we believe that we cannot predetermine patients' suffering to be untreatable until we have corrected any potential social factors that may have contributed to or exacerbated people's psychosocial trauma. ∎

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Deep Uncertainties in the Criteria for Physician Aid in Dying for Psychiatric Patients

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In their insightful article, Brent Kious and Margaret Battin (2019) correctly identify an inconsistency between an involuntary psychiatric commitment for suicide prevention and physician aid in dying (PAD). They declare that it may be possible to resolve the problem by articulating "objective standards for evaluating the severity of others' suffering," but ultimately they admit that this task is beyond the scope of their article since the solution depends on "a deep and difficult" question about comparing the worseness of two possible scenarios: letting someone die (who could have been helped) with not letting someone die (whose suffering could only be alleviated by death). In our commentary, we argue that creating such standards is more difficult than the authors assume because of the many types of deep uncertainties we have to deal with: (1) diagnostic, (2) motivational, and (3) existential (cf. Żuradzki 2017).

A "diagnostic" uncertainty was overlooked by Kious and Battin since they did not fully recognize the unique nature of the diagnosis of mental illnesses. They rightly point out that terminality in physician aid in dying requests is not important per se and should be treated rather as an instrument to determine that a further life for a given patient would be most likely "worse than death." However, this may only be grasped in some cases of somatic illnesses, where it is at least sometimes

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possible to make an unquestionable diagnosis and prognosis based on the understanding of pathophysiological mechanisms. For example, if a doctor supposes that a patient has prostate cancer, she can easily verify her hypothesis by referring the patient for a prostate biopsy. In the case of mental illnesses, there is usually no such a laboratory method of diagnosis confirmation, even if one considers mental illness as caused by subtle malformations of the brain (Regier 2012, 293). Mental illnesses are diagnosed by physicians almost entirely on the basis of an interview with a patient and observation of a patient's behavior, and therefore do not capture any information about the underlying pathophysiology that causes the mental disorder (Farah and Gillihan 2012). These epistemic limitations of psychiatry, which amount to limited laboratory testing and imaging methods of diagnosis confirmation, make the diagnosis of mental illnesses more uncertain than many somatic diseases, especially serious cancers, which are typical reasons for a physician aid in dying (e.g., about 80% of the patients requesting and receiving PAD in Oregon have been diagnosed with cancer; see Sumner 2017).

Moreover, diagnostic uncertainty in psychiatry has a deeper dimension. Some maladies described by a single term of, say, "depression" may in fact not constitute a single illnesses but a set of different ones caused by varying factors, and the mechanism of the formation and development of such an illnesses is not yet understood (Farah and Gillhan 2012; Stegenga 2018, 66). If the etiology of mental illness is unknown, it may be difficult for a psychiatrist to formulate any reliable judgment on the development of the illness or the expected quality of life of a psychiatric patient (cf. Vandenberghe 2017, 157–158). Patients' self-reports and external observations of their behavior, even if frequently conducted, are insufficient to satisfy any reasonable threshold of certainty, which is necessary in cases of physician aid in dying.

There are at least two counterarguments against this view. One could argue that the etiology of many somatic diseases is also unknown (e.g., hypertension, migraine) yet these types of diseases are rarely reasons for physician aid in dying requests. One could also argue that most PAD requests (or euthanasia requests, if legal) are often done not because of direct physical pain or suffering but rather for psychological or existential suffering, such as perceived or expected loss of dignity or fear of future physical suffering (Chambaere et al. 2010). This is true, but in many somatic diseases, in contrast to psychiatry, physicians have better tools to check whether patients' expectations and fears are adequate (or not) to the seriousness of their illness (Hyman 2010). Thus, although we agree with Kious and Battin that "the suffering associated with mental illnesses can sometimes be as severe, intractable, and prolonged as the suffering due to physical illnesses," we wonder how, if at all, we can learn about the sources of this suffering and how, if at all, decisions granting euthanasia requests from persons with mental suffering could be institutionally monitored and controlled.

This problem is even more visible in the second type of uncertainty ("motivational"), which is related to the patient's decision-making capacities. Kious and Battin agree with existing regulations (in countries where PAD is legal) that uniformly require that recipients of PAD are not suffering from impaired judgment due to an illness and they believe that this requirement may at least sometimes be fulfilled by persons with severe mental illnesses. Therefore, to resolve the inconsistency in question, the standards they propose should provide criteria for dealing with decision-maker uncertainty about a patient's motives for seeking death: whether and to what extent the patient's exhibited values are distorted by her illness, and whether a wish for death is intrinsic or not to her illness ("is more likely to be a reaction to the illness … than a reaction from it"). Unfortunately, instead of defining these precise criteria, they provide a hypothetical, but hardly surprising, example (i.e., "someone with a severe phobia of dogs") to show that it is conceptually possible to distinguish a reaction to the illness from a reaction from illness, even in cases of illness for which suicidal ideation are characteristic.

Kious and Battin also suggest that it is feasible to pinpoint proper motives for PAD requests in such a way that our judgments about a patient's mental capacity do not hinge on our judgments about the patient's values. Again, this is highly controversial, because the assessment of mental capacity (including the sources of a wish for death) does not consist only in checking structural relations between one's attitudinal mental states independently of whether those states are justified. If we want to check how a patient responds to reasons (e.g., about expected suffering or the prospect of her illness), we must use some normative standards about what constitutes reasonable or appropriate reactions and attitudes (Banner 2012). Moreover, the authors assume that the justified judgment that one's suffering is so great it is better to die should be a reaction to the medically diagnosable bodily or psychological state or condition. This means that they exclude any cases of mental or psychological suffering due to (currently) nondiagnosable sources (euthanasia is allowed for such reasons in some countries, e.g., The Netherlands, provided that the suffering is unbearable, there is no prospect of improvement, and the other legal requirements are met). Of course, mental suffering stemming from nondiagnosable sources covers different types of suffering, such as emotional, existential, or spiritual, but the distinction between (diagnosable) psychical suffering and (nondiagnosable) mental suffering is also value loaded (Raus and Sterckx 2019). In particular, this is visible if we take into account the fact that current psychiatry tends to pathologize normal behaviors and promotes a biomedicalization of common problems in life that may result from the tremendous impact of the pharmaceutical industry on psychiatric research (Bueter 2019).

Finally, the "existential" type of uncertainty is characteristic for all life-and-death medical decisions and stems from a need to weigh expected harms of existence that are full of suffering with the alleged "benefits" of dying earlier. At first glance, these values are incommensurable, like apples and oranges, which makes the project of their weighing conceptually unsound. Furthermore, their weighing depends on solving the age-old philosophical question about the wrongness of death. Moreover, the authors suggest that we should also weigh the severity of a patient's suffering, "both now and in the foreseeable future," which refers again to problems with "diagnostic" uncertainties in psychiatry. At the end of their article they recall "a deep and difficult" question that should be solved if we want to deal with an inconsistency between an involuntary psychiatric commitment for suicide prevention and PAD: "When is it worse that someone dies, whether from suicide or with physician assistance, who could have been helped, and when is it worse that someone whose suffering could only be alleviated by death continues to suffer?" We find this description too simplistic (e.g., it is not clear what kind of worseness relation they have in mind, i.e., what is worse than what?). Instead, we understand that in such situations a decision maker has two possible decisions: to reject the PAD request or to accept it. This may produce four possible outcomes: 1a, a patient has "a nonauthentic" wish for death and it is rejected; 1b, a patient has "a nonauthentic" wish for death and it is accepted; 2a, a patient has "an authentic" wish for death and it is accepted; 2b, a patient has "an authentic" wish for death and it is rejected. We understand that their worry is that the standard they try to propose at the beginning of their article should be helpful in balancing the risks of the two types of errors that using the terminology from statistics we can name: a type I error (false positive or our point 1b) and a type II error (false negative or our point 2b). In our opinion, the main discussion between advocates and opponents of the legalization of PAD depends on attitudes toward weighing these two types of risks: The opponents believe that avoiding errors such as in 1b is much more important than avoiding those in 2b. In particular, they claim that the importance of avoiding this type of error stems from its irreversibility: It is better to bet against allowing psychiatric patients to die, even if we risk not recognizing some "authentic" wishes for death (i.e., making error 2b).

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