathologies are often likely to affect the patient's decision-making capacity^{46,47}. Several studies on average mental capacity of psychiatric patients have shown that it can generally be deemed somewhat reliable^{48,49}. Therefore, as for end-of-life decisions, the mere presence of a mental disease does not automatically rule out the possibility to freely and autonomously seek assistance in dying. Clinical psychology can rely on two main tools for the purpose of determining a patient's ability to exercise self-determination: counseling and observation. During clinical counseling sessions, doctors implement psychodiagnostics testing and projective techniques in order to establish whether patients seeking euthanasia or assistance in dying are really aware of the consequences of their choices and determined to pursue them all the way. Mental capacity assessment methodologies are based on interpretative standards that are at least in part subjective. Psychodiagnostics testing methods are in fact mere questionnaires, such as the well-known Minnesota Multiphasic Personality Inventory (MMPI), through which specialists collect data on the individual personality profile and on the current mental state, which are then interpreted

in a subjective or standardized fashion in order to determine the current presence of self-determination capacity. Intellectual capabilities are obviously a key contributing factor as well in the determination of mental capacity, which are often measured by the Wechsler Adult Intelligence Scale (WAIS). Projective techniques are tools by which patients are asked to provide an interpretation of neutral or ambiguous stimuli; based on such depictions, the doctors will then proceed to draw up each patient's psychological profile, their needs and internal conflicts. From a more specific perspective, the set of guidelines titled "Treatment and Care of Elderly Person Dependent on Care", devised and released by SAMS, offer instructions on how to verify patient self-determination skills. Specifically, doctors need to make sure that patients are able to understand all relevant information related to the decisions that have to be made, to correctly evaluate the overall situation as well as the consequences of choosing possible alternatives and to make and express an autonomous decision. It is the duty of health care operators to accurately verify each patient's capacity in any given situation. Tools such as the Mini-Mental State Examination (MMSE), which can determine the degree of possible cognitive prejudice, and the MacArthur Competence Assessment Tool for Treatment have proven to be effective in that regard. The latter is among the most widely used tools for the verification of competence in patients seeking physician-assisted suicide. The test scores make account of results from other tests as well, which integrate the overall score, in addition to measurements relative to the four elements of capacity⁵⁰. Applebaum has recommended a method for verifying the soundness of any request for assistance in dying. Such a method breaks down into four criteria: 1) the ability to express a choice, 2) the capacity to understand all relevant information, 3) being able to critically judge situations and the consequences of one's choices, 4) the ability to formulate critical remarks about any alternative treatment proposed by doctors⁴⁹. Applebaum also advises physicians to ultimately make a decision after striking a balance between the patient's right to self-determination and the medical obligation to protect patients from the negative consequences stemming from a decision, ending one's own life, that may not be an authentic expression of their will⁴⁹.

ON WHAT GROUNDS DO DOCTORS INTERPRET THE CLINICAL DATA LINKED TO THE REQUEST FOR ASSISTANCE IN DYING?

Since physical pain is often the primary cause for assisted suicide and euthanasia requests, it is common practice for doctors to evaluate their patient's level of pain according to two fundamental criteria: consistency and comparison. By applying the consistency standard, doctors make sure that any description from patients as to their living conditions really matches their lifestyle. The comparison method, doctors liken their patient's situation to other individuals' who are in similar health conditions. Doctors then find out whether such patients lament a similar degree of unbearable suffering⁵¹. Such criteria may be used to evaluate capacity. Ultimately, doctors declare their patients competent if the latter's conducts are perceived as consistent and "suitable" within a giv-

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en context, which is identified by a comparison with other patient's behaviors. Both the consistency and the comparison yardstick, however, entail a personal assessment from medical specialists. As a consequence of that, should doctors ultimately view the patient's behavior as "inconsistent and irrational", the request for assistance in dying or voluntary euthanasia will be turned down for failing to meet the requisite standards. It is however necessary to avoid a return to the medical paternalistic approach, by which psychiatric patients are mentally incompetent by definition.

The 1964 Declaration of Helsinki and the 1997 Oviedo Convention have enshrined the inalienability of the individual right to self-determination in health care, which must be guaranteed via informed consent. Informed consent necessarily entails a proactive cooperation and interaction between doctors and patients, which need to be guaranteed at all times throughout the therapeutic process for somatic and mental diseases alike. Such a communication-based therapeutic alliance is also grounded in mutual trust and respect. As for assisted suicide or euthanasia requests, doctors are required to assess on a case-by-case basis whether the patient's depressive disorder has compromised his or her capacity at that juncture; hence, doctors must verify whether the patient's wish to receive assistance in dying is a genuine expression of free will, rather than a symptom of the mental disease itself. The European Court of Human Rights, in its ruling on the case *Haas vs Switzerland*, has reasserted the essential nature of a thorough psychiatric assessment prior to the prescription of the deadly chemicals used for assisted suicide; by such evaluations, the competence of psychiatric patients seeking assistance in dying has to be verified⁵². Probably the best-suited solution in order to ensure that the patient's right to self-determination is upheld, while avoiding any "slippery slope" scenario, would be to rely on a case-by-case medical assessment, rather than denying psychiatric patients access to assisted suicide altogether.

UNDERLYING FACTORS FOR PATIENTS TO SEEK ASSISTANCE IN DYING

Roughly 80% of doctors practicing in Switzerland would be willing to provide assistance in dying to cancer patients if they so requested, as highlighted in Table 1³¹. The SAMS research study has also found that approximately a quarter of all cancer patients who seek to receive assistance in dying show the symptoms of depressive disorders⁵³. Since depression can provably impair mental capacity, it can at least theoretically nullify a request for assistance in dying. With that premise, however, a question comes to mind: why do most doctors believe that depressive disorders in cancer patients do not compromise their decision-making capacity? Why do the medical community believe that depression alone can adversely affect a patient's capacity, leading to a denial of their requests for assisted suicide?

In order to answer those questions, it is necessary to make two premises. Firstly, severe pain is a typical symptom in those afflicted with cancer: between 30% and 50% of patients in fact experience pain, which rise to up to 90% in the advanced stages of the disease⁵⁴. Secondly, there is a close relation between physical pain and mental anguish. A study re-

leased by the Harvard Medical School has shown that chronic pain is frequently ascribable to mental disorders. Patients in chronic pain are three times more likely to suffer from depressive disorders than healthy individuals. By the same token, depressed individuals are three times more likely to be afflicted by chronic pain than average⁵⁵. Such a close correlation has been substantiated by the fact that approximately 90% of those who suffer from chronic pain also have mental disorders, particularly depression, anxiety disorders and substance addiction, with 60% experiencing personality disorders. Hence, assistance in dying requests from terminally ill patients could be seemingly motivated by some sort of depressive disorder. Based on that association, depression could therefore be viewed as a contributing factor for those cancer patients who decide to seek physician-assisted suicide, as a consequence of chronic somatic pain and as a pain-provoking condition in itself. A survey conducted in Holland on 60 cancer patients seems to bear out that theory⁵⁶. According to the study, 27% of cancer patients had sought assistance in dying; 94% of those had characterized their sufferings as unbearable. Yet, 87% of patients who had not sought physician-assisted suicide, although they too had described their pain as intolerable. Besides, those who had requested assisted suicide shared the same kind of symptoms with those patients who had not, among which (76), loss of meaning (88), loss of dignity (36), experience to be a burden to others (41), fear of future suffering (18), anxiety (6), depressive thoughts (6)⁵⁴. The findings from the Dutch study may lead one to conclude that the urge to seek assistance in dying could be motivated by extreme sadness, rather than the magnitude of the patient's suffering. Still, it is necessary to avoid any confusion between sadness and clinical depression. Only the latter can in fact impair one's decision-making skills and be extremely hard to reverse. Sadness is a physiological condition that leads to mood deterioration under difficult circumstances. Terminal illness, or any other illness for that matter, either physical or mental, may cause sadness. Depression, on the other hand, is a pathological condition that can negatively impact one's mental capacity. The above-mentioned Dutch study has shown that in many cases, the patients who apply for assisted suicide cannot put up with the loss of autonomy and dignity, along with the inability to enjoy life as they did and engage in daily activities.

Such symptoms and sentiments are not to be underestimated, since they have a potential to engender in patients' feelings of sadness, even to the point of triggering depressive disorders.

A risk factor that could potentially induce patients to seek assistance in dying is the inadequacy of palliative care options, which entail a higher risk of patient suicide and premature death, whereas suitable treatment options for depression and pain management could possibly mitigate the urge to end one's own life. The International Association for Hospice and Palliative Care appears to confirm that theory, stating that no country should consider legalizing euthanasia and physician-assisted suicide until patients are guaranteed universal access to palliative care with proper medication.

It could be inferred from such data that physical suffering is not at all the only cause for some patients to seek euthanasia or assistance in dying. As a matter of fact, the reasons behind such decisions are far more complex and multifactorial. In addition to illness-related pain, asking for eu-

thanasia or assistance in dying may be motivated by psychological, existential and social factors^{57,58}. Many such requests are based on the fear of one's inability to enjoy life any longer, or the fear of death, social/familial isolation, or the fear of becoming a burden for, and/or dependent on, family members. Hence, assisted suicide requests ought to be viewed as cries for help, arising from the desperate need to find something else worth living for⁵⁹. Viktor Frankl's famous words come to mind in that regard: after surviving internment in a concentration camp, he wrote: «Any attempt to restore a man's inner strength [...] has first to succeed in showing him some future goal. Nietzsche's words, "He who has a why to live, can bear with almost any how," [...] Whenever there was an opportunity for it, one had to give them a why-an aim-for their lives, in order to strengthen them to bear the terrible how of their existence"»⁶⁰. Doctors should therefore help their patients find "a why", a goal in order to strengthen them to bear with the immense burden of their suffering, rather than seeking access to euthanasia or assisted suicide.

CLOSING REMARKS ON EUTHANASIA AND ASSISTED SUICIDE REQUESTS AND DEPRESSION

European norms in favor of assisted suicide herein reported only allow access to such measures for terminally-ill patients. Instead, the cited Italian Constitutional Court ruling, issued on 25th September 2019, has made access legal for mentally competent patients being kept alive by life-sustaining procedures. Such legal standards, however, do not allow depressed patients (i.e. non-terminally ill and not on life support) to gain access to physician-assisted suicide.

Moreover, scientific literature has shown that there are numerous doubts and misgivings surrounding euthanasia and assisted suicide where such practices are legal. Apparently, there is a growing awareness that euthanasia and assisted suicide could come to constitute a shortcut, which frees states of the responsibility to put in place effective social and health care policies for the weakest among patients: lonely, depressed or ill-advised people. Health care professionals ought to take action in order to ensure that the symptoms that afflict clinically depressed patients are properly managed, rather than fulfill their desire to die. It is vital to take extreme caution before granting a request for assisted suicide from a depressed individual, even to the point of automatically denying it in presence of a medically verified depressive disorder of significant severity, according to some clinically and ethically well-founded opinions on the subject. After all, recent studies have proven that the oversight mechanisms in Holland, Belgium and Luxembourg can be circumvented with relative ease: in some instances, lethal drugs have even been administered to patients against their will, or with no terminal illness whatsoever. It bears repeating that the vast majority of psychiatric disorders that can ignite suicidal ideation are not permanent and can be successfully reversed by psychopharmacological therapeutic interventions, psychotherapy or other options. Furthermore, in such scenarios, suicidal ideation often does directly indicate the actual will to commit it.

Consequently, even in terminally-ill patients who meet the legal requirements to access assisted suicide, if they are

clinically depressed greater attention should be paid before granting their requests. In general terms, doctors have a duty to research and thoroughly assess the family, social, professional and emotional circumstances in order to figure out what induced the patient to seek assisted suicide, so that help can be provided and better prospects can be found in order to perhaps make the patient's daily life more tolerable. Any attempt should be made, and all avenues explored in order to treat depression by any means, considering that various forms of depressive disorders seem to be incurable, but there are still under-researched or unexplored therapeutic options⁶¹. It is worth stressing that one of psychiatry's main goals is to prevent suicides of mentally ill patients, given that suicide in such instances is generally irrational.

Often, patient requests for assisted suicide are granted on psychological and social grounds; nonetheless, it has been proven that implementing treatments aimed at symptom management and providing suitable psychological counseling and support could persuade patients to withdraw their requests. Many such patients have in fact no intention to actually die but are indeed determined to end their sufferings. Adequate depression treatment opportunities and pain management can likely dispel suicidal purposes.

The World Health Assembly⁶² has stressed the need to improve patient assistance throughout the different stages of their depressive conditions, by means of timely palliative care, which may help to restore a sense of autonomy and purpose in such patients, thus improving their quality of life. It is therefore of utmost importance to make palliative care options widely available. Admittedly, not all requests for assisted suicide will be prevented by enhancing palliative care options⁶³. In presence of intractable and unremitting symptoms, patients can resort to deep sedation⁶⁴. Palliative sedation is substantially different from euthanasia, in that it does not aim to end the patients' lives, but rather to abate their sufferings. Psychiatry has a crucial role in treating clinically depressed patients who request assistance in dying: it is responsible for establishing whether their requests are based on solid and fully aware volition.

Conflict of interests: the authors have no conflict of interests to declare.

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