MEDICAL ASSISTANCE IN DYING FOR THE PSYCHIATRICALLY ILL

REPLY TO BUTUROVIC

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In a recent Response published in the *Journal of Medical Ethics*,[1] Zeljka Buturovic provides two criticisms of my argument in 'Is the exclusion of psychiatric patients from access to physician-assisted suicide discriminatory?'[2] Firstly, Buturovic argues that my argument effectively "erases the distinction between healthy adults and patients (whether somatic or psychiatric) essentially implying that PAS should be available to all, for all reasons or, ultimately no reason" (pg. 1).[1] Secondly, Buturovic argues that opening the doors to medical assistance in dying (MAID) for psychiatric patients could have a number of undesirable implications. In particular, Buturovic highlights the potential negative implications for relations of trust in medicine – psychiatry in particular – along with potential effects upon the rate of organ donation. I would here like to respond to these two criticisms.

In short, my response to Buturovic's first argument is that the slope is not nearly as slippery as Buturovic suggests. The reason for this is that the plausibility of Buturovic's argument rests upon a significant misinterpretation of my argument, along with an important equivocation in her own.

Buturovic argues that, under the three criteria that I propose for the provision of medical assistance in dying – sufficient decision-making capacity, demonstrated treatment-resistance, and a lack of substantially negative implications for existing standards of psychiatric treatment and research – the provision of MAID for trivial reasons, even no reason at all, is justifiable. The main problem with this argument is that I propose no such positive criteria. My argument is that none of the three arguments addressed in my previous paper are sufficient to justify the *exclusion* of any and all psychiatric patients from access to MAID. I do not claim, in other words, that any individual that meets the criteria that these arguments support ought to be eligible to receive MAID. The conditions may be *necessary* for eligibility, but they are not *sufficient*. Of course, this point requires some further clarification. If these criteria are not sufficient, then what other criteria are needed? And how do they lead psychiatric patients to be eligible for MAID without leading us down the slippery slope?

As noted above, Butorovic suggests that my argument erases the distinction between healthy adults and sick patients. If this were true, it would certainly be difficult to argue against her conclusions. If there is no morally relevant difference between a healthy individual and an individual that is severely unwell in relation to MAID, the slippery slope to euthanasia-for-all would appear to be particularly well-greased. Yet Buturovic's claim that I erase this distinction is only plausible if we accept her misinterpretation of my argument: that decision-making capacity, irreversible suffering, and a lack of negative implications of psychiatric treatment and research are sufficient for the provision of MAID.

Thankfully, as previously noted, this is not my claim. I believe, rather, that the arguments supporting these three criteria are sufficient neither to justify the *exclusion* of psychiatric patients from access to MAID, nor to justify the immediate *inclusion* of any individual who meets them. Indeed, what in my view justifies the inclusion of psychiatric patients in eligibility to receive MAID (over and above the reasons already discussed) *is precisely their status as sick patients as opposed to healthy adults.* In this sense, rather than effacing this distinction, my arguments affirm and depend upon it.

With these points in mind, let us evaluate what I think is Buturovic's central argument. Buturovic uses the following scenario to argue that, if we accept my argument, we would thereby be led down the slippery slope into unpalatable or unjustifiable conclusions: Suppose that a healthy adult is contemplating suicide, largely stimulated by the sudden loss of their child. "Her loss is irreversible, she believes that unbearable suffering she is experiencing will be with her forever and nobody can guarantee that this will not be the case (pg. 1)"[1] According to my argument, Buturovic claims that this individual ought to be eligible to receive MAID. Buturovic then leverages this scenario to lead us all the way down the slippery slope to a future in which MAID is permissible for even the most trivial of reasons, including unrequited love or the closing of one's favourite restaurant. After all, she claims, these circumstances may too be irreversible, and the request for MAID could be made by someone whose decision-making capacity remains uncompromised.

Yet the problem with this argument is that the scenario upon which it rests trades illicitly upon the distinction between irreversible *states of affairs* and irreversible (or treatment-resistant) *psychiatric illness*. Buturovic highlights that the individual's *loss* is irreversible, but not that their psychiatric suffering has in any way indicated strong evidence of resistance to treatment. But this misses the point. The loss is certainly irreversible, but the question is not whether the catalysing circumstances of one's suffering are irreversible but rather whether the suffering itself demonstrates strong evidence of irreversibility due to serious psychiatric illness. Similarly, the fact that a patient *believes* her suffering to be irreversible and that no one can guarantee her otherwise is not conclusive indication of treatment-resistance or medical futility, which is the central point.

Let us then return to the central question: By accepting the moral permissibility of MAID for psychiatric patients, is Buturovic correct that we are thereby embracing the slippery slope toward death-on-demand? Given my preceding argument, I think the answer is a firm no.

But let's now move on to her second criticism, which proceeds in two parts. As for the first part, Buturovic argues that the provision of MAID for psychiatric patients may contribute to declining levels of trust in medical institutions and individual professionals – particularly psychiatrists, whom she notes to have a reputation in the U.S. that is closer to bankers than other medical practitioners. "It is doubtful," claims Buturovic, "that freely dispensing or even casually contemplating offering suicide pills to their patients will help reverse these trends" (pg. 2).[1] Although this highlights an important point, its implications are exaggerated here. Given that the provision of MAID to psychiatric patients need not – and should not – lead us down the slippery slope to euthanasia-for-all, I see no reason to believe that psychiatrists would be willing to consider the option of MAID for their patients frivolously, as Buturovic here suggests.

In the second part of her second criticism, Buturovic applies these concerns relating to trust in medicine to a particular case: the issue of organ donation and transplantation. Buturovic argues that the provision of MAID to psychiatric patients could turn the public against transplantation by virtue of strengthening the apparent link between MAID and organ donation. Given that psychiatric patients are more likely to have viable organs for transplantation compared to somatic patients, Buturovic suggests that psychiatric MAID may lead to a significant increase in the number of organs taken from MAID recipients. The problem that Buturovic sees here is that strengthening the public's awareness of the link between MAID and organ donation – particular with relation to psychiatric patients – may significantly turn them against the practice. "As the enduring appeal of movies like 'Coma' illustrates," she suggests, "a fear that one might be abducted or killed for his organs has been alive in the public mind for a long time" (pg. 2).[1]

In short, my reply to these two parts of Buturovic's second criticism is that although potentially negative implications that may result from the institutionalisation of psychiatric MAID ought to be taken seriously, the possible consequences highlighted by Buturovic are at present largely speculative. As such, rather than warranting the rejection of the practice, these concerns warrant a monitoring of the effects of psychiatric MAID for relations of trust in medicine along with public attitudes to organ donation, and a re-evaluation of the practice in the instance of substantially negative implications in either domain. It would certainly be reckless to allow for psychiatric MAID if doing so would foreseeably have disastrous effects for relations between the medical institution and the general public, sparking further conspiratorial theorising, declining adherence to public health initiatives, and

deference to snake oil therapies as opposed to traditional medicine, among other things. Yet at present there is little evidence to think such disastrous effects are likely to occur.

References

1. Buturovic Z. Embracing slippery slope on physician-assisted suicide and euthanasia could have significant unintended consequences. *J Med Ethics*. 2020. doi:10.1136/medethics-2020-106089

2. Hatherley JJ. Is the exclusion of psychiatric patients from access to physician-assisted suicide discriminatory? *J Med Ethics*. 2019;45(12):817-820.