

**Is the exclusion of psychiatric patients from access to physician-assisted suicide
discriminatory?**

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Abstract: Advocates of physician-assisted suicide (PAS) often argue that, although the provision of PAS is morally permissible for persons with terminal, somatic illnesses, it is impermissible for patients suffering from psychiatric conditions. This claim is justified on the basis that psychiatric illnesses have certain morally relevant characteristics and/or implications that distinguish them from their somatic counterparts. In this paper, I address three arguments of this sort. Firstly, that psychiatric conditions compromise a person's decision-making capacity. Secondly, that we cannot have sufficient certainty that a person's psychiatric condition is untreatable. Thirdly, that the institutionalisation of PAS for mental illnesses presents morally unacceptable risks. I argue that, if we accept that PAS is permissible for patients with somatic conditions, then none of these three arguments are strong enough to demonstrate that the exclusion of psychiatric patients from access to PAS is justifiable.

Physician-assisted suicide (PAS) refers to the provision of a lethal substance to a patient by a physician at the patient's sound request. The substance is provided in order for the patient to self-administer so that they may bring about their own death. Many authors in medicine, philosophy, and public policy believe that there are certain circumstances in which PAS is morally permissible, and there are a growing number of jurisdictions that have introduced laws to ratify this practice. Most often, the circumstances under which PAS is considered morally (and legally) permissible are those wherein a patient is suffering from a terminal, somatic illness, to the exclusion of those suffering from psychiatric illnesses. Notable exceptions to this are Belgium and the Netherlands, where PAS on the basis of psychiatric suffering has been permitted since 2002.[1]

Supposing that it is morally permissible for a person suffering from a terminal, somatic condition to receive PAS, what reasons do we have to exclude persons with mental illnesses from receiving the same treatment? What are the morally relevant differences that make PAS morally permissible for one group but not for the other? A number of arguments have been given in the literature. In this paper, I will address three. Firstly, it is argued that PAS is morally impermissible

when it is provided to persons whose decision-making capacity is compromised. Mental illnesses are conditions which negatively affect a person's decision-making capacity. Consequently, it is morally impermissible to allow those with mental illnesses to receive PAS. Secondly, it is argued that PAS is only morally permissible when it is known that a person's condition is refractory or 'treatment-resistant'. The issue here is that it is very difficult for a physician or psychiatrist to truly know when a person's mental illness is truly refractory. Finally, it is argued that even if PAS for the mentally ill is not morally impermissible *per se*, the ethical implications of institutionalising the practice for the mentally ill would be morally unacceptable. I will argue that, if we accept that PAS is permissible for patients with somatic conditions, then none of these three arguments are strong enough to demonstrate that the exclusion of psychiatric patients from access to PAS is justifiable.

1. Mental illness and decision-making capacity

Attempts to draw a moral distinction between PAS for psychiatric and somatic conditions frequently revolve around the notion of decision-making capacity. For example, a number of authors have discussed this issue in relation to depression and its affect upon a person's capacity for sound decision-making. Kissane and Kelly, for example, claim that "[u]ndoubtedly, competence is lost with severe depression [...] Pain and other physical symptoms, demoralisation, depression or coercion from another may gradually confound the autonomy of any decision." [2] This concern is also expressed by Olie and Courtet. [3]

The basic argument that Kissane and Kelly, [2] Olie and Courtet, [3] and other authors [4] present against the moral permissibility of voluntary psychiatric euthanasia can be represented as follows:

1. Decision-making capacity is often compromised by mental illness, and persons with compromised decision-making capacity are unable to make autonomous and well-considered requests for PAS
2. In order for it to be morally permissible to grant an individual's request for PAS, the individual's request must have been autonomous and well-considered
3. Therefore, it is morally impermissible to grant an individual's request for PAS if that individual has a mental illness

The main empirical premise upon which this argument is based – i.e. that decision-making capacity is often negatively affected by mental illness – is fairly uncontroversial, as it has been corroborated in a number of empirical studies. [5-8] One of the most well-known of these studies, the MacArthur Treatment Competence Study, [5-7] examined the decision-making capacity

of three groups of patients with separate illnesses (depression, schizophrenia, and some form of physical illness), in addition to a control group with no illness. It assessed their decision-making capacity across three separate areas: 1. ability to understand relevant information; 2. ability to appreciate the nature of a situation and its likely consequences; and 3. ability to manipulate information rationally. The study found that “on the measures of understanding, appreciation, and reasoning, as a group, patients with mental illness more often manifested deficits in performance than did medically ill patients and their non-ill control groups.”[7]

Despite this, the argument is problematic. For even if all three of its premises are true, the conclusion does not necessarily follow. The first premise only states that mental illness can *often* compromise a person’s decision-making capacity, not that it *always* compromises this capacity. If it is true that mental illnesses do not always result in a person’s decision-making capacity being compromised, then the argument cannot demonstrate that it is always morally impermissible for persons with mental illnesses to receive PAS.

Perhaps the effect of mental illness upon decision-making capacity is more pervasive than these authors suggest. If it were true that the presence of mental illness thereby indicated that a person’s decision-making capacity was compromised, their argument certainly would suggest that we have good reason to believe that PAS for the mentally ill is morally impermissible. This, however, does not appear to be the case. Studies that have been conducted into mental illness and decision-making capacity have shown that mental illness is insufficient to demonstrate incompetency.[7] The authors of the MacArthur Treatment Competence Study, for instance, conclude that being diagnosed with even a severe mental illness like schizophrenia does not preclude a patient from being competent.[8]

Indeed, many authors who have objected to the moral permissibility of PAS for the mentally ill on the basis of their reduced competency have noted this limitation in the empirical research. Kissane and Kelly, for example, note that “the transition phase through which competence is sustained before a depressed patient loses their previously-held positive world view is unclear,” suggesting that it is possible for someone to be both depressed *and* competent.[2] Similarly, Olie and Courtet also note that “[p]sychopathology does not automatically mean that a patient lacks mental capacity.”[3]

Thus, if it is not true that people with severe psychiatric illnesses have *all* been rendered incompetent or have had their decision-making capacities compromised by their illness, then the argument is only able to justify a weaker conclusion that still admits the moral permissibility of psychiatric PAS in at least some instances. Given this, insofar as physicians have a duty to assess and treat patients as individuals as opposed to members of statistically circumscribed groups, they have a duty to assess the competency of each patient individually, regardless of

the nature of their illness. To do otherwise would be an instance of unjustifiable discrimination against the members of the particular social group in question.

There are two objections that may be made here. Firstly, that allowing psychiatric patients to receive PAS despite the potential for their illness to compromise their decision-making capacity ignores certain clinical realities of psychiatric practice. Capacity assessments performed in the Netherlands for psychiatric patients seeking assistance in dying, for instance, have been limited to global assessments of decision-making capacity, as opposed to more granular, cautious evaluations.[9] Allowing psychiatric patients to receive PAS despite this significant limitation is taken by some to allow for an unacceptable margin of error.

Now, there is certainly good reason to believe that this current practice provides insufficient safeguards for persons as vulnerable as those experiencing psychiatric illness. However, the outright exclusion of psychiatric patients from access to PAS on this basis seems disproportionate and reactionary, given that assessment standards could be raised to rectify this weakness in the process. For instance, a number of MacArthur Competence Assessment Tools have been developed for various practical applications, based upon the aforementioned MacArthur Treatment Competence Study. Commercially available tools have been developed for consenting to treatment (MacCAT-T), consenting to participation in clinical research (MacCAT-CR), and participating in criminal adjudication (MacCAT-CA). These tools assess patients' decision-making capacity across four key areas: understanding, reasoning, appreciation, and expressing a choice. It seems plausible, then, that instead of excluding psychiatric patients from access to PAS, a more detailed and cautious assessment of the decision-making capacity could be implemented, perhaps based upon the existing MacArthur Competence Assessment Tools.

A second objection that could be made is that although a patient's decision-making capacity may not necessarily be *compromised* by psychiatric illness, their desire to die may be a *symptom* of their mental illness. This factor distinguishes mental from somatic conditions, in that a desire to die may indeed be a *consequence* of the symptoms of a somatic illness, or of its practical or emotional implications for the patient, but not itself a symptom. This has important implications, since it suggests that a psychiatric patient's autonomy could be compromised despite their decision-making capacity remaining intact.

There are two things to say about this. Firstly, that while a desire to die can certainly emerge as a symptom of psychiatric illness, it is unlikely – if not implausible – that it would do so without significantly impairing the patient's decision-making capacity.[10] The suggestion that a patient's decision-making capacity could remain intact despite their death wish emerging as a symptom of their illness verges on clinical irrelevance. Secondly, that although this factor certainly necessitates greater caution in the assessment of requests for PAS from psychiatric patients compared to those with somatic conditions, it does not necessitate the outright exclusion

of psychiatric patients. In this vein, it would be reasonable to follow the suggestion of Joris Vandenberghe, a practicing Belgian clinical psychiatrist, who offers a sensible suggestion for the evaluation of PAS request from psychiatric patients. Any assessment of a psychiatric patient's request for assistance in dying, Vandenberghe suggests, ought to be conducted over a minimum period of one year. During this period, the patient ought to have at least ten sessions with one of the psychiatrists on the assessment panel. The assessments must not only explore the possibility of PAS, but take a 'dual-track' approach that also explores any feasible alternatives to PAS.[10] This approach seems eminently reasonable, since it is sensitive to both the greater complexity of these patients' requests, and the need for greater caution in their evaluation.

2. Mental illness and prognostic uncertainty

It has been argued that PAS for psychiatric conditions is morally impermissible because of the uncertainty of psychiatric prognoses compared to those of somatic conditions. For instance, Blikshavn, Husum, and Magelssen argue that patients with 'treatment-resistant' depression ought not be given the option of PAS because a diagnosis of 'treatment-resistance' does not demonstrate that there is no reasonable chance that a person's mental suffering could be relieved or cured.[11] This is for two reasons. Firstly, the diagnostic categories of mental illnesses – unlike those of somatic illness – are merely descriptions of behaviour. A diagnosis of depression, for example, is not based upon the psychopathological mechanism(s) that have caused the illness, but rather upon how the illness expresses itself, i.e. its symptoms. Consequently, "diagnostic categories are bound to include patients with vastly different aetiology and maintenance factors that underlie the current symptoms and behaviour,"[11] and any prediction of a person's prognosis can only be based upon statistical generalisations, as opposed to the actual causes underlying the illness in each individual case.

But this uncertainty does not necessarily cut against the moral permissibility of psychiatric PAS. The fact that psychiatric diagnoses frequently include patients with wide aetiological variance not only magnifies the uncertainty of prognoses, but also the uncertainty of treatment effectiveness. By being able to characterise the psychopathological or pathophysiological mechanism(s) that are causing an illness, physicians are better placed to identify suitable and effective treatments compared to instances wherein the causes of an illness are unknown. This puts psychiatric patients at a significant disadvantage in terms of receiving treatment that is both effective and consistent with their own value-judgements of individual appropriateness. Furthermore, psychiatric patients that request PAS are likely to be those who have suffered from their

illness for lengthy periods of time with histories of psychiatric treatment,¹ where the potential effectiveness of further treatments would appear even slimmer. Given these considerations, the provision of PAS for psychiatric patients would seem eminently reasonable, given their significant disadvantage when it comes to receiving appropriate and effective treatments and therapies compared to patients with somatic illnesses. The certainty of relief that PAS would bring, then, would be far preferable to the uncertainty of further dubious treatments.

But secondly, Blikshavn, Husum, and Magelssen argue that treatment-resistant depression is most often understood in the literature as a lack of response to pharmacological treatment, yet there are many other treatments and interventions that are available (e.g. psychosocial interventions, electroconvulsive therapy, deep brain stimulation, etc.) which are neglected by this label.[11] A simple response to this objection would be that the definition of treatment-resistance ought to be widened to include these additional therapeutic methods. But even if patients are non-responsive to a wide variety of treatments for an extended period of time, there is still hope that they will eventually improve. As Blikshavn, Husum, and Magelssen note, “[s]tories of hopeless battles won are not rare among clinicians, and permanent remission of depression is described in well-documented case studies even following up to twenty-nine years of unremitting depressive symptoms.”[11] The certainty of a refractory diagnosis is thus always open to doubt, as there is always at least a sliver of hope that the patient will recover.

But again, the certainty of relief from suffering that a patient would receive from PAS may be far preferable to them than an indefinite future of continued suffering, despite the possibility that they may make a spontaneous recovery years or decades down the line. Suppose that a patient has suffered from their condition for 15+ years, and has undergone a wide variety of interventions aimed at treating their condition, to no avail. Their psychiatrist has diagnosed their condition as refractory, which has been corroborated by an independent examination. They have made multiple voluntary requests for assistance in dying, and their decision-making capacity has been deemed sound according to the standards of the MacArthur Competence Assessment Tools for Clinical Research and for Treatment (MacCAT-T), which have “emerged as the gold standard to assess mental capacity to consent to treatment.”[13] They understand and appreciate that there is a possibility that their condition may improve in the coming years or decades, yet they remain steadfast in their preference to end their suffering over rolling the dice on enduring further treatment and pain. Blikshavn, Husum, and Magelssen’s argument suggests that the self-determination of such a patient ought to be overridden in the interest of beneficence. Yet rather than acting in the best interests of the patient, denying the request for PAS

¹ Between 2011 and 2014, at least 68% of psychiatric patients that received assistance in dying had psychiatric histories of over 11 years. It is likely that this percentage is in fact higher, since 15% of patients described listed their psychiatric histories as “years,” “decades,” or “longstanding.”[12]

would undermine the self-determination *in spite* of the patient's best interests to be relieved of their suffering. The relative uncertainty of psychiatric diagnoses and prognoses compared to those relating to somatic conditions, then, does not necessitate the exclusion of psychiatric patients from access to assistance in dying.

3. The risks of institutionalisation

Perhaps, then, what makes PAS for those with mental illnesses morally impermissible has to do with the risks of institutionalisation. The thought is that, even if PAS for psychiatric illnesses *is* morally permissible in some instances, the risks associated with the institutionalisation of such a practice may be great enough to outweigh the benefits of offering persons with unbearable psychiatric suffering a potential exit from their misery. In this section, I will evaluate two concerns of this sort that have been expressed in the literature. Firstly, that allowing people with mental illnesses to receive PAS may inhibit the improvement or maintenance of current standards of psychiatric care and/or the development of new and promising psychiatric treatments. Secondly, that institutionalising PAS for psychiatric illnesses would create a vicious cycle of hopelessness in psychiatric treatment.

The first concern has been expressed by, for instance, Olie and Courtet:

Considering euthanasia for psychiatric patients may reinforce poor expectations of the medical community for mental illness treatment and contribute to a relative lack of progress in developing more effective therapeutic strategies.[3]

Concerns of this nature are important and ought to be taken seriously. However, they do not succeed in demonstrating a moral distinction between psychiatric and somatic illness in relation to PAS. This is for three reasons. Firstly, as previously noted, PAS for psychiatric conditions has been permitted in Belgium and the Netherlands for 17 years. Yet there is currently no evidence to suggest that standards of care or the rate of progress of medical research into psychiatric treatments has suffered as a result. In fact, the Netherlands has the highest research productivity in psychiatry in the world, when adjusted for GDP.[14] Secondly, it is equally plausible that the institutionalisation of PAS for psychiatric suffering may stimulate greater care and productivity in psychiatry and medical research. For instance, psychiatrists may feel a greater sense of responsibility towards their patients given the higher stakes of their care. Moreover, the medical research community may receive greater funding for research into psychiatric therapy for similar reasons. Thirdly, aside from concerns regarding hopelessness which will be addressed next, there is no reason to think that the institutionalisation of psychiatric PAS would have different

consequences than the institutionalisation of PAS for somatic conditions. Objecting to the institutionalisation of psychiatric PAS on this basis, therefore, fails to provide a morally justifiable basis upon which to exclude psychiatric patients from access to assistance in dying.

The second concern that has been expressed is that the institutionalisation of PAS for psychiatric illnesses is problematic because it introduces hopelessness into psychiatric treatment.[2, 11] This is because the feeling of hope has a distinct therapeutic significance in psychiatric treatment that is absent in the treatment of somatic illnesses like cancer or AIDS, since feelings of hopelessness can affect the progression of a mental illness, but not the progression of an advanced cancer. For those with mental illnesses, it is claimed that “the *likelihood of improvement* is dependent upon the *hope in improvement*.”[11] By admitting that some cases of psychiatric illness are hopeless or futile, we may be allowing for the possibility of self-fulfilling prophecies wherein, by reinforcing a patient’s feelings of hopelessness, we are thereby undermining that patient’s potential for improvement or recovery. The institutionalisation of PAS for psychiatric conditions may therefore make some psychiatric patients vulnerable to becoming recipients of PAS in cases wherein their improvement or recovery was a genuine possibility.

But this concern is not limited to voluntary psychiatric euthanasia as many of these authors suggest. For feelings of hopelessness have been shown to have a crucial relation to feelings of unbearable suffering for those experiencing both mental *and* physical illnesses.[15] Consequently, although the reinforcement of feelings of hopelessness may not have a direct effect upon the progression of an advanced, somatic condition, it may nevertheless have a profound effect upon the *severity* of a person’s suffering. [16] By admitting that certain instances of cancer, AIDS, heart disease, and so on, are medically futile, we may be making individuals with terminal illnesses vulnerable to experiencing their suffering as unbearable, leading them to seek out medical assistance in dying where they may not otherwise have done so. Hopelessness, therefore, is introduced into both psychiatric and somatic treatment by the institutionalisation of PAS. And, in both instances, the admission of hopelessness introduces the risk of making individuals with these illnesses vulnerable to seeking out these services in instances where other options could have been available to them. Consequently, if we accept these risks for the terminally, physically ill, or believe that they can be overcome through medical and legal safeguards, then we have good reason to do the same for those with psychiatric conditions.

4. Conclusion

A number of arguments have been given for the exclusion of psychiatric patients from access to PAS. In this paper, I have addressed three. If we accept that PAS is permissible for patients with somatic conditions, I have argued that none of these three arguments are strong enough to justify the exclusion of psychiatric patients from access to PAS. If my arguments are sound, this

would suggest that, in relation to the moral permissibility of PAS, the divide between mental and physical illnesses is significantly weaker than is commonly assumed. One important implication of this would be that, in jurisdictions wherein PAS is currently permitted for those suffering from somatic conditions, the exclusion of psychiatric patients on the basis of any of the three arguments addressed in this paper would constitute an instance of unjustifiable discrimination against those suffering from psychiatric conditions.

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