Theor Med Bioeth (2013) 34:227–238
DOI 10.1007/s11017-013-9252-6

Euthanasia in psychiatry can never be justified. A reply to Wijsbek

Christopher Cowley

Published online: 24 April 2013

Abstract In a recent article, Henri Wijsbek discusses the 1991 *Chabot* "psychiatric euthanasia" case in the Netherlands, and argues that Chabot was justified in helping his patient to die. Dutch legislation at the time permitted physician assisted suicide when the patient's condition is severe, hopeless, and unbearable. The Dutch Supreme Court agreed with Chabot that the patient met these criteria because of her justified depression, even though she was somatically healthy. Wijsbek argues that in this case, the patient's integrity had been undermined by recent events, and that this is the basis for taking her request seriously; it was unreasonable to expect that she could start again. In this paper, I do not challenge the Dutch euthanasia criteria in the case of somatic illness, but I argue that both Chabot and Wijsbek are wrong because we can never be sufficiently confident in cases of severe exogenous depression to assist the patient in her irreversible act. This is partly because of the essential difference between somatic and mental illness, and because of the possibility of therapy and other help. In addition, I argue that Wijsbek's concept of integrity cannot do the work that he expects of it. Finally, I consider a 2011 position paper from the Royal Dutch Medical Association on euthanasia, and the implications it might have for *Chabot*-style cases in the future.

Keywords Chabot · Euthanasia · Wijsbek · Integrity · Depression · Grief

The Chabot case

In a recent article [1], Henri Wijsbek describes the tragic story of Mrs. Boomsma in eloquent detail, so there is no need for me to do more than summarize here. (The legal aspects of the case are well described in Griffiths [2].) In 1991, Dutch citizen

C. Cowley (✉)
School of Philosophy, University College Dublin, Dublin, Ireland
e-mail: christopher.cowley@ucd.ie

Mrs. Boomsma was 50 years old, and had left a long and abusive marriage a few years previously. She had had two sons on whom she had doted. In 1986, the elder son committed suicide after his girlfriend broke off the relationship. In May 1991, the younger son died of cancer. Mrs. Boomsma tried unsuccessfully to commit suicide a few days after. Later that summer, she got in contact with Dr. Boudewijn Chabot, a psychiatrist who was also a volunteer with the Dutch Right to Die Society (NVVE). After twelve lengthy discussions with Mrs. Boomsma, and after consulting seven independent experts, Chabot helped Mrs. Boomsma to die in September 1991.

At the time, Dutch legislation allowed a doctor immunity from prosecution for assisting suicide if he could demonstrate that the patient's suffering was "unbearable" and the patient's condition was "severe" and "without prospect of improvement" (or "hopeless" as I shall say for brevity). Most requests for euthanasia, both then and now, are from patients with terminal *somatic* conditions, especially cancer. With stage IV cancer, for example, the patient's prognosis is very bleak, and doctors can fairly reliably establish that there is indeed no prospect of improvement. The "unbearable suffering" condition is more subjective, obviously: some stage IV cancer patients manage to bear their suffering well enough, and choose to soldier on. But importantly for my purposes, the "unbearable suffering" criterion is not entirely subjective—to be credible, it still depends on a general understanding of the painful nature of certain severe kinds of somatic diseases, such as cancer. One could not claim unbearable suffering from a blister on one's foot.

In this paper, I do not want to challenge the Dutch practice in cases of severe somatic illness, nor do I want to discuss the morality of suicide or physician-assisted suicide. My question is whether the Dutch practice can be unproblematically applied to cases of *mental* illness.[1]

If the mental illness is serious enough to undermine the patient's legal capacity, then the answer is clearly no, for the patient would not be in a position to autonomously request euthanasia. As in other countries, there are cases of withholding medical treatment from patients with severe dementia or in a permanent vegetative state, but this raises other issues which are not my concern here. Mrs. Boomsma, on the other hand, had legal capacity but suffered from severe depression. She certainly had capacity to manage her legal affairs and to sign contracts; and there was no doubt that, in requesting suicide, she understood what she was requesting.

Importantly, Mrs. Boomsma considered her depression to be permanent. To her, it was caused not by random transient chemical states in her brain, but by the death of her sons; it was "exogenous"[2]—and in this respect, Chabot agreed that there was no "prospect of improvement." Furthermore, Chabot judged that her resulting suffering was both intelligibly severe and unbearable enough to meet the second criterion. George Graham speaks of an exogenous depression being "justified" or

[1] My question is similar to that posed by Huxtable and Möller [3], when they ask whether "suffering from life" is sufficient to justify physician assisted suicide. I will return to this question in the final section.

[2] An anonymous reviewer chides both Wijsbek and myself for using the term "exogenous," now considered old-fashioned among psychiatrists. I have preserved the term simply to indicate that the depression comprises an intelligible response to situational causes.

not by the circumstances [4]. For the purposes of this article, I will be taking Mrs. Boomsma's depression to be uncontroversially justified in Graham's sense.

For completeness, Chabot considered *two* reasons for assisting with Mrs. Boomsma's suicide. First, he accepted that her depression was severe, hopeless, and unbearable; second, she had tried and failed to commit suicide earlier that summer, and made credible threats to attempt it again if Chabot did not help her. In a 1998 interview, Chabot admitted, "I did not agree with Mrs. [Boomsma's] decision to kill herself, but I felt that the greater evil would have been her dying alone" [5, p. 241]. Indeed, he believed that Mrs. Boomsma's suicidal impulses would inevitably lead to her death sooner or later: "a persistently suicidal state can be as reliably diagnosed as an incurable illness" [5, p. 243].

This is where I would raise my first objection to Chabot's judgement. The credible threat of suicide is not normally considered a good enough reason to grant the threatener's wishes, although it *is* a good reason to offer the threatener other kinds of help. What Chabot is describing seems very much like blackmail, as if Mrs. Boomsma had argued, "if you don't help me, then I'll do it myself; it will probably be painful, I might botch it, I'll be lonely and miserable, and it'll all be your fault." Importantly, when asked about this in the same interview, Chabot denied he had been blackmailed [5]; as a psychiatrist, he said, he had been trained to deal with blackmail, and had dealt with it on other occasions. Be that as it may, as far as possible, I want to avoid the question of blackmail in this paper: I will only be considering whether a justified exogenous depression can, on its own, justify the doctor assisting suicide within the Dutch context.

The Chabot case went to the District Court and the Court of Appeals, and then in 1994, the Dutch Supreme Court eventually accepted Chabot's case, although it complained of a procedural problem: that none of the seven experts consulted by Chabot had actually met or examined Mrs. Boomsma. For this reason they found Chabot guilty of assisting suicide, but did not sentence him to any punishment. They also reproached Chabot for not insisting that Mrs. Boomsma try a course of antidepressant medication before agreeing to assist her suicide. The case was very controversial at the time, and the controversy returns to the Dutch press every few years. However, "psychiatric euthanasia," as it is sometimes known, remains very rare, with only a handful of cases every year. In general Dutch doctors and psychiatrists remain extremely unwilling to accept that a competent patient with severe depression in fact has no prospect for improvement.

Henri Wijsbek's integrity argument

Henri Wijsbek defends Chabot's decision by invoking the concept of the patient's *integrity*. Every life has a certain integrity, or wholeness, and the main structural support for this integrity comes from the patient's most important cares and commitments. These cares and commitments give the life its distinctive shape over time. In Mrs. Boomsma's case, the center of her life was her two sons, and she fulfilled herself as their devoted mother:

> … with both her sons she enjoyed an unquestioned intimacy, a mutual acceptance that she could always take for granted. All her self-esteem stemmed from being a mother, and she was proud that her children had never had a nightmare, and had never complained that she was not there when they needed her. With two children dead at the age of twenty, she found her life empty and vain. Her children had been all she lived for, all she cared for, her only goal in life, and she could not replace them by anything else. [1, p. 3]

I certainly do not want to challenge the depth of Mrs. Boomsma's loss, and the utter despair that drove her to attempt suicide on her own and then to plan it with Chabot's help. It was truly a life of tremendous tragedy and bad luck, and her wish to end it all is completely comprehensible. It is hard to imagine how any of us would react in her situation. It might be tempting to criticize Mrs. Boomsma for ending up in a position where she was so psychologically dependent on her sons as a source of meaning in her life. But such a criticism comes too late: Chabot had to deal with the specific person who turned up at his door, aged 50, with all her specific character and vulnerability. Wijsbek accepts that Mrs. Boomsma was unfortunate to have only one "ultimate goal":

> Perhaps that is unusual; it is certainly a limitation we should try to avoid burdening our children with, but, given her character and life story, it was a limitation she was stuck with. She identified herself with her one goal, and committed herself to pursuing it wholeheartedly. She was a mother and nothing else, and well aware of her limitations. [1, pp. 6–7]

Wijsbek holds that it is no longer reasonable to blame Mrs. Boomsma for the decisions in the past that contributed to her narrow dependence, but in addition, he accepts that it is now too late for Mrs. Boomsma to start again, given the irreparable loss of her integrity:

> Now that the sole source of meaning in her life had disappeared she could not go on, nor could she bring herself to adopt another ultimate goal to live for. Should she have tried harder? Did she cling too rigidly to what she had lost? Even if it is impossible to acquire or give up ultimate goals directly by will, it is possible to do so by more indirect means. But I don't think that would have been reasonable to expect of her.… [T]o ask a woman of fifty to pluck up her courage and start anew would amount to a kind of tyranny. [1, p. 7]

In the remainder of this article, I wish to criticize certain aspects of Chabot's decision and Wijsbek's invocation of integrity in support of it.

Depression and recovery

I want to start by considering a powerful counterexample to Wijsbek's argument: Mrs. Boomsma's 20-year-old son Peter. Peter committed suicide after his girlfriend left him. I want to ask, how would Chabot have reacted to Peter's request for assistance in dying? Once again, we can accept that his depression was sincere and

justified and perhaps severe; we can even understand his suicidal urges. But surely in this case we would want to say that Peter was in some deep sense *mistaken* in thinking that his life was not worth living without his girlfriend. The possibility of such a mistake is precisely what lies behind the normal prohibition on assisting suicide, even if the agent competently consents to such assistance. In terms of Wijsbek's integrity argument, we would want to say that Peter was not being—and indeed could not be—"true to himself" in seeking suicide.

This is a special kind of mistake. The most familiar kind of mistake is about a matter of fact, and this can be corrected by a second examination, better instruments, an encyclopaedia, etc. Another familiar kind of mistake involves the discovery of arguments or evidence supporting a different judgement, which one comes to see as an improvement on the old, mistaken judgement. Most of us think that our present moral, political, and aesthetic judgements are better, wiser, or more subtle than the mistakes we made in the past. Peter's mistake is of an entirely different order. He is so overwhelmed with grief and his confidence so undermined that his perception of his interests, his future, or his potential is obscured, and he can make no judgement at all.[3] Judgement implies a reasoned choice between viable options, and Peter could not conceive of any option but suicide. But those of us who are older than 30 can remember the extreme variations of mood that characterizes youth, and the vast majority of us pull through without too much damage. We could only hope to reach Peter in time for his mood to pass, and his power of judgement to be restored.

We could imagine Peter in Chabot's office, with Chabot reassuring Peter that "there were more fish in the sea," that he "should be grateful for many things," or that "he should think of how much suicide would hurt the people who love him." There are plenty of things one can say to a young suicidal patient to at least get them to see the situation differently or to distract them for long enough that they start seeing other reasons to live again. I am pretty certain that Chabot would not have helped Peter to die, however persuaded he was of the depth and sincerity of his depression, and however concerned he might have been about Peter committing suicide himself. Instead, Chabot would have organized the healthcare and social services to help Peter; in the extreme, Chabot could have had him temporarily sectioned.

But if this intuition about Peter is correct, we have to ask where exactly the difference between Peter and Mrs. Boomsma lies. After all, it was perfectly possible that the girlfriend and the relationship with him was the sole source of meaning in Peter's life. In which case we could use Wijsbek's words to describe Peter thus: "now that the sole source of meaning in [his] life had disappeared [he] could not go on, nor could [he] bring [himself] to adopt another ultimate goal to live for." We may pity Peter for being so emotionally invested in his relationship with his girlfriend, but, Wijsbek could say, "given [his] character and life story, it was a limitation [he] was stuck with." So my worry is that Wijsbek's integrity argument seems to accommodate other cases that we would intuitively resist.

[3] The impact of demoralization on autonomous choice is explored in [6], where the assumptive world of a patient immersed in hopelessness and meaninglessness can interfere with the patient's autonomy, and the patient can fall into what Applebaum and Grisso [7] have termed the "MacArthur Test." My thanks to an anonymous reviewer for this reference.

One important difference, of course, is that Peter was at the beginning of his adult life, and Mrs. Boomsma was in the middle of it. Most people of Peter's age are still developing their character, still considering their career options, and are at least vaguely conscious about romantic options. Even if Peter was unusually lacking in confidence and luck and wider interests, every psychiatrist would retain an attitude of hope on his behalf for the future, and would err on the side of keeping him alive. If we cannot know for sure what someone else is thinking, then we should not make any irreversible decisions.

However, I believe that the same attitude of hope would have been appropriate with Mrs. Boomsma; her options were more limited than Peter's, yes, but they were not absent altogether. She was not at the *end* of her life, after all; by all accounts, she could count on another 20 or 30 years of physical health, which would allow her to make decisions involving emotional investments (into friendships, projects, hobbies) into the longer term. Of course it would have been difficult; but I would say that if in any sort of doubt, a psychiatrist should avoid any irreversible decisions, and should err on the side of keeping her alive. I am saying that Mrs. Boomsma's opinion on the matter, however weighty and authoritative, could simply not be taken as decisive.[4] In stark contrast to people with severe somatic conditions who genuinely are near the end of their lives, Mrs. Boomsma still had plenty to live for, even if she did not believe she did.[5]

Wijsbek considers that to ask Mrs. Boomsma to "pluck up the courage and start anew" would have been "a kind of tyranny." This is a peculiar judgement. Surely every psychiatrist and psychotherapist is asking their depressed patients—of whatever age—to do just that? And not just asking them to start anew, but *helping* them to start anew. That's their job. In saying this, note that I am not making the argument often voiced against euthanasia that a doctor's job is to cure and not to kill; I have accepted that the doctor's job is also to reduce suffering and that in the case of a somatically severely ill patient, the only way to do this might be to grant them their wish for assistance in suicide. But here, the patient with advanced cancer cannot start anew, even in principle, for he simply does not have the time; and there it may well be insensitive (I would not say "tyrannical") to suggest that the patient pluck up the courage and start anew.

Ultimately, the remaining 20 or 30 years of Mrs. Boomsma's life was *her* responsibility, not Chabot's. If she wanted to commit suicide, that was of course her prerogative, and short of sectioning her, it may have been difficult for anyone to stop her if she was determined enough. But because she had so many more years of healthy somatic life left over, her suicide not only ended her undoubted suffering but also eliminated those remaining years. It cannot have been tyrannical to refuse

[4] Indeed, it could be argued that if we consider an 18-year-old to have enough autonomy and legal capacity to join the army (and in the Netherlands in 1991, if we *required* an 18-year-old to enlist), to carry a dangerous weapon, and to risk his life in combat, then we should also consider him autonomous enough to be assisted in suicide. As it happens, the 20-year-old Peter was conscripted into the Dutch army, and it was with a Dutch army rifle that he killed himself.

[5] There is a significant amount of empirical data on suicidal patients who later change their mind [8, 9], and who showed improvement after treatment for depression [10, 11]. I am grateful to an anonymous reviewer for these references.

to help her eliminate those years while offering to help her recover and enjoy them. If she had refused Chabot's therapeutic assistance, then there would have been a strong sense in which she would have ceased to be his problem. Chabot's refusal would have been tyrannous only if he had been in full control of her future life, for example, if he had been her jailor.

The refusal to accept therapeutic help

What more can we say about Mrs. Boomsma's refusal of psychiatric help? Part of her refusal was based on her earlier experience of therapy, after the death of her first son. She claimed it did not help, and that she pulled through only because she still had the second son. So her refusal was partly based on her pessimism about whether drugs or therapy could help. "Anti-depressants would make it easier, but what would it solve?" she asked. After all, the drugs would not bring her sons back to life [1, p. 4]. No, but they might have allowed her to weather the current storm *until* she had learned to deal with her loss: it is not the facts that depressed her, but the significance and the impact of the facts, and both of these can change in time. But even if she had known the drugs and therapy were effective, she would have still refused them. She said, "I don't want to become another person than the one I was when I was a mother and happy" [1, p. 4]. This quotation grounds Wijsbek's integrity argument.

This is certainly an intelligible response by a grieving mother, and one that would elicit the full sympathy of both doctors and laypeople. As a justification for assisting her suicide, however, it involves some disturbing assumptions. Is it necessarily the case that misfortune turns one into a different person, and coming to terms with such misfortune into an even more different person? Even if she were to become another person, she cannot yet know what it will be like. And that other person is not an *entirely* other person, she would still be Mrs. Boomsma, with the same fond memories of her sons that she has now, but with some new source of meaning sufficient to overcome her present despair. Why exactly would she not want that, if it helps? The refusal of therapy seems to come uncomfortably close to a kind of self-indulgence.

My calling her suffering self-indulgent will strike some as an appallingly harsh judgement of Mrs. Boomsma. But it is important to remember what she is asking for: assistance with dying. This is a huge request, and one that should really be the *very last resort*, when everything else has failed. And yet she refuses to even try therapy, partly because of her unjustified belief that it must fail because it failed in the past, and partly because she is worried it will change her.

Besides, even Mrs. Boomsma was aware that her position might appear self-indulgent. Wijsbek writes, "One of her friends reproached her for cherishing her grief, and yes, she agreed, that was exactly what she did: in grief, she cherished her sons" [1, p. 3]. But why can she not cherish her sons and try to work through the grief? Why think that she would ever stop cherishing her sons, no matter what sort of "other person" she became? At the very least, Chabot should have asked her to sincerely try drugs and/or therapy as a condition for assistance with suicide after, say, a year. During that year he and the social services system could have offered Mrs. Boomsma whatever other kinds of help and support she might have needed.

And while the Supreme Court also felt that antidepressants should have been tried, they chose not to punish Chabot for failing to offer them—in this I would challenge the Court's judgement.

The following quote from Wijsbek not only supports the self-indulgence interpretation, but goes even further by invoking a clearly pathological and obsessive understanding of love. He writes, "Her children had been all she lived for, all she cared for, her only goal in life, and she could not replace them by anything else. Indeed, we would probably think less of her if she could…. To give up her grief would be to renounce her commitment to her children, to betray herself as their mother" [1, p. 3–4]. Consider the Hindu tradition of suttee, outlawed by the British in 1829, according to which a living widow was expected to burn alive on her dead husband's funeral pyre. The thought behind such a practice was that self-immolation was the only acceptable expression of the widow's love and grief for her husband; she was expected not to want to go on living without him. Needless to say, this practice did not always involve the full co-operation of the widow, and has come to be seen as a straightforward example of misogynist oppression. If the Hindu widow went on to develop new interests, why on earth would she or anyone else be inclined to call them a "replacement" for or a "betrayal" of her dead husband? Why on earth would anyone "think less" of her for finding some way to fill the remainder of her life?

Besides, nobody is suggesting that Mrs. Boomsma "give up on her grief." Mrs. Boomsma will grieve for the rest of her life, and will never renounce her commitment to her children. The question is whether she can, with help, come to terms with her grief. I also suggest that the children themselves, if still alive, would want her to try to come to terms with it, and would not see her efforts as a betrayal. Again, if Mrs. Boomsma sincerely believes that surviving would constitute a betrayal of her sons and of her love for them, that is her business. But she cannot expect Chabot to agree with this interpretation without challenge, let alone to assist her irreversible decision to commit suicide on the basis of it. My argument is about doubt; so long as there is any doubt that Mrs. Boomsma had correctly interpreted the situation and the consequences for her, there is too much doubt to assist her suicide.

Finally, while psychotherapy might not have worked in Mrs. Boomsma's past, it should be remembered that there is something essentially unpredictable about exogenous mental illness, precisely because of its highly individual nature—it is always worth trying again. In contrast, somatic diseases like cancer are essentially predictable; when we cannot predict the course of a particular somatic disease, it is because we are still ignorant of so many of the relevant causal mechanisms. But medical research is entirely premised on the existence of such mechanisms. With somatic illness, the individual's perspective is irrelevant (except for psychosomatic effects); all that matters is that his body or the relevant part of his body be of a general type and be vulnerable to disease and injury in the same general ways. Endogenous mental illness, caused by damage to the brain or by biochemical imbalances, is essentially predictable in this sense. But exogenous mental illness like Mrs. Boomsma's depression, caused by outside events, is based on the singularity of the individual's biography and perspective and on the singularity of the interaction with those events. While there are some general principles in therapeutic treatment, they are much cruder; there is much greater room for

mystery. Just as different people respond to the death of a loved one in different ways, so too, different people recover from justified depression in different ways.

Wijsbek's comparison of Mrs. Boomsma to Martin Luther

Wijsbek draws an analogy between Mrs. Boomsma's refusal to go on living, and Martin Luther's refusal to end his protests against the corruption of the Catholic Church, despite the clear risks to Luther's life. For both of them, writes Wijsbek, refusal was the only way to preserve their integrity. Just as we admire and respect Luther's refusal, we should also admire and respect Mrs. Boomsma's: "Like Luther, she knew what really mattered to her, but unlike him she could not guide her life in accordance with it any longer. He had a world to win; hers was irretrievably lost" [1, p. 4]. The implication is that if circumstances had been different, Luther too would have chosen death rather than to go against his beliefs. But this analogy does not work. Luther took a stand and risked his livelihood, perhaps even his life, *for* something, for the sake of an idea that is independently admirable. His protest might not have succeeded, in which case he may have become a martyr or forgotten. Luther's case is a matter of *moral* integrity, for he is ready to pay a huge cost, even death, for his moral principles. Ultimately, he did not want to die. If he could have achieved the same political aim (reforming the Church) without dying, then he would have certainly chosen that.

In contrast, Mrs. Boomsma's wish to die was not *for* anything, or at least it was not for anything of independent value for which other people were inspired to follow and also to die. Her wish was simply to end the pain by annihilating herself.

While Luther was fighting, Mrs. Boomsma was surrendering. While we admire Luther, we can only pity Mrs. Boomsma. If Luther's conscience suffered from the corruption of the Catholic Church, we would not have offered him drugs and therapy to help him deal with it. And while it would have made sense to advise Mrs. Boomsma to "try" to find new meaning in her life, it would have revealed either a gross misunderstanding or gross cynicism if, in response to Luther's ringing declaration "here I stand, I can do no other," we had advised him to "try." In all these respects, Luther's case is radically different.

It might be said that Mrs. Boomsma died for her ideal of motherhood or for her love for her sons. But this would be a correct description only if the ideal or the sons somehow benefited, or might have benefited, from what would then become her self-sacrifice. Mrs. Boomsma would be much closer to Martin Luther if she had died, say, while rescuing her son from a burning building. But Mrs. Boomsma did not sacrifice her life; she simply wanted to end it. She was not supporting an ideal; she was protecting it from what she—mistakenly, as I argued above—felt would be the loss and betrayal associated with further life.

If there is a concept of integrity that is relevant to this discussion, it is not moral integrity, but mere structural integrity. People's lives and their self-conceptions have a certain integrity that can be threatened by dementia, for example; and as such it makes sense for a sufferer of early-stage dementia to seek to end his life before he really does become a different person, or loses all the essential properties of adult

personhood. Severe justified exogenous depression, such as Mrs. Boomsma's, could plausibly threaten the structural integrity of her life, and I have accepted that her own suicide would be intelligible as an expression of her grief. But this is not enough to justify someone else's assisting her suicide. So long as *some* people manage to come to terms with grief, there remains the possibility that she might too, preserving her structural integrity in the process. The lives of the bereaved will be very different from their old ones, to be sure, and it will take time to accommodate the past in the present; but it is in the very nature of a human life to move through different phases. As long as outside observers can talk about the person as leading a single life, then that person has preserved a structural integrity which need not be threatened by grief, regardless of the protagonist's conviction that she cannot go on.

Epilogue: the 2011 KNMG position paper

I have argued that Chabot was wrong to assist Mrs. Boomsma so readily because he could not be certain enough that she met the three criteria of severity, hopelessness, and unbearableness stipulated by the Dutch euthanasia legislation in 1994. At the very least, he should have insisted that she try therapy for an extended period. In this I am agreeing with the Supreme Court, but I suggest that the Supreme Court was wrong not to punish Chabot for that important omission. There remains an open question: if Mrs. Boomsma had accepted the condition of making a sincere effort to come to terms with her grief through an extended period of therapy, and had emerged with a renewed determination to commit suicide, would Chabot *then* be permitted to assist her? My intuition would be to say no, for all the reasons given above. However, I would be hopeful, evidently more than Chabot, that the therapy would help her find a new reason to live.

Chabot assisted Mrs. Boomsma's suicide more than 20 years ago, and some things have changed in the law and in the general public discussion surrounding euthanasia. In this concluding section, I want to consider a 2011 position paper by the Royal Dutch Medical Association (KNMG) entitled, "The Role of the Physician in the Voluntary Termination of Life" [12], to see what light it can shed on the *Chabot* case. The Position Paper draws from another Dutch Supreme Court ruling on the 2002 *Brongersma* case. Brongersma was an 86-year-old who wanted to die because he was "suffering from life"—he was lonely, he was deteriorating, increasingly dependent, and he found his existence generally pointless. He asked his physician, a general practitioner (GP), to help him commit suicide, and the GP agreed. The GP was charged with the crime of assisting suicide, and the case eventually went to the Supreme Court. The Court rejected the GP's appeal, and declared that for the doctor to be granted immunity from prosecution, the patient's suffering must have "its principal source" in "medically classifiable somatic or psychological illnesses or conditions"—and Brongersma had none.

The Court ruling seems to overturn the *Chabot* ruling, and the Position Paper's endorsement of this "principal source" clause would suggest, at first glance, that Chabot would not have been allowed to assist Mrs. Boomsma if she had approached him in 2011. However, the Position Paper makes a further elaboration:

> Aside from the somatic dimension, other dimensions of suffering stemming from mental and psychosocial ailments and ailments of a spiritual nature may also require alleviation or remediation through palliative care. Psychosocial problems can also be described as existential suffering, existential distress, Meaning in Life problems, emptiness, meaninglessness or preventing humiliation. Psychosocial or existential suffering therefore also fall within the medical domain [12. p. 21].

This would suggest the opposite conclusion about both Mr. Brongersma and Mrs. Boomsma—that their condition could have its principal source in a medically classifiable condition. However, this definition then means that the medical doctor is no longer qualified to judge on his own whether the suffering is without prospect of improvement: "in cases where this dimension tips the balance in the determination of whether the suffering is unbearable, specialists in the field of psychosocial and Meaning of Life problems, such as social workers, psychologists and spiritual counsellors, are designated to perform or take part in that assessment" [12]. Although Chabot consulted seven experts from different professions, none of them personally examined the patient, and again he was reproached for this by the Supreme Court.

The Position Paper contains an interesting ambiguity that is also relevant to the Chabot case. The Paper states: "The question of whether suffering is unbearable is one that only the patient can answer" [12, p. 20]. The point of this is clearly to emphasize that it is the patient who must decide whether or not to commit suicide, and that nobody else can recommend it, let alone apply pressure on the patient to do so. This much is uncontroversial. However, the fact that this point was phrased in terms of unbearability raises a complication, as we shall see. Further down the same page, we read: "When it comes to deciding whether or not to perform euthanasia or assisted suicide, however, this consideration is not determinative. The physician must be convinced of the nature of the suffering, based on his professional assessment of its duration in relation to the unbearableness of the patient's suffering." Again, there is a straightforward reading of this, which is to say that the patient's mere desire to commit suicide does not place any obligation on the physician to assist that suicide. This clause is designed to allow the physician to dismiss the request of the lovesick 20-year-old, for example. In dismissing the 20-year-old's request, however, the physician is essentially telling him that the suffering is not as unbearable as he sincerely thinks it is.

But then the question arises, why should the physician accept Mrs. Boomsma's sincere belief that her suffering is unbearable? Certainly her suffering is much greater than the 20-year-old's, but is it literally unbearable? If I suffer, and I believe that my suffering is without hope of improvement, and I conclude that I can no longer bear the suffering (partly because it will be endless), then I have chosen to kill myself. That is simply what "unbearable" must mean in this context. But then we are back to the problem of blackmail. Mrs. Boomsma tries unsuccessfully to commit suicide, and that is already evidence of the unbearability of her suffering. She approaches Chabot and asks for his help, and it is clear to him that she will attempt it again if he refuses her. The Position Paper would therefore suggest that such evidence would be enough to permit any doctor to assist her suicide. However,

it would also be plausible for a physician to reject Mrs. Boomsma's request, even after she had attempted suicide on her own, on the grounds that she is mistaken about the unbearability—with enough therapy and time, she might discover that it is not unbearable after all—and that her suicide should not be assisted until she has tried the therapy. But if that possibility exists, then it is not strictly true that "the question of whether suffering is unbearable is one that only the patient can answer."

Ultimately, I return to my position of doubt. The wish to kill oneself is at once so horrifying and so mysterious that it must be approached with the greatest of caution, and the request for assistance should be granted only when the physician and his team are utterly confident that it is the last resort. I have accepted that in the case of serious somatic illness without prospect in improvement, the physician and his team can be confident enough. But in the case of severe grief or "suffering from life," I do not think such confidence is possible. This is not a testable empirical hypothesis; it is an argument based on the meanings of the very concepts at stake here and of our ordinary lives.

References

1. Wijsbek, H. 2012. To thine own self be true: On the loss of integrity as a kind of suffering. *Bioethics* 26(1): 1–7.
2. Griffiths, J. 1995. Assisted suicide in the Netherlands: The Chabot case. *Modern Law Review* 58(2): 232–248.
3. Huxtable, R., and M. Möller. 2007. Setting a principled boundary? Euthanasia as a response to life fatigue. *Bioethics* 21(3): 117–126.
4. Graham, G. 1990. Melancholic epistemology. *Synthese* 82: 399–422.
5. Klotzko, A.J. 1995. Arlene Judith Klotzko and Dr. Boudewijn Chabot discuss assisted suicide in the absence of somatic illness. *Cambridge Quarterly of Healthcare Ethics* 4: 239–249.
6. Kissane, D.W. 2004. The contribution of demoralization to end-of-life decision making. *Hastings Center Report* 34(4): 21–31.
7. Applebaum, P.S., and T. Grisso. 1988. Assessing patients' capacities to consent to treatment. *New England Journal of Medicine* 319(25): 1635–1638.
8. Chochinov, H.M., K.G. Wilson, M. Enns, et al. 1995. Desire for death in the terminally ill. *American Journal of Psychiatry* 152(8): 1185–1191.
9. Breitbart, W., B. Rosenfeld, H. Pessin, et al. 2000. Depression, hopelessness, and desire for hastened death in terminally ill patients with cancer. *Journal of the American Medical Association* 284: 2907–2911.
10. Ganzini, L., M.A. Lee, R.T. Heintz, J.D. Bloom, and D.S. Fenn. 1994. The effect of depression treatment on elderly patients' preferences for life-sustaining medical therapy. *American Journal of Psychiatry* 151: 1631–1636.
11. Hooper, S.C., K.J. Vaughan, C.C. Tennant, and J.M. Perz. 1996. Major depression and refusal of life-sustaining medical treatment in the elderly. *Medical Journal of Australia* 165: 416–419.
12. Royal Dutch Medical Association. 2011. The role of the physician in the voluntary termination of life. http://knmg.artsennet.nl/Publicaties/KNMGpublicatie/Position-paper-The-role-of-the-physician-in-the-voluntary-termination-of-life-2011.htm. Accessed Apr 12 2013.