Depression, physician-assisted suicide and the Dutch *Chabot* case[1]

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In 1991, the 50-year-old Dutchwoman Mrs. Bosscher (known in the legal case[2] as Mrs. B) visited psychiatrist Dr. Boudewijn Chabot and asked him to provide the means and assistance for her to commit suicide. At that time, there was a long-standing legal convention that in the event of physician-assisted suicide (PAS) or active euthanasia (for a physically incapacitated but competent patient), the doctor would be able to defend himself against a formal charge of murder or assisting suicide by the defence of 'necessity' (in Dutch: noodtoestand). Such a defence still required a stringent set of substantive and procedural conditions to be met: the patient had to be suffering from a serious and identifiable somatic disease that was untreatable though not necessarily terminal; the suffering had to be 'unbearable' and 'hopeless'; the patient had to be competent enough to understand the situation and the consequences of what she was requesting, and the request had to be 'persistent'.

Mrs. Bosscher presented with a physiologically healthy body, but with deep depression. The depression was nothing new; she had been seeing psychiatrists for 20 years, but it had come to a head because of recent events. She had been married to an abusive alcoholic from the ages of 22 to 47, after which she finally left him; the elder of her two sons committed suicide when she was 45; and the younger had just died from cancer three months prior to her visit to Dr. Chabot – she was now 50. The same evening of the second son's death, Mrs. Bosscher attempted suicide by overdosing on pills that she had been hoarding for just that purpose; the attempt failed, and she recovered two days later in hospital. During the three months after that, she was openly making detailed plans for further attempts, in consultation with others, including her sister, some of her friends, and her family doctor. In Dr. Chabot's opinion, Mrs. Bosscher was 'experiencing intense, long-term psychic suffering that, for her, was unbearable and without prospect of improvement' (as cited in Griffiths 1995 p. 235).

Chabot consulted seven other professionals about the matter (five doctors, a clinical psychologist and a professor of medical ethics), and took detailed notes. He repeatedly advised her to try pharmacological and psychotherapeutic treatment, but she consistently and confidently refused: all she wanted was to die. In the end he provided Mrs. Bosscher with a lethal dose of barbiturates, which she drank in the presence of him and one of her friends. He then immediately contacted the public coroner, and submitted his detailed case and discussion notes. Dr. Chabot was duly charged under Article 294 of the Dutch Penal Code, and his attempted defence of necessity was ultimately rejected by the Supreme Court three years later, in 1994. The main reason for the rejection, however, was that Dr. Chabot had failed to invite another qualified medical practitioner to examine Mrs. Bosscher for themselves; importantly, the Court did not object in principle to the possibility of 'psychic suffering' henceforward being a sufficient reason to grant effective immunity to prosecution. In recognition of this fine line, the Court imposed no punishment on Dr. Chabot.

This case of 'psychiatric euthanasia' caused a certain amount of controversy, both in the Netherlands and abroad, for it seemed to be a giant leap on the oft-predicted slippery slope. In practice, during the 17 years since Chabot, there have never been more than three or four

[1] My thanks to Guy Widdershoven, David Levy, Christopher Hamilton, and Cliona McGovern for comments on earlier drafts.

[2] All the legal details of the case have been masterfully summarised (in English) and discussed in Griffiths 1995.

cases of psychiatric euthanasia per year,[3] out of an annual Dutch total of, for example, 1933 reported cases of PAS and euthanasia in the year 2005 (Buiting et al. 2009). Despite its rarity, the controversy continues to flare up now and then.[4]

The case is unsettling, and in this paper I would like to explore possible reasons for its unsettling nature. This is not a paper about euthanasia *per se*; and for the sake of argument and contrast I will accept that (i) somatic suffering can be objectively measured, and (ii) that it can be reliably deemed sufficiently unbearable and hopeless so as to morally and legally justify physician-assisted suicide or active euthanasia. I want to argue, however, that mental suffering and somatic suffering are two radically distinct experiences, and that both Chabot and the Dutch Supreme Court were wrong in failing to distinguish them sufficiently: Dr. Chabot should not have helped Mrs. Bosscher to die. In reaching this conclusion, however, I want to stress two things. First, I am acutely aware of my ignorance of the particularities of the Dutch legal and healthcare systems, and indeed of the semantic nuances of the Dutch language, so my arguments should be taken as more general. Second, this is not an article about the moral permissibility or impermissibility of euthanasia in non-institutional contexts. I am primarily interested in the doctor's dilemma, while remaining agnostic on the question of whether it would be morally or rationally justifiable for Mrs. Bosscher to commit suicide on her own, or with the help of a close friend. [5]

[A] Somatic suffering vs. the mental suffering of depression

More needs to be said about the distinction between somatic suffering associated with a broken leg, the flu and cancer, and the mental suffering associated with depression: after all, isn't all suffering ultimately mental? The difference has to do with the link to events in the world. The link is clearest in the case of physical trauma: the fracture is caused by the tree's impact on the skier's leg. Although the suffering is ultimately mental if we assume with the scientist and philosopher some sort of identity between mind and brain, phenomenologically it is the leg that hurts. And it is this first-personal phenomenology that interests me here, more than a third-personal scientific account. Central to the first-personal experience is precisely the distinction between self and world, that is, between me on the one hand, and the tree, the impact, the broken leg and the pain on the other. (This is not to assume an implausible dualism, with the self as essentially separate from the body; it is merely to make a point that the suffering of a broken leg is localised.)

A more complicated case of somatic suffering is that brought about by an invisible pathogen (such as an airborne flu virus) or by abnormal cellular growth and subsequent organ failure (cancer). In both cases the patient first notices the suffering and the superficial symptoms, and uses the subsequent scientific picture to help make sense of the suffering; even if the patient is not a scientist, enough of the process can be understood metaphorically by imagining, say, aggressors overcoming defences. Throughout, however, the distinction between self and world remains intact: I still have my plans and projects, but their progress has become restricted, cramped, hindered by my dysfunctional body in the world. The cause of the pain remains clear enough: a foreign object, a malfunctioning component, a disease entity. I can still use the language of possession: I have a broken leg, the flu, cancer, and it is

[3] Number supplied in personal correspondence with Ron Berghmans.

[4] The Chabot case is similar to the 1998 case of Brongersma, where PAS was granted to an elderly patient who claimed to be 'tired of life'. See Huxtable and Moller 2007. My arguments for refusing to PAS to Mrs. Bosscher would apply even more strongly here.

[5] For reasons I have discussed elsewhere (Cowley 2005), I do not believe a suicide can be rational or irrational. This is because the concept of rationality makes an essential reference to the future, and suicide removes the future.

causing me pain. (It is true that once the somatic suffering reaches extreme levels, then the distinction between self and world starts to blur, and I can only scream. But in the Dutch euthanasia cases I am assuming that the patient is still able to repeatedly and consistently articulate their wish to die, which is one of the conditions for assistance.) Somatic medicine provides a detailed taxonomy of injury and disease, allowing inductive comparison and contrast with past and present cases, so that the objective symptoms corroborate and explain the subjective reports. Different people with the same stage two liver cancer will, other things being equal, have the same symptoms, the same prognoses, and the same treatment options available. Even if the precise nature of the somatic suffering may differ from patient to patient, the suffering is anchored in the general scientific description.

Even if there is always a certain amount of guesswork in diagnosis and prognosis, a post mortem examination can then confirm or falsify a good deal about the disease and its attempted treatment retrospectively. This point about confirmability is important, because the assumption of somatic medicine is that there is a clear set of objective facts underlying the suffering, and that any uncertainty in diagnosis and prognosis is merely epistemic, based on the limitations of science and the difficulty of intrusive testing on a living body.

The link to the world is also important for our own empathetic understandings – and moral judgements – of other people's somatic suffering resulting from their encounters with the world. Not only can I confidently understand most of what it feels like when you suffer a scraped elbow, a knee to the groin, an ear infection or a burn, but I can sometimes confidently reproach you for your complaints: 'keep walking, you big wimp, it's just a blister.' In this sense there is an objective aspect to unbearability: we would say that the hiker was mistaken in claiming his blistered foot to be unbearable. Guy Widdershoven agrees: 'Dutch physicians will not be satisfied with a simple declaration by the patient on the subject of suffer. They will interpret such declarations in the context of the patient's total situation' (Widdershoven 2002 p. 99).

Even when I have no direct experience of a severe disease such as cancer, I can imaginatively extrapolate using the usual metaphors to achieve some vague idea of what you must be going through, and can admire your courage in keeping a cheerful disposition. All of this serves to anchor the suffering patient in the world: the ordinary world of dangerous trees and cars, the scientific world of causal explanations and invisible pathogens, and the moral world of praise and blame.

Things are much less clear with the mental suffering of depression. In what follows I'm going to focus entirely on depression, since I am not sure how far my thesis would apply to other kinds of mental illness such as compulsions or delusions or dementia or multiple personality disorders, and the phenomenology of the various mental illnesses varies so much, and is often so complicated, especially in its effects on the will. And while depression is basically intelligible, since we have all had feelings of sadness or worthlessness or hopelessness, it is not clear whether other mental illnesses are so readily intelligible or imaginable. (Perhaps the most extreme forms of depression are not intelligible, but I am taking Mrs. Bosscher's depression to be sub-extreme.) I'm also going to avoid the case of bipolar depression, where a single agent's response to the same set of facts can vary markedly in time. Here it is much more plausible to speak of an underlying somatic cause.[6]

[6] Warnock and MacDonald (p. 25) give the example of Philip Graham, who killed himself during a lucid, non-depressed state because he feared the consequences for himself and his family of his next depressive episode. I would take this as an example similar to the suffering anticipated by a patient with a progressive somatic condition such as motor neurone disease, and as such I, for one, would not object to a Dutch doctor assisting such a person's suicide.

Mrs. Bosscher's depression, on the other hand, was brought about by intelligibly depressing events in her life, and for this reason George Graham (1990) would call her depression 'justified' – and I'm going to follow his usage. (Other terms for the same class are 'reactive' or 'exogenous'.) Now it is tempting to consider depression to be, by definition, a mental illness that is sufficiently serious to render the patient legally incompetent, to render PAS requests invalid and irrational, and to reject all possibility of justification. My own response to this sceptical position comes simply from having known justifiably depressed people who were very much competent; like other sceptical claims, I'm not sure how much this one can be philosophically refuted, and I'm not going to try.

I say that Mrs. Bosscher's depression was 'brought about' rather than 'caused' by events precisely because I want to emphasise that Mrs. Bosscher is interpreting those events in terms of her own life. Already this marks an important distinction between mental and somatic suffering. The tree, and the skier's brute impact with that tree, requires no interpretation. Interpretation only comes in later on, when the skier has to decide what sort of a role to allow the suffering to play in his life, for example whether he will ignore it or draw others' attention to it. The case of somatic diseases such as cancer is more complicated, since the pain in my abdomen has to be medically interpreted (diagnosed); but this interpretation comprises a strictly causal story, making reference solely to the general facts of the human body-machine and to laws of nature, not to specific facts of the patient's life. Even when the diagnosis is not clear, the nature of two doctors' disagreement is very different from the sort of disagreement that Mrs. Bosscher's sister might have with her about the conclusions that she draws from her sons' deaths. For completeness, I should mention an important class of 'grey' cases, involving perceived non-medical causes of somatic disorders, as when I interpret my cancer as divine punishment for earlier transgressions. Insofar as this leads to mental suffering and not merely somatic suffering, then what I say below about depression will also apply to such cases.

The concept of justification refers to some sort of shared standards or norms. In the case of depression, the idea is that certain familiar events will justify depression in any human life: unemployment, bereavement, debt, imprisonment, etc.. Insofar as a depression is justified, then it is intelligible to other people once the events are described. Not only will such events justify the depression, they also account for its phenomenology: the depressed person's consciousness is filled not with a disease entity, not with some 'thing' called depression, but with the event-objects themselves.[7] If I ask Mrs. Bosscher 'why are you depressed?' her answer will refer to her sons and to her relationship with them; she is suffering not from depression but from their death. If I ask the cancer patient 'why are you suffering?' they will reach for a scientific causal account, or perhaps a religious causal account – or they may not understand the question.

There is of course a parallel here between the vulnerability of human lives to general types of personal disasters and the vulnerability of human bodies to certain general types of injury and disease. However, the point about the centrality of interpretation is important here, for the depressive response is radically individuating in a way that somatic suffering is not. Not only is there empirically a much narrower range of particular responses to a broken leg than to the death of a loved one, but the precise contours of a particular person's grief will depend greatly on that person's character and background, on their relationship to the loved one, on the capacity of their other relationships and projects to sustain them through the grief etc.. Indeed, there is sometimes a degree of surprise in that the person ends up grieving much

[7] However, I can accept the therapeutic value of reifying the depression in order to allow the patient to fight 'it' better.

more than they or others would have predicted while the loved one was alive. We might therefore say that depressing events, much more than other kinds of adversity (including somatic illness), reveal the character of the person suffering the events, and reveal the deeper nature of her relationships with others, living and dead.

[A] Depression and suicide

If we can accept that Mrs. Bosscher's depression is justified, there is now a separate question about whether Chabot would be justified in assisting her suicide (Graham distinguishes the questions on p. 407), and I shall argue that he would not. Let us return to the criteria of the Dutch convention: the suffering has to be 'unbearable' and 'hopeless'. Hope is an attitude toward the future: if I am genuinely hopeful, then any present adversity can be borne. But for hope to be sensible and not naïve, it has to bear some relationship to objective probabilities. So once again we find a radical difference between the hopelessness of cancer and the alleged hopelessness of Mrs. Bosscher's depression. A somatic illness usually conforms to a type, which can be observed across populations and across time: this means that predictions can be made more or less reliably, based on different treatment options, and compared to the option of non-treatment. Certain treatments can be withdrawn or withheld because they have been inductively revealed as hopeless (in the sense of futile), or overly burdensome, in a sufficient number of sufficiently similar past efforts. Although the precise definition of futile could be the subject of reasonable disagreement between equally well-informed doctors, there has to be enough agreement in the profession about most treatment decisions in order to teach the relevant generalisations to the next generation of medical students.

Justified depressive responses to the same event type vary so widely because they individuate the patient so much, and therefore the particular course of the patient's depression is essentially unpredictable. After all, many people suffer a family member's suicide without becoming suicidal themselves. In addition, pharmacological treatments for depression are themselves so patient-specific, and seem to be evolving so rapidly, that it is tempting to say that there are always reasonable grounds for hope that a future treatment might work well enough after trial and error. Psychotherapeutic treatments take a longer time because the therapist needs to get to know the patient well, but again there is no reason in principle to think that psychotherapy will not work well enough eventually. And yet Mrs. Bosscher confidently rejected all the treatments that Dr. Chabot repeatedly offered. It is not clear what to make of this refusal. On the one hand it is of course the competent patient's right to refuse any treatment, for any reason. Presumably she thought that no amount of treatment could change the situation and bring her sons back to life; in that sense all treatment for her was futile, and just served to prolong her suffering. On the other hand she wanted assistance from the medical profession, and the profession could surely have made such assistance conditional on at least trying the treatment, especially since the treatment in question would probably not be anywhere near as burdensome as, say, chemotherapy; to refuse to even try treatment comes uncomfortably close to a sulk. Indeed, the Dutch Medical Association's Disciplinary Committee rebuked Chabot for not making a 'more vigorous attempt to persuade her to try antidepressant medication' (cited in Burgess and Hawton 1998 p. 117). And the Dutch Supreme Court claimed that Chabot 'ought to have considered treating her with antidepressants, if necessary against her expressed refusal' (Berghmans 1998 p. 133). (It is not clear what the committee meant by 'vigorous', nor what the Court meant by 'against her refusal'. Were they recommending that she be declared incompetent, incarcerated, and then forcibly treated, for example?)

Mrs. Bosscher sincerely believes her condition to be sufficiently unbearable and hopeless to justify suicide. But in the absence of corroborating somatic conditions with clear inductively-

justified prognoses, I suggest that there are no grounds to consider the depression hopeless in any demonstrable sense. Although the coming weeks and months will no doubt be hard, and the view from the present is bleak, there is no reason in principle to think that she is incapable of discovering new sources of value, new relationships or activities to fill the thirty odd years that she can still expect to live in good somatic health. Such a view of the future is essential to most of the medical profession, but particularly to psychiatry. While medical optimism can be corrupted by an obsession with technological rescues long past the point of futility and dignity, it is much harder to speak of futility in treating Mrs. Bosscher's kind of depression, because somatic illness is simply and brutally caused by the insistent biological facts of the world, while Mrs. Bosscher's depression relies in part on what she makes of the facts of the world. Psychiatry's 'optimism' (if this is the best word) is grounded in the widespread belief among non-doctors that suicide is something to be prevented as far as possible, that the life of the somatically healthy suicidal person can never be as hopeless as she thinks, and that those friends and family who fail to prevent a suicide will be very likely to blame themselves for not foreseeing and helping enough (see Warnock and Macdonald 2008 p. 22-23). The only reluctant exception to this widespread view of suicide, I suggest, would be a suicide designed to end a life marred by irremediable somatic suffering.

Burgess and Hawton (p. 117) consider the semi-fictionalised example of Robin, a 20-year old student devastated and suicidal after rejection by his girlfriend. Here we have justified depression, but there is clearly no way that any Dutch doctor would agree to assist the boy's suicide, no matter how sincerely unbearable and hopeless Robin considered his own suffering; for there are good reasons to hope, even if he cannot yet see those reasons. So this is a paradigm of what any legalised PAS system has to avoid. It is perhaps unfair to compare Mrs. Bosscher to Robin, but Dr. Chabot needs a clinically (and philosophically) robust way to distinguish the two, since the basis of both requests would ultimately be the patient's feelings. For in the same way that the doctor could tell Robin 'these feelings will pass, you will discover other women,' why can Chabot not tell Mrs. Bosscher 'these feelings will pass'? Things would be different if Mrs. Bosscher had a terminal illness and simply did not have time to discover new sources of values, new ways to go on living; things would be different if she had a somatic condition that would continue generating unbearable pain with no prospect for imminent release. But somatically, she is still in the middle of her life, just like Robin. We could argue that Robin has his whole adult life before him, while Mrs. Bosscher has the bulk of her working life, at least, behind her; she wouldn't be able to start a new career, for example. But this seems too thin a difference on which to base a policy of life and death.[8] In the Dutch system, the patient and the doctor are supposed to work together through to the conclusion that there is 'no option' but to end the patient's life in order to prevent further suffering (Widdershoven 2002). I'm finding it difficult to see, in the case of a depressed patient, how a doctor can ever come to this conclusion.

Mrs. Bosscher might well respond that all this talk of hope is just whistling in the wind, that all these judgements about the future by well-meaning doctors and philosophers are irrelevant because nobody else finds themselves in her life; nobody can understand just how close she was to her sons, just how much of her life was wasted in marriage to an abusive drunk. Precisely because she is the one who has to live on outside the therapist's consultation room, to get through the long sleepless nights, to force herself out of bed in the morning, to get through the weeks and months, this means that her wishes must carry a certain authority,

[8] In the example, Robin was considered to be sufficiently at risk that he was sectioned under the Mental Health Act for a period of six months, during which time he co-operated in taking his medication and gradually lost his desire to kill himself. The question then is whether Mrs. Bosscher should have been treated in the same way, as the Dutch Supreme Court seemed to advocate.

including the authority required to have one's suicidal wishes taken seriously. If the Dutch state has already decided not to respond to the suicidal cancer patient with the condescending recommendation that 'others have learned to live with cancer, and so can you,' then there is no relevant difference here. Besides, it should be remembered that Mrs. Bosscher, unlike Robin, had already been depressed for the better part of 20 years, had tried different treatments, and had been holding on only for the sake of her sons. So it is not as if her depression had suddenly descended, perhaps implying that it could suddenly lift again if only the psychiatrist can stall her for long enough. No, if any depression can be termed hopeless it was surely Mrs. Bosscher's, and this is what Dr. Chabot judged it to be. Psychiatry had already tried to help her, and had evidently failed; in rejecting Dr. Chabot's offer of further treatment, Mrs. Bosscher knew what she was talking about. In addition, can we not credit Mrs. Bosscher with a certain degree of self-knowledge after 30 years of adult life?

It will also be objected that for Chabot to refuse Mrs. Bosscher would be to abandon her at her moment of greatest need; and would be to condemn her to a suicide that would very likely be messy, violent, and probably unfairly traumatic to others (e.g. to those who find the body). It must not be forgotten that Mrs. Bosscher had already attempted suicide on the same evening of her second son's death, and was already planning to make further attempts. The standard response to this still holds, however: that the medical profession cannot give in to what is effectively blackmail. 'Kill me cleanly, or I will kill myself messily' should be rejected as a threat in the same way as the junkie's plea to the pharmacist 'give me the drugs or I will steal them.' But the argument from abandonment actually cuts both ways. In the first version, the doctor is negligent for abandoning the patient when she needs help to kill herself. But in the second version, if the doctor concurs with her decision that life is indeed hopeless, this could itself be seen as abandonment – from the perspective of the family and of the medical community. It could also be seen as abandonment from the perspective of the hesitant patient (i.e. not Mrs. Bosscher): 'even my GP, who has always been on my side, agrees that I should die. Now I'm just wasting his time.' Part of the doctor's job is, simply stated, to reinforce the will to live and to flatly deny the will to die. This is entirely compatible, it should be stressed, with the transformation of the doctor's role from curative to palliative efforts, and with the withdrawal of treatment that is now futile or overly burdensome after a somatic illness has progressed too far. But the claim that a depression, however justified, has gone 'too far' is much more problematic and controversial, and it suggests that a Dutch doctor should err on the side of refusing suicidal requests.

Besides, in refusing to assist her suicide, it is to be assumed that the Dutch healthcare and social welfare systems would step in to ensure that she was not abandoned: treatment and support would be available. So just because she wants the suicide does not mean that a refusal will constitute abandonment, for it has yet to be established that she has a right to assistance with the suicide on the grounds of unbearable and hopeless suffering. In the same way, the refusal does not constitute a 'condemnation' to years of misery; at some point the state has to step back and say: 'it's your life, you have to make the best of it.' Many people are miserable, more or less justifiably, and the state cannot be expected to guarantee happiness. It may come to pass, after the state has stepped back, that Mrs. Bosscher cannot bear it any longer, but the expression of the unbearability of her suffering has to be the fact that she makes her own plans and efforts to commit her own suicide, that the suicide be something difficult to accomplish, and that she do it in defiance of the reassuring optimism of her family and her doctors.

[A] The conversation between the doctor and the patient

It might be felt that I have not yet satisfactorily responded to the claim that Mrs. Bosscher's depression, precisely in virtue of the 20-year history of her suffering, is sufficiently hopeless to justify assistance with her suicide. In order to build on my response, I want to imagine the possible conversations between her and Dr. Chabot.

In a 2002 article, Raphael Cohen-Almagor asked a fascinating question to a number of Dutch doctors. Instead of the more familiar questions that we find in discussions of euthanasia, questions such as 'Do you agree with the legal permissibility of euthanasia?' or 'Would you perform covert euthanasia if a competent patient requested it?', he asked: 'Should doctors suggest euthanasia to their patients?' Such a suggestion does not need to be as blatant as the used car salesman's pushiness, of course; it could merely be a certain emphasis on a certain word, as in 'are there any other options you'd like to discuss?' In the Dutch context, doctors would be wary of being too pushy, but when the doctor knows that the patient knows that euthanasia is legal, the issue is already on the table, so to speak, and the question is whether the doctor can subtly draw attention to it if the patient seems to hesitate for whatever reason.

In order to understand the problem, we might consider a well-known distinction in the theory of rights: (i) under one conception a person has a right to an option, and is aware that he has that right, (ii) under another conception a patient is offered, by an appropriate authority, an option to which he has a right. It is a mistake to think there is never any meaningful difference between these. And in most areas of human activity there may not be any such difference: if I have a right to have a lawyer present when I am being interrogated by the police, for example, then the police should be obliged to offer me one, and to offer me one not as a favour but as a recognition of that right. I should never be in the situation where I have to demand the lawyer. Only in this way can the temptations of police power be appropriately curbed, and can individuals resist the inevitable intimidation of the interrogation environment.

Now strictly speaking no Dutch citizen has a legal right to euthanasia, and no Dutch doctor has a legal duty to provide it. But insofar as a Dutch citizen understands and fulfils the criteria and conditions that will generate the situation of 'necessity' required to immunise a volunteer doctor from legal prosecution, then it may be said that this citizen is in the position to make a de facto legitimate claim. So it is in the context of this relationship between patient and doctor that Cohen-Almagor's question has to be understood. Once again, it is important to remember that the doctor is not offering a service to a confident customer on a take-it-or-leave-it basis: the patient is at one of the most vulnerable points of her life, in Mrs. Bosscher's case confused and disoriented about many of her deeper values – and she is quite literally desperate. But Cohen-Almagor argues, against the opinion of some of the doctors he interviews, that euthanasia should always be a last resort, and that this can only be ensured if the doctor is always on the back foot within the conversation: even if the patient fulfils all the criteria, she should still have to demand it, without prompting, and then to demand it again, and again. Only in this way can the doctor be sure that her wish is authentic.

Although Cohen-Almagor was talking about euthanasia in general and not about psychiatric euthanasia, his argument has important ramifications for the distinction I am trying to draw between the appropriate responses to somatic suffering and mental suffering. For I agree with him that psychiatric euthanasia should be prohibited, while allowing that patients can make a legitimate claim for euthanasia in response to unbearable and hopeless suffering from somatic illnesses. And I agree with Cohen-Almagor that doctors should not suggest euthanasia to patients such as Mrs. Bosscher (or even hint at it), but I disagree with him when it comes to patients with somatic illnesses within the Dutch context.

The point about somatic illnesses is that in the Netherlands the political debate about somatic suffering has been settled, and there is no serious movement for reform. It is discussed openly in public, and every elderly person will know about the possibility. It is the patient who has already made the first move – the authentic first move – by contacting a doctor who is a volunteer member of the Dutch Association for Voluntary Euthanasia. By the time they enter the doctor's surgery, they have already thought about it and discussed it with friends. If the patient is reticent, this is not from any shame or stigma that would have prevented him from coming to the consultation in the first place; it is more from embarrassment about discussing such a private matter with a stranger, and so the doctor's breaking the ice may indeed be appreciated. But here again my point about the separation of self and suffering comes in: the patient's somatic suffering has the same status, within her perspective, as the patient's somatic illness. They are both part of the shrinking world, and therefore localised and intertwined: to discuss the illness is to discuss the suffering. The doctor and the patient can discuss the suffering as if it was separate from the both of them, and they can reach a conclusion together on the best course of action to deal with that suffering.[9]

In contrast, consider again the encounter between Dr. Chabot and Mrs. Bosscher. In Griffiths' discussion of the case, he states: 'in letters and discussions with [Dr. Chabot], she presented reasons for her decision clearly and consistently, and showed that she understood her situation and the consequences of her decision' (Griffiths 1995 p. 235). What sort of reasons could these be? Obviously she would start by describing the relevant facts of her situation, especially how attached she was to her sons, and that the sons are now dead. Those facts certainly justify her depression, but are they enough to justify suicide, to persuade Dr. Chabot to assist her? The only reason that she seems able to offer for this further step is 'because I don't want to live without them.' The problem is that this is not a statement about the world, this is a statement about her. And so if Chabot agrees with her request, he is effectively making a judgement about her life, not about her suffering; he thereby crystallises her interpretation of her own life without sufficient objective warrant, and entirely rejects the possibility that she might be mistaken. I consider this terribly cruel and deeply irresponsible.

To put it another way, the crucial difference between a somatic patient and Mrs. Bosscher is that the somatic patient, I suggest, at least in the vast majority of cases, does not want to die. If their condition could be treated, if the pain could be reduced, if some degree of functionality could be restored to their body, etc. – then they would live on. (It is true that some somatically ill people are also weary of life, or exhausted by the struggle, and so genuinely do want to die.) Mrs. Bosscher's body is fine, but she doesn't want to live on without her sons: she wants to annihilate herself. The desire to annihilate oneself is deeply mysterious. As such the somatic patient's request for euthanasia is easier to make sense of, and easier to respect.[10]

I have been arguing against a medical doctor, with all the state's recognition and the profession's moral authority, assisting the suicide of a justifiably depressed patient. However, nothing in what I have said would condemn a friend or family member helping that patient to

[9] This conception of joint decision-making under a 'deliberative' and/or 'relational' model of autonomy is brought out by Widdershoven (2002), and represents an important challenge to the prevailing 'liberal' view of autonomy as merely the absence of obstacles. In the case of a Dutch cancer patient, she might well discuss the possibility of euthanasia with friends and family, but only come to make up her mind during extended discussions with her doctor.

[10] It's true that Mrs. Bosscher might be a Christian, and might want not annihilation but to join her sons in the next world. If so, the situation would be complicated by the general Christian prohibition against suicide. There would then be further dilemma for the doctor about whether to engage Mrs. Bosscher in a theological argument.

commit suicide in a non-institutional capacity. For in such cases it would be clear that the friend could know the patient well enough to make such a serious decision, and to articulate an authoritative judgement on what is best for her. In addition, the friend, unlike the doctor, will be implicated in the suicide, for they will be losing a friend in the process and this will add moral seriousness to the decision. In principle the Dutch doctor is meant to get to know the patient before making a decision about assisting suicide, and often the doctor will have been the patient's family doctor of many years. But if the doctor knows the patient well enough to be his friend, and therefore well enough to assist him with his suicide when the patient claims to be suffering from unbearable depression, then the doctor should offer such help off-duty, as it were.

Of course the assisted suicides of depressed people would have to be investigated to make sure there was nothing close to murder, but the present legal arrangement in the UK and many other countries would seem to allow an official prohibition against euthanasia to co-exist with a refusal to prosecute cases of compassionate assistance between, for example, long-married spouses.[11]

[11] In 2009, the UK Director of Public Prosecutions issued an interim policy describing the conditions for the state to refrain from prosecuting the assistance of suicide. See: http://www.cps.gov.uk/news/press_releases/144_09/ [accessed June 2011].