Alex James Miller Tate – SAP Postdoctoral Scholarship Report

I am extremely grateful to have held a Society for Applied Philosophy Postdoctoral Scholarship throughout April-October 2021. I worked on two papers while holding the scholarship, both relating to a wider project reflecting on recent proposals to adopt a **palliative approach** to some psychiatric conditions.

1. Terminal Psychiatric Illness

Michael Cholbi (2013), and others (Lopez, Yager & Feinstein 2010; Trachsel et al 2019; Levitt & Buchman 2020), have argued that exclusion of people with certain psychiatric conditions from palliative services such as hospice care and even physician-aid-in-dying (PAD), on the grounds that their conditions are not terminal, is a moral error premised on a conceptual one. According to Cholbi, while psychiatric illnesses are rarely **fatal** (i.e. they do not refer to disease processes that, alone, irreversibly progress towards death), they may nevertheless be **terminal** (they may be necessary causal conditions of death, in combination with agential and social factors). In this sense, a person with severe anorexia who competently refuses life-saving artificial nutrition, or a person with severe depression who chooses to end their life, may thereby *make* their condition terminal, just as surely as somebody who competently refuses a life-saving blood transfusion while experiencing an acute sickle cell crisis.

I argue that this understanding of 'terminal' is incapable of justifying the courses of action that Cholbi and his allies want it to[1]. Firstly, it makes 'terminal' illness hard to identify at the crucial decision-making points, since it involves the output of human agency and causally complex environmental factors. Though you may retrospectively know that a psychiatric illness 'killed' somebody, you could not have established with confidence that they were 'dying' from it until it was too late. Secondly, it threatens practical incoherence. On this conception of terminal illness, presumably one might render a condition terminal by deciding to seek only comfort care or access physician-aid-in-dying. Allowing such situations to thereby *justify* accessing such services trivialises the 'terminally ill' qualifying condition, but not doing so involves putting a theoretically unwarranted restriction on the scope of what should (according to Cholbi) count as a 'terminal' illness. This motivates a search for better concepts for 'Palliative Psychiatry' to make use of.

2. Psychiatry & Futility

Futility has an unhelpful but understandable reputation of being a term doctors use when they are 'giving up' on a patient, and, in its least controversial form, futility is tied to terminal illness. Nobody should want to give up on people with severe psychiatric illness, nor (as I argued previously) can we easily describe any such individuals as 'terminally ill'. Much ink has already been spilled trying to clarify and prosecute debates arising from this (e.g. Geppert 2015; Pienaar 2016; Levitt & Buchman 2020).

Although existing, defensible, concepts of futility struggle to make sense of even refractory cases of psychiatric illness, I argue that 'qualitative' futility, which ties decisions about care to the balance between the likely iatrogenic suffering of ongoing curative treatment and the likely benefits of such treatment *from the patient's point of view*, comes close. The main residual problem, as I see it, is how to determine the benefits of treatment from the patient's point of view, when it is widely understood that many psychiatric conditions essentially involve the distortion of individuals' values, especially when it comes to their own wellbeing.

I argue that the solution is to tie psychiatric futility judgments to patients' *authentic* values and goals. I defend a notion of authenticity that rests on stability over time and narrative coherence in the context of an individual's life (Goldberg 2020). Thus, I am neither quick to include, nor crucially exclude, goals and values that emerge from illness, so-called 'pathological values' (Tan et al 2006), from consideration when it comes to determining whether further intervention is 'futile'. This results in a patient-centred account of futility, designed for the psychiatric context, which can be investigated further to determine what kinds of approaches to care it may be able to license.

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[1] This is not an implicit endorsement of the claim that a 'terminal' (in any sense) qualifier for such services is generally appropriate, or that PAD in general is justifiable. In fact, I oppose PAD laws on disability rights grounds. Nevertheless, it is instructive to analyse Cholbi's position on its own terms.