Phenomenology, Existential Intractability, and Physician-Assisted Suicide Practices in the Netherlands and the United States

I will be presenting phenomenology, the case of Aurelia Brouwers, and the legality and practice of physician-assisted suicide (PAS) on psychiatric and terminally-ill grounds in the Netherlands and the U.S. I will reference euthanasia but focus on PAS. It is crucial to distinguish between PAS and euthanasia; PAS refers to a physician prescribing a lethal dose of medication for a patient to consume independently. Euthanasia, the physician, administers a lethal substance directly to the patient. PAS and euthanasia on physical and psychiatric terminality are legal in the Netherlands. PAS is legal in the U.S. only for terminal physical illnesses (e.g., ALS, specific cancers, leukemia) at certain state levels, not federally. PAS, euthanasia, and the medical recognition of intractable psychiatric suffering is highly controversial and why the Netherlands has adopted legislation, reporting protocols, and review committees surrounding its practice. I am not arguing to include euthanasia in any U.S. legislation. What I will explore is that Dutch physicians have compassionately recognized patients can define phenomenological loss as permanent psychological, existential intractable pain. Furthermore, jurisprudence in the Netherlands endorses vigilant medical practice for those who can no longer live a rudimentary quality-of-life due to their incessant mental suffering - a framework the U.S. could adopt.

Phenomenology and Existential Intractability

Phenomenology is an individual's subjective discernment of personal consciousness and experience. This philosophy provides an ethical grounding as to how one may perceive existence and self-identify in their world. Applying phenomenology in medicine allows the patient an ability to utilize his/her first-person reflections to define living with their illness, of body and/or mind. Phenomenology illuminates the importance of a patient's understanding and the impact of personal loss to self, which affects a basic quality-of-life. Havi Carel suggests five dimensions of loss; wholeness, certainty, control, freedom to act, and the familiar world, affecting an individual's ability to exist and experience life holistically (Carel 1).

An array of traumatic experiences or adversities can invoke insufferable mental anguish for specific individuals. Persons can also inherit or develop vast mental illnesses that dramatically alter brain function. These changes can cause psychiatric distress, which is often

manageable with current medical treatment; however, for some, this dimension of distress results in a persistence of unbearable suffering. Personal suffering, at times, can be nearly impossible to measure objectively, through scientific or medical lenses, and goes beyond the daily management of living with a mental illness. A sister philosophy of phenomenology is Existentialism, which offers insight into an individual's inner conflict. Soren Kierkegaard posited, "that to exist the individual is always to be confronted with this question of meaning" (Crowell). Understanding an individual's phenomenological perspective of Carel's five dimensions of loss, Existentialism offers a way to articulate that the idea of existing may longer meaningful. Individuals who suffer from a subjective loss of meaning, in constant despair with their existence, could define this perpetual psychological state as existential intractability.

Aurelia Brouwers

In 2018, Dutch 29-year-old Aurelia Brouwers, was granted physician-assisted suicide from lifelong struggles with psychiatric disorders. At 12, Brouwers was diagnosed with depression and borderline personality disorder. The diagnoses continued, "attachment disorder, chronic depression, I'm chronically suicidal, I have anxiety, psychoses, and hear voices" (Pressly, BBC). After surviving 20 attempts at suicide and denied by her own physicians' physician-assisted suicide or euthanasia, she applied to the end-of-life clinic in the Netherlands called Levenseindekliniek. This clinic functions as a last resort for patients and judiciously evaluates cases to grant or deny that patient aid-in-death. In Brouwers' circumstance, her long-term psychiatric suffering and unbearableness were synonymous with her phenomenological loss and existence, "I'm stuck in my own body, my head, and I just want to be free, I have never been happy - I don't know the concept of happiness" (BBC).

Psychiatrist, Kit Vanmechelen, not directly involved with Brouwers but works at the clinic, reflects on the gravity of patients suffering from such severe psychiatric helplessness. His interpretation of a niche case like Brouwers is that when a patient has a degree of psychological suffering understood to be terminal for that patient there is justification for considering PAS, "if a patient has gone through multiple treatments for the same diagnosis, there is a reasonable moment to say enough is enough" (BBC). In Brouwers' case, the physicians at Levenseindekliniek compassionately recognized her medical treatment and care had repeatedly failed, and her ability to flourish as a human no longer existed. Before her death, she celebrated

with friends and family, said goodbye, and then consumed the medication prescribed by her physicians and died. (BBC).

Brouwers's phenomenology of personal wholeness and loss of experience living a basic quality-of-life resulted in a dogmatic state of meaninglessness, for her. She could no longer generate an ability to function in this world, or her world holistically, and her 20 attempts at suicide show that there was an unrelenting degree of grief incapable of being treated. Available treatments were not enough for Brouwers and her definition of personal wholeness no longer existed, which should require medical obligation.

Medical Practices in the Netherlands

The 2002 Dutch Termination of Life Act (Review Procedures) expanded the scope of aid-in-dying in the Netherlands. In addition to PAS, euthanasia was legalized, and the grounds upon which patients could seek aid-in-dying was extended to those who "suffer unbearable pain, with no prospect of improvement,", eliminating the previous distinction of physical terminality (MJ en Veiligheid, Gov't of the Netherlands). Additionally, following a patient's death, the doctors involved must submit detailed reports which are reviewed by committees consisting of physicians, bioethicists, and lawyers, then made available to the public. Since the Procedures Act, one doctor has been guilty of violating the law (MJ en Veiligheid, Gov't of the Netherlands).

The Review Procedures Act increased fears within global medical and spiritual communities. Apprehensions primarily center around arguments of patient capacity, vulnerability, and slippery-slope. Was Brouwers competent to choose PAS, or is this wish a manifestation of her psychiatric issues? How can society reconcile her death and her "capacity" to "competently" choose ending her life? Especially on the grounds of what many still believe to be an "invisible" illness, not clearly prognosticated. If we grant her the right-to-die, how can society halt this practice from spiraling into unintentional deaths on physical or mental grounds? Yet, her narrative is an example where legally adopted safeguards coalesced with a patient's recognition of phenomenological loss and psychiatric terminality. The physicians communicated with Brouwers to determine capacity and compassionately hasten medical death, acting upon legal protections to provide appropriate care for her as a patient and person.

In June, another case in the Netherlands made headlines – the death of teenager Noa Pothovan, who died from her personal decision to withhold nutrition/hydration. Early traumas

spawned years of struggle with multiple psychiatric diagnoses. Pothovan applied to Levenseindekliniek but was denied PAS and euthanasia. The clinic stipulated that she was too young and needed to "complete a trauma treatment and wait until her brain was more fully developed" (WaPo). Noa's story exemplifies a patient who also defined her phenomenological loss and existential intractable pain as terminal but rejected aid-in-death. Her capacity and vulnerability, as a patient, were assuaged by physicians. Highlighting that the Dutch instituted pertinent judgment, upheld the law to compassionately preserve the life of a young patient with psychiatric suffering. Offering skeptics, a case which recognized that PAS on the grounds of existential intractability was withheld.

Both cases illuminate compassionate patient-centered care. In Brouwers's case, physicians legally granted her the right to end her life with medical intervention, not through suicide. In Noa's case, the physicians denied PAS; she was too young, her brain was not fully developed and needed to attempt more treatments. For a physician to practice aid-in-dying and help care for a patient who has decided to end their life, they must appeal to an innate understanding of essential human compassion that ending life is the ultimate transformative medical decision for the patient and physician. Physicians must invoke compassion and foster immense empathy for any patient who suffers unbearably, mentally and physically, and is no longer able to function with a fundamental quality-of-life (Ritchie, NPR).

Medical Practices in the United States

Autonomy is vital to the patient's decision-making process and provides the underpinning for how and why U.S. states have legally enacted laws offering aid-in-death. The laws have opened a new type of demand in patient autonomy, a right-to-die, where medical practitioners ought to offer assistance in death to those who seek it. In 2020, nine U.S. states and D.C. will legally offer PAS for terminally-ill patients. The laws allowing aid-in-death include a few key distinctions, the most crucial being the patient must have a terminal illness pathologized, prognosticated, and corroborated by two physicians that the patient will die within six months (ProCon). Other safeguards include affirming mental competency, and the patient must be over the age of 18. Currently, there is no U.S. law recognizing terminal to be defined as intractable psychological illness.

Within the U.S. medical community, and virtually around the world, the paramount provision of the physician-patient relationship has centered on the principle of nonmaleficence or do no harm (Beauchamp and Childress 150). Patient-centered care must maintain that a physician should never inflict harm or suffering on her/his patient. Therefore, how can the harm of hastening death ever be justified? As a society, the U.S. has slowly progressed towards physicians breaking the medical dictum of nonmaleficence to approve PAS for a patient, only if that patient's imminent harms of death, is prognosticated as six months or less to live. If Brouwers lived in the U.S., she would not have the option of PAS. Her patient-centered care would be subjected to additional psychological treatment, medications, and therapies. Her phenomenological definition of self would be met with medical intervention and a hope of restoring or mitigating a purpose of existence. However, whose existence is the U.S. trying to save? Brouwers's or a societal consciousness regarding the impermissibility of allowing PAS on the grounds of existential intractability? Physicians in the U.S. could look towards the Dutch to compassionately understand a patient can define their meaningless psychological existence as a phenomenological understanding of loss, to deliver incredibly nuanced care, and hasten death for patients who define this loss as a terminal illness of the mind.

Reflection

The circumstances of Brouwers' case were clear from her phenomenological standpoint; she had a loss of self-wholeness, had attempted suicide over 20 times, and stated that she has never known the concept of happiness. The dimensions of her intractability rendered her in a state of unbearable hopelessness and meaninglessness. Her capacity to confer, collaborate, and provide capacity surrounding aid-in-death, is a crucial distinction. The physicians in the Netherlands acted upon compassion to provide patient-centered care and relieve her existential pain by hastening death. They recognized her holistic nature as a competent patient, respected her definition of loss, and understood that her fundamental personal quality-of-life no longer existed, validating her right for medical aid-in-death.

If medicine and treatment fail for a patient who suffers from a mental state of phenomenological loss and the ability to be in this world, as a society what do we have left to offer this person? Wouldn't it feel morally problematic if rare patients, like Brouwers, were forced to live in a meaningless existence whereby they took their own lives? Aiding in the dying

process for a patient is an acceptable practice only when strict guidelines are met and dignifiedly upheld, with jurisprudent criteria outlined. Individuals in terminal states, albeit physical or mental, and voluntary choose death, merit certain rights as those who are living. Beauchamp and Childress state, "physician-assisted suicide, in hastening death, could be viewed as part of a continuum of medical care" (185). In the U.S., physicians could harness the Dutch's compassionate recognition of phenomenological loss and existential intractability to help inform and offer acceptance of a patient's mental terminality. Consequently, U.S. law could be expanded to accommodate Brouwer's-type cases of psychiatric terminality to justify PAS as a continuation of patient-centered care morally.