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## ETHICS CASE

## When Is Depression a Terminal Illness? Deliberative Suicide in Chronic Mental Illness


Case and Commentary by Constance E. George, MD, MA



**Abstract**

This commentary explores the utility of hope as a therapeutic tool for intervention in the case of a patient with a mental illness that is refractory to treatment over time, who expresses her intention to commit suicide. It begins with a short discussion differentiating a deliberative consideration of suicide from an impulsive act. Then the commentary defines hope, how it might be used as a therapeutic tool, and which limitations a clinician might confront in such a case. This commentary also considers the role of a physician in orientation not only to the patient but also to her own thoughts, feelings, and emotions regarding a patient's expressed desire to end her life.


### Case

Ms. G is a 55-year-old white female who is treated in Dr. C's office for bipolar affective disorder. A lifetime of relapsing mood episodes resulted in failures at school, limited capacity to hold steady employment, and an inability to sustain intimate relationships or friendships. She lives with her father, who is currently ill and unlikely to survive long. Her mother died recently, and Ms. G has no siblings.

Over the years, Ms. G's depressions varied in severity but she never fully recovers. She survives in a state of chronically depressed mood. At this point, however, she does not meet criteria for clinical depression. Dr. C's treatment for Ms. G over the last 10 years has covered the range of pharmacotherapy, psychotherapy, electroconvulsive therapy (ECT), and experimental agents offered through a number of clinical trials and second opinions. In a session one day, Ms. G states to Dr. C that she will live as long as her father is alive, but, after his death, she will elect to stop her medications and commit suicide. When asked by Dr. C to explain this more fully, she states, "I see no hope for my future. After he dies, no one, other than you, Dr. C, will be left to grieve for me." Dr. C wishes the patient to live, but even she is doubtful an effective treatment for Ms. G exists.

Dr. C is uncomfortable and wonders what to do next.

### Commentary

This case introduces three important ethical questions. The first two have to do with whether and when hopefulness is an appropriate therapeutic goal to cultivate. The third has to do with how Dr. C should orient herself personally and professionally to Ms. G.

To begin, the contemplation of suicide in this case should not be characterized as an impulsive act under conditions of stress but as a reasoned choice based on the consideration of alternative courses of action [1]. This distinction is important when considering the relative autonomy of the impulsive versus the deliberative patient and how that might affect a psychiatrist's decision to intervene and whether suicide is considered a reasonable choice. If we employ the "three condition" theory regarding autonomy as put forth by Beauchamp and Childress [2], autonomous action is framed in terms of a normal chooser who acts with intent, with understanding, and without controlling influences, be they internal (within the chooser) or external (outside of the chooser). By contrast, an impulsive patient makes a decision to commit suicide without autonomy, that is, his or her decision is influenced—internally controlled—by the acute symptoms of an illness, for example, by auditory hallucinations. The hallucinations result in a distorted view of reality that renders such patients compromised in terms of understanding their action, consequences of their action, or even the reasons they intend an action. A patient in danger of an impulsive suicide provides arguable grounds for psychiatric intervention given that a patient would likely think and act otherwise once the acute symptoms resolve.

The case described above is quite different. Ms. G's autonomy is intact, as evidenced by her understanding of her illness, her ability to act with intent (pursue a multitude of treatments and adhere to treatment), her ability to recognize consequences of her actions (that her suicide will negatively impact her father and her psychiatrist, for example) and her freedom from influences internal (psychotic symptoms) or external (none apparent). Furthermore, Ms. G states as her reason for electing suicide, "I see no hope for my future." Since hope is identified as the focal point that is lacking, how should it inform the psychiatrist's next steps? Should she intervene by addressing hope? Should she abide by the patient's intention as adequately deliberated and reasonable?

*Tempering hope with realism as a therapeutic strategy*. Should Dr. C, despite knowing that there is no reliable "cure" for Ms. G's condition, try to convince Ms. G to abandon her suicide plan by encouraging her to hope for symptom relief?

Hope is difficult to define, let alone use as a therapeutic intervention. Jerome Groopman, in his bestselling book, *The Anatomy of Hope: How People Prevail in the Face of Illness* [3], gives the following definition: "Hope is the elevating feeling we experience when we see—in the mind's eye—a path to a better future. Hope acknowledges the significant obstacles and deep pitfalls along that path. True hope has no room for delusion" [4]. A more clinical, but closely related concept of hope is given by the late C.R. Snyder, a specialist in positive psychology and professor at the University of Kansas. He outlines

two components of hope: (1) a belief in, or a perceived capability to produce, workable routes (pathways) to desired goals and (2) the motivation (agency) to use those routes [5]. Applying these definitions of hope to this case, it seems Ms. G has lost hope for a workable route to a life she would find worth living. Ms. G can be described as hopeless, and she certainly has many of the traits one could attribute to hopelessness: sadness, weariness of all the various treatments, and isolation [6].

Dr. C's difficulty with Ms. G's decision could lie, in part, with Dr. C's own internal hope that perhaps there is another answer, an alternative treatment, a better clinician, a drug in the future for Ms. G. What likely began in treatment as the patient's desire and hope for amelioration of symptoms was laid squarely in the lap of Dr. C. Those feelings were transferred to Dr. C, who now herself has thoughts and emotions regarding the patient; that is, she harbors hope for the patient. In psychiatry, this is referred to as countertransference. Broadly, countertransference encompasses all of the clinician's feelings toward the patient [7]. This is often a productive process; physicians want to help others and part of this mission to help others is engendered by the interaction between clinician and patient, which constitutes the therapeutic relationship. In this case, however, is Dr. C's hope reasonable? The patient knows as well as Dr. C that treatment options are likely exhausted. For the patient to hope, there must be a route, a path to the patient's goals; it cannot be delusional, it cannot be false hope perpetuated by Dr. C.

This commentary is not about losing hope. A physician's orientation to hope is as important as her clinical acumen. The power of hope to keep the human body going is truly remarkable and well documented [3]. Hopes can vary: hope for a cure, hope for improvement in condition, hope for relief of pain, hope for an easy death. But hope for a cure as an end in itself might not be useful, and like all therapeutic interventions, it is accountable to the truth.

*Hope, therapeutic capacity, and outcomes*. Should Dr. C continue the course of treatment for Ms. G as it is and count on the strength of the therapeutic capacity of their relationship to maintain the hope that Ms. G will change her mind about committing suicide? As stated in the case report, Dr. C wishes her patient to live. There's no neat and tidy relationship between the strength or weakness of the therapeutic bond between clinicians and patients and good or poor outcomes for patients, and though the role of hope in the establishment and maintenance of that bond is not clear, caregivers can and should create and hold hope for patients when it's reasonable to foresee a path to the hoped-for outcome [8]. Dr. C can express, "I have hope for you," and encourage the patient to draw upon that hope as a route to a better future (achieving her goals). A number of clinically and ethically relevant questions arise here. For example, is Dr. C's hope enough, or even wanted? Should her hope be modest or robust (or modestly or robustly expressed), both, or neither? Is it fair of Dr. C to ask Ms. G to "hang in there," to

stay alive, because to Dr. C, any possibility of life is preferable to the finality of death? Is it appropriate for Dr. C, or anyone, to define death as a good or poor outcome for Ms. G and, if so, on which and on whose terms?

In my experience, for many seriously ill patients there often comes a time at which hope for a good outcome becomes the hope for a good death, for example, a peaceful death, or a death with as little pain as possible but, notably, a death under the control of the person dying [9]. Is it possible that this is what Ms. G wants? A good death for Ms. G might mean an end to her painful symptoms without causing others (her father, especially) pain. Dr. C's hoping Ms. G will change her mind could, once again, be indicative of countertransference. Dr. C's inability to accept Ms. G's death (and death wish) reflects Dr. C's feelings about the loss (or pending loss) of Ms. G, not Ms. G's readiness for death.

Perhaps an ethical way through for Dr. C lies in the consideration of Ms. G's condition as terminal. The difficulty here is elucidated by Michael F. Myers and Glen O. Gabbard in their book, *The Physician as Patient*:

> Most of medicine is palliative, except for certain infectious diseases and surgical procedures. Some outcomes are not preventable. Psychiatrists in particular may have difficulty accepting the idea that some psychiatric disorders in some patients are terminal [10].

The thought of suicide by a reasonable human being who contemplated options, remained compliant with treatment for years, diligently looked at alternatives, and tried various treatments but now comes to the conclusion that she can't endure the day to day pain of her illness is not palatable because, as just alluded to, suicidality is popularly considered a symptom, not a terminal response to symptoms of another illness, such as refractory depression. Suicide for Ms. G in this case might be assumed by some to be too self-indulgent to be characterized as a good death. Historically, this stance has support; there are and have been social and legal proscriptions against the act of suicide [1]. Similarly, psychiatrists could face malpractice lawsuits involving the suicide of a patient that is deemed to be caused by professional negligence [11].

The deliberative suicide, however, might not be so different than those decisions made every day by, say, oncology, endocrinology, nephrology, or neurology patients who are terminally ill and make reasoned decisions to stop treatment and find their own paths to a good death. In Oregon, for example, the Death with Dignity Act [12] expresses legal acceptance that terminally ill patients should have recourse to hasten death given the potential for suffering. Similarly, unendurable psychological suffering could be a legitimate reason for stopping treatment and hastening death by suicide [11]. Without delving into the meaning of unendurable psychological suffering, we might consider that a lifetime of refractory mental illness might be unendurable and can—and, for many,

does—result in a shortened life span [11]. The illness, in fact, proves terminal, be it from disease, accident, or intent.

But even if Dr. C accepts this view of Ms. G's condition as terminal, she still might feel uncomfortable acquiescing to Ms. G's plan and wonder what to do.

*Psychiatrists' personal and professional orientation to suicidality.* If Ms. G's suicide cannot be prevented, but Dr. C finds it untenable, should Dr. C inform Ms. G of the need to find alternative care that could honor Ms. G's right to take her own life after her father's death? Or would that constitute Dr. C's abandonment of Ms. G?

This is a difficult set of questions. On one hand, Dr. C can acknowledge Ms. G's right to take her own life and stay with her until the end despite her objections. But Dr. C might also wish to divest herself of an option she sees as untenable both personally and professionally. If Ms. G takes her own life, Dr. C might experience feelings of failure, guilt, and loss. Given the issues involving countertransference already discussed, this is likely given Dr. C's orientation as a healer and her long-standing relationship with the patient. There is a tangible risk to Dr. C's mental health. Is Dr. C obliged to stay with a patient who is making a decision Dr. C profoundly disagrees with and could cause harm to her? Is Dr. C obliged to watch the patient die? Perhaps not. Dr. C is not refusing to find the patient alternative care; transfer of care occurs in medicine on a frequent basis when differences between patients' and professional treatment goals arise. Dr. C could simply express to Ms. G that she is unable to help her with this particular goal and that another clinician could be more supportive, at least from an ethical standpoint, if not from a clinical or legal standpoint.

However, in this particular case, if Dr. C chooses to refer Ms. G to another psychiatrist, it could cause harm to Ms. G. Dr. C knows she is the last person that matters to Ms. G, the patient has clearly said so, and the years of working together has likely made this clear. The patient has no one else. Is there a point at which the interests of Ms. G outweigh the interests of Dr. C or vice versa? Dr. C is a professional and is thus held to standards of professionalism that Ms. G is not. In general, professionalism not only demands a level of medical competence, but also requires one to act ethically, that is, to express a respect for others, to act with beneficence and to do no harm, to be compassionate and, put simply, to abide with patients, to reside in the patients' corner [13, 14]. Perhaps in this case, part of what it means for Dr. C to abide by Ms. G's decision is to acknowledge that though Ms. G's actions affect her, they are not about her. Dr. C's hope is not the patient's hope; Dr. C's desire for Ms. G to live is not the patient's desire; and the possible death of Ms. G is not a reflection of Dr. C's success or failure as a physician.

**Conclusion**

Ultimately, regardless of whether Ms. G lives or dies, the tragedy for both Ms. G and Dr. C lies not in culpability, but in isolation. Ms. G will be alone in her life or in her death. In all

likelihood, in the case of Ms. G's death, Dr. C will not sit at the bedside and hold her patient's hand during her final moments; she will not receive cards from loved ones or kudos from colleagues. It is a lonely place for both patient and physician.

So, an important lesson for physicians and physicians-in-training from cases like this one has to do with understanding that mental illness can be a terminal illness and that the concept of hope has therapeutic limitations. Patients' concerns that the symptoms of their illness might be refractory and that their physician might not have treatments that can ameliorate their symptoms must be discussed. The patient must be free to speak—and to speak openly—about suicide, and, in a case such as this, the discussion must occur in the context of suicide as a deliberative decision from an autonomous patient, agreed with or not. Given the finality of death, the physician is obligated to motivate hope when it is reasonable to foresee a path to the hoped-for outcome. By the same token, a physician is obligated to avoid perpetuating false hope and therefore must address his or her own thoughts and feelings regarding the patient, his or her own fears of loss and failure, in order to avoid perpetuating a false hope that only serves his or her ends and not those of the patient. In this case, the utilization of hope as an intervening tool in this patient's suicide plan might not be justifiable from an ethical perspective.

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