

Physician Aid-in-Dying and Suicide Prevention in Psychiatry: A Moral Crisis?

Abstract: Involuntary psychiatric commitment for suicide prevention and physician aid-in-dying (PAD) in terminal illness combine to create a moral dilemma. If PAD in terminal illness is permissible, it should also be permissible for some who suffer from non-terminal psychiatric illness: suffering provides much of the justification for PAD, and the suffering in mental illness can be as severe as in physical illness. But involuntary psychiatric commitment to prevent suicide suggests that the suffering of persons with mental illness does not justify ending their own lives, ruling out PAD. Since both practices have compelling underlying justifications, the most reasonable accommodation might seem to be to allow PAD for persons with mental illness whose suffering is severe enough to justify self-killing, but prohibit PAD for persons whose suffering is less severe. This compromise, however, would require the articulation of standards by which persons' mental as well as physical suffering could be evaluated. Doing so would present a serious philosophical challenge.

Keywords: suicide; physician aid-in-dying; psychiatry; civil commitment; mental illness; competence; suffering

I. Introduction

Psychiatry and other mental health professions in the United States may be about to face a moral crisis. It has long been the case that mental health providers in the U.S. and other countries have been empowered to use coercive measures, particularly involuntary civil commitment to psychiatric hospitals, to prevent death by suicide in persons with mental illness. This practice is a

crucial element of mental health care. We think, however, that it is deeply inconsistent with a somewhat more recent trend, namely the legalization of physician aid-in-dying (PAD; also referred to as physician-assisted suicide and medical aid-in-dying). The inconsistency we see, which is already being felt more intensely in Canada, the Netherlands, and other jurisdictions that have gone farther in legalizing PAD and euthanasia, is that the implicit rationale for laws allowing PAD in the U.S. is that suffering can be an adequate reason for self-killing; but this implies, we argue, that suffering due to mental illnesses should at least sometimes be an adequate justification for self-killing, too. On the other hand, laws allowing involuntary civil commitment for the purpose of suicide prevention imply that suffering due to mental illness is pretty much never a good reason for self-killing. The inconsistency between PAD and involuntary commitment procedures matters because both practices seem morally justified; neither can be rejected out of hand. Nor, we think, can the inconsistency be dismissed by understanding the rationale for PAD differently: although the explicit rationale for laws allowing PAD in the U.S. is usually respect for autonomy rather than the alleviation of suffering, the ultimate justification for respecting the autonomy of people with terminal illnesses who seek PAD is the recognition that their suffering can be severe. Instead, we argue, resolving the inconsistency in a satisfactory way would require us to articulate objective standards for evaluating the severity of others' suffering. The conflict between PAD and involuntary commitment poses a difficult question: when is a person's suffering so bad that it is reasonable for her to kill herself, and when is it not? And to what extent can the judgment that her suffering is so severe as to justify killing herself be left up to the person herself?

To avoid any misconceptions, we should clarify early on that the problem we see is *not* merely that PAD, from the standpoint of psychiatry, is a form of suicide, while psychiatry is opposed to suicide. Regardless of how they should be classified (Pies 2018), we think there are

many important differences between the kinds of deaths typically resulting from PAD and most suicides, as detailed in a 2017 statement of the American Association of Suicidology (AAS) ([omitted for review]) with which one of us ([omitted for review]) was involved. Nor do we think that psychiatrists should reflexively, and non-reflectively, interfere with all persons who reveal that they are planning on killing themselves when these plans are in accord with existing PAD laws (Yager, et al. 2018). Likewise, our concern is not that PAD laws in the U.S. allow assisted dying for most persons with mental illness; they do not. All U.S. laws to date require that a (physical) illness be “terminal” (i.e., that death reasonably can be expected to occur within six months), and that the person making the decision is does not suffer from impaired judgment because of a mental illness or other condition. Many persons who would seek PAD for a mental illness would fall afoul of one or both of these exclusions. Rather, we think, PAD and civil commitment processes are in conflict because they reflect mutually incompatible ideas about the disvalue of suffering and the value of life.

II. Suffering, Autonomy, and Mental Illness

Suffering as legal rationale

Let us first consider the implications of PAD laws for persons with mental illness. We think there is one main justification for pursuing PAD in central cases—physical-illness-only cases like severely painful and untreatable metastatic cancer or advanced amyotrophic lateral sclerosis (ALS). It is that those conditions cause *suffering*. We embrace Cassell’s claim that “suffering occurs when an impending destruction of the person is perceived; it continues until the threat of disintegration has passed or until the integrity of the person can be restored in some other manner” (Cassel 1982), and note that others have defined suffering similarly (Charmaz 1983). Diseases

like ALS can cause suffering in two very broad ways. First, they cause suffering by producing unpleasant sensations and emotions—pain, in short—that seems to threaten one’s personal integrity by its very intensity, or which is regarded as being without meaning, or which one feels one does not have adequate reason to endure. The second way physical diseases cause suffering is by diminishing one’s capacities and thereby threatening one’s dignity, identity, selfhood, or independence. We believe both types of concerns can motivate individuals’ decisions to pursue PAD.

Some have criticized Cassell’s analysis of suffering on various grounds (Braude 2012, Svenaeus 2014, Bueno-Gomez 2017), and one might also question whether our application of the concept is wholly consistent with Cassell’s. But our use of the term “suffering” is intended primarily to designate a diverse set of personal experiences that could motivate terminally ill persons to end their own lives; we think our dual categorization of those experiences, though probably imperfect, is close enough to correct, and sufficiently capacious to capture the majority of them. The most common reasons given for their actions by those who pursued PAD in Oregon were, in addition to the avoidance of pain, wanting to control the circumstances of death, and concerns about loss of independence, poor quality of life, and inability to care for one’s self (Ganzini, et al. 2009). Similarly, a Dutch survey of those who had pursued euthanasia “showed that patients express their unbearable and unrelieved suffering in terms of pain, weakness, functional impairment, dependency, being a burden, hopelessness, indignity, intellectual deterioration, perception of loss of oneself, loss of autonomy, and being tired of life” (Dees, et al. 2010).

The rationale of alleviating suffering in this sense is explicit in most European PAD/euthanasia laws and in the Canadian supreme court decision in *Carter v. Canada*, which

reference the notion of “unbearable” or “intolerable” suffering (Termination of Life on Request and Assisted Suicide Act 2001, McLachlin, et al. 2015). We think it is also implicit in the practice of PAD in the U.S, although in most states that have legalized the practice the relevant statutes merely make reference to “suffering from a terminal illness” and do not explicitly state that the relief of suffering itself is a prerequisite or even an understandable motive for PAD (Oregon Death with Dignity Act 1994, Washington Death with Dignity Act 2009, Vermont Patient Choice at End of Life Act 2013, California End of Life Act 2015, Colorado End-of-Life Options Act 2016, District of Columbia Death with Dignity Act 2016). The Our Care, Our Choice Act recently passed by Hawaii is an exception, as it clearly states that its rationale is to provide “the right to choose to avoid an unnecessarily prolonged life of pain and suffering” (Hawaii Our Care, Our Choice Act 2018).

To be sure, our point is not necessarily that all of the lawmakers and voters who decided to permit PAD in various U.S. jurisdictions to date were motivated by a desire to relieve patients’ suffering or that they believed that severe suffering due to a terminal illness could justify PAD. But we do think that much of the moral appeal of the legalization of PAD rests on recognition of the fact that it can be reasonable to want to end one’s life when one’s illness causes, or at least threatens, sufficiently severe suffering. After signing California’s assisted suicide law, Governor Jerry Brown stated: “In the end, I was left to reflect on what I would want in the face of my own death.... I do not know what I would do if I were dying in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill. And I wouldn’t deny that right to others” (Megerian 2015). This echoes the rhetoric that patients who have advocated for access to PAD have used. Holly Warland, an Australian woman with limb

girdle muscular dystrophy, a severe degenerative illness, explains her support for assisted-dying legislation in terms of concern about her own suffering:

I have been given the opportunity to advocate for issues close to my heart. One of these issues is the legalization of Voluntary Assisted Dying in my state. The unfortunate reality for me is that this condition will eventually make life unbearable for me and I want a safe and reliant option to end my life when I am ready. I never thought this was an issue I would become so passionate about but when I stopped to think about it, it's my only humane option. I could wait until I die naturally but that might be decades of more pain and suffering. I work with a group called Dying with Dignity Queensland to convince and work with politicians to pass fair and merciful voluntary assisted dying laws (Warland 2018).

Perhaps most compellingly, Brittany Maynard, a newly married young woman with terminal brain cancer who moved from California to Oregon to use the latter state's death with dignity law to end her life, articulated her reasons for doing so in terms of her suffering:

Because my tumor is so large, doctors prescribed full brain radiation. I read about the side effects: The hair on my scalp would have been singed off. My scalp would be left covered with first-degree burns. My quality of life, as I knew it, would be gone. After months of research, my family and I reached a heartbreaking conclusion: There is no treatment that would save my life, and the recommended treatments would have destroyed the time I had left. I considered passing away in hospice care at my San Francisco Bay-area home. But even with palliative medication, I could develop potentially morphine-resistant pain and suffer personality changes and verbal, cognitive and motor loss of virtually any kind.

Because the rest of my body is young and healthy, I am likely to physically hang on for a long time even though cancer is eating my mind. I probably would have suffered in hospice care for weeks or even months. And my family would have had to watch that. I did not want this nightmare scenario for my family, so I started researching death with dignity (Maynard 2014).

Suffering versus autonomy

Despite these appeals, one might read the existing statutes prior to Hawaii's as motivated primarily by protection of patients' autonomy. While respect for autonomy is an important part of the justification for the laws in Hawaii and other states, we think that public willingness to allow persons to make this choice for themselves must be underwritten by the recognition that it is sometimes reasonable, and this is presumably because of the suffering involved. In contrast, respect for autonomy is frequently withheld in legal contexts when the choices at issue are widely regarded as unreasonable, as with decisions to use certain illicit drugs or to ride a motorcycle without a helmet (Dworkin 1972). We also surmise that medical aid in dying would typically be made available by clinicians only in cases where a patient is suffering substantially or is likely to do so in the near future. It is true that data collected in Oregon and elsewhere cites "loss of autonomy" as highest among the reasons for a patient's desire for PAD (Ganzini, Goy and Dobscha 2009), but we understand this concern as relating to the loss of autonomy in the sense meaning personal integrity and independence. And this is, again, a sort of suffering. Finally, the effect of laws allowing PAD is not merely to authorize patients to end their own lives, but to permit physicians to assist them in doing so. The decision to relax a standing prohibition on aiding others in dying is therefore not *merely* a question of choosing to respect autonomy; for if that were so,

the prohibition should be relaxed generally, and not only for the terminally ill and the physicians who care for them (for a different interpretation of these issues, however, see den Hartogh 2017).

The parity argument

So we think it is clear that the justification for PAD laws in the U.S., as elsewhere, depends in large part on the recognition that suffering—whether due to painful sensations or to the loss of dignity, self, or independence—can sometimes be an adequate reason to end one’s own life, and that persons who suffer severely because of a terminal physical illness and who retain decision-making capacity should be allowed to pursue PAD. Either kind of suffering, though, could plague persons afflicted by mental illnesses, even in the absence of any physical illness. It is true, of course, that fewer people with mental illness would suffer as severely as they do if they had better access to psychiatric care and other services, and true as well that existing psychiatric treatments are not as effective as anyone would like. Still, we think it is clear that the suffering associated with mental illnesses can sometimes be as severe, intractable, and prolonged as the suffering due to physical illnesses. Accordingly, it seems to us that if severe suffering can justify PAD for some persons with terminal physical illnesses, it should justify PAD for some persons with mental illnesses, too. Call this the *parity argument*. As Ogilvie and Potts, writing in the United Kingdom and hence in the proximity of countries where euthanasia is legal, say regarding persons with depression, “the intensity of psychic pain suffered by some patients with severe affective disorders must be acknowledged. In moments of candor some professionals may admit sympathy for the view that in severe and persistent depressive illness, when all appropriate physical treatments, including polypharmacy, electroconvulsive therapy, and psychosurgery, have apparently been

exhausted, voluntary euthanasia may sometimes seem to be as justifiable an option as it does in intractable physical illness” (Ogilvie, et al. 1994).

Suffering versus terminality

The parity argument is relatively simple, but defending it is more complex. Opponents of PAD in mental illness, such as the American Psychiatric Association (Joint Reference Committee 2016) and several psychiatrists who have recently written on this subject (Komrad 2017, Pies 2017) might be inclined to dispute it by a variety of methods. First, they might reasonably suggest that the permissibility of PAD in some physical illnesses depends not only on the suffering associated with them but also on the fact that they are terminal. Why might terminality matter? One thought is that when an illness is terminal it means that the life lost to PAD is minimal, lowering the justificatory bar. Another is that terminality means that PAD does not *really* cause death but merely changes the timing of it, where it is *really* caused by the disease.

Neither of these, though, would be a good reason to deny access to PAD to all persons who suffer because of mental illness. The first objection invokes a balancing of the value of a certain unit of time alive against the disvalue of suffering (an idea to which we will return later). But if it is simply a matter of balancing harms and benefits, it is easy to imagine cases where the suffering due to mental illness is so severe that even with a relatively long expected natural lifespan, ending one’s life would still be justifiable: continuing life is not a benefit in this case, but a harm. And even if one were to somehow reject the idea that terminality matters because of the balance of harms and benefits, and insist that it is something about the nearness of death itself that makes PAD acceptable, one has to consider cases where a person has intense suffering due to mental illness and is already so aged that he is near the end of his natural lifespan. Then, the requirement

that the amount of life lost to PAD should be small would be satisfied and PAD should, at least for elderly persons, be regarded as a reasonable request.¹

We find the claim that PAD does not really cause death, but only changes its timing, to be problematic. Were it true, it would imply that murdering a terminally ill person against her wishes does not cause her death, which is false. We would also note that in some cases where PAD in physical illness is clearly permissible, the illness may not really be terminal in the sense of dramatically shortening the life of the patient. Perhaps such cases are not strictly legal in the U.S., but we suspect it sometimes occurs that physical illnesses are deemed “terminal” because the suffering associated with them is severe, even though death is not really predicted to occur soon (there is some practical laxity in the idea that “death can reasonably be expected to occur within six months”). An elderly man in intense and unrelenting pain from metastatic prostate cancer might live for several years in that state (Gandaglia, et al. 2015); so, too, might a person who has lost his independence from ALS (Byrne, et al. 2013); still, both should, and sometimes—perhaps even often—would, be deemed “terminal” and eligible for PAD if they requested it.

The biggest problem with objections rooted in terminality, however, is that terminality is not itself a reason to pursue PAD. It would be strange to help someone die *merely* because she is already dying, if there is nothing else for her (or others) to gain by it. Accordingly, it must be suffering, or the prospect of such, that provides the moral justification for PAD in cases of physical illness. Terminality is, then, merely a *safeguard*, and not a *rationale* for PAD. But if a safeguard, presumably it is designed to prevent a slippery slope, at the bottom of which there are people who might otherwise lead (sufficiently) long, happy lives who access PAD inappropriately. In that case, however, to exclude persons with intense suffering due to mental illnesses, who are clearly

¹ We will mention but not argue for the controversial idea that some mental illnesses could also be considered terminal; were that the case, it would be a further reason for thinking terminality cannot exclude all mental illnesses from PAD.

not leading happy lives and are never very likely to do so, on the grounds that they are non-terminal seems question-begging.

Mental illness and decision-making

A different kind of objection to the parity argument is that persons who request PAD in mental illness typically lack decision-making capacity as a result of their afflictions, and therefore should *never* qualify under U.S. laws, even if those laws permitted PAD for other non-terminal illnesses; after all, existing U.S. statutes uniformly require that recipients of PAD not be suffering from impaired judgment due to a mental illness. Oregon’s Death with Dignity Act, for example, states “If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient’s life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment” (Oregon Death with Dignity Act 1994).

We certainly accept, as a general rule, that persons with clearly impaired decision-making capacity should not be eligible for PAD. But the other premise on which this objection is founded is suspect. While mental illnesses sometimes undermine judgment and decision-making capacity, this is not always the case. For one thing, mental illnesses are often episodic. Persons with bipolar disorder, substance use disorders, schizophrenia, and even unipolar depression are sometimes better (indeed, virtually symptom-free), and sometimes worse (Ciompi 1980, Judd, et al. 2002). But if so, then a person with a mental illness could have intact decision-making capacity between episodes of that illness, while also having a reasonable expectation that he will suffer severely in

the future, such that he might understandably request PAD to avoid the inevitable recurrence of the intolerable episodes. Virginia Woolf's suicide could be a case of this sort; sensing the approach of another episode of her bipolar illness, she wrote in a suicide note to her husband: "I feel certain that I am going mad again. I feel we can't go through another of those terrible times. And I shan't recover this time. I begin to hear voices, and I can't concentrate. So I am doing what seems the best thing to do." (Woolf 1941).

Then too, on some occasions, persons with severe mental illness might retain capacity in spite of *active* illness, at least with respect to some decisions (Roberts 1998, Hougham, et al. 2003, Dunn, et al. 2007, Candilis, et al. 2008). Although we tend to think of mental illnesses as affecting a person globally and impairing all of her thought processes, in reality, mental illnesses vary in their effects and many do not limit all of a person's capacities in all contexts. Decision-making capacity has roughly two conditions. The first is that the reasoning, knowledge, and other cognitive abilities backing the decision be relatively intact. The second is that the decision is voluntary and authentic, which typically means that the values and other motives producing the decision are "one's own." Mental illnesses can undermine capacity by affecting either condition (Charland 2002, Charland, et al. 2016). It is, we will suppose, uncontroversial that a request for PAD made because of cognitive processes that are disrupted by illness is invalid. But we think it is at least possible that a person with a mental illness could retain the capacity to choose PAD *even though* the illness has affected her values.

There are several ways this could be true. One thing to consider is that mental illnesses may not affect all of a person's values equally, and so may undermine her capacity to make some decisions and not others. A person with anorexia nervosa, for example, may not have the capacity to decide whether she should try to lose weight, or even, at times, to decide what she will eat for

lunch, because those sorts of decisions are rooted in values that are distorted by her illness (Tan, et al. 2003, Tan, et al. 2006). But when her decisions are not thematically related to her illness, she is more likely to have capacity—such as when she makes a decision about which college to attend or whom to marry. Accordingly, if a person with a mental illness chooses PAD, and his illness is unlikely to have affected the values underwriting that decision (and if he is not suffering from cognitive distortions because of the illness), we have less reason to suspect that his illness has thwarted his capacity. Thus, we should at least acknowledge the potential capacity behind requests for PAD in illnesses such as obsessive-compulsive disorder or substance use disorders, to which suicidal ideation, hopelessness, and other motives for seeking death are not intrinsic. In these cases, if a person is hopeless and wishes for death, it is more likely to be a reaction *to* the illness afflicting her than a reaction *from* it.

But what about illnesses like major depressive disorder and borderline personality disorder for which hopelessness and suicidal ideation are characteristic (American Psychiatric Association 2013), which therefore *are* frequently marked by distortions in values that would make someone more likely to pursue PAD? Then, requests for PAD are less likely to be made with full capacity. Even in these cases, however, it is far from clear that the illness always compromises each of the values and other motives to which it could be thematically related. We might imagine, to choose a simpler example, that someone with a severe phobia of dogs could still *voluntarily* choose to avoid a particularly dangerous or aggressive neighborhood dog on his morning walk, since this is something many who lack his phobia would choose, and it is at least possible that the desires motivating his decision are his own. We might similarly imagine that someone with severe, active depression might both have a suicidal desire as a reaction *from* her depression and a suicidal desire as a reaction *to* her depression, because she independently, authentically feels she should no longer

have to suffer the other pains associated with the illness. If the latter desire is the dominant one, she would, we imagine, retain the capacity to request PAD.

An independent reason to think that persons with mental illness can sometimes retain the capacity to request PAD is that medicine is committed to assuming that persons with mental illnesses *are* often competent to make other choices about life-threatening matters, even when those choices could be affected by core characteristics of their disorders. Persons with severe mental illness are frequently deemed competent to make decisions about medical or psychiatric treatment, such as to request admission to the hospital, to take medications, or to undergo electroconvulsive therapy. But decisions of this sort at least occasionally require the same level of decision-making capacity as decisions to pursue PAD, since the complexity of the decision (in terms of the reasoning and background knowledge of one's medical condition required) is presumably similar, and the harms and benefits are sometimes, though not always, similar in magnitude—after all, ECT can sometimes be lifesaving, and the patient seeking PAD judges, in contrast, that her life is no longer livable. Accordingly, it follows that persons with severe mental illness at least sometimes possess the capacity to make decisions to pursue PAD.

To reject this conclusion, you would have to suppose that persons with mental illness who choose PAD *necessarily* lack capacity because they are choosing something *bad*. There are at least three problems with this, however. First, it begs the question against proponents of PAD in mental illness by assuming that choosing death in the case of suffering due to such illness *is* always bad. Second, some might be uncomfortable with the idea that our judgments about others' capacity should hinge on judgments about their values (Kious 2016). Finally, it is often observed that standards for capacity vary depending on the risks associated with the decision in question (Buchanan, et al. 1989): in cases where the suffering involved is considerable, this would seem to

reduce the relative risks of the decision (by increasing the expected benefit, the elimination of more severe suffering), which implies that sometimes the threshold for capacity for persons with mental illness should sometimes be relatively low.

We acknowledge, though, that even if a person with a mental illness can sometimes have the capacity to make decisions in spite of her illness, there is still an epistemic problem: how should we know that this is the case? As Gupta and Desmarais ask, “how can one be sure that one is not unwittingly colluding with a person’s pathology rather than respecting a person’s well-considered judgment?” (Gupta, et al. 2016). Attempts to answer this question to date have relied primarily on clinical assessments of whether the person requesting PAD or euthanasia is depressed. When, for instance, the Dutch psychiatrist Boudewijn Chabot helped “Mrs. B.” to die, he judged that, although she saw continued existence as a pointless burden and craved death, she was *not* depressed (Klotzko, et al. 1995). One difficulty, however, is that such clinical judgments are highly subjective (Charland, Lemmens and Wada 2016), and to that extent likely to be influenced by whether the clinician is favorably disposed to the patient’s initial request. A second difficulty is that this approach offers little help to clinicians who are not confident about what to do in the first place. Ultimately, we do not see an easy way to resolve this epistemic worry. But we would note that it cuts both ways: although Gupta and Desmarais are correct that allowing PAD in mental illness might sometimes mean we are colluding with a person’s pathology in bringing about her death, it is also true that by forbidding PAD in mental illness we could sometimes refrain from giving much-needed succor to a person who is suffering severely and whose request for death is reasonable and made with full capacity.

The severity of suffering

A third kind of objection to the parity argument focuses on our premise that suffering due to mental illness can be as bad as suffering due to physical illness. To be sure, we have no way of demonstrating definitively that the two can be on a par, though we would point out that some persons with mental illness—those who harm themselves intentionally—appear to prefer physical pain to emotional pain (Madge, et al. 2008). We would also invite interlocutors to imagine someone with a relatively painless, terminal physical illness who chooses PAD to end or prevent the *emotional* or *existential* suffering that her illness brings. If that is justifiable (and it seems to be permitted by PAD statutes in the U.S.), PAD in mental illness should sometimes be justifiable, too. After all, mental illnesses are (at least sometimes) *also* physical illness, even if they are not consistently understood to be such. And why should it matter whether the cause of the emotional suffering is physical or mental, inside the body or outside it, if either way it is intense and irremediable?

Finally, one could challenge the argument by objecting to the claims that the suffering due to mental illness can be as intractable or as prolonged as that due to physical illness. We, at least, regard such objections as unpersuasive: there is ample evidence that those afflicted with mental illness can suffer from it for years, even decades, and in some cases, this is in spite of aggressive treatment with nearly all available modalities (Greden 2001, Nemeroff 2007). We acknowledge the worry that some instances of PAD or euthanasia for mental illnesses in Europe have occurred in persons who had not exhausted all reasonable treatments (Kim, et al. 2016). But this does not preclude the existence of persons who really have tried every option. [Omitted for review] would point out, regretfully, that he meets such patients all too frequently.

III. Suicide and Psychiatry

Civil commitment

Psychiatry and related mental health disciplines are deeply devoted to preventing suicide. In doing so, psychiatry sometimes employs coercive measures, such as forcibly admitting patients to locked hospital wards (Monahan, et al. 1995). Although the legal constraints vary from one state to another, in many jurisdictions in the U.S., patients who are suffering from a mental illness and who are severely suicidal can be held involuntarily for a period, sometimes several days, sometimes a week or more, while awaiting evaluation in court, and may then receive an involuntary commitment order to treatment lasting months (Treatment Advocacy Center 2016). Most states also permit the involuntary administration of medications to persons who are at risk of harming themselves or others because of a mental illness, if certain criteria are satisfied (Treatment Advocacy Center 2016).

In fact, the majority of states (46, plus the District of Columbia) allow persons to be committed *solely* because they have a mental illness and are at risk of harming themselves (Treatment Advocacy Center 2016). To be sure, some state laws (in Alabama, Illinois, Iowa, Kansas, and Utah) allow civil commitment only if a person is judged to be *incompetent* (that is, to lack decision-making capacity) in addition to being at substantial risk of harming herself. Still, we would speculate (based on [omitted for review]’s clinical experience) that serious suicidal ideation is generally taken as *de facto* evidence of incapacity in those states that require incapacity (or incompetence) for civil commitment, and that the bodies responsible for ordering commitment rarely conduct independent assessments of capacity in those cases. For the courts, often, being suicidal is enough.

Such practices are at odds with permitting PAD in mental illness. Most persons with mental illness who contemplate, attempt, or complete suicide are motivated by a desire to end their

own emotional suffering (Schnyder, et al. 1999, Bryan, et al. 2013), while others are motivated by a desire to avoid imposing burdens on others or to make others better off (Brown, et al. 2002, Joiner, et al. 2002, May, et al. 2013). Laws permitting the involuntary psychiatric hospitalization of suicidal persons, however, suggest that suicide is *unreasonable*. And to the extent that suicide is deemed unreasonable, its motivating judgments—the judgment that one’s suffering is so great it is better to die—must also be deemed unreasonable.

If the above is correct, however, it would imply that PAD in mental illness would often be unreasonable, since it would presumably be motivated by the ill person’s own judgment that their suffering is an adequate reason for self-killing, much as in ordinary suicide. Moreover, to the extent that psychiatry should be empowered to prevent suicide in persons suffering with mental illness, this argument holds, society should not permit PAD for persons suffering solely from a mental illness.

There are, of course, some objections to consider. It would be easy to dismiss the legal *status quo* surrounding civil commitment as *merely* a legal, rather than a moral, matter. But we think that involuntary commitment laws reflect important moral truths. Suicide is typically tragic; it often represents an unnecessary loss; it is right for us to fear that it might touch our family or friends and to fight against it when we can. Imagine discovering that a child, a partner, or a sibling was depressed and wished to die, that he planned to kill himself, that he was on the cusp of overdosing or shooting himself. In that case, one would prevent the act if one could, and enlist any available medical help to do so.

There have, of course, been challenges to the moral justifiability of civil commitment processes, most along the lines that it is inefficacious, overly paternalistic, aversive, and coercive (Szasz 1971, Morse 1982, Szasz 1986, Appel 2007, Prinsen, et al. 2009, Moncrieff 2014).

Although many of these concerns have at least some merit, we regard the notion that involuntary civil commitment for suicidal persons is sometimes permissible to be mainstream and plausible. In this respect, it is much like the notion that PAD in terminal illness is permissible, which is clearly somewhat controversial, too.

One could instead object that psychiatry's moral imperative to prevent suicide is not merely, or even partially, dependent on an assessment of the values motivating the action, but is instead driven by the fear that the suicidal person is acting impulsively, out of confusion or agitation, or because they are reasoning poorly. Again, as the AAS has pointed out, suicides typically differ from physician-assisted deaths in these ways, and others ([omitted for review]). In that case, psychiatry's reasons for preventing suicide would not apply to many decisions to seek PAD. Assessments of capacity would suffice to prevent problematically, impulsively, unreasonably suicidal persons from using PAD to die.

The problem with this objection, though, is that psychiatry as it is currently practiced does not generally require an assessment of whether the suicidal person is acting impulsively or unreasonably to justify its interventions. Being suicidal in the context of a mental illness *per se* is enough. Again, most involuntary commitment laws in the U.S. ask only whether the person with mental illness is at risk of harming herself before allowing her civil commitment. We would also point out that, in practice, the more persistent a patient's suicidal motives are, and the more considered or premeditated her plan for suicide, the more alarming her clinical condition tends to be, and the more likely she is to receive an involuntary commitment in order to prevent her suicide, if commitment has been sought. Thus it is also the desire to kill oneself because of one's suffering, and not merely the matter of whether one's actions are impulsive or poorly reasoned, that is held to justify involuntary commitment procedures.

VI. Solutions?

We think, therefore, that U.S. medicine generally and psychiatry in particular face a dilemma—indeed, an impending moral crisis—in the face of legal PAD. On the one hand, part of the core justification for laws permitting PAD in physical illnesses is the alleviation of severe suffering, even if that is not explicitly articulated in U.S. statutes. Since suffering due to mental illness can, at least sometimes, be as severe as suffering due to physical illnesses, it would also seem to provide an adequate justification for PAD in some cases, at least when capacity requirements are satisfied. On the other hand, the suffering that frequently motivates suicide among persons with mental illness is generally not accepted as an adequate reason for suicide, implying that it should not be enough to justify PAD in such cases, either. We recognize, of course, that parallel dilemmas might be raised by other issues related to those described here: whether PAD sometimes is thought to reduce the social and economic burdens imposed by persons with severe illnesses, whether permitting PAD increases stigma toward those with terminal illness or mental illnesses, and more.

So how to resolve the dilemma we have posed? Two simple but extreme solutions would be either to conclude that psychiatry (and society more generally) is wrong to prevent people from attempting suicide, even in the least controversial cases, or instead that PAD is wrong, even in the least controversial cases. But given the compelling reasons supporting both PAD and the involuntary commitment of suicidal persons, neither of these simple solutions is adequate. A more nuanced approach is indicated, and we see three initial possibilities.

The first possibility is to keep PAD laws and involuntary civil commitment practices as they are, despite their deep inconsistencies. This would be to continue to require that the illnesses

for which PAD can be granted must be terminal. Such a policy has the advantage of simplicity. Its conservatism might also seem a virtue: because suicide occurs far more often than PAD in states where PAD is legal (for instance: in Oregon 133 people died under the Death With Dignity Act in 2016, while at least 772 died by suicide) (Centers for Disease Control and Prevention 2018, Death with Dignity 2018), we might worry that if we were to extend PAD to include non-terminal illnesses, it would encompass too many people with mental illnesses whose plans to kill themselves are unreasonable.

The problem with this solution, of course, is just that it remains inconsistent, that it ignores the fact that suffering due to mental illness, like suffering due to physical illness, can be really bad, and genuinely without hope of improvement. By holding the line we refuse to hear some legitimate pleas for help. The *status quo* might seem callous.

The second approach could be to allow PAD for some persons with mental illnesses, while changing practices of involuntary civil commitment in a corresponding way, by reemphasizing the roles that decision-making capacity plays in both. We might take the view that anyone should have access to PAD, if they decide to pursue it *and* have the capacity to make that decision, irrespective of whether their underlying medical diagnosis is physical or mental, terminal or non-terminal. This is more or less the European way of doing things: there, people who are suffering severely and who have capacity can choose PAD or euthanasia irrespective of whether their underlying illness is terminal or not, so long as it involves intolerable suffering that cannot be relieved by any means acceptable to the patient. To achieve consistency with this, psychiatry would have to limit itself to preventing suicide through involuntary civil commitment only when a suicidal person lacks decision-making capacity. There are obvious merits to this compromise. It would help satisfy those who advocate for stronger self-determination at the end of life *including*

with respect to suicide, and would still leave a substantial scope for civil commitment, since many persons who are already subject to commitment for suicidal ideation would continue to be so, as their decisions to kill themselves are clearly made without capacity because of the effects of psychosis, intoxication, or severe but short-lived emotional duress (den Hartogh 2016).

But there is a problem here, too. As we noted earlier, it is generally thought that the effects of a mental illness on a person's values sometimes mean that he lacks capacity even if his cognitive abilities are intact (Elliott 1997, Charland 2002, Rudnick 2002). Although, as we argued above, a person with mental illness may not always be incapacitated because her illness alters her values, we are still confronted by Gupta's and Desmarais's worry: how can we tell when she is, and when she is not? To reemphasize assessments of capacity in civil commitment laws would require us to answer this question. And, we suspect, doing so will ultimately depend on whether we think the mentally ill person's suffering presents a good enough reason for self-killing—so that the authenticity of someone's values and the voluntariness of her decision depend in large part on our assessment of whether her values are reasonable (Kious 2016).

The third approach—into which the second might ultimately collapse—is to devise a metric for suffering in both mental and physical illness and to allow PAD (and, likewise, suicide) for persons whose suffering exceeds some threshold designated as “unbearable,” while allowing the involuntary commitment and treatment of persons who plan to kill themselves because of suffering but whose expected suffering falls below that threshold. The practical challenges of this—such as whom we should appoint to make such decisions, the possible role of psychiatrists and other mental health providers in serving as gatekeepers for PAD, and how we should require patients to submit to their judgment—are surely serious. But the approach has several more theoretical difficulties, too. First, there is the issue of the metric itself: how are we to gauge the

severity of someone's suffering when he tells us he wishes to die in order to be spared it? We can, of course, just *ask him*, but this will generally fail to differentiate suffering that justifies death from suffering that does not, since the answer will be the same in both cases. Second, as Cassell and others have noted, the badness of suffering—indeed, to a degree, even *whether* someone suffers in a particular set of circumstances—depends not only on the sensations and emotions that underpin that suffering, but on the individual's implicit beliefs about the meaning of those experiences, on how long she assumes they are likely to last, on how much control she takes herself to have over it, on how much anxiety it produces, and so on. How to evaluate each of these dimensions when we cannot wholly trust first-person reports is deeply unclear. Most seriously, even assuming that we are able to measure and rank the severity of different persons' suffering, determining what degree of suffering is enough to justify death requires contentious public and professional value judgments. There will be cases (indeed, there *are* cases) where individuals say that the suffering they face is reason enough to die, but psychiatrists are professionally obliged to disagree. Who is right? How much suffering can we reasonably demand that others tolerate for their own good?

Similar difficulties arise in assessing the likelihood that one's suffering will resolve (either spontaneously or through treatment) and in determining *how unlikely*, given a particular degree of suffering, recovery ought to be before we say further attempts at treatment are futile. We can, of course, trot out the available statistics about the chance that a person with a particular set of characteristics will respond to a particular degree to a particular intervention. But sometimes relevant statistics are not available, which is especially true in cases of treatment-refractory mental illness, as they are rarer and often not systematically studied. Moreover, making this determination requires a comparison of expected harms and benefits, which ultimately requires, again, that we weigh both the severity of a person's suffering, both now and in the foreseeable future, and the

value of her life without it. Yet we must also recognize that this is to try to objectify degrees of suffering, and risks insensitivity to the individual's own unique experiences of states he or she cannot tolerate.

Whether we take the second or the third approach, then, we think resolving this dilemma (rather than consenting to leave it unresolved, as with the first option) depends on a deep and difficult question: when is it worse that someone die, whether from suicide or with physician assistance, who could have been helped, and when is it worse that someone whose suffering could only be alleviated by death continues to suffer? The answer to this question still eludes us; while we are waiting for it, the best we can do is to hope for enough improvement in the treatment of severe mental illness, including increases in access to existing types of treatment, that it arises less and less frequently.

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