

Assisted dying for mental illness: a contemporary concern that requires careful and compassionate consideration

Gin S. Malhi

Summary

With assisted dying becoming increasingly available to people suffering from somatic diseases, the question arises whether those suffering from mental illnesses should also have access. At the heart of this difficult and complex matter are values such as equality and parity of esteem. These issues require humane deliberation.

Keywords

Assisted dying; medical assistance in dying; mental illness; request; evaluation.

Copyright and usage

© The Author(s), 2024. Published by Cambridge University Press on behalf of Royal College of Psychiatrists.

The Feature article¹ in this issue of the *BJPsych* is the product of a somewhat unique situation in Canada, where, although legislation has been passed to provide medical assistance in dying (MAiD) to those with a mental illness, its implementation has been deferred because of widespread concerns regarding its provision to so-called vulnerable populations. Therefore, while matters are in a state of abeyance, appropriate safeguards are being sought. To this end, the authors of the Feature¹ propose a detailed framework² for evaluating MAiD for individuals who wish to end their life because of unbearable suffering caused by a mental illness. Not unreasonably, they assume that MAiD will become more broadly available in Canada in 2027 and therefore do not address the question of whether it should be available *per se*. Therefore, Canada is considering legislation to allow assisted dying for mental illness, similar to the legal frameworks in place in The Netherlands, Belgium and Switzerland.³ In most other places around the world, assisted dying is not available at all, for any condition, and is not provided to anyone.⁴ Neither of these approaches (assisted dying for everyone or no one) will ever be acceptable to all, and although one may disagree with either of them, at least both of them treat everyone the same and cannot be accused of discriminating against any particular group. This is also true of some of the arguments made on both sides of this contentious debate.

For instance, those that argue against assisted dying based on the belief that human life is sacred – the sanctity of life claim – make the case for everyone equally, both those with a somatic disease and those with a mental illness.⁵ Similarly, concerns that assisted dying may have a negative impact on the professional role that doctors fulfil as healers, and that it likely compromises the relationship between doctors and their patients, again apply to all illnesses. Opponents also have concerns that assisted dying may be subject to abuse and refer to a potential ‘slippery slope’, whereby rules concerning eligibility and safeguards designed to protect the vulnerable gradually become more relaxed over time. These are all real risks, and hence the suggestions made by the authors in the Feature¹ regarding safeguards in assisted dying practices are important.

On the other side of this debate, proponents of assisted dying argue for autonomy and the right of individuals to choose how they die – consistent with the widely accepted idea that people should be able to choose how they live.⁶ They also argue on the basis of compassion that assisted dying should be permitted to relieve the unbearable and unnecessary suffering of individuals. Like the arguments put forward by opponents of assisted dying, its proponents champion reasons

that apply to all individuals with any kind of illness. That is not to say that there are no challenges with either position, indeed there are likely to be exceptions on both sides of the debate, but in terms of *a priori* discrimination against mental illness neither of these positions seems to be biased or unfair. However, some jurisdictions distinguish between somatic diseases and mental illness with respect to access to assisted dying and purposely exclude the latter.

Distinguishing between somatic disease and mental illness

An example of a jurisdiction that has recently adopted this position is Australia, which offers voluntary assisted dying but, like New Zealand and several US jurisdictions, limits this to individuals with a terminal somatic disease.⁴ This creates a situation in which there is marked disparity. It is unclear on what basis this distinction is made. If, for instance, it is based on the level of suffering, then few of those who have lived experience would deny that this is the same for those with a mental illness as it is for those with a somatic disease. Indeed, many individuals who have experienced both severe mental illness and somatic diseases rate the suffering associated with their mental condition as being far more severe.⁷ Further, one could argue that suffering in the case of a mental illness is potentially greater, given that the illness itself does not lead to death and the person will therefore live much longer and eventually suffer for a much longer period of time. Therefore, if the relief of suffering is the primary purpose of assisted dying, then the justificatory force for assisted dying in the case of mental illness is the same as that for somatic disease. Another possible reason for the disparity could be that there are concerns about the nature of mental illness that reduce confidence in the validity of the request for assisted dying; it could also be a combination of the two.⁸ To better understand this, it is necessary to take a closer look at the process of making a request for assisted dying.

The decision to request assisted dying

In practice, a request for assisted dying begins with the individual weighing up whether it is in their best interest to continue to live while suffering. To do this they need to be able to evaluate their life holistically, which entails carefully deliberating their

relationships, purpose, values and beliefs: all of these, along with other factors, contribute to their sense of worth as an individual. In addition, they must be able to consider the impact of their decision on others. These thoughts are critical, as they have to be able to make a well-considered decision that they alone can make.⁹ First, they need to evaluate their illness and their degree of suffering, for which they need to know whether their illness can be treated and what is its likely prognosis. They then have to decide whether they can live with the level of suffering that they may need to endure – in other words, to determine to what extent it is bearable. To do this, they need to have deliberative capacity, which allows them to think carefully and assess their life, the nature of their illness and the extent of their suffering, and to make a considered decision as to whether they wish to end their life.

In the case of a somatic disease, the consequences of the illness unfold over a period of time and initially appear sequentially, affecting the person's life and leading to cumulative suffering as the illness develops. Assessing their illness, the person is reliant on information and knowledge about it. If it is a disease such as cancer, then many aspects can be known with reasonable certainty. Tests and investigations can tell whether the illness is progressing or responding to treatment, and what is the likely prognosis. Treatments can be trialled with the knowledge that the illness can be tracked, and this is helpful when the person assesses their suffering and whether this is bearable. In essence, the illness is seen as separate. The experience of suffering even in the context of a somatic disease is invariably subjective, but its evaluation is easier if the factors involved – those intrinsic to the illness and those separate from it – can be judged accurately and seen as distinct. Through a process of careful deliberation, a person suffering from a somatic disease is usually able to arrive at a decision in which they have reasonable confidence because the majority of important contributory factors have been adequately taken into consideration. Many of these factors are 'quantifiable' – at least in terms of subjective worth – and therefore the final decision is regarded as authentic.

In contrast, in mental illness, there are two problems. First, mental illness itself lacks definition to the same level as a somatic disease. Second, it necessarily overlaps and potentially interferes with deliberative capacity and the person's experience of suffering. For example, in depression, even when extremely severe and characterised by melancholic features, it is often not possible to provide the diagnostic clarity achievable with a cancer diagnosis of equivalent severity. This is primarily because its nature is unknown. For the same reasons its prognosis and response to treatment are difficult to predict. This uncertainty regarding the ontology of depression, in and of itself, makes it difficult to know for sure the extent of the illness. Consequently, the suffering caused by depression is conflated with its nature and is viewed as a part of the illness and not as a broader experience or one that is a corollary of being depressed. Similarly, it is queried whether the desire to die is a symptom of depression – essentially the same as suicidal ideation and thinking – instead of being a well-considered and formulated decision that has been carefully deliberated. In depression, indecisiveness is also a common symptom and therefore the ability to weigh up matters and make a considered judgement may also be regarded with suspicion. In keeping with this line of thinking, many aspects of arriving at a decision to want to end one's life are viewed cautiously, and the desire to die is thought not to be genuine. These suspicions are not unreasonable, but at the same time they warrant closer examination and should not be automatically assumed to be true. On the other hand, the suspicions are also plausible and as such may cast doubt on the validity and veracity of any request for assisted dying made by a person with a mental illness.

The right to ask

Importantly, doubts such as these have an impact on the step prior to any formal evaluation of eligibility for assisted dying, namely, having the option to make a request – the right to ask. This 'right' depends on having legal permission that is granted by law, and if legislation that makes assisted dying possible is not in place, then there is no opportunity even to ask for assistance of this kind. This is the situation in jurisdictions that allow assisted dying for somatic diseases but not mental illness. Perhaps the exclusion of mental illness at this early juncture is a matter of expediency, because preventing the evaluative process before it even gets started is likely to save funds. Therefore, rather than initiation of the process being based on suffering, the very first step, that of having permission even to make a request, is altogether removed because of downstream concerns.

Conclusion

It is important to note once again that I am not advocating for, or against, assisted dying, and that I am not suggesting that assisted dying should be available for mental illness. Instead, I am simply positing some points for consideration and my arguments are conditional. If in a particular jurisdiction assisted dying is available: should it not be equally accessible to those with a mental illness as to those that are suffering from a somatic disease? Is it not unfair that one group has access and the other does not, even though they are clearly the same in important respects, such as their experience of suffering? Would it not be better to allow those with a mental illness at least to make a request for assistance to ensure that they are heard and have equity of access and parity of esteem?

Having said this, because the nature of mental illness is indeed different, and more uncertain, it seems appropriate that its evaluation should be more thorough. Maybe the evaluation can be conducted along the lines proposed by the Feature article,¹ but with more comprehensive assessments, each of them involving several specialists, including psychiatrists, with more stringent criteria and over a longer time. Of course, all of this only matters if assisted dying is available in the first place, and whether in the future it will be an option in the UK, and if so, for whom, remains to be seen.

Gin S. Malhi , MBChB, BSc (Hons), MSt, MD, FRCPSych, FRANZCP, Academic Department of Psychiatry, Kolling Institute, Northern Clinical School, Faculty of Medicine and Health, The University of Sydney, Sydney, New South Wales, Australia; CADE Clinic and Mood-T, Royal North Shore Hospital, Northern Sydney Local Health District, St Leonards, New South Wales, Australia; Department of Psychiatry, University of Oxford, Oxford, UK; and Oxford Uehiro Centre for Practical Ethics, Faculty of Philosophy, University of Oxford, Oxford, UK

Correspondence: Gin S. Malhi. Email: gin.malhi@sydney.edu.au

First received 28 Apr 2024, accepted 28 Apr 2024

Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

Acknowledgement

I am grateful for feedback from reviewers.

Author contributions

G.S.M. researched, drafted and edited this manuscript. The views in this article are his alone.

Funding

Research for this article received no specific grant from any funding agency, commercial or not-for-profit sectors.

Declaration of interest

G.S.M. is the College Editor, Editor-in-Chief of *BJPsych* and a member of the RCPsych Assisted Dying Working Group. As a researcher he has received grant funding from the American Foundation for Suicide Prevention, the National Health Medical Research Council in Australia, Australian Rotary Health, NSW Health, the Ramsay Research and Teaching Fund and the North Foundation in Sydney. He presently holds an Ignition grant from the University of Sydney and the National University of Taiwan. He has received an educational grant from Lundbeck and research grant funding for an investigator initiated study (IIS) from Janssen-Cilag. As a speaker, he has received honoraria from Elsevier, AstraZeneca, Janssen-Cilag, Lundbeck, Otsuka and Servier, and as a consultant on Advisory Boards has received honoraria from Janssen-Cilag, Lundbeck and Servier.

Transparency declaration

The author guarantees that this manuscript is an honest, accurate and transparent account.

References

- 1 Bastidas-Bilbao H, Castle D, Gupta M, Stergiopoulos V, Hawke LD. Medical assistance in dying for mental illness: a complex intervention requiring a correspondingly complex evaluation approach. *Br J Psychiatry* 2024; **224**: this issue. Available from: <https://doi.org/10.1192/bjp.2024.21>.
- 2 Skivington K, Matthews L, Simpson SA, Craig P, Baird J, Blazeby JM, et al. A new framework for developing and evaluating complex interventions: update of medical research council guidance. *BMJ* 2021; **374**: n2061.
- 3 Health Canada. *Final Report of the Expert Panel on MAiD and Mental Illness*. Government of Canada, 2022.
- 4 House of Commons Health and Social Care Committee. *Assisted Dying/ Assisted Suicide: Second Report of Session 2023–24* (HC 231). House of Commons, 2024 (<https://committees.parliament.uk/publications/43582/documents/216484/default/>).
- 5 Grassi L, Folesani F, Marella M, Tiberto E, Riba MB, Bortolotti L, et al. Debating euthanasia and physician-assisted death in people with psychiatric disorders. *Curr Psychiatry Rep* 2022; **24**: 325–35.
- 6 Moureau L, Verhofstadt M, Liégeois A. Mapping the ethical aspects in end-of-life care for persons with a severe and persistent mental illness: a scoping review of the literature. *Front Psychiatry* 2023; **14**: 1094038.
- 7 Dembo J, Schuklenk U, Reggler J. 'For their own good': a response to popular arguments against permitting medical assistance in dying (MAiD) where mental illness is the sole underlying condition. *Can J Psychiatry* 2018; **63**: 451–6.
- 8 Nicolini ME, Kim SYH, Churchill ME, Gastmans C. Should euthanasia and assisted suicide for psychiatric disorders be permitted? A systematic review of reasons. *Psychol Med* 2020; **50**: 1241–56.
- 9 Calati R, Olié E, Dassa D, Gramaglia C, Guillaume S, Madeddu F, et al. Euthanasia and assisted suicide in psychiatric patients: a systematic review of the literature. *J Psychiatr Res* 2021; **135**: 153–73.