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The Shanti De Corte case: euthanasia for mental disorder between clinic and bioethics, between law and medico-legal implications

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Summary. Introduction. In recent months, a great uproar has been aroused by the case of a 23-year-old Belgian woman who requested and obtained euthanasia because she was suffering from a mental disorder, in the absence of any somatic pathology. The news raises some questions and stimulates some reflections both on the general theme of euthanasia carried out for the simple presence of a mental disorder, and for the indefiniteness of the clinical information on the case in question, as well as on the ethical and medico-legal questions connected to such indefiniteness. **Case presentation.** The information on the case was derived essentially from the press and from websites, with no specific access to actual clinical documentation and without in-depth knowledge of case details. One wonders what the real clinical diagnosis of the patient was, only hypothetically identifiable in a Post-traumatic Stress Disorder associated with Major or Chronic Depressive Disorder, probably on the basis of a possible Personality Disorder. One wonders if all the necessary therapeutic interventions had been implemented, in a clinical case that did not theoretically have the characteristics of incurability. One wonders why the death request was considered valid, in a subject perhaps suffering from a mental disorder of such severity as to alter the ability to express valid consent to medical treatment. One wonders why the death request was not considered as an indicator of the severity of the disease, rather than simply being considered as a free choice of a subject capable of self-determination. One wonders why the negative opinion of the patient's family members was not considered. **Conclusions.** Belgian legislation provides for euthanasia for patients suffering from mental disorders who, like those suffering from somatic disorders, experience a condition of constant, unbearable and incurable suffering. But the case in question raises numerous perplexities both on the clinical and ethical coherence of Belgian legislation and on the ways in which the rules of this legislation have been observed in this specific situation.

Key words. Clinical indefiniteness, ethics, euthanasia, medico-legal implications, mental disorder, psychoanalysis, young people.

Il caso Shanti De Corte: l'eutanasia per i disturbi mentali tra clinica e bioetica, tra legge e implicazioni medico-legali.

Riassunto. Introduzione. Negli ultimi mesi un grande clamore è stato suscitato dal caso di una donna belga di 23 anni che ha richiesto e ottenuto l'eutanasia in quanto affetta da un disturbo mentale, in assenza di alcuna patologia somatica. La notizia pone alcuni interrogativi e stimola alcune riflessioni sia sul tema generale dell'eutanasia effettuata per la sola presenza di un disturbo mentale, sia per l'indefinitezza delle informazioni cliniche sul caso in questione, come anche sui quesiti etici e medico-legali connessi a tale indefinitezza. **Presentazione del caso.** Le informazioni sul caso sono derivate essenzialmente dalla stampa e da siti web, senza specifico accesso alla reale documentazione clinica e senza conoscenza approfondita dei dettagli. Ci si chiede quale fosse la reale diagnosi clinica della paziente, solo ipoteticamente individuabile in un disturbo da stress post-traumatico associato a disturbo depressivo maggiore o cronico, verosimilmente sulla base di un possibile disturbo di personalità. Ci si chiede se tutti i necessari interventi terapeutici fossero stati messi in atto, in un caso clinico che non presentava in teoria le caratteristiche dell'incurabilità. Ci si chiede perché la richiesta di morte sia stata considerata valida, in un soggetto forse affetto da un disturbo mentale di gravità tale da alterare la capacità di esprimere un valido consenso a un trattamento medico. Ci si chiede perché la richiesta di morte non sia stata considerata come indicatore di gravità di malattia, piuttosto che essere considerata semplicemente come una libera scelta di un soggetto capace di autodeterminarsi. Ci si chiede perché non sia stato considerato il parere negativo dei familiari della paziente. **Conclusioni.** La legislazione belga prevede l'eutanasia per pazienti affetti da disturbi mentali che, come quelli affetti da disturbi somatici, sperimentino una condizione di sofferenza costante, insopportabile e incurabile. Ma il caso in questione suscita numerose perplessità sia sulla coerenza clinica ed etica della legislazione belga sia sulle modalità con cui le norme di tale legislazione sono state osservate in questa specifica situazione.

Parole chiave. Disturbo mentale, etica, eutanasia, giovani, implicazioni medico-legali, indefinitezza clinica, psicoanalisi.

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Introduction

The legalization of assisted death, which includes so-called euthanasia, in which it is the doctor who administers a lethal dose of the drug to a patient, and physician-assisted suicide (PAS), in which the patient himself takes the dose lethal drug, is on the rise worldwide and, in countries where it is not yet, the majority of the population is in favor of rapid legislation on the issue[1] To date, 7 countries have adopted a law on euthanasia (Netherlands, Belgium, Luxemburg, Colombia, Canada, Victoria and Western Australia). PAS is legally practiced in Switzerland and in ten USA countries, and over 200 million people around the world are living in countries allowing some form of assisted dying[2]. In 2017, more than 13,000 patients died from both methods of assisted death and rates have increased in all countries where the practice is legalized[3].

The debate on this issue is heated, imposing reflections on the social, medical and legislative transformations of the contemporary world. The legislation on the subject of assisted death, in its two main variants, emphasizes the autonomous and "rational" decision-making process without considering at all the ambivalence towards living and dying which is tragically hypertrophied in the decision to end one's life and which has very little to do with a defensive vision of "rational suicide" and which instead is fought primarily at an unconscious level not only in the person subject to the decision but also in the "therapeutic" relationship with the doctor who actively or passively accompanies and assists assisted suicide[4].

The difficulty in finding a suitable terminology to clarify the critical issues we are talking about is also demonstrated. An emblematic example of this is the fact that in German-speaking countries these terms are respectively "killing on request" (Tötung auf Verlangen) and "assisted suicide" (assistierter Suizid), because the term "euthanasia" is associated with the Nazi killing of about 200,000 people with mental disorders and disabilities[4]. In this regard, it is worth noting that the so-called assisted dying in some countries, including Belgium, is also authorized for mental disorders[5].

The case

At the beginning of October, the news concerning the case of euthanasia practiced in Belgium, actually a few months earlier, to a 23-year-old woman, Shanti De Corte, from Antwerp, who had request it on the basis of a mental disorder, according to her resulting from the traumatic experience of having survived the terrorist attack that took place in 2016 at the Brussels airport, in which many of her friends had died, spread widely in the press. The information that could be deduced from the press articles was, as frequently happens, very sparse, limited to the few news data available: the pre-existence of indefinite psychic disorders, the worsening of mental suffering reported as a consequence of the experience of the attack, the history in the subsequent years of profound, even if indefinite, mental suffering, even with two, not well defined, repeated suicide attempts, some psychiatric hospitalizations and psychopharmacological treatments, also these not well defined, the repeated request to obtain euthanasia, the favorable opinion of the commission appointed to it, the contrary opinion of family members, the carrying out of euthanasia, her story told on television after death.

In no article there was a clear reference to an explicit psychiatric diagnosis, while the condition of "constant, unbearable and incurable psychological suffering" was naturally underlined, which is a requirement for the acceptance of the request for euthanasia under Belgian law. The numerous comments, in reality limited in their depth by the scarcity of available data, underlined, on the basis of considerations of principle, even different from each other, the uniqueness of the case and the perplexities, despite the different ethical, ideological or religious views of the commentators , in front of the young age of the protagonist and the real fulfillment of the criteria for acceptance of the request for euthanasia in relation to the only presence of a mental disorder, moreover not known in its real official diagnosis, in the absence of any other complained or documented somatic pathology.

Despite the wide media coverage of the news and the numerous comments from journalists and opinion leaders, we have witnessed an apparently paradoxical situation. Faced with the extreme case of euthanasia practiced on a young woman for exclusively psychiatric reasons, the voice of psychiatrists was practically absent, at least in this first phase of information on the event.

This is not a new phenomenon due to the new self-definition of the role of the psychiatrist in the face of problems with bioethical implications[6,7], but on the contrary it appears absolutely necessary to make some synthetic considerations, both of a clinical, ethical and medical-legal nature, and ask some essential questions about a case that presents a profile of absolute singularity.

Considerations and questions

The Belgian law on euthanasia is based on the assumption that the human body is something different from the person and, therefore, the acts of

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disposition of the body are subject to the principle of self-determination of the individual.

The starting point for the considerations that will follow is that Belgian legislation allows euthanasia even for people with mental disorders.

In fact, the text of the law specifies some specific conditions in order for euthanasia to be legal (Article 3) (the original pronouncement is that of the law of 28 May 2002, with the introduction, on 22 March 2014, of the possibility of euthanasia also for minors) These conditions are different depending on whether the patient is conscious or unconscious.

In the case of conscious patients, a fundamental prerequisite is represented by the voluntary request of the subject, a request that must be reiterated and considered and must not be the consequence of any external pressures.

The condition underlying the request must include the existence of unbearable physical or mental suffering. The latter does not necessarily have to be accompanied by physical suffering. In other words, the subject must present a hopeless medical situation and must report constant or unbearable (physical or mental) suffering that cannot be relieved and that results from an accidental condition or from a serious or incurable disease. The law, however, does not provide for a list of the "qualifying" conditions for accessing this "path". But the criteria for the existence of an "acute or chronic incurable disease" and its "irreversibility" emerge clearly in the text of the law.

It is in fact important to underline that no clinical diagnosis is specified for the "constant, unbearable and incurable psychological suffering" provided for in the criteria for accepting the request for euthanasia. It can be, as probable in the case in question based on the information available, a Major Depression, or a Chronic Depressive Disorder, likely comorbid with a Post-Traumatic Stress Disorder (incidentally, two morbid conditions that every psychiatrist knows about curability based on the adequacy and timing of the treatments), as well as any other mental disorder that is recognized as having the potential to induce such characteristics of suffering. It is evident that this criterion is also correctly applicable to many Personality Disorders, often a source of intense subjective and relational suffering of the interested parties, even in the absence of real association with a specific mental disorder, basic conditions that notoriously lengthen the times of clinical response to therapies. In support of this, it has been shown that requests for assisted suicide are closely linked to mental health. Up to 60% of people who requested assisted death were diagnosed with depression[8,9].

But in the case in question it must be underlined how the diagnostic indefiniteness, which separates the individual suffering from the morbid condition in which it occurs, constitutes ground for a possible level of arbitrariness of judgment of those appointed to verify the existence of criteria for the acceptance of the request for euthanasia, which are evaluated exclusively in relation to the subjective experience reported by the patient, without the necessary support provided by the diagnostic context in which the suffering is generated. Of course, the procedure for accepting the request for euthanasia involves the obvious clinical checks. In the case in question there is indefinite news about admissions to psychiatric structures, but actually there is no information from the press reports about this clinical and diagnostic context. And this absence imposes essential questions for both a clinical and ethical and medico-legal evaluation of the case.

Has a precise psychiatric diagnosis been made? What mental disorder was the patient suffering from? From a single disorder or from multiple comorbid disorders? As already mentioned, the very little information available leaves the hypothesis of a prevailing serious Depressive Disorder, Major or Chronic, associated with a Post-Traumatic Stress Disorder (again as already mentioned, both treatable and with highly probable outcome in remission/healing).

Was there an underlying Personality Disorder, a condition that makes vulnerable to the development of specific mental disorders and that represents a primary factor that affects the intensity and chronicity of suffering and that requires longer treatment times to obtain a therapeutic response from the latter?

What pharmacological treatments did the patient carry out? With the right indication, at effective dosages, with the necessary associations, for the necessary time? Did she follow a psychotherapeutic path? In the face of any insufficient therapeutic response, has she carried out physical treatments, such as rTMS or, at least, electroconvulsive therapy which, as worldwide recognized, has the highest antidepressant potential in patients resistant to other treatments?

In the articles it is recalled, as claimed by the patient in support of her request, that she was taking "11 antidepressants" per day, which reduced her to the state of "a ghost".

But, beyond the obvious consideration that they were very likely not really 11 antidepressant drugs but an association of drugs of different classes, including antidepressants, how many psychiatrists do not have the almost daily experience of patients who, due to psychopathological complexity or because of resistance to treatments, require a very large number, often even much higher, of drugs to obtain a real therapeutic response? And can the number of drugs taken be considered an objective judgment criterion, regardless of their nature, their

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dosage, timing of administration, etc.? Or could, on the contrary, a too high number of incongruously prescribed drugs have constituted a malpractice, a sign of the difficulty of the treating psychiatrists in formulating an effective diagnostic and therapeutic project and a source of further suffering for the patient?

Without going into the details of treatments performed of which there is no news, it is evident to any clinical psychiatrist that drugs that induce in a person the feeling of being "a ghost" are not antidepressant drugs and that this experience could be much more likely attributed to other classes of pharmacological agents, perhaps in the case in question inappropriately or incorrectly associated, if not substituted, with antidepressant therapies.

Nor we can forget how the depressive condition itself can lead to the experience of detachment or death of one's body or that PTSD can involve experiences of a dissociative nature ("being a ghost"), falsely attributable, in the patient's experience, to the consequences of treatments taken.

The criteria that justified the decision to euthanasia include that of the "duration" of the suffering. But how many clinical psychiatrists can reasonably assign the prognostic judgment of an incurability or an indefinite extension over time to a clinical condition that, although probably complex, was essentially located in the area of Mood Disorders ("... I laughted and cried until the last day...")? Or would they not predict, even in the case of apparent resistance, a positive outcome in an adequate temporal projection? Or would they not identify in the possible coexistence of a Personality Disorder, for example of Cluster B, as more likely in the case in question, a factor of psychopathological and therapeutic complexity, but not of definite negative prognosis, compared to the hypothesis of a positive clinical evolution? In addition, the request for assisted dying is not stable: about half of the terminally ill who take PAS seriously have changed their minds over time with better symptom control and psychological support[10,11].

There are evidently many clinically founded questions that cast a light of uncertainty on the therapeutic management of the case and on the consequences of this uncertainty on the request for euthanasia itself, as well as above all on the real deepening of the clinical characteristics of the case by those who have evaluated the existence of conditions for responding positively to the death request.

Between clinical aspects and ethical and medico-legal implications

Furthermore, starting again from a strictly clinical level, it is possible to ask a fundamental psychopathological question.

From the scarce information provided by the press, it emerges that the request for euthanasia itself has recognized its origin not only in the prolonged emotional and affective suffering in progress, but also and perhaps above all in the feeling of the inescapability of its continuation over time, of the "incurability", of the extinction of one's vital experience ("a ghost") attributed, in an at least partially misleading way, to the ineffective treatments carried out. In other words, in a deeply depressive experience, indicative of the severity of the clinical picture, in the context of which the death request takes on a specifically symptomatic value, in any case analogous to the death wish that drives the suicidal behavior of depressed patients[12].

Why this clinically founded perspective has not been adopted, or at least evaluated, which would have absolutely recommended the intensification of treatments, together with the search for a more positive therapeutic alliance with the patient, rather than the acceptance of her symptomatic request for death?

In almost all depressed patients in which suicidal ideation prevails, this is based on a distortion of both the feeling and the judgment of reality, which leads to the situation that an existential condition, on the contrary potentially limited in time, is felt as definitive and incurable. So that the capability to objectively judge the factors at the origin of the situation, as well as the nature of the situation itself, is similarly distorted.

It is clear that this distortion of the emotional experience and the judgment of reality can greatly influence the person's ability to express valid consent to a medical act, be it a therapeutic treatment or the request to receive euthanasia[13].

This is a bioethical problematic area of wide repercussions, which goes alongside the serious and controversial ethical issues inherent in the very theme of euthanasia, extended to all possible types of death requests, from euthanasia to assisted suicide, to murder of the consenting person and to every possible type of situation relating to the end of life[14,15], but even more dramatic in the case of a request made in a context of recognized mental disorder, primarily the severely depressive one.

Could not having adequately assessed both the psychopathological significance of the request for euthanasia and the possible reduced or excluded ability of the interested party to provide conscious consent to this same request have led to a decision that a more careful and competent evaluation would have advised to not adopt? Particularly in light of the fact that the law does not systematically identify the criteria for access to this determination?

Have these reflections, of a clinical but also bioethical nature, been adequately considered? Has sufficient consideration been given to the medico-

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legal implications linked to the risk of their superficial evaluation, which would seem to have accepted a death request in a meaning of conscious adequacy, while it could instead represent a symptomatic element indicating the clinical severity of the disease, with consequent necessity for further treatment?

Even if the Belgian law considers the opinion of family members to be irrelevant, the value of environmental information on the seriousness of the clinical case itself has been given to this, openly opposed to the euthanasia of their relative, such as to invalidate, or at least to raise doubts about the validity of the death request?

The request for assisted suicide therefore involves deep complex and multifactorial reasons[9,11]. The "psychological, existential and social reasons"[11] intersect with the unconscious conflict between death wish and end-of-life thought excitement, much more present in people with mental disorder. But there is another aspect of fundamental importance. The request for euthanasia or PAS ignites a powerful relational emotional field. Transference and countertransference have been found to influence decision making in 25% of assisted suicide requests[16].

These are clinical and bioethical considerations and questions now posthumous with respect to the case in question, but of central relevance in a more in-depth reflection in view of other situations of similar drama that will certainly be likely to recur in the future.

Conclusions

Shanti De Corte died, because her request for euthanasia was deemed valid and therefore accepted. But psychiatrists should ask themselves, and disseminate the result of their reflection, if it really was the simple, coherent and legal response, within the framework allowed by the extremely permissive Belgian law, to the request of a person with "constant, unbearable psychological suffering and incurable".

Because if only one of the above considerations or only one of the questions proposed above were not adequately answered, we could find ourselves in front of a completely different scenario, both on a clinical and medical-legal and, above all, ethical level from what appears in the official version of the case.

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

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