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Mental Illness and Medical Assistance in Dying

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I. Introduction

Medical Assistance in Dying (MAID) has been legal in several states for almost two decades.[1] First legalized in 1997 in Oregon,[2] ten states and Washington D.C. now have legislation or case law that permits MAID in cases of terminal illness.[3] No state permits MAID to patients whose sole diagnosis is mental illness.[4]

Medically assisted suicide for individuals with unbearable and irremediable mental illnesses should be an option in the United States of America, in limited circumstances. This paper proposes that extant state statutes should be amended to include MAID for patients with irremediable mental illnesses.

First, this paper explores the relevant MAID laws that the Netherlands, Belgium, and Canada have adopted to allow MAID for patients with mental illnesses. Comparing the progressive Netherlands and Belgian practices with the hesitant actions of the Government of Canada (at the request of physicians), reveals the controversial nature of physician assisted suicide for patients with psychiatric disorders. Next, this paper presents a review of current United States case law and legislation regarding medically assisted suicide. After, this paper investigates a case study of a patient who actually received medical assistance in death for a severe mental disorder in order to show the impact that these laws have on real people who are

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[1] A. E. Chen, *Legalized Physician-Assisted Suicide in Oregon - - the first year's experience,* NEW ENGJ MED, Feb. 18. 1999, at 1, https://pubmed.ncbi.nlm.nih.gov/10021482/

[2] Id.

[3] CAL. CODE FORMS, BUS. & PROF. § 3519 Form 4 (West's 4th ed.), § 11.6 COLORADO END-OF-LIFE OPTIONS ACT, COCLE-EPH 11.6, HAW. REV. STAT. ANN. § 327L-1, 22 M.R.S.A. § 214, NJ. STAT. ANN. § 52:17B-139.13 (2019), Baxter v. State, 2009 MT 449, OR. REV. STAT. ANN. § 127.800 (2023), Vt. Stat. Ann. tit. 18, § 528, Wash. Rev. Code Ann. § 11.125.420, DC ST § 7-661.01

[4] Id.

suffering. After reviewing all of that information, this paper proposes that medically assisted death for patients with severe mental illnesses should be an option in a limited capacity in the United States. Specifically, states that already have laws legalizing physician assisted suicide should amend their statutes to permit medically assisted suicide for patients with mental illnesses.

II. Background

While medically assisted suicide for individuals who suffer from severe mental illnesses is currently illegal in the United States, it is an option in Belgium and the Netherlands [5] In these nations, physician-assisted suicide has been provided for patients who suffer from schizophrenia, PTSD, debilitating eating disorders, autism, personality disorders, and grief.[6]

A. The Netherlands

In the Netherlands, physician-assisted suicide is legal as long as it meets the Termination of Life on Request and Assisted Suicide (Review Procedures) Act that was passed in 2002.[7]

The Netherlands outlines specific criteria that patients need to meet in order to qualify for medically-assisted suicide.[8] On a broader spectrum, patients must possess decision-making capacity, and their suffering must be both unbearable and irremediable.[9] There are also six "due care" criteria physicians must ensure are met: (1) that the patient's request is voluntary and well considered; (2) that the patient's suffering is unbearable and there is no prospect of improvement; (3) that the patients has been informed of his or her situation and further

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[5] Y.H. Kim Scott, *Should Assisted Dying for Psychiatric Disorders be Legalized in Canada?*, CAN MED ASS'N J, Oct, 4, 2016, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5047832/
[6] Id.
[7] SMP van Veen, *Physician Assisted Death for Psychiatric Suffering: Experiences in the Netherlands*, PUDMED CENTRAL, June 20, 2002, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9251055/
[8] Id.
[9] Id.

prognosis; (4) discuss the situation with the patient and come to the joint conclusion that there is no other reasonable solution; (5) consult with at least one other physician with no connection to the case, who must then see the patient and state in writing that the attending physician has satisfied the due care criteria listed in the four points above; and (6) exercise due medical care and attention in terminating the patient's life or assisting in his/her suicide".[10] The Netherlands permit physician assisted suicide for children between 12 years old and 16 years of, as long as they receive parental consent.[11] Children ages 16 and 17 do not need parental consent, but they must involve their parents in the decision-making process.[12]

While the Netherlands outlines due care criteria that physicians must follow before deeming a patient who suffers from a psychiatric disorder eligible for MAID, these criteria are not always clearly fulfilled. The Netherlands requires that a patient have no prospect of improvement in her mental condition, with no other available solutions or treatments.[13] This legal requirement causes some issues to arise because mental illnesses are not terminal from a physical standpoint.[14] As a result, physicians have struggled with determining whether a patient's psychiatric disorder is truly irremediable.[15] In addition, because it is exceedingly difficult to predict the effect that treatment will have on mental disorders, it can be nearly impossible for healthcare providers to give a reliable prognosis pertaining to a patient's psychiatric suffering and the outcome that the treatment may or may not provide.[16]

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[10] Id.
[11] *Euthanasia, Assisted Suicide, and non-resuscitation on request in the Netherlands*, GOVERNMENT OF THE NETHERLANDS, https://www.government.nl/topics/euthanasia/euthanasia-assisted-suicide-and-non-resuscitation-on-request
[12] Id.
[13] SMP van Veen, *Physician Assisted Death for Psychiatric Suffering: Experiences in the Netherlands*, PUDMED CENTRAL, June 20, 2002, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9251055/
[14] Id.
[15] Id.
[16] Id.

Significant debate exists around whether a patient who refuses treatment can actually be considered irremediably suffering because it is unknown whether that treatment would have improved the patient's condition.[17] Patients often refuse treatment because they do not believe it will work. This conundrum has not presented a significant barrier to MAID; one study showed that 56% of Dutch patients who received medically assisted suicide on the basis of a mental illness diagnosis had refused treatments.[18] Relatedly, 44% of Dutch psychiatrists, in a survey of 248 psychiatrists, stated that they believed showing that a patient with a psychiatric disorder was irremediably suffering was either impossible or virtually impossible.[19]

Some psychiatrists believe that irremediable suffering does not simply mean that no treatment will ever succeed.[20] The Dutch Psychiatric Association defines irremediability to include "'that there must be a reasonable balance between the expected treatment results and the burden of treatment' as well as a 'real prospect of improvement' with a 'reasonable period of time.'"[21] This standard acknowledges the impossibility and impracticability of only allowing MAID for patients that physicians can ascertain with certainty will never recover or cease to suffer.[22] Admittedly, this standard can produce false positives, meaning it can sometimes diagnose a patient with irremediable suffering when that may not be the case.[23] However, the Dutch Psychiatric Association supports this calculation because it limits patient suffering, rather than attempting to fit patients into such tight and unrealistic categories.[24] The same issues arise

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[17] Id.
[18] Id.
[19] Id.
[20] William Rooney, Udo Schuklenk & Suzanne Van de Vathorst, *Are Concerns About Irremediableness, Vulnerability, or Competence Sufficient to Justify Excluding All Psychiatric Patients from Medical Aid in Dying?* HEALTH CARE ANALYSIS, June 17, 2017 https://link.springer.com/article/10.1007/s10728-017-0344-8#Sec1
[21] Id.
[22] Id.
[23] Id.
[24] Id.

when determining whether a patient experiences irremediable suffering when they refuse certain psychiatric treatments.[25] The Dutch Psychiatric Association approaches this question using a cost-benefit analysis pertaining to how treatments will affect the patients.[26] For example, when a treatment is likely to be beneficial to a patient, yet it is refused by the patient, a physician should refuse that patient's request for MAID.[27] On the other hand, if a competent patient refuses a treatment that will likely have little to no benefit to the patient, that patient's refusal should not bar her from MAID.[28] In the Netherlands, the focus is on inclusion and protection of competent patients with irremediable suffering, rather than restriction of an entire class of patients.[29]

The decision-making capacity of a mentally ill patient is a huge factor in determining whether the patient qualifies for MAID in the Netherlands.[30] Decision making capacity is defined "as the ability of an individual to make their own healthcare decisions."[31] One of the major issues with assessing the decision-making capacity of patients with psychiatric disorders is that it is challenging to determine whether a patient's desire to die is a reflection of their actual decision-making capacity, or if it is a result or side effect of the psychiatric disorder itself.[32] Experts are torn on this issue.[33] Some experts believe that patients with psychiatric disorders should be excluded from physician assisted suicide because assessing a patient's decision-making capacity is simply too complex and unknown in that context.[34] On the other hand, other experts believe that (1) patients with psychiatric disorders that have decision making capacity

[25] Id.
[26] Id.
[27] Id.
[28] Id.
[29] Id.
[30] Id.
[31] Id.
[32] Id.
[33] Id.
[34] Id.

will suffer even more without access to physician-assisted suicide, and (2) "cognitive distortions and irrational health beliefs should be assessed for every patient requesting PAD, as they are also present in patients suffering from somatic disorders."[35]

The Netherlands have three main safeguards in place in order to protect physicians: legal protection, specially trained Support and Consultation on Euthanasia in the Netherlands (SCEN) consultants, and a Euthanasia Review Committee.[36] The first safeguard, legal protection, protects physicians by ensuring that all physicians that act in accordance with the Netherland's criteria of due care will not be subjected to any legal repercussions.[37] The second safeguard, SCEN consultants, is a group of consultants with special training in how medical assistance in dying is carried out in the Netherlands.[38] These consultants are available within 48 hours.[39] Their job is to meet with the family, meet with the patient, examine patient records, and ensure that the law is being followed and that the physician involved is protected.[40] The third safeguard, the Euthanasia Review Committee, receives all information after an intervention.[41] This information is reviewed by the Euthanasia Committee that consists of a lawyer, physician, and ethicist who meet each month to review cases and ensure that the law is followed. The Committee requests extra information if necessary.[42]

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[35] Id.
[36] Barbara Sibbald, *MAid in the Netherlands led by Physicians*, CANADIAN MEDICAL ASSOCIATION JOURNAL, Dec. 6, 2016, https://www.cmaj.ca/content/188/17-18/1214
[37] Id.
[38] Id.
[39] Id.
[40] Id.
[41] Id.
[42] Id.

Despite the safeguards that are in place, the practice of MAID for patients with mental illnesses in the Netherlands is far from perfect.[43] There is evidence of extensive discussion among Dutch physicians pertaining to the difficulty of interpreting some of the due care criteria, specifically determining the unbearable and irremediable suffering criteria.[44] A Dutch study of 2,100 physicians revealed that, "among physicians who had received a request for EAS, 25% had experienced difficulty with decision making regarding the due care criteria, in particular with the 'unbearable and hopeless suffering' and 'voluntary and well-considered' request criteria."[45] Despite these sizeable difficulties, between 2002 and 2016, when there were 49,287 cases of EAS in the Netherlands, only 89 of these cases failed to meet the due care criteria.[46] That makes the rate of cases that fail to meet the due care criteria 0.18%, despite 25% of physicians experiencing difficulty making decisions using the criteria.[47]

B. Belgium

Euthanasia was legalized in Belgium in 2002.[48] The Belgian Euthanasia Act dictates that euthanasia is permissible if: 1. the patient is in a medically hopeless situation; 2. of constant and unbearable physical or mental suffering; 3. that cannot be alleviated; and 4. resulting from a serious or incurable disorder; 5. caused by an illness or accident." [49] Other requirements include

[43] David Gibbes Miller, Scott Y.H. Kim, *Euthanasia and physician-assisted suicide not meeting due care criteria in the Netherlands: a qualitative review of review committee judgements*, BMJ, October 25, 2017, https://bmjopen.bmj.com/content/7/10/e017628.abstract
[44] Id.
[45] Id.
[46] Id.
[47] Id.
[48] Trudo Lemmens, *The Conflict Between Open-Ended Access to Physician-Assisted Dying and the Protection of the Vulnerable*: *Lessons from Belgium's Euthanasia Regime for the Canadian Post-Carter Era*, UNIVERSITY OF TORONTO, Feb 26, 2016, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2734543
[49] Id.

that the patient is competent and has made a voluntary request to be euthanized.[50] The patient does not have to be an adult; minors who are deemed competent to request euthanasia as long as their suffering is somatic and they obtain parental consent, along with the above factors.[51] The Belgian Act does not permit assisted suicide; only euthanasia.[52] Euthanasia, as opposed to physician-assisted suicide, requires the physician to administer the life, rather than the recipient.[53] This decision was seemingly a political decision based on the fact that legalizing assisted suicide would have prolonged parliamentary deliberations.[54]

There are also multiple steps that must be fulfilled so the physician can fully determine whether a patient qualifies for euthanasia.[55] First, the physician must discuss with the patient his or her prognosis, condition, and the possible treatment options going forward.[56] The purpose of this conversation is for the physician to determine that the patient lacks any other reasonable solution other than euthanasia, and the patient made the request on his or her own free will.[57] Second, "the physician has to ascertain the 'persistent physical or mental' [literal translation; psychic] suffering of the patient and the lasting nature of her request".[58] This is legally required to be determined over the course of 'multiple conversations' that must be spread out over a

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[50] Id.
[51] Id.
[52] Saad, Toni, MA., *Euthanasia in Belgium: Legal, Historical and Political Review*, ISSUES IN L MED, Fall 2017, https://www.proquest.com/familyhealth/docview/1943044477/1131180040214808PQ/2?accountid=13793&sourcetype=Scholarly%20Journals
[53] Id.
[54] Id.
[55] Trudo Lemmens, *The Conflict Between Open-Ended Access to Physician-Assisted Dying and the Protection of the Vulnerable*: *Lessons from Belgium's Euthanasia Regime for the Canadian Post-Carter Era*, UNIVERSITY OF TORONTO, Feb 26, 2016, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2734543
[56] Id.
[57] Id.
[58] Id.

'reasonable amount of time'.[59] Third, another independent physician must be consulted.[60] The purpose of this independent consultation is to ensure that the patient's physical or mental suffering cannot be alleviated in any other way.[61] It is important to note that the second, independent physician does not have veto power over the original, primary physician's decisions.[62] The primary physician can proceed with his or her decision, regardless of whether the second physician completely disagrees.[63]

There are special safeguards implemented into the Belgium Act for patients seeking euthanasia that suffer from mental illnesses rather than somatic diseases.[64]. In that case, there are two additional requirements.[65] First, an independent physician, which can be either a psychiatrist or another physician that specializes in the patient's condition, must be consulted.[66] Second, there must be a minimum of a month delay between the patient's request for euthanasia and the actual act of euthanasia.[67]

In addition, the Belgian Act outlines specific steps that physicians must take to notify authorities following acts of Euthanasia.[68] The information regarding the act must be submitted to the Federal Control and Evaluation Commission.[69] This commission is composed of "senior

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[59] Id.
[60] Id.
[61] Id.
[62] Id.
[63] Id.
[64] Id. There are additional steps in the process if a patient is not expected to die within the foreseeable future.
[65] Id.
[66] Id.
[67] Id.
[68] Saad, Toni, MA., *Euthanasia in Belgium: Legal, Historical and Political Review*, ISSUES L AND MED, Fall 2017, https://www.proquest.com/familyhealth/docview/1943044477/1131180040214808PQ/2?accountid=13793&sourcetype=Scholarly%20Journals
[69] Id.

physicians, lawyers and those who have dealing with people who are terminally ill."[70] The forms that are submitted to the Commission detailing the circumstances of the acts of euthanasia are reviewed for legality.[71] The Commission votes to determine whether the Act was properly adhered to; if a two-thirds majority votes act of euthanasia was illegal according to the Belgian Euthanasia Act, the case is given to a public prosecutor is the relevant jurisdiction.[72]

Research suggests physicians in Belgium do not always carefully follow the required procedures outline by the Belgian Act.[73] From 2002-2007, only half of all cases of euthanasia in Flanders were reported.[74] As previously mentioned, the Belgian Euthanasia Act specifies that physicians must notify the Committee of every case of euthanasia so it can be properly evaluated.[75] These cases were not reported because they were not "perceived or labelled as euthanasia by the physician involved."[76] Failure to report is in direct conflict of the law, but thousands of these cases were not reported.[77] In addition, a study of patients who died between June and November 2007 in Flanders showed that "of the 208 deaths involving life-ending drugs reported, 66 were without explicit request."[78] This statistic reveals that a significant number of non-voluntary euthanasia, which is entirely illegal, occurred.[79] In addition, there were instances of nurses administering life-ending drugs, which is also illegal under the Belgium Euthanasia Act.[80]

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[70] Id.
[71] Id.
[72] Id.
[73] Id.
[74] Id.
[75] Id.
[76] Id.
[77] Id.
[78] Id.
[79] Id.
[80] Id.

C. Canada

The Canadian Supreme Court overturned the prohibition of physician assisted suicide in *Carter v. Canada* in 2015,[81] holding that the Criminal Code provisions that criminalized helping a person end her life violated the Canadian Charter of Rights and Freedoms.[82] The Canadian Supreme Court specified its holding, stating that "physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including a disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition" will no longer be criminalized.[83] The following timeline of the Canadian legislation reveals the concerns that the Canadian government has pertaining to opening eligibility for MAID for patients with mental disorders.

The Canadian Parliament responded quickly, enacting legislation in 2016 that allows adults who meet certain the criteria outlined above in *Carter v. Canada* to obtain medical assistance in dying.[84] On October 5, 2020, Bill C-7: An Act to Amend the Criminal Code (Medical Assistance in Dying) was introduced.[85] The bill proposed changes in Canada's Medical Assistance in Dying law, and the revised law in 2021 no longer required an individual's natural death to be "reasonably foreseeable".[86] This change was informed by the Superior Court of Quebec's *Truchon* decision, which held that the "reasonable foreseeability of natural death"

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[81] Carter v. Canada (Attorney General) 2015 SCC 5, [2015] 1 S.C.R. 331
[82] Id.
[83] Id. This case invalidated former laws that placed a prohibition on physician assisted suicide in the entire country.
[84] *Canada's Medical Assistance in Dying (MAID) Law*, GOVERNMENT OF CANADA, Mar 1, 2024, https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html#s0
[85] Id.
[86] Id.

eligibility criterion was unconstitutional.[87] As of March 17, 2021, the following criteria for receiving medical assistance in dying includes: (1) the individual must be at least 18 years old and have decision-making capacity; (2) the individual must be eligible for publicly funded health care services; (3) the individual must make a voluntary request for medical assistance in dying that does not result from any type of external pressure; (4) the individual must give informed consent, which means that the individual has consented to receiving medical assistance in dying after they have received all the information necessary to make this decision; (5) the individual must have a serious and incurable disease or disability (excluding temporarily any mental illness); (6) the individual must be in an advanced stage of irreversible decline in capability; and (7) the individual must have enduring and intolerable physical or psychological suffering that cannot be alleviated under conditions that the individual considers acceptable.[88]

In 2022, the Ministers of Justice, Health, and Mental Health and Addictions announced that Canada intended to extend the nation's temporary exclusion of eligibility for individuals who suffer from mental illnesses to seek physician assisted suicide.[89] During that announcement, the ministers stated that the date of expansion would be delayed until March 17, 2023.[90] The following explanation was included in the joint statement: "Our government, the provinces and territories, and their medical communities have made important progress in preparing for March 2023. Delaying eligibility for persons whose sole medical condition is a mental illness would allow more time for dissemination and uptake of key resources by the medical and nursing

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[87] Id.
[88] Id.
[89] Id.
[90] *Statements by Ministers Lammetti, Duclos and Bennett on Medical Assistance in Dying in Canada*, DEPARTMENT OF JUSTICE CANADA, Dec, 15, 2022, https://www.canada.ca/en/department-justice/news/2022/12/statement-by-ministers-lametti-duclos-and-bennett-on-medical-assistance-in-dying-in-canada.html

communities. We know that we need more time to consider the final report of the Special Joint Committee on Maid, expected in February 2023."[91] The ministers continued to explain that the purpose of this delay was to ensure the safety and security of vulnerable individuals while simultaneously supporting their autonomy.[92]

The final report of the Special Joint Committee on Maid detailed the concerns related to MAID for patients whose sole underlying condition is mental illnesses in Canada.[93] Some of the main concerns regarded whether protocols, guidance, and safeguards would be addressed properly by March 2023.[94] The report acknowledged that there was concern as to whether all of these facets, including standards of practice, training for physicians, comprehensive patient assessments, and oversight could be sufficiently implemented quickly enough.[95] The report also reflected that preventing patients whose sole condition is a psychiatric disorder from MAID could be seen as discrimination and "is unlikely to stand up in court review."[96] However, further concerns included whether MAID can be distinguished from suicide, and the difficulty of assessing irremediability.[97]

On February 2, 2023, Canadian legislators introduced another bill to extend the temporary exclusion of individuals once again with mental illnesses from accessing physician-assisted suicide for another year, until March 17, 2024.[98] Once again, just recently, on February 29, 2024, Canada introduced legislation to extend temporary exclusion of eligibility for medical

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[91] Id.
[92] Id.
[93] *Medical Assistance in Dying in Canada*: Choices for Canadians, REPORT ON THE SPECIAL JOINT COMMITTEE ON MEDICAL ASSISTANCE IN DYING, Feb. 2023, https://www.parl.ca/documentviewer/en/44-1/AMAD/report-2/page-108#24
[94] Id.
[95] Id.
[96] Id.
[97] Id.
[98] *Canada's Medical Assistance in Dying (MAID) Law*, GOVERNMENT OF CANADA, Mar 1, 2024, https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html#s0

assistance in dying for individuals who suffer from mental illness for three more years, until March 17, 2027.

It is important to note that the temporary exclusion of individuals who suffer from mental illness includes mental and psychiatric conditions that are primarily treated within the scope of psychiatry.[99] This includes disorders such as depression and personality disorders.[100] The temporary mental illness exclusion does not include neurocognitive and neurodevelopmental disorders, or other disorders that may affect an individual's cognitive abilities and functioning.[101]

The Government of Canada's repeated legislative extensions for temporary exclusions of individuals with mental illness from being eligible to receive medical assistance in dying reveals some legitimate concerns in the practice.[102] The extensions allow more time for provinces and territories to prepare their health care systems.[103] This includes further development of regulations and guidance to determine how and under what conditions to fairly and safely provide medical assistance in dying to individuals with mental illnesses.[104] The repeated extensions will also give physicians and practitioners the necessary time to participate in training and familiarize themselves with the guidelines, standards, and support systems that will eventually be implemented.[105]

The new law that was enacted following the latest extension added another requirement that must be completed prior to lifting the temporary exclusion for patients who suffer from mental disorder from receiving medical assistance in dying.[106] It requires that a joint

[99] Id.
[100] Id.
[101] Id.
[102] Id.
[103] Id.
[104] Id.
[105] Id.
[106] Id.

parliamentary committee must undertake a comprehensive review of the eligibility of medical assistance in dying for patients who suffer from a mental disorder rather than a physical illness.[107]

D. MAID in the United States

MAID is available in ten states and Washington D.C.[108] While patients are presumed to have a constitutionally protected right to refuse unwanted life-sustaining treatment, there exists no right to MAID. *Cruzan v. Director, Missouri Department of Health,*[109] and *Washington v. Glucksberg*[110] are two landmark United States Supreme Court cases pertaining to end-of-life care and physician-assisted suicide.

In *Cruzan v. Director, Missouri Department of Health*, the Supreme Court held that "a State may apply a clear and convincing evidence standard [of the patient's wishes] in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a permanent vegetative state." [111] As a result, an incompetent individual's guardian must meet a heightened level of scrutiny to prove that the wishes of the incompetent patient to end his or her life is valid because there are situations in which the guardian does not have the best interests of the patient in mind.[112] More broadly, *Cruzan* does establish that in Missouri, patients have the right to refuse life-sustaining treatment, but they must be competent. Otherwise, their relatives must show clear and convincing evidence that that patient does wish to discontinue life-sustaining measures.

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[107] Id.
[108] West's Cal. Code Forms, Bus. & Prof. § 3519 Form 4 (4th ed.), § 11.6 COLORADO END-OF-LIFE OPTIONS ACT, COCLE-EPH 11.6, Haw. Rev. Stat. Ann. § 327L-1, 22 M.R.S.A. § 214, NJ. Stat. Ann. § 52:17B-139.13, Baxter v. State, 2009 MT 449, Or. Rev. Stat. Ann. § 127.800, Vt. Stat. Ann. tit. 18, § 528, Wash. Rev. Code Ann. § 11.125.420, DC ST § 7-661.01
[109] Cruzan v. Missouri Dep't of Health, 497 U.S. 261 (1990)
[110] Washington v. Glucksberg, 521 U.S. 702, (1997)
[111] Cruzan v. Missouri Dep't of Health, 497 U.S. 261, 284 (1990)
[112] Id.

In *Washington v. Glucksberg*, the court held that the right to physician-assisted suicide is not protected by the United States Constitution as a liberty interest under the Due Process Clause of the Fourteenth Amendment.[113] The court emphasized that Washington as a state interest in preserving life.[114] Additionally, the court reasoned that individuals who commit suicide, whether or not they are terminally ill, often suffer from psychiatric disorders.[115] The court reasoned that therefore, "legal physician-assisted suicide could make it more difficult for the State to protect depressed or mentally ill persons, or those who are suffering from untreated pain, from suicidal impulses."[116] *Glucksberg* also discussed that the state has an interest in protecting the integrity of the medical profession, which outweighs the potential liberty interest of the right to physician-assisted suicide.[117]

While the majority of states have not legalized MAID, the ten states and Washington D.C that have legalized MAID should amend their statutes to include MAID for irremediable and unbearable psychiatric suffering. California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, Washington, and Washington D.C. have all legalized medical aid in dying through the legislative process.[118] The other state, Montana, has legalized medical aid in dying through a court ruling rather than legislation.[119]

The United States state laws regarding medical aid in dying are relatively consistent with one and other, but there are a few significant differences that are important to note. For example,

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[113] Washington v. Glucksberg, 521 U.S. 702, (1997). See also Quill v. Vacco, 80 F.3d 716, (2d Cir. 1996)
[114] Id.
[115] Id.
[116] Id.
[117] Id.
[118] West's Cal. Code Forms, Bus. & Prof. § 3519 Form 4 (4th ed.), § 11.6 COLORADO END-OF-LIFE OPTIONS ACT, COCLE-EPH 11.6, Haw. Rev. Stat. Ann. § 327L-1, 22 M.R.S.A. § 214, NJ. Stat. Ann. § 52:17B-139.13, Baxter v. State, 2009 MT 449, Or. Rev. Stat. Ann. § 127.800, Vt. Stat. Ann. tit. 18, § 528, Wash. Rev. Code Ann. § 11.125.420, DC ST § 7-661.01.
[119] Baxter v. State, 2009 MT 449

Oregon does not require patients who seek medically assisted suicide to be a resident of the state.[120] This change was made on May 29, 2022.[121]

The United States of America currently has not legalized medical aid in dying for any patients whose sole diagnosis is a mental illness or disorder.[122] Currently, the patient eligibility requirements in the United States where physician-assisted suicide is legal include: (1) the patient must be at least 18 years old,[123] (2) the patient must reside in state (except in Oregon)[124]; (3) the patient must be capable of making and communicating health care decisions for themselves[125], and (4) the patient must be diagnosed with a terminal illness that will lead to death within six months.[126]

III. Case Study

In order to help determine whether physician-assisted suicide for individuals with severe mental illnesses should be legalized in the United States of America, it is helpful to look into the experience of an individual who actually went through the process.[127] Here, the 29 year old patient who went through with the entire process suffered from borderline personality disorder,[128] attachment disorder and chronic depression.[129] The patient described herself as

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[120] OR. REV. STAT. ANN. § 127.805
[121] Id.
[122] West's Cal. Code Forms, Bus. & Prof. § 3519 Form 4 (4th ed.), § 11.6 COLORADO END-OF-LIFE OPTIONS ACT, COCLE-EPH 11.6, Haw. Rev. Stat. Ann. § 327L-1, 22 M.R.S.A. § 214, NJ. Stat. Ann. § 52:17B-139.13, Baxter v. State, 2009 MT 449, Or. Rev. Stat. Ann. § 127.800, Vt. Stat. Ann. tit. 18, § 528, Wash. Rev. Code Ann. § 11.125.420, DC ST § 7-661.01.
[123] Id.
[124] Id.
[125] Id.
[126] Id.
[127] Linda Pressly, *The Troubled 29-year-old Helped to Die by Dutch Doctors*, BBC NEWS, Aug, 8, 2018, https://www.bbc.com/news/stories-45117163
[128] Id.
[129] Id.

chronically suicidal, having anxiety, experiencing psychoses, and hearing voices inside of her head.[130] Her healthcare providers described her as unstable and unable to speak very well at all towards the end of her life, except when discussing euthanasia.[131] The healthcare provider states that "she was very clear on that."[132] This patient had attempted to commit suicide about twenty times without success.[133] The patient stated that "I'm stuck in my own body, my own head, I just want to be free… I have never been happy - I don't know the concept of happiness."[134] The psychiatrist who treated the patient stated that you can never be completely sure whether a patient's death wish is a symptom of the patient's mental disorder.[135] However, she stated, "But you must have done everything to help them diminish the symptoms of their pathology. In personality disorders a death wish isn't uncommon. If that is consistent and they've had their personality disorder treatments, it's a death wish the same as a cancer patient who says, 'I don't want to go on to the end.'"[136] The psychiatrist believes that in the cases where it is very clear that a patient will kill themselves if they are not granted access to physician assisted suicide, those patients should be regarded as having terminal illnesses.[137] This view is not held by all psychiatrists.[138] Another psychiatrist who was interviewed regarding this case states that he has worked with suicidal patients his entire career and they are not terminal patients and should not be considered terminal.[139] In fact, no physician signed off on her request.[140]

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[130] Id.
[131] Id.
[132] Id.
[133] Id.
[134] Id.
[135] Id.
[136] Id.
[137] Id.
[138] Id.
[139] Id.
[140] Id.

The journalist who wrote about this case asked, "But could a death wish have been a symptom of her psychiatric illness?" [141] This question was analyzed by philosopher Hane Htut Maung in two parts: "whether or not it is possible to dissociate the person's wish to die from the person's mental disorder" and "what implications this has for whether or not the person's wish to die is deemed valid."[142] He argues that our conceptualization of mental disorders do not make it possible to differentiate a wish to die from a person's mental disorder. In this case, the patient suffered from borderline personality disorder. A symptom of this specific disorder is a wish to die. However, he does not believe that this should warrant this patient's wish to die invalid because "the assessment of a request for psychiatric euthanasia in the case of borderline personality disorder should focus on determining whether the request is voluntary, whether it is reasonable, and whether there is any reasonable alternative that could ameliorate the suffering, rather than on trying to determine whether or not the wish is a symptom of the mental disorder."[143]

IV. Arguments for and Against Medically Assisted Death for Individuals who Suffer from Severe Mental Disorders

States should amend their MAID statutes to allow medical assistance in dying for individuals who suffer from severe mental disorders. However, it is important to parse through the arguments for and against MAID to ascertain the complexity and differing views on the subject.

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[141] Hane Htut Maung, *Psychiatric Euthanasia and the Ontology of Mental Disorder,* J APPLIED PHILOSOPHY, Sept. 6, 2020, https://onlinelibrary.wiley.com/doi/full/10.1111/japp.12462
[142] Id.
[143] Id.

When delving into arguments for and against MAID for individuals who suffer from severe mental disorders, it is important to discuss the general arguments, as well as the views of different groups.[144] This section of the paper will discuss both general arguments for and against MAID in patients with psychiatric disorders, as well as the views and opinions of specific groups, including: the general population, relatives of patients with psychiatric disorders, and physicians.[145] This array of views comes from a study conducted by searching the major databases (including Embase/Medline, Psychlit, PsychINFO, and the Cochrane Library).[146] The data was collected from January 2011- June 2021.[147]

The general population's views tend to be morally driven. Those who oppose MAID for patients with psychiatric disorders (and often MAID in general) tend to use religion as a basis for their arguments.[148] Specifically, they believe that the sanctity of life should be upheld, and in order to follow the Hippocratic Oath, physicians must avoid damage to their patients by all means, which includes MAID.[149] They argue that the duty of physicians is to preserve human life and prevent suicide.[150] In their eyes, MAID completely undermines these facets.[151] Additionally, oppositions to MAID for patients with psychiatric disorders are skeptical the fact that determining whether mental illnesses are irremediable in unclear, while determining whether a somatic disease is irremediable is clear cut.[152] On the other hand, those who support MAID for patients with mental illnesses and view it as morally permissible take the position that an

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[144] Luigi Grassi, *Debating Euthanasia and Physician-Assisted Death in People with Psychiatric Disorders*, COMPLEX MEDICAL-PSYCHIATRIC ISSUES, June 9, 2022, https://link.springer.com/article/10.1007/s11920-022-01339-y#Sec2
[145] Id.
[146] Id.
[147] Id.
[148] Id.
[149] Id.
[150] Id.
[151] Id.
[152] Id.

individual should have complete autonomy when it comes to making decisions about her life. The supporters of MAID argue that the prolonging of an unbearable life full of agony and loss of dignity is immoral.[153] Further, supporters argue prohibiting MAID limits an individual's rights to personal liberty.[154]

In this study, the general population's views were also split between the views of different nations.[155] This study focused on the distinctions between the United States and the Netherlands.[156] In the Netherlands, 53% of respondents supported MAID for patients with psychiatric disorders, while only 15% stated opposition to this practice.[157] However, in the United States, only one-third supported MAID for people with physical disability such as cerebral palsy, and dementia or mental illness.[158]

The views of relatives of patients with psychiatric disorders have not been broadly studies.[159] However, a qualitative Dutch study did make some findings pertaining to the opinions of families of patients with psychiatric disorders.[160] The study revealed that while the relatives of these patients showed compassion for their wish to die and fear that the patient would commit suicide if denied the choice of MAID, they did wish that their family members would not go through with MAID.[161]

There are large variations in the opinions of physicians regarding MAID for patients with psychiatric disorders.[162] In the Netherlands, 20% of physicians support MAID for patients with

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[153] Id.
[154] Id.
[155] Id.
[156] Id.
[157] Id.
[158] Id.
[159] Id.
[160] Id.
[161] Id.
[162] Id.

mental illnesses.[163] In a Dutch study, about 2/3 of psychiatrists believe it is possible to determine whether a patient's psychiatric suffering is irremediable.[164] This statistic is significant because mental health care professionals in the Netherlands are particularly well-versed in what goes in to the determination of whether a patient should be eligible for MAID.[165]

V. Amending State Law in the United States

The states in the United States of America that previously legalized physician assisted suicide should amend their statutes to include an option for patients with severe mental illnesses to have access to medical assistance in death. In order to amend these statutes, these states should look to the laws of Belgium and the Netherlands for guidance because they have legalized medically assisted suicide for many years and have the data and practices in place that can be analyzed. To illustrate this point, Oregon's physician assisted suicide legislation will be used as a model. Oregon will be used for this example because Oregon was the first state to legalize MAID in the United States, and it is a good example of a state that has a differing clause from other states that will have to be modified in order to make MAID for patients with mental illnesses workable.

A. Changes Oregon Needs to Make to Its Current MAID Criteria Before Allowing Patients with Mental Illnesses to Become Eligible

As previously stated, Oregon does not require patients who seek medically assisted suicide to be a resident of the state.[166] This practice cannot continue if Oregon were to amend its statute to include physician assisted suicide for patients with mental illnesses. In the Netherland's

[163] Id.
[164] Id.
[165] Id.
[166] OR. REV. STAT. ANN. § 127.805

medical assistance in death act, the law requires six due care criteria to meet in order to allow a patient access to physician assisted suicide.[167] These criteria require that the physician and the patient thoroughly discuss the patient's condition and options.[168] Additionally, another physician must meet with the patient and ensure that the previous physician met the first four due care criteria before signing off on the termination of the patient's life.[169] If Oregon were to adopt medically assisted suicide for patients with severe mental illnesses, it could not allow patient who are not residents of Oregon to participate in this practice. Ending the life of a person with a mental illness is much more precarious than ending the life of a person with a somatic illness. A physician can ascertain whether a somatic illness is terminal by looking at a patient's medical records. The same cannot be done when mental illness is involved. There are too many variables, and it would be irresponsible to allow physicians to sign off on medically assisted death for patients with mental illness whom they have not thoroughly consulted, worked with, and treated. If the Oregon state legislature desires to allow patients with somatic illnesses from other states to continue to be eligible for MAID, that is fine, but the state cannot allow the same for patients with psychiatric disorders.

B. Patient-Specific Criteria Oregon Needs to Add to its Amendment

Oregon should use the Netherlands six due care criteria as a starting point for its amendment. This would allow Oregon to keep its current laws for physician-assisted suicide (except for allowing patients who are not residents of Oregon to be eligible) and using Netherland's language as an amendment to the current statute.

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[167] SMP van Veen, *Physician Assisted Death for Psychiatric Suffering: Experiences in the Netherlands*, PUDMED CENTRAL, June 20, 2002, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9251055/
[168] Id.
[169] Id.

However, based on the data from the Netherlands that reveals that 25% of Dutch physicians experienced difficulties with some of the Netherlands due care criteria, specifically the 'unbearable and hopeless suffering" and "voluntary and well-considered request" criteria, the United States needs to put more safeguards into place before amending the MAID statutes. In order to help alleviate the issues that Netherland's experiences with its due care criteria. Oregon should also adopt Belgium's safeguards that are in place specifically for patients who request MAIFD for psychiatric disorders. Belgium requires additional steps and precautions to be taken for patients who request medically assisted suicide for their severe mental illnesses, rather than somatic terminal illnesses.[170] These steps are taken any time a patient is not going to die from his or her illness in the foreseeable future.[171] First, an independent physician, which can be either a psychiatrist or another physician that specializes in the patient's condition, must be consulted.[172] Second, there must be a minimum of a month delay between the patient's request for euthanasia and the actual act of euthanasia.[173]

C. Reporting and Oversight Criteria

Oregon should also amend its statute to include a Commission that reviews all cases of Medical Assistance in Dying. The Belgian Euthanasia Act requires that all cases of euthanasia be sent to the Federal Control and Evaluation Commission the lethal drugs are administered to the patient to ensure that physicians are following the proper criteria.[174] Oregon's amendment should include a similar commission to regulate the practice and ensure all criteria is followed.

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[170] Trudo Lemmens, *The Conflict Between Open-Ended Access to Physician-Assisted Dying and the Protection of the Vulnerable*: *Lessons from Belgium's Euthanasia Regime for the Canadian Post-Carter Era*, UNIVERSITY OF TORONTO, Feb 26, 2016, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2734543

[171] Id.

[172] Id.

[173] Id.

[174] Saad, Toni, MA., *Euthanasia in Belgium: Legal, Historical and Political Review*, ISSUES IN LAW AND MEDICINE, Fall 2017,

However, based on the data from Belgium that revealed that Belgium doctors were not reporting all cases and were administering lethal drugs to patients without proper consent, Oregon should take extra steps.[175] Instead of sending the case to an oversight commission after the lethal drugs are administered, an oversight commission of doctors and lawyers should review each case prior to the administration of lethal drugs to ensure all criteria is carefully followed.

VI. Concerns

In the Netherlands and Belgium, there are two particularly concerning issues with the practice.[176] First, neither country has specified the amount of previously attempted treatments necessary to define the patient's illness as irremediable.[177] This is concerning because it seems that there is no minimum amount of attempted treatment necessary before determining whether a mentally ill patient truly cannot get better. Specifically, in the Netherlands, the standard for irremediably used by the Dutch Psychiatric Association weights the costs and benefits of particular treatments for the patient.[178] As discussed earlier, physicians determine likeliness that a treatment will benefit the patient.[179] If it likely will benefit the patient, and the patient refuses, MAID should not be offered.[180] However, if the treatment is unlikely help the patient, MAID is not barred.[181] Outside of this cost-benefit analysis, which is a good starting point, including a

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[175] Id.
[176] Matteo Scopetti, *Assisted Suicide and Euthanasia in Mental Disorders*: *Ethical Positions in the Debate Between Proportionality, Dignity, and the Right to Die*, MDPI, May 18, 2023, https://www.mdpi.com/2227-9032/11/10/1470
[177] Id.
[178] William Rooney, Udo Schuklenk & Suzanne Van de Vathorst, *Are Concerns About Irremediableness, Vulnerability, or Competence Sufficient to Justify Excluding All Psychiatric Patients from Medical Aid in Dying?* HEALTH CARE ANALYSIS, June 17, 2017 https://link.springer.com/article/10.1007/s10728-017-0344-8#Sec1
[179] Id.
[180] Id.
[181] Id.

minimum amount of attempted treatments or a minimum amount of therapy sessions would minimize the uncertainty and discrepancies between how patients are evaluated. For states in the United States of America to amend their statutes to include medically assisted death for patients with mental illness, their amendments should require a minimum standard of treatment before medically assisted death can even be discussed. This likely requires significantly more research by physicians.

Second, the concept of a "medically futile condition" has not been definitively defined by physicians in Belgium or the Netherlands.[182] This is problematic because there is no standard as to which mental illnesses are "futile enough" to qualify for medically assisted death. The lack of standard is concerning. This is likely another aspect of medical assistance in dying for individuals with mental illness that should and will be studied more before states consider amending their statutes to include the option of physician-assisted suicide for patients with severe psychiatric disorders.

It is obvious that Canadian lawmakers and physicians have the same concerns.[183] Canada has pushed temporarily back the implementation of the amendment to allow physician-assisted suicide for patients with several mental illnesses multiple times.[184] These actions, coupled with public opinion and wariness and discrepancies between physicians shows that while Canada understands that this practice should be permitted in certain circumstances, they do not feel comfortable implementing these laws without further research that their lawmakers have given them more time to conduct.[185] Specifically, as previously discussed, the Government of Canada

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[182] Id.
[183] *Canada's Medical Assistance in Dying (MAID) Law*, GOVERNMENT OF CANADA, Mar 1, 2024, https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html#s0
[184] Id.
[185] Id.

has determined that more time is necessary to prepare physicians, healthcare systems, and determine what amendments need to be made to the current medical assistance in dying criteria and eligibility before opening up access to patients with severe mental illnesses.[186]

VII. Conclusion

Medical assistance in death for patients with mental disorders is an evolving science and practice. States in the United States of America should amend their existing Medical Assistance in Dying Statutes to include patients with severe mental disorders in limited circumstances. However, more research by physicians is likely required before this can be implemented. Legislators and physicians need to work together to make this happen in a way that is safe, fair, and securely monitored. As discussed, using the laws and safeguards implemented by the Netherlands and Belgium is a good starting point. Their procedures and laws should be carefully studied and reviewed by lawmakers and physicians. These laws should be a starting point supplemented by additional safeguards that can eventually be added into existing statutes. When more research is done, the implementation of these procedures will be a significant addition to the ever-changing landscape of mental health practices in the United States of America.

I recommend that more research be conducted by physicians and scientists to flesh out whether there is a way to definitively define and diagnose a medical disorder as incurable. A potential consideration could be to outline which psychiatric disorders can be deemed irremediable. This would allow physicians to adopt a clearer standard pertaining to whether an individual who suffers from a severe mental illness is eligible for physician assisted suicide. Discovering this would create a more black and white system for doctors to use, rather than the

[186] Id.

gray practice that is currently being used in the Netherlands and Belgium, which has shown to be fallible at times.

After this research progresses, it will be much easier for legislators in the United States of America to amend their existing physician-assisted suicide statutes to include medical aid in dying for patients with mental illnesses because it will become a safer and more nuanced practice. In conclusion, after more extensive research, states should amend their physician-assisted suicide statutes and expand them to include medical aid in dying for patients with mental illnesses.