Research paper on old age and assisted suicide laws

Life, Death

Personality and developmental theorists have always been embroiled in controversies of one type or another. By the very nature it is controversial theorizing. The study of people and how they interact and how they respond may seem alarming to many. Freud developed his theories of psychodynamics that, while not wholly discredited, have fallen out of academic favor (Oxford Handbook of Psychiatry, 2005, p. 774). Freud was and remains controversial for both his use of drugs and postulations on the role sexuality plays in developing the psyche. Erikson, a student of Freud's, seemingly tried to sanitize the sexual aspects of Freudian theory and generated an eight-stage developmental process based on Freud's original five (Erikson, Erikson, 1998).

The final stage of development according to Erikson is psychosocial stage 8: old age. The fundamental conflict at this stage in life is one of integrity versus despair. The stage is generally thought of as beginning at the age of 65. It is the final stage and comes immediately middle adulthood. While this is usually the 8th stage of development, it is possible that this becomes an earlier stage if there is some sort of catastrophic terminal illness. This stage of life is inherently reflective – a person looks back on his life and decides if he is fulfilled and content (Erikson, Erikson, 1998, p. 62). In a certain way, this stage is recovery from the stresses of adulthood and child rearing. If one is able to look back on life and believe that they have completed their goals and made meaningful contributions then we are said by Erikson to have a feeling of integrity. On the other hand, if one looks back at their life and is unhappy with their accomplishments, feels that they were unproductive, and that our goals remain unaccomplished, this is a stage of deep despair.

Integrity or despair will effect the experience of death, both for the individual who is dying and for their loved ones. If one is said to have integrity than there will be acceptance of fate and reality, and death will path smoothly. If one is said to have despair, there will be regrets and bitterness and death will be a very difficult process for everyone involved (Erikson, Erikson, 1998, p. 64).

Assisted suicide is a hotly debated subject in modern law and medicine. For the purposes of this paper we will limit our discussion to active assistance, as opposed to passive euthanasia, where the physician simply withholds a potentially life preserving treatment. The legality of active euthanasia varies by jurisdiction with most nations prohibiting the procedure for a variety of reasons. In some nations, assisted suicide is strictly prohibited. In others, such as The Netherlands and Switzerland the laws are famous for their liberality in allowing the terminally ill to seek someone who will assist them in ending their lives. And still in others, there is a grey zone, allowing for suicide, but prohibiting physician assistance to accomplish this goal, such as in Canada. In the United States only four states allow assisted suicide: Vermont, Montana, Oregon, and Washington. The procedures in the American states vary, for instance, in Oregon a physician may prescribe medication that will effectively terminate an individual’s life, but it must be self-administered. Furthermore, there must be a written request followed by two oral requests, and a confirmation in writing by the physician that the request occurred. In Montana on the other hand, there is no legislation proscribing the process assisted suicide may take, but in the court case of Baxter v. Montana (2009), it was ruled that there was no explicit right to

physician-assisted suicide but there was also nothing that expressly forbid the practice.

Elderly males have a relatively high suicide rate as compared to other groups. Indeed many demographic predictors of suicide methods exist. For instance, elderly white males most commonly perform a successful suicide attempt by firearms. A Hanging and suffocation death is most commonly found in younger males, minorities, and the never married. Defenestration suicides are most commonly performed by African-American, elderly, never married females. Suicide by sharp instrument is the preferred method of elderly foreign-born individuals. Finally suicides using various poisons were more likely to be female, however, different poisons have slightly different demographics with gas being common in the elderly male population (Lui et al, 2013). In contrast to these violent methods of suicide that provide considerable distress to the surviving family members, physician-assisted suicide provides the potential for a much smoother and less dramatic exit from life. Indeed, withholding of care in order to hasten death is a common practice amongst medical practitioners with only 6% of physicians reporting that they had never done so (Kraus et al, 1977)

Erikson’s stage 8 of development is relevant insofar as the integrity vs. despair internal debate that an individual has may affect their views on suicide and their willingness to seek assistance in accomplishing this gruesome goal. Indeed, in one study it was found that a full twenty percent of those seeking assisted suicide in Oregon had clinical depression (Ganzini, Goy, Dobscha, 2008). While patients that are suffering from depression may feel that the world is too much to bare and that death offers a convenient

solution to their woes, depression is a treatable illness and attempts must be made to treat depression before allowing a rash decision to end a life to be made.

In a large meta-analysis performed by Rietjens, Deschepper, Pasman, and Deliens, the methods of end of life decisions were studied between various patient populations (2012). After identifying 6377 papers, 51 were ultimately included in their analysis which found that active euthanasia was the less commonly used as a method of ending life in the elderly, women, and less educated patient as opposed to younger, males, and well-educated patients who were more likely to seek active termination of life. Indeed, non-treatment was the preferred method of ending the lives of patients older than eighty. Palliative sedation resulting in death was less likely to be performed on the very old. However, the withholding of medical care should not be seen strictly through the lens of euthanasia because at extreme old age the morbidities and the potential quality of life are significant factors that lead both physicians and family members to conclude that there is not significant purpose in extending the life and life-prolonging treatment is not viewed as beneficial. The elderly seem to be more interested in care that improves quality of life rather than the quantity of life, and once this is no longer a viable option they prefer that care be withheld (Biola et al, 2010). Furthermore, the meta analysis concluded that access to palliative care plays a substantial role in end-of-life decision making. In nations and centers with well-developed palliative care there is a lower demand for physician assisted suicide (Rietjens et al, 2012). Women are less likely to explicitly request palliative sedation and are more likely to be allowed to die through

non-treatment. There are various theories for the reasons women are less likely to seek active euthanasia. Firstly, women may feel a special role as a care-giver, even in old age and this may create a psychological block when it comes to terminating ones life. Another theory is that men are more socially isolated and have less social support and this leads to increased use of active euthanasia and the more frequent suicide attempts as noted above (Rietjens et al, 2012). Finally, the Reitjens et al study found that the poor are less likely to seek active euthanasia than the rich. The authors allude to several reasons, such as, financial resources dictating the place of death, and that the wealthier have better social support than their poor brethren. Furthermore, lower socio-economic status corresponds to less patient involvement in treatment decisions (2012).

Another issue that may come up in patients in the 8th stage of development is dementia. Normally, a desire to commit suicide is viewed as a pathological symptom of depression. Most telling of this is the fact that most people who attempt suicide are actually quite happy to find themselves alive after their attempt (Gather, Vollmann, 2013). It is actually a very small subset of the population that can be said to have made a reasoned decision to end their life and there is some controversy as to how the physician should go about treating such a patient: to prevent the suicide attempt, to accept it, or even to assist. However, in patients with dementia there is an inherent problem with mental capacity and patient autonomy. To date the literature is sparse regarding patients with dementia and assisted suicide, which is odd, considering the increase in the elderly population throughout the world. It is safe to assume though that the future literature will discuss this ethical

problem more completely (Gather, Vollmann, 2013). Gather and Vollmann conducted a review of physician-assisted suicide and provided several international perspectives. In Switzerland, the Netherlands, and Oregon, where physician assisted suicide is legal under certain conditions there must be a request to aid in suicide by a terminally ill patient with an incurable somatic disease. In the Swiss context, in 2009 there were some 300 cases of assisted suicide of which 44% had cancer, 19% had a neurodegenerative disorder, and 9% had cardiovascular disease. In Oregon and the Netherlands the vast majority of patients requesting aid in terminating their lives were cancer patients (> 80%). Of the Swiss cases it was found in a subsequent study that 9 of those cases had primary mental disorders. There are no reports in Oregon of patients with primary mental disorders receiving assisted suicide, however, in the Netherlands there are reports of physicians assisting in the suicide of patients with primary dementia - the patients in the Netherlands tended to be young and with atypical course of dementia (Gather, Vollmann, 2013). Dementia presents a special concern because there are currently no effective treatments to reverse or halt the progression of the disease and there is a definite cognitive deficit that develops as a result of the course of the disease. Most problematically, palliative care for the disease is poorly developed, leaving patients and families to suffer as they watch the steady decline of an individual who once may have been quite formidable. Furthermore the nature of self-determination and autonomy is severely threatened by the dementia disorders making the idea of an autonomous informed decision for suicide an ephemeral notion. There are many factors that perhaps limit the decision-making capacity of the

demented patient including disease course and the various treatment protocols. A further consequence of the dementia disorders is often a secondary mood disorder – under these conditions it may be impossible to determine whether or not there is a true desire to end ones life or it is simply the throes of severe neurological disease (Gather, Vollmann, 2013).

Aside from the underlying condition that may affect the decision making process, there is substantial concern in the literature about the notion of a rational choice to terminate ones life. Hector Wittwer mapped out the philosophical background to our current understanding of the value of life and the possible rational basis for a desire to commit suicide. Ancient philosophers did not view life as intrinsically sacred and while condemning suicide, acknowledged that there was a point when death was the preferred option. In the modern era though, philosophically, self-preservation is viewed as fundamental to practical reason. From these philosophers, modern medicine, psychiatry, and psychology all formed their conception of suicdiality as a pathological state, beyond the bounds of a rational person. This conception of rationality and opposition to suicide has been upended in recent decades and there are three basic reasons for this: technological progress, the growth of the crisis hotline, and increasingly paternalistic interventions that make suicide more difficult. Ultimately, this leads to a growth in the desire for a physician-assisted suicide (Wittwer, 2013).

Ultimately Wittwer’s article concludes that the idea of suicide as being irrational rests on false premises and that there van be very good reasons to commit suicide.

Returning to Erikson’s 8th stage of development, it is desirable to

understand what type of person would seek aid in suicide. Would it be the person who has integrity and has seen the proper fruits of his life ripen and is happy with the course his life has taken, and now just wants to die silently and within their total control? Or, would it be the person who goes through the 8th developmental stage in a state of despair due to an unfulfilled and incomplete life? Laws should be put in place that would prohibit the latter from ordering their own death because it is very likely that in the course of their regrets and unhappiness with life that they are suffering from a mental disorder such as depression which can respond to treatment. However, in the case of the former, if one feels that they lived a good life and are happy with the fruits of their life's labor and are simply seeking to avert a painful death brought about by a terminal disease, perhaps assisted suicide should be a legal and viable option. There will always be controversies that arise as a result of differing diseases and the limits of mental capacity, but the approach taken in the various states in the United States that permit physician assisted suicide seems to handle the controversy well.

Works Cited:

Biola, H., Sloane, P. D., Williams, C. S., Daaleman, T. P., & Zimmerman, S. (2010).

Preferences versus practice: life-sustaining treatments in last months of life in

long-term care. Journal of American Medical Directors Association, 11(1), 42-51

Erikson, E., Erikson, J. (1998). The Life Cycle Completed. New York: W. W. Norton &

Company.

Ganzini, L., Goy, E. R., Dobscha, S. K. (2008). Prevalence of depression and anxiety in

patients requesting physicians' aid in dying: cross sectional survey. BMJ 337: a1682. doi: 10. 1136/bmj. a1682.

Gather, J., Vollmann, J. (2013). Physician-assisted suicide of patient with dementia. A

medical ethical analysis with a special focus on patient autonomy. International Journal of Law and Psychiatry. http://dx. doi. org/10. 1016/j. ijlp. 2013. 06. 016

Kraus, A. S., et al. (1977). Potential Interest Of the Elderly In Active Euthanasia.

Canadian Family Physician, 23(357). 123-127.

Liu, R. T., Kraines, M. A., Puzia, M. E., Massing-Schaffer, M. Kleiman, E. M. (2013).

Sociodemographic predictors of suicide means in a population-based surveillance system: Findings from the National Violent Death Reporting System. J Affect Discord. doi: 10. 1016/j. jad. 2013. 06. 023

Rietjens, J. A. C., Deschepper, R., Pasman, R., Deliens, L. (2012). Medical end-of-life

decisions: Does its use differ in vulnerable patient groups? A systematic review and meta-analysis. Social Science & Medicine, 74. 1282-1287. doi: 10. 1016/j. socscimed. 2011. 12. 046

Semple, D., Smyth, R., Burns, J., Darjee, R., McIntosh, A. (2005). Oxford Handbook of

Psychiatry. New York: Oxford University Press.

Wittwer, H. (2013). The problem of the possible rationality of suicide and the ethics of

physician-assisted suicide. International Journal of Law and Psychiatry.

http://dx. doi. org/10. 1016/j. ijlp. 2013. 06. 009