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Suicide and Physician-Assisted Death for Persons With Psychiatric Disorders How Much Overlap?

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Physician-assisted death (PAD) of persons in which psychiatric disorders are the basis for the procedure (psychiatric PAD) remains infrequent but rising in number in Belgium and the Netherlands where it is legal, comprising about 1% to 2% of PAD. There were 83 cases in the Netherlands in 2017[1] (per capita US equivalent would be about 1580 cases). Canada's euthanasia law generally excludes psychiatric PAD, but there are court challenges to expand the law.

In those states within the United States where PAD is legal, the procedure is limited to the terminally ill but we believe there will be efforts to expand the laws to include psychiatric PAD. One indication of this comes from a surprising source, the American Association of Suicidology (AAS), an organization dedicated to the prevention of suicide. The AAS recently released a statement asserting that "legal physician assisted deaths should not be considered to be cases of suicide and are therefore a matter outside the central focus of the AAS."[2] The statement largely relies on a contrast between PAD in a person with terminal illness (eg, a patient who is already dying and wishes to control how he or she dies, a "foreseeable death occurring a little sooner but in an easier way"[2]) and suicide in a person with mental illness ("suicide in the ordinary, traditional sense"[2]). Given this contrast, it would have been quite understandable if the AAS had limited its statement to PAD for terminal illness—especially because the organization is based in the United States (where psychiatric PAD is not legal) and dedicated to preventing suicides (which occur mostly among persons with mentalillness[3]).Yet the AAS statement's support for PAD explicitly

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includes legalized PAD of all types, including PAD for non–terminally ill persons with psychiatric disorders.[2] It does so without discussing whether psychiatric PAD can be distinguished from "suicide in the conventional sense"[2]—a key issue given "the established societal responsibility to prevent suicides by people with mental illness."[4]

The statement that PAD for persons with psychiatric illness is distinguishable from suicide as we ordinarily know it and, therefore, not the purview of an organization dedicated to preventing suicide,[2] suggests that evidence supports the distinction. However, juxtaposing the AAS statement's descriptions of "suicide in the ordinary, traditional sense"[2] with the existing evidence on psychiatric PAD reveals that the features of persons who die by suicide that are said to distinguish them from persons who seek PAD for terminal illness are, in fact, features shared by those who receive psychiatric PAD.

The AAS statement lists many features of persons who die by suicide (eg, mental illness, isolation, loneliness, personality disorders) which purportedly distinguish them from those seeking PAD. However, persons who receive psychiatric PAD share these characteristics: they all have some form of mental illness; most also have personality disorders, have attempted suicide, and are socially isolated or lonely.[5] Indeed, some receive PAD shortly after a suicide attempt, like a man who jumped off a building, survived the fall with broken thighs, and then received PAD during the ensuing hospitalization.[5]

Still, sharing risks or characteristics of those who die by suicide need not mean PAD is the same as suicide. It could be that even persons seeking psychiatric PAD have different mindsets and motivations—just as persons with terminal illness seeking PAD are said to have different motivations[2]—from those who die by suicide. Thus, the AAS statement notes that "[s]uicide… typically stems from seemingly unrelenting psychological pain and despair; the person cannot enjoy life or see that things may change in the future….[and] suffers from…loss of meaning."[2] However, research shows that these common features of suicide are not only present in psychiatric PAD but are cited as justifications for PAD (to show that a person is *suffering intolerably*, as defined in and required by the Dutch law and Code of Practice[1]). Consider, for example, this characterization of a patient by a physician who provided her psychiatric PAD: "She suffered from the meaninglessness of her existence, the lack of a prospect of a future and the continuous feeling of finding herself in a black hole… she experienced deep despair and loneliness [Patient 2015–32]."[1]

This patient shares another feature with persons with suicidal thoughts. As the AAS statement notes, in suicide, "the person often 'sees no way out' of their desperate situation."[2] The statement's assumption is that the perspective of a person with suicidal thoughts is distorted, that the person's experiences can be made tolerable and the will to live restored with treatment. Thus, it might be thought that psychiatric PAD would be granted only to those who have exhausted all reasonable treatment options. While in theory a patient and the physician together must agree that there is "no prospect of improvement,"[5] the criterion is now overstretched to emphasize the subjective component, according to psychiatrists interviewed in a Dutch government study.[6] This view is consistent with evidence showing that most patients receiving psychiatric PAD refuse available treatments (such as electroconvulsive therapy or monoamine oxidase inhibitors for depression) but are still

deemed to meet the futility criterion.[5] When a patient terminally ill with cancer refuses burdensome interventions to control how he or she dies, it does seem unjustified to call this behavior suicidal; a refusal of available psychiatric treatment by a patient in despair who wishes to die seems a rather different kind of refusal.

Finally, it may be that despite sharing risks for suicide and having similar motivations for desiring death, a person seeking psychiatric PAD may be distinguished from someone considering suicide if physicians can identify suicidal persons as those who are, as the statement notes, “unable to assess his or her situation clearly or objectively.”[2] How one evaluates a patient’s decision making and choice will depend on how reasonable the patient’s desire for death seems to the evaluator. The evidence shows that, contrary to the expectation that physicians evaluating psychiatric PAD requests would apply a high degree of scrutiny and a high threshold for decisional capacity, this is not the standard practice for most cases.[7] So a person with persistent psychosis and anxiety-provoking delusion and requesting PAD can in practice be pronounced competent to receive PAD with no specific justifications from the evaluators.[7]

Physician-assisted death at the end of life is about the desire to control how one dies, not whether one lives or dies. In contrast, psychiatric PAD is about whether one lives or dies—as it is in suicide. When a suicide prevention organization such as the AAS disregards this distinction and explicitly extends its support to psychiatric PAD, the public deserves an evidence-based explanation. In fact, the emerging evidence does not support their position, and actually goes in the opposite direction. Such evidence has led even some supporters of legalized psychiatric PAD to call for either a much more rigorous method of evaluating psychiatric PAD requests (eg, longer repeated evaluations by multiple evaluators with specialty expertise; prospective panel reviews; rigorous application of more objective medical criteria for futility) or rejecting its legalization altogether.[8]

In the debate about psychiatric PAD, important considerations are raised by both sides.[4,8]One of the most concerning is how the practice of psychiatric PAD will affect the longstanding societal commitment to the prevention of suicide. It should give us pause when a leading suicide prevention organization minimizes this problem while ignoring the evidence that psychiatric PAD is difficult to distinguish from suicide.Regardless of one’s position on the policy debate,all sides should at least be committed to a more evidence-based dialogue.

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