

Physician Assisted Suicide and Behavioral Health

Steve Lindquist

Assistant Vice President for Behavioral Health

Avera Behavioral Health Center

Sioux Falls, SD

steve.lindquist@avera.org

The 1946 movie, “It’s a Wonderful Life”, is a familiar Christmas classic. One of my favorite scenes is the one in which the lead character, George Bailey, played by Jimmy Stewart, is about to jump off a bridge into the icy waters below. George intends to kill himself because he sees no way out of a financial mess he is in which was unintentionally caused by someone else. He feels his life is crashing down around him and comes to the conclusion that he is worth more dead than alive. Just before he jumps, his guardian angel, Clarence, who is trying to “win his wings” by helping George, jumps into the water first. George selflessly jumps in to rescue this stranger.

The two take refuge in the bridge toll keeper’s station to warm themselves. The

toll keeper asks Clarence how he fell into the water.

--“I didn’t fall in. I jumped in to save George,” said Clarence.

-- “To what? To save me?” George responds.

-- “Well I did. You didn’t go through with it did you?”

--“With what?”

--“Suicide.”

The toll keeper overhears and says, “That’s against the law to commit suicide around here.”

Clarence the angel responds, “That’s against the law where I come from too”.

The toll keeper’s comments represent the legal view that suicide is prohibited by law. Clarence’s comments represent the moral or

ethical view that taking one's own life is wrong. There was congruence between the legal and the moral views.

For most of my career at Avera Health, I have been involved with behavioral health services as a provider, administrator or policy maker. Our goal is to help people improve their mental health condition and positively work through challenging issues. We do what we can medically. Legally, states have long-standing laws that allow involuntary commitment when the person, due to a mental illness, is a danger to themselves or others. The intention is to protect the person or others from harm even when the person is unwilling to seek treatment voluntarily. I have seen individuals who at one time were very determined to end their lives and later express gratitude for their treatment and thankfulness that they are still alive. Sometimes this outcome is only possible because the law allows us to intervene.

Danger to self takes the form of harming or killing one's self through direct or indirect means which can be intentional or unintentional due to a mental illness. At one time state laws were rather vague as to

the criteria for committing a person with mental illness although the general theme was protecting the public and the person. The concept of *parens patriae* took precedence, giving the state power to act as guardian for those who are unable to care for themselves, often children or those who are incapacitated or unable to exercise informed consent. In cases where there might be doubt, it was typical to err on the side of caution and protection. More recently, individual rights and civil liberties have assumed greater prominence, creating a necessary tension between individual rights and public interest.

In recent years, there have been attempts to tackle the growing suicide rate by identifying suicidal ideation earlier and taking steps to prevent suicidal actions. On February 24, 2016, The Joint Commission sent out Sentinel Event Alert, Issue 56, titled "Detecting and Treating Suicide Ideation in All Settings". That publication notes that the rate of suicide is increasing in the U.S. and is now the 10th leading cause of death, taking more lives than traffic accidents and more than twice as many as homicide. The alert also notes that health care providers often do not identify patients

who have suicidal thoughts. It recommends appropriate patient screening and staff training that will identify suicidal thinking early and provide a path to treatment and after care.

The national Zero Suicide initiative of the Suicide Prevention Resource Center (SPRC) is one attempt to achieve that end. It is “a commitment to suicide prevention in health and behavioral health care systems and is also a specific set of strategies and tools.” The foundational belief of Zero Suicide is that suicide deaths for individuals under the care of health or behavioral health systems are preventable. Currently many entities, including Avera Health, are instituting practices identified by Zero Suicide.

It began in 2001 with an effort by Henry Ford Health Center to reduce suicides that resulted from depression. Their efforts, initially called, the “Perfect Depression Care Initiative”, cut the suicide rate among the people in its insurance plan dramatically, achieving ten consecutive calendar quarters without an instance of suicide among patients participating in the program. Today Zero Suicide is national in scope and is a key

priority of the Suicide Prevention Resource Center. The SPRC website says the challenge of Zero Suicide:

is not one to be borne solely by those providing clinical care. Zero Suicide relies on a system-wide approach to improve outcomes and close gaps rather than on the heroic efforts of individual practitioners. This initiative in health care systems also requires the engagement of the broader community, especially suicide attempt survivors, family members, policymakers, and researchers.

The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through multiple cracks in a fragmented and sometimes distracted health care system, and on the premise that a systematic approach to quality improvement is necessary.

(<http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org>)

It is interesting to note that a study published in *Health Affairs* found that 45% (78% among older adults) of those who died by suicide had seen a primary care provider in the thirty days before they died.¹ Another study found that of those who had contact with a health care provider, “Mental health diagnosis was absent in over half of all individuals in the year before death and approximately 75% in the 4 weeks before death. Mental health diagnosis was less common among disadvantaged groups with lower levels of education and income”.² These are startling figures. They show that the risk of suicide is not confined to individuals who are in behavioral health treatment. They also show that primary care providers are in an excellent position to identify suicidal tendencies and get patients into treatment.

Attempts to reduce the incidence of suicide stand in stark contrast to the movement in favor of physician assisted suicide (PAS). PAS arises in situations where the person has a terminal medical condition, but there is often an exclusion for individuals who have a major mental illness. However that boundary seems to be eroding. On November 21, 2016, a court in New Jersey

ruled that a young woman could refuse food and treatment related to eating disorders. In court proceedings, the state attorney general’s office argued she was not mentally competent because of chronic depression. It said anorexia was not a terminal condition and asked the court to approve force-feedings as requested by the State Department of Human Services. The court found that the woman’s testimony was compelling and that her parents, doctors, psychiatrists and court-appointed medical guardian as well as the ethics committee at the hospital where she was located, all supported her decision. She was allowed to refuse treatment and died a few months later.³

British author on religion and ethics, Paul Vallely, described a different situation in the case of a Belgian child, Danny Bond. Bond had a health condition from birth which caused severe and increasing chronic pain. At age 13 he started talking about wanting to die. Eventually at age 21 Bond decided he would end his life by starvation and subsequently died (2004). Vallely writes, “The Belgian parliament last week (2014) responded to cases like Danny’s by making it legal for any child, at any age, to ask to be

killed – if they are ‘close to death’, experiencing ‘unbearable suffering’ and can show they are truly able to ‘discern the consequences of what they are asking.’ The politicians rejected amendments to extend euthanasia to mentally ill children. But the main proposal was passed with a two-thirds majority.”⁴

Previously, state intervention would have protected the person from “self-harm”. In the current environment, will involuntary treatment for danger to self be seen as in conflict with the trend toward PAS? Will there be a time when a court will rule that regardless of the person’s mental capacity (note Belgium’s extending this decision capacity to minors) there is an inherent right to end one’s life regardless of that person’s medical or mental status?

Part Five of *The Ethical and Religious Directives for Catholic Health Care Services*, Fifth Edition, states: “The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives and, hence, do not have absolute power over life. We have a duty to preserve our life and to use it for the glory of God,

but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome. Suicide and euthanasia are never morally acceptable options.”

The trend towards PAS is accelerating and is a problem in itself. But I think we are at the point in which it is appropriate to ask whether this trend will change the consensus about mental health commitment laws, designed to protect individuals who are a danger to themselves. If it does, behavioral health providers will lose a valuable tool in their campaign to achieve “zero suicide” among mentally ill patients.

References

¹ “Suicide Prevention: An Emerging Priority for Health Care”, Hogan, Michael F. and Grumet, Julie Goldstein. *Health Affairs* June 2016. 1085

² Health Care Contacts in the Year Before Suicide Death”, Ahmedani, Brian, Simon, Gregory et al. *J Gen Internal Medicine*. 2014;289(6):870-7

³ “Anorexic, bulimic woman who fought force-feedings dies at 30,” Morristown, NJ, Associated Press (February 22, 2017)

<https://apnews.com/4c7db0d0f8a34a31acbd7932afd3>

⁴ Paul Valley, “Child Euthanasia: Too Hard to Live, Too Young to Die” (*The Independent* [United Kingdom] February 16, 2014).