

Analysing the Issue of Psychiatric Assisted Dying from the Perspective of Parity: Does Parity Demand Access?

Allegra Enefer*

ABSTRACT

The UK is ostensibly committed to achieving parity of esteem between mental and physical health, yet the attempts to legalise assisted dying in recent years have focused exclusively on physical suffering. In this article, I will analyse the issue of psychiatric assisted dying from a 'parity perspective'. According to this perspective, a blanket prohibition on access for psychiatric patients would only be justified if there existed a relevant difference between mental and physical illness in relation to assisted dying which could not be accommodated with proportionate safeguards. Three justifications for treating these cases differently have been advanced in the literature: firstly, that the normative rationale for assisted dying could only apply to physical suffering; secondly, that severely mentally ill patients cannot be considered competent to request assisted dying; and thirdly, that mental illness cannot be considered 'incurable'. As I will demonstrate, none of these justifications are persuasive. Furthermore, risks which do exist specifically in the psychiatric context can be accommodated through parity-focused safeguards. I will conclude that no relevant difference exists between mental and physical illness that proportionally justifies a blanket prohibition on psychiatric assisted dying. Therefore, any attempt to legalise assisted dying in England and Wales must permit access for certain psychiatric patients.

* LLB (LSE) '20. The author is most thankful to Professor Emily Jackson and Dr Cressida Auckland for their supervision.

INTRODUCTION

The UK is now committed to achieving parity of esteem, and yet successive attempts at legalising assisted dying appear to have privileged patients with physical illnesses and disregarded the question of access for patients with psychiatric disorders. Parity of esteem demands the equal provision of healthcare to mentally and physically ill patients. A blanket prohibition on psychiatric assisted dying would only be justified if there existed a relevant difference between mental and physical illness in relation to assisted dying which could not be accommodated with proportionate safeguards. Three justifications for treating these cases differently have been advanced in the literature. As I will demonstrate, none are persuasive. Firstly, it could be argued that the normative rationale for assisted dying could only apply to physical suffering. I will consider three potential rationales: relief of unbearable suffering; autonomy; and incurability, and I will conclude that some psychiatric patients could qualify for access under all three. Secondly, in relation to the autonomy rationale, some academics (such as Paul Appelbaum, Matthew Broome, and Angharad de Cates) have advanced arguments to the effect that severely mentally ill patients cannot be considered competent to request assisted dying. I will reject this claim by asserting that such patients can be competent to request assisted dying insofar as their desire to die is ‘authentic’, and parity-focused safeguards can aid clinicians in assessing the authenticity of requests. Thirdly, in relation to the incurability rationale, authors such as Paul Appelbaum and Thomas Bilkshavn argue that mental illness cannot be considered ‘incurable’ such that the provision of assisted dying is not justified. I will reject this argument by advancing a ‘qualitative’ understanding of incurability in the psychiatric context and argue that this understanding is necessary to achieve parity of esteem. Where specific risks do exist in the psychiatric context, they can and should be accommodated from a parity perspective. Any attempt to legalise assisted dying in England and Wales must therefore permit access for certain psychiatric patients.

The law on assisted dying

‘Assisted dying’ is an umbrella term which refers to voluntary euthanasia and assisted suicide. Both forms of assisted dying are criminalised in the UK,

including for patients with physical illnesses. Voluntary euthanasia is prohibited under the ordinary criminal law of murder,¹ and assisted suicide is criminalised under section 2(1) of the Suicide Act 1961.² In recent years, there have been various attempts to legalise assisted dying. Several bills proposing to legalise assisted dying for competent patients diagnosed with a terminal illness have been brought before Parliament, but none have succeeded.³ A new bill, with substantially similar provisions, is awaiting its second reading in the House of Lords.⁴ There have also been several judicial challenges against the prohibition of assisted suicide,⁵ arguing specifically that the prohibition violates patients' right to private and family life under Article 8 of the European Convention of Human Rights (ECHR) as applied by the Human Rights Act 1998.⁶ The Supreme Court has expressed serious concern about the compatibility of section 2 of the Suicide Act with Article 8.⁷ They have so far declined to make a declaration of incompatibility, instead referring the issue back to Parliament.⁸

I. PARITY

I will adopt a 'parity perspective' to the issue of psychiatric assisted dying. If the UK is to legalise assisted dying, then according to this perspective, a blanket prohibition on its provision for psychiatric disorders would undermine the UK's legal commitments to parity, unless one could prove that there exists a relevant difference between mental illness and physical illness in the context of assisted dying which cannot be accommodated by proportionate safeguards.

The UK is expressly committed in law to achieving parity of esteem between mental and physical health. Parity of esteem is defined as, among other things, equal access to effective care and treatment, equal status within health care

¹ R (*Nicklinson and Another*) v *Ministry of Justice* [2014] UKSC 38 [2015] AC 657.

² Suicide Act 1961, s 2(1).

³ Assisted Dying Bill [HL] 2014-15; Assisted Dying (No. 2) Bill 2015-16; Assisted Dying Bill [HL] 2016-17.

⁴ Assisted Dying Bill [HL] 2019-21.

⁵ R (*on the application of Pretty*) v *Director of Public Prosecutions* [2001] UKHL 61 [2002] 1 AC 800; R (*on the application of Purdy*) v *Director of Public Prosecutions* [2009] UKHL 45 [2010] 1 AC 345; *Nicklinson* (n 1); R (*on the application of Conway*) v *Secretary of State for Justice* [2018] EWCA Civ 1431 [2020] QB 1.

⁶ Human Rights Act 1998, art 8.

⁷ *Nicklinson* (n 1) [111]-[113].

⁸ *ibid.*

practice, and equal status in the measurement of health outcomes.⁹ Whilst there is no uniform approach across the devolved administrations, the clearest source of this commitment can be found in the Health and Social Care Act 2012, which imposes a legal responsibility on the NHS in England and Wales to deliver parity of esteem.¹⁰ The government requires NHS England to work towards parity through the NHS Mandate,¹¹ and NHS England has consequently established a Parity of Esteem Programme.¹² As a signatory of the UN Convention of the Rights of Persons with Disabilities (CRPD), under international law, the UK is committed to achieving the treaty's obligations. In relation to prohibiting access to assisted dying on the basis of a psychiatric illness, the key provisions which may be contravened include the obligation under Article 1 to prevent discrimination on the basis of disability ('disability' including a long-term mental impairment);¹³ the obligation under Article 25(f) to prevent discriminatory denial of health care or health services on the basis of disability;¹⁴ and the obligation under Article 3(1) to respect the inherent dignity and autonomy of persons with disabilities.¹⁵

Despite this commitment to parity, recent attempts in Parliament to legalise assisted dying have focused exclusively on physical suffering. Legislators in the UK appear to have assumed that it is self-evident that the mentally ill should not be able to access assisted dying. For instance, Huw Merriman MP expressed concern that the Assisted Dying (No. 2) Bill 2015-16 'would make it easier for future Parliaments to amend and broaden the applicability beyond those with terminal illness perhaps to those suffering from mental illness'.¹⁶ However,

⁹ The Royal College of Physicians, *Whole-person care: from rhetoric to reality: achieving parity between mental and physical health* (OP88, RCP, 2013) 20.

¹⁰ Chris Naylor, 'Is there "parity of esteem" between mental and physical health? Big election questions' (*King's Fund*, 19 May 2017) <<https://www.kingsfund.org.uk/publications/articles/big-election-questions-parity-mental-physical-health>> accessed 03 May 2020.

¹¹ Centre for Mental Health, *Briefing 46: The NHS Mandate and its implications for mental health* (2013).

¹² NHS East Midlands Mental Health Clinical Network, *Parity of Esteem: Overview and Report: Improving the Physical Health of People with Serious Mental Illness in the East Midlands* (November 2019) 4.

¹³ UN Convention on the Rights of Persons with Disabilities (adopted 24 January 2007A/RES/61/106) (UN CRPD) art 1.

¹⁴ *ibid* art 25(f).

¹⁵ *ibid* art 3(1).

¹⁶ HC Deb 11 September 2015, vol 599, col 719W.

psychiatric assisted dying is an issue on which jurisdictions, authors, and campaigners take widely different approaches. Public campaigners have come to prominence in recent years arguing that some psychiatric patients ought to be allowed assistance in dying, notable examples being Adam Maier-Clayton in Canada¹⁷ and Aurelia Brouwers in the Netherlands.¹⁸ Assisted dying is available to certain psychiatric patients in the Netherlands, Belgium, Luxembourg,¹⁹ Switzerland,²⁰ and arguably, in Canada.²¹ Clearly, it is not self-evident that the mentally ill, as a category, should be entirely prohibited from access to assisted dying. This is an issue which requires a thoughtful legislative response. Arguments for not extending assisted dying to psychiatric patients ought to be challenged if the UK is fully committed to achieving parity of esteem.

At a basic level, one underlying assumption may be that psychiatric patients are an especially 'vulnerable' population who ought to be shielded from the risk of an avoidable death via assisted dying. The term 'vulnerable' was used twenty-three times in the second reading of the UK Assisted Dying Bill 2015-16 in the House of Commons and often interchangeably with mental illness.²² Lyn Brown MP labelled vulnerable patients as 'troubled' and asserted that '[his] mum was not vulnerable. She was not alone or a depressive'.²³ Fiona Bruce MP raised similar concerns for 'the particularly vulnerable in our society, such as those with mental health difficulties'.²⁴ It is essential from a parity perspective that this assumption be challenged. Psychiatric patients are a diverse category, incorporating different disorders, such as mild anxiety and acute psychosis, and there are significant dangers posed to their autonomy and care by appealing to stereotypes and

¹⁷ Stuart Hughes, 'Adam Maier-Clayton's controversial right-to-die campaign' *BBC News* (Ontario 19 July 2017) <<https://www.bbc.co.uk/news/world-us-canada-40546632>> accessed 03 May 2020.

¹⁸ Linda Pressly, 'The troubled 29-year-old helped to die by Dutch doctors' *BBC News* (The Netherlands 9 August 2018) <<https://www.bbc.co.uk/news/stories-45117163>> accessed 03 May 2020.

¹⁹ Kirsten Evenblij, H Roeline W Pasmán, Rosalie Pronk, Bregje D Onwuteaka-Philipsen, 'Euthanasia and physician-assisted suicide in patients suffering from psychiatric disorders: a cross-sectional study exploring the experience of Dutch psychiatrists' (2019) 19(74) *BMC Psychiatry* 2.

²⁰ Ruling 03.11.2006 2A.48/2006 of the Federal High Court of Switzerland.

²¹ Jocelyn Downie, Justine Dembo, 'Medical Assistance in Dying and Mental Illness under the New Canadian Law' (2016) 1 *Journal of Ethics in Mental Health*.

²² HC Deb 11 September 2015, vol 599.

²³ *ibid* col 669W.

²⁴ *ibid* col 670W.

vulnerability rhetoric. Justine Dembo and others noted that this rhetoric is used to ‘remove agency’ from psychiatric patients,²⁵ and Rosamond Rhodes argued that a lack of respect for the patient is inherent in this kind of labelling, as it implies a lack of effort to see that person’s choices as reasonable from their perspective.²⁶ Stigma is especially dangerous in the psychiatric context as it can exacerbate suffering and negatively impact treatment efficacy.²⁷ Specific factors in the context of mental illness may exacerbate the risk that specific individuals are especially vulnerable. However, from the parity perspective, the law ought to accommodate that risk within the existing framework where possible, rather than deny access to healthcare on that basis. Considering our commitments to parity, healthcare provision should not be denied to psychiatric patients on the basis of vague notions of ‘vulnerability’.

A commitment to parity tells us little about what kind of equal treatment is required in the context of assisted dying. It raises the question in what respect mentally and physically ill patients should be treated as equal. According to the formal principle of equality, like cases should be treated alike.²⁸ Mental and physical illness cannot be treated unequally without sufficient reason. According to this principle, if one could point to a relevant difference between mental and physical illness in the context of assisted dying, it may be legitimate to prohibit psychiatric patients from access.

However, on a more substantive ‘proportional’ principle of equality,²⁹ mentally and physically ill patients can be treated differently in order to achieve ‘equal treatment’ in real terms. The Mental Health Act 2007 and the Mental Capacity Act 2005 have been embedded with the principle of proportionality to

²⁵ Justine Dembo, Udo Schuklenk, Jonathan Reggler, “‘For Their Own Good’: A Response to Popular Arguments Against Permitting Medical Assistance in Dying (MAID) where Mental Illness is the Sole Underlying Condition’ (2018) 63(7) *The Canadian Journal of Psychiatry* 451, 451, 454.

²⁶ Rosamond Rhodes, ‘Rethinking Research Ethics’ (2010) 10(10) *The American Journal of Bioethics* 19, 23.

²⁷ Alison J Gray, ‘Stigma in Psychiatry’ (2002) 95 *Journal of the Royal Society of Medicine* 72.

²⁸ Aristotle, *Nicomachean Ethics*, V.3. 1131a10-b15.

²⁹ *ibid* 1130b-1132b.

be compatible with the ECHR.³⁰ In the context of assisted dying, proportionality may mean that psychiatric assisted dying requires additional safeguards to account for risks or vulnerabilities specific to the psychiatric context, rather than resorting to a blanket prohibition. The UN CRPD adopts a substantive understanding of equality, where it states under Article 5 that ‘in order to promote equality and eliminate discrimination, State Parties shall take all appropriate steps to ensure that reasonable accommodation is provided’.³¹ In my view, this principle brings us closer to real parity between mental and physical health. By accommodating the particular disadvantages posed by psychiatric illness, this approach achieves equality of provision and outcomes in real terms.

I will therefore adopt a ‘parity perspective’ which applies a proportional approach to equality. If an assisted dying regime granted access to the physically ill, but prohibited access to the mentally ill, the only way that parity would not be breached would be if there was a relevant difference between psychiatric and physical illness in the context of assisted dying, which could not be accommodated within the existing framework through appropriate safeguards. I will focus on three ways in which it may be argued that mental and physical illness could be treated differently as they are well-rehearsed in the literature: firstly, that the normative justification for assisted dying could only apply to physical illness; secondly, that severely mentally ill patients could not be considered competent to request assisted dying; and thirdly, that psychiatric illnesses could not be considered incurable. I will reject all three propositions in turn, concluding that no relevant difference exists between mental and physical illness that proportionally justifies a blanket prohibition on psychiatric assisted dying. Therefore, parity demands that any attempt to legalise assisted dying in England and Wales includes access for certain psychiatric patients.

II. NORMATIVE RATIONALE

One way in which discrimination could be legitimate is if the normative justification for assisted dying could only apply to people with physical illnesses and not to those with mental illnesses. To assess whether this is true, I will explore

³⁰ Martin Curtice, Fareed Bashir, Sanjay Khurmi, Juli Crocombe, Tim Hawkins, Tim Exworthy, ‘The proportionality principle and what it means in practice’ (2011) 35 *The Psychiatrist* 111.

³¹ UN CRPD (n 13) art 5.

three normative justifications for assisted dying: unbearable suffering; autonomy; and incurability. These justifications are the most well-rehearsed in the literature on assisted dying, and any of them would be sufficient to justify assisted dying, provided that there are sufficient safeguards in place. To be clear, I refer to the ‘normative rationale’ as the fundamental principle which justifies assisted dying, rather than acting as the sufficient criteria for access to assisted dying. Under any rationale, additional criteria and safeguards will necessarily exist. My analysis of each rationale will conclude that assisted dying for a mentally ill patient in certain circumstances is no less ethically justified than assisted dying for a physically ill patient in comparable circumstances. Therefore, a blanket prohibition on access to assisted dying for patients with mental illnesses cannot be justified at the normative level.

III. RATIONALE 1: UNBEARABLE SUFFERING

The first possible rationale for assisted dying is relieving unbearable suffering. Brent Kiouss and Margaret Battin argue that much of the moral appeal of legalising assisted dying rests on recognition that ‘it can be reasonable to want to die when one’s illness causes or threatens severe suffering’.³² This rationale is explicit in the laws of jurisdictions that have legalised assisted dying. For instance, the Dutch ‘due care criteria’ requires that a patient is experiencing unbearable suffering with no prospect of improvement.³³ Similarly, patients in Belgium must be suffering from an ‘unbearable and untreatable’ disorder.³⁴ Notably, there is a link between unbearable suffering and the suffering being irremediable, because if the disorder could be treated to relieve suffering, then the ethical justification for assisted dying would be weaker. It may, therefore, be the case that the fundamental ethical principle, which justifies the provision of assisted dying, is the compassionate maxim to relieve unbearable suffering.

This rationale is also illustrated in contributions to parliamentary debates on legalisation of assisted dying in the UK. In a House of Commons debate in

³² Brent M Kiouss, Margaret Battin, ‘Physician Aid-in-Dying and Suicide Prevention in Psychiatry: A Moral Crisis?’ (2019) 19(10) *The American Journal of Bioethics* 29, 30.

³³ Agnes van der Heide, Bregje D Onwuteaka-Philipsen, Mette L Rurup, Hilde M. Buiting and others, ‘End-of-life Practices in the Netherlands under the Euthanasia Act’ (2007) 356(19) *The New England Journal of Medicine* 1957, 1958.

³⁴ Paul S Appelbaum, ‘Physician-assisted death in psychiatry’ (2018) 17(2) *World Psychiatry* 146.

January 2020, Alicia Kearns MP stated that ‘the crux of the matter is to recognise the terror and agony there must be in having your body turn on you, with it racking you with pain or torturing you’,³⁵ and Elliot Colburn MP submitted that ‘it seems almost cruel to let someone live with that and prolong their suffering for no reason’.³⁶ Indeed, the status quo reflects this understanding of assisted dying. The Director of Public Prosecutions has issued outlining the factors for and against prosecuting individuals who assist someone in procuring an assisted death, which set out that a compassionate motivation to relieve an individual of their suffering will weigh as a factor making prosecution less likely.³⁷ This may be read as an implicit endorsement of the view that relief of unbearable suffering provides an ethical justification for assisted dying.

Mental illness can cause suffering as unbearable as that which can be caused by physical illness. To the extent that this is true, providing assisted dying to mentally ill patients is, in principle, as ethically justified as providing it to the physically ill. It is important to note that suffering is a subjective experience and there is no objective way of measuring its severity. I am seeking to highlight that the mentally ill can experience immense suffering. At the clinical level, we know that psychiatric disorders are constituted by symptoms which inherently cause suffering. For instance, Michael Cholbi notes that the diagnostic criteria for major depression includes anhedonia (inability to feel pleasure), depressed mood, and disturbed sleep.³⁸ Psychological pain is also highly pervasive in that it ‘interferes with multiple aspects of personhood’.³⁹ Cholbi highlights that severe psychiatric disorders ‘define one’s outlook on the world and on one’s own existence’ and manifest as a ‘profound sense of alienation from one’s cares and from oneself’, to such an extent that the ordinary language of ‘pain’ and ‘suffering’ cannot do justice to the experience of severe psychiatric disorders.⁴⁰

³⁵ HC Deb 23 January 2020, vol 670, col 198W.

³⁶ *ibid* col 193W.

³⁷ DPP Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide (CPS 2010) s 45.

³⁸ Michael J Cholbi, ‘The terminal, the futile, and the psychiatrically disordered’ (2013) 36 *International Journal of Law and Psychiatry* 498, 499.

³⁹ Justine Dembo, ‘Addressing treatment futility and assisted suicide in psychiatry’ (2010) 5(1) *Journal of Ethics in Mental Health* 1, 1-2.

⁴⁰ Cholbi (n 38) 499-500.

Unbearable psychiatric suffering is illustrated in *A Local Authority v E*,⁴¹ a case of a 32-year-old woman with an extremely severe form of anorexia nervosa, who expressed a wish to refuse life-sustaining treatment. E described her life as ‘a pure torment’.⁴² Her sleep was invaded every night when woken up for nursing procedures. E could not move without support and suffered from osteoporosis due to impaired nutrition. In order to keep E alive against her wishes, doctors would have to forcibly feed her for at least a year, under physical or chemical restraint, via a tube through her nose or her stomach wall. E stated, and doctors concurred, that this process would feel like reliving the extensive sexual abuse she suffered as a child, approximately four times every hour. By any stretch of the imagination, this suffering is unbearable.

Unfortunately, as Ryan Tanner highlights, the notion persists in public and political discourse that psychological suffering is more tolerable and transient than physical suffering.⁴³ Jeanette Hewitt notes that states like depression and anxiety are seen as ‘products of an affluent but disaffected society’ and many associate such conditions with ‘weakness of will or a remediable biochemical brain abnormality’.⁴⁴ Perhaps of even greater concern, these misconceptions appear to exist among some mental health professionals, as Tanner found that some refer to their role as assisting patients in ‘accepting and embracing the pain as a part of life’.⁴⁵ Thus, Hewitt identifies that discussions of rational suicide tend to treat psychological suffering as fundamentally different, privileging physical suffering and disregarding psychological suffering as somehow more tolerable or transient.⁴⁶

It must moreover be pointed out that any absolute distinction between physical and psychological suffering is artificial. Even if one does not accept my previous argument that psychological suffering can be equally as unbearable as physical suffering, one could not then coherently privilege only physical suffering

⁴¹ *A Local Authority v E* [2012] EWHC 1639 (COP).

⁴² *ibid* [76].

⁴³ Ryan Tanner, ‘An Ethical-Legal Analysis of Medical Assistance in Dying for Those with Mental Illness’ (2018) 56(1) *Alberta Law Review* 149, 159.

⁴⁴ Jeanette Hewitt, ‘Why Are People with Mental Illness Excluded From the Rational Suicide Debate?’ (2013) 36 *International Journal of Law and Psychiatry*, 360.

⁴⁵ Tanner (n 43).

⁴⁶ Hewitt (n 44).

in the context of assisted dying. These two forms of suffering are strongly correlated and often intersect, and it is not easy to distinguish the experience of one entirely from the other.⁴⁷ To illustrate this point, it is constructive to highlight the cases of physically ill patients that have been key to the debate on assisted dying in recent years. Tony Nicklinson's request for assisted dying was triggered by his locked-in syndrome, a physical condition, but the suffering from which he sought escape was the mental anguish of spending decades alive with the condition. In his own words:

I need help in almost every aspect of my life. I cannot scratch if I itch, I cannot pick my nose if it is blocked and I can only eat if I am fed like a baby – only I won't grow out of it, unlike the baby. I have no privacy or dignity left. I am washed, dressed and put to bed by carers who are, after all, still strangers. I am fed up with my life and don't want to spend the next 20 years or so like this.⁴⁸

Nicklinson's concerns are shared by physically ill patients requesting assisted dying in Oregon. There, the most commonly cited reasons that the physically ill gave for wishing to end their life were not physical pain or discomfort, but the psychological pain that came as a result of the disorder, in terms of losing their autonomy, dignity, and ability to participate in activities that made life enjoyable.⁴⁹ On the other side of the coin, some of the suffering induced by psychiatric disorders will be physical. For instance, depressed individuals are three times more likely to report chronic bodily pain than non-depressed individuals.⁵⁰ In the most severe cases, psychiatric disorders can create excruciating psycho-somatic pain for the individual, such as the crippling burning sensation that Adam Maier-Clayton felt all over his body when he tried to talk, think, or read.⁵¹ Therefore, if one accepts that relief from unbearable suffering provides the normative justification for assisted dying, it would be artificial to assert that only patients suffering

⁴⁷ Cholbi (n 38) 500.

⁴⁸ Robert Booth, "'Locked-in' syndrome man demands right to die" *The Guardian* (19 July 2010) <<https://www.theguardian.com/society/2010/jul/19/locked-in-syndrome-die-dpp>> date accessed 03 May 2020.

⁴⁹ Public Health Division, *Oregon Death with Dignity Act: Data Summary 2016* (Center for Health Statistics 2017).

⁵⁰ Cholbi (n 38).

⁵¹ Hughes (n 17).

unbearably as the result of a physical illness are ethically justified in accessing assisted dying. Part of that suffering will be psychological. It would also be artificial to suggest that psychological pain is more tolerable or transient than physical pain, given that the two will often be interconnected in severe cases of psychiatric illness.

If the normative rationale for assisted dying is to relieve unbearable suffering, and one accepts my argument that the mentally ill can suffer unbearably, then there is no relevant difference between mental and physical illness which justifies a blanket prohibition on psychiatric assisted dying.

IV. RATIONALE 2: AUTONOMY

Many argue that a fundamental justification for assisted dying is respect for patient autonomy, in terms of their ability to choose when and how they die. In an address to the US Supreme Court, six philosophers asserted that ‘most of us see death – whatever we think will follow it – as the final act of life’s drama, and we want that last act to reflect our own convictions, those we have tried to live by, not the convictions of others forced on us in our most vulnerable moment’.⁵² Dworkin has further argued that ‘making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny’.⁵³ Medical law in England and Wales is now clearly committed to maximising patient autonomy. Patients are ‘widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession’,⁵⁴ and clinicians are guided to ‘maximise patients’ opportunities, and their ability, to make decisions for themselves’.⁵⁵

The right of competent individuals to refuse medical treatment already extends to end-of-life decisions, as ‘an adult whose mental capacity is unimpaired has the right to decide for herself whether she will or will not receive medical or

⁵² Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, Thomas Scanlon, Judith Jarvis-Thompson, The Philosopher’s Brief (*Washington et al. v Glucksberg* 117 S Ct 2258 (1997) and *Vacco v Quill* 117 S Ct 2293 (1997)).

⁵³ Ronald Dworkin, *Life’s dominion: an argument about abortion, euthanasia, and individual freedom* (New York, Alfred A Knopf, 1993) 21.

⁵⁴ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 [2015] AC 1430 [75].

⁵⁵ General Medical Council (GMC), *Consent: patients and doctors making decisions together* (2008)

surgical treatment, even in circumstances where she is likely or even certain to die in the absence of treatment'.⁵⁶ It arguably follows that the principle of patient autonomy ought to extend to the right to request death on terms that are acceptable to the patient. Respect for patient autonomy may therefore justify assisted dying.

On this normative understanding of assisted dying, a blanket prohibition on access to assisted dying would not be justified if one accepts that a psychiatric diagnosis does not vitiate the patient's capacity to make the request. Medical law is now committed to upholding and empowering patient autonomy in a psychiatric setting wherever possible. The Mental Capacity Act 2005 'expanded the group of patients able to make decisions for themselves' in terms of finding more patients competent to make medical decisions.⁵⁷ Under Article 3(1) of the UN CRPD, the UK is also committed to respect the inherent dignity, autonomy, and independence of persons with disabilities.⁵⁸ In practice, GMC Guidance asserts that clinicians 'must not assume that a patient lacks capacity to make a decision solely because of their [...] medical condition (including mental illness)'.⁵⁹ The UK is therefore committed to respecting the autonomy of patients with mental illness on an equal footing to patients with physical illness. On this basis, and if the normative rationale for assisted dying is autonomy, a blanket prohibition on psychiatric assisted dying is not justified *ex ante*.

A. Competence

A patient is competent where they have the capacity to make decisions for themselves. The argument I advance in this article is restricted to competent patients. This may indeed be problematic. Allowing access for competent patients, but denying access for incompetent patients, raises issues around fairness and could create a perverse incentive for a patient with a degenerative psychiatric disorder to travel to a permissive jurisdiction before they lose capacity and become ineligible. The competency restriction is therefore left open to question. For the purposes of analysing the issue of psychiatric assisted dying from a parity

⁵⁶ *Re T (Adult: Refusal of Treatment)* [1993] Fam 95 (Staughton LJ).

⁵⁷ Emily Jackson, *Medical Law: Texts, Cases, and Materials* (4th edn, OUP 2016) 286; Mental Capacity Act 2005 (MCA 2005).

⁵⁸ UN CRPD (n 13).

⁵⁹ GMC (n 55) 27.

perspective, I intend to argue that psychiatric patients can be considered competent to request assisted dying. A full discussion of psychiatric assisted dying as it relates to patients who lack capacity is thus beyond the scope of this article.

If all mentally ill patients lacked the capacity to make autonomous choices to request assisted dying, then, according to the autonomy rationale, psychiatric assisted dying would not be ethically justified. Opponents to psychiatric assisted dying raise two objections with regards to capacity. Firstly, some argue that, in principle, patients with severe psychiatric illness cannot make the decision to request assisted dying without being unduly influenced by the disorder itself. Few authors go as far as to make this assertion in relation to the entire patient group, instead emphasising that severe psychiatric disorders are highly likely to have an undue influence on the patient's decision-making because the desire to die will often be symptomatic of the disorder.⁶⁰ If one accepted that the risk was high enough, this would mean that psychiatric assisted dying would not be legitimate under the autonomy rationale (and indeed it would raise concerns under the other rationales). Alternatively, authors such as Scott Kim and Trudo Lemmens accept that some psychiatric patients could be competent to request assisted dying but raise the separate contention clinicians could not assess competence with sufficient certainty.⁶¹ They assert that the complexities involved in a capacity assessment in relation to a request for assisted dying in a psychiatric context are such that the risk of error is high enough to justify a blanket prohibition.

In this section I will argue that some psychiatric patients can make a competent decision to request assisted dying. I will do so by defending three claims. Firstly, and least controversially, that mentally ill patients can be competent. Secondly, that mentally ill patients can be competent to request assisted dying insofar as their desire to die is authentic. And thirdly, that clinicians can assess a mentally ill patient's capacity in relation to a request for assisted dying with sufficient certainty.

Hereafter, the terms 'capacity' and 'competence' will be used interchangeably.

⁶⁰ Frankin G Miller, Paul S Appelbaum, 'Physician-Assisted Death for Psychiatric Patients - Misguided Public Policy' (2018) 378(10) *N Eng J Med* 883.

⁶¹ Scott Y-H Kim, Trudo Lemmens, 'Should assisted dying for psychiatric disorders be legalised in Canada?' (2016) 118(14) *Canadian Medical Association Journal* E337.

B. Mentally ill patients can be competent

From a parity perspective, it is especially important to challenge the assumption that capacity is a problem for all psychiatric patients. A significant risk is posed to the autonomy and care of psychiatric patients by underlying assumptions about their capacity. Section 2(3) MCA asserts that a patient's lack of capacity cannot be established merely by reference to a condition of his 'which might lead others to make unjustified assumptions about his capacity'.⁶² The intention of this section is 'to remind health care professionals that they should not rely on stereotypes and assumptions when judging capacity'.⁶³ The UK is also obligated under Article 3(1) and Article 12(2) of the UN CRPD to respect the inherent autonomy of persons with disabilities and to recognise that they enjoy legal capacity on an equal basis with others (although the Convention itself challenges the very concept of 'legal capacity', denying that it should exist). It is a matter of law and medical ethics that mental illness and incapacity are not synonymous. A presumption of capacity applies to all patients, regardless of whether they have a mental illness.⁶⁴ While mentally ill patients are more likely to have their capacity assessed, capacity is still assessed on an individual basis. Therefore, mental illness in itself does not vitiate competence.

The issue for our purposes will be whether patients who are experiencing the extremes of psychiatric suffering, to the extent that they wish to end their lives, can be competent. Mental incapacity is certainly more prevalent in patients admitted involuntarily to psychiatric wards, and many of those patients will be the most unwell.⁶⁵ In spite of this, the presumption of competence applies equally to all patients regardless of psychiatric illness. Capacity assessments are then made at the clinician's discretion. Jacob Appel notes that one can be both deeply depressed and capable of making rational decisions.⁶⁶ It is also worth pointing out

⁶² MCA 2005 (n 57) s 2(3).

⁶³ Jackson (n 57) 254.

⁶⁴ MCA 2005 (n 57) s 1(2).

⁶⁵ Gareth S Owens, Genevra Richardson, Anthony S. David, George Szmukler, Peter Hayward, Matthew Hotopf, 'Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study' (2008) 337(7660) *British Medical Journal* 40.

⁶⁶ Jacob M Appel, 'A Suicide Right for the Mentally ILL? A Swiss Case Opens a New Debate' (2007) 37(3) *The Hastings Center Report* 21, 22.

that mental illnesses are often episodic,⁶⁷ and therefore, that decision-making capacity can be intact between episodes during a temporary remission of symptoms.⁶⁸ Others might retain capacity in spite of active illness.⁶⁹ From a parity perspective, therefore, the starting point must be that psychiatric patients who request assisted dying are *prima facie* competent.

C. Mentally ill patients can be competent to request assisted dying

When a patient decides to request assisted dying, the clinician may assess whether the patient has the capacity to make that decision. The critical question is whether the patient is capable of making that decision, not whether the decision itself is wise.⁷⁰ For a patient to be capable of making that decision, they must be able to understand and retain the information relevant to the decision and be able to use or weigh that information as part of the process of decision-making. Psychiatric patients, as a category, do not necessarily face difficulties with cognitive ability in terms of understanding and retaining information.⁷¹ The specific issue for our purposes will be whether the patient can competently use and weigh the information relevant to the decision to request assisted dying. The patient would not be competent to request assisted dying if, when weighing information relevant to the decision, their disorder compels them to place undue weight on the desire to die and feeling of hopelessness.

The key concern is that the psychiatric disorder has an undue influence on the internal values motivating the request. This concern arises because ‘patients are likely to experience, as a manifestation of the illness itself, intense feelings and distorted cognitions that their lives are worthless and their situations hopeless’.⁷² The MCA Code of Practice recognises that psychiatric disorders can vitiate competence to weigh information, stating with the example of anorexia nervosa that the patient ‘may understand information about the consequences of not eating [b]ut their compulsion not to eat might be too strong for them to ignore’.⁷³

⁶⁷ Kious and Battin (n 32) 33.

⁶⁸ Appel (n 66).

⁶⁹ Kious and Battin (n 32).

⁷⁰ *The Mental Health Trust v DD* [2014] EWCOP 11.

⁷¹ MCA 2005 (n 57) ss 3(1)(a)-(d).

⁷² Miller and Appelbaum (n 60).

⁷³ Mental Capacity Act Code of Practice 2005, s 4.22.

This was certainly Peter Jackson J's finding in *A Local Authority v E*,⁷⁴ where he asserts that 'E's obsessive fear of weight gain makes her incapable of weighing the advantages and disadvantages of eating in any meaningful way'.⁷⁵ The concern in relation to assisted dying for psychiatric patients would be that the desire to die, which may be symptomatic of the disorder,⁷⁶ becomes 'the card that trumps all others' when the patient weighs information relevant to the decision.⁷⁷ This concern is particularly acute in the context of psychiatric assisted dying because patients who suffer so severely that they wish to die are the most likely of the patient group to lack mental capacity.⁷⁸

I would endorse the argument made by authors such as Malcolm Parker and Ron Berghmans and others, that the decision to request assisted dying can be made competently where the patient's desire to die is authentic. The desire to die will be authentic where it is not symptomatic of the disorder, or where the patients' wish to die is the result of a rational assessment of their circumstances.⁷⁹ In contrast, the desire to die will be inauthentic where, were it not for the intensity of that symptom, the patient would otherwise find their quality of life worthwhile. In this scenario, the disorder has compelled the patient to place undue weight on the desire to die, such that they are not capable of weighing information relevant to the decision out of their own free will. I am therefore making a distinction between a competent and an incompetent request for assisted dying based on the authenticity of the desire to die. A request for assisted dying can be made competently by a mentally ill patient where the values motivating the request are authentic, meaning not unduly influenced by the disorder itself.

This distinction was supported in relation to a termination of pregnancy in *Re SB*,⁸⁰ where it was found that, even though aspects of SB's decision-making were influenced by her paranoid and delusional thoughts, she was nevertheless competent because she also genuinely held a range of rational reasons for her

⁷⁴ *A Local Authority v E* (n 41).

⁷⁵ *ibid* [49].

⁷⁶ Miller and Appelbaum (n 60).

⁷⁷ *A Local Authority v E* (n 41).

⁷⁸ Owens and others (n 65).

⁷⁹ Malcolm Parker, 'Defending the indefensible? Psychiatry, assisted suicide and human freedom' (2013) 36 *International Journal of Law and Psychiatry* 485.

⁸⁰ *Re SB (A Patient) (Capacity to Consent to Termination)* [2013] EWHC 1417 (COP).

decision.⁸¹ In the context of assisted dying for psychiatric disorders, many authors support this distinction. For instance, Berghmans and others assert that a patient may be competent to request assisted dying, if the decision is rooted in a 'rational evaluation of one's former, present, and future life situation and not the result of compelling influences connected to the patient's mental illness'.⁸² Tanner further asserts that the desire to die is not always pathological, given that 'there is no definitional or conceptual component of mental illness, even suicidal depression, that renders a sufferer unable to make a competent decision to seek assisted dying'.⁸³

In order to illustrate this point, I will draw a contrast between the requests of two hypothetical patients:

Patient A: Patient A has recently been diagnosed with depression. Around the same time as the diagnosis, he developed an intense feeling that his situation is hopeless, and that his life is not worth living. These feelings have been exacerbated by interpersonal and environmental stresses, which could be remedied. So far, he has tried two different anti-depressant drugs with no alleviation of his suffering. He is yet to try many more indicated treatments, some of which he would be willing to endure. If these treatments were successful, he would feel less hopeless about his situation, and his quality of life would otherwise be acceptable enough for him to want to continue living. Nevertheless, due to the intensity of his current feelings, he has requested assisted dying.

Patient B: Patient B has suffered severe depression for over thirty years. She has tried many indicated treatments to alleviate the suffering, none of which have been successful. She has also made genuine attempts at experiential acceptance through the Cognitive Behavioural Therapy, but still finds that she cannot bear her suffering any longer. She has been well-informed that some indicated treatments remain available to her, but she has concluded that she cannot endure the burdens they involve.

⁸¹ *ibid.*

⁸² Ron Berghmans, Guy Widdershoven, Ineke Widdershoven-Heerding, 'Physician-assisted suicide in psychiatry and loss of hope' (2013) 36 *International Journal of Law and Psychiatry* 436, 442.

⁸³ Tanner (n 43) 166.

She has therefore made the informed and subjective assessment that her condition is irremediable. She has also made an informed and subjective assessment of her quality of life, given that her unbearable suffering appears to be irremediable. She has concluded that she cannot suffer in these circumstances any longer and has requested assisted dying.

In Patient B's case, it appears the disorder itself has not placed undue weight on her desire to die. She holds genuine reasons for wanting to die, in that she cannot bear the pain any longer and she has no acceptable or reasonable prospects for recovery. It is less likely that her cognitive process, in weighing the advantages and disadvantages of staying alive, has been unduly influenced or distorted by her depression.

In Patient's A case, it is more likely his disorder, exacerbated by additional stresses, compelled him to place undue weight on his desire to die and feeling of hopelessness. It does not appear that he holds authentic reasons for feeling that his situation is hopeless, given that a range of indicated treatment options remain available and acceptable to him. If those treatments were successful, Patient A would likely find that the advantages of continuing to live outweigh the disadvantages.

Clearly, I have contrasted two cases that are at either end of the spectrum. There will be a large grey area between these two cases where clinical expertise is required to tease out the authenticity of a psychiatric patient's desire to die. The key factors which differentiate the two cases, namely the length of their illness, the number of treatments attempted, and the apparent incurability of their illnesses, do not inherently make a desire to die authentic or inauthentic. I am using these cases to illuminate that certain factors may make it more likely that the patient's desire to die is inauthentic. Where a patient is suffering with a short-term psychiatric disorder, and a range of treatment options remain acceptable to them, and if those treatments were successful, they would find their quality of life acceptable, then it is more likely that the disorder unduly influenced their expressed desire to die.

There is potential here for a conflict with the right to make unwise decisions. A key principle underpinning the MCA 2005 is the imperative that a person is not to be treated as unable to make a decision merely because they make an unwise

decision.⁸⁴ In the subsection ‘parity considerations for legalisation’, I will propose tests which can be added to section 3(1) of the MCA that attempt to capture the authenticity of a decision to request psychiatric assisted dying without breaching the patient’s right to make unwise decisions. The question is not whether the clinician agrees that, considering the patient’s circumstances, it is reasonable they would wish to die. The question is whether the patient’s reasons for wishing to die, whatever they may be and however much one may disagree with them, are genuinely held by the patient. For the benefit of clarity, I do not refer to the patient’s ‘authentic’ self as a self entirely independent of their psychiatric disorder. To some extent, a patient suffering with a severe psychiatric disorder will necessarily be defined by their illness.⁸⁵ For instance, Patient B has lived in a miserable reality for thirty years as a result of her illness, and it would be artificial to assert that her ‘authentic self’ is in no way constituted by her illness. What I am asserting is that her wish to die is an expression of her authentic self because it arose out of her assessment of her circumstances in suffering from depression and is not the undue depression itself. It is rationally motivated by her experience of living with the disorder, rather than distorted cognition as a result of the disorder itself. She feels, authentically, that she should no longer have to suffer. By contrast, Patient A’s wish to die arose directly as a symptom of his illness and is likely determined by the illness itself. His request for assisted dying is less likely to reflect a genuine appraisal of his circumstances, in that he would no longer wish to die if treated in a way that was acceptable to him.

D. Clinicians can assess a mentally ill patient’s capacity to request assisted dying

Authors such as Scott Kim and Trudo Lemmens accept that, in theory, a severely mentally ill patient could make an authentic request for assisted dying, but raise the further objection that authenticity would be impossible or too difficult for the clinician to assess in practice.⁸⁶ Clinicians will never be able to achieve absolute certainty when assessing the capacity of any patient, but Kim and Lemmens argue that the risk of a false positive in the context of psychiatric assisted dying may be great enough as to justify a blanket prohibition on the entire

⁸⁴ *The Mental Health Trust v DD* (n 70).

⁸⁵ Udo Schuklenk, Suzanne van de Vathorst, ‘Treatment-resistant major depressive disorder and assisted dying’ (2015) 41 *Journal of Medical Ethics* 577.

⁸⁶ Kim and Lemmens (n 61).

patient group. A psychiatric diagnosis does increase the risk of the patient lacking capacity,⁸⁷ and in the context of assisted dying, the outcome of a false positive is an avoidable death.

Firstly, I would argue that the actual process of assessing capacity in this context can and does work. The process itself is intersubjective, whereby the clinician and patient come to a shared decision on whether the reasons for the patient's decision are genuine.⁸⁸ The clinician will inform the patient about their condition and their future prospects for recovery, including potential (or lack of) treatment options and symptom relief, as well as informing the patient that margins of uncertainty always apply.⁸⁹ The patient will use this information, in weighing the advantages and disadvantages of ending their life, to reach a conclusion on whether they find these circumstances liveable. When the patient is assessing these factors, the clinician will be alert to the possibility that the disorder may unduly influence the patient in wanting to die. Specifically, the clinician will be alert to the weight that the patient places on certain factors in their decision-making, such as having the wish and need for control, experiencing burnout from unrelenting disease, being afraid of what the future may hold, and a lack of social support.⁹⁰ To the extent that such factors influence the patient's decision-making, the clinician will want to consider these factors critically.⁹¹ They may reduce the authenticity of the patient's expressed desire to die and could be addressed individually to reduce their influence on the decision.

Secondly, I would argue that this assessment can be carried out to a sufficient degree of certainty. A 'sufficient' degree of certainty is not the same as absolute certainty. In any context, clinicians can never be absolutely certain that a patient has or lacks capacity, so absolute certainty cannot be required in the context of psychiatric assisted dying from a parity perspective.⁹² In *Carter v Canada*,⁹³ the Supreme Court of Canada rejected Canada's argument that there is

⁸⁷ Owens and others (n 65).

⁸⁸ Berghmans and others (n 82).

⁸⁹ *ibid.*

⁹⁰ *ibid.*

⁹¹ *ibid.*

⁹² Justine Dembo, Derryck Smith, 'Assisted Dying for patients with psychiatric disorders' (2016) 118(14) *Canadian Medical Association Journal* 1036.

⁹³ *Carter v Canada (Attorney General)* 2015 SSC 5.

no reliable way to carry out capacity assessments in psychiatric assisted dying,⁹⁴ stating that '[t]he risks that Canada describes are already part and parcel of our medical system'.⁹⁵

Clinicians already tease out the authenticity of decisions in a similar way when mentally ill patients refuse life-saving treatment. For instance, in *Re C (Adult: Refusal of Treatment)*,⁹⁶ Thorpe J was satisfied that a man with paranoid schizophrenia had the capacity to refuse a life-saving leg amputation, despite his decision being influenced by paranoid delusions, because he was still able to weigh the relevant information to arrive at a clear choice.⁹⁷ It is unclear why it would necessarily be harder to assess authenticity in the context of a request for assisted dying, as the potential for the disorder to influence the decision appears to be equal compared to a request to refuse treatment, and the outcome of either decision is death. If it is necessarily harder to assess authenticity in the context of psychiatric assisted dying then, from a parity perspective, a blanket prohibition would not be justified unless the risks cannot be accommodated with additional safeguards. As the Supreme Court asserted in *Carter*,⁹⁸ 'it is possible for physicians, with due care and attention to the seriousness of the decision involved, to adequately assess decisional capacity' with 'a carefully designed and monitored system of safeguards'.⁹⁹ As I will outline below, there are a range of potential safeguards which could accommodate risks specific to this context.

E. Safeguarding competence within a parity-centred legal framework

From a parity perspective, the model for legalising psychiatric assisted dying must strike an adequate balance between, on the one hand, respect for the autonomy of the patient as an individual and, on the other hand, justified paternalism where genuine concerns exist in the psychiatric context. In relation to the competence requirement, parity demands that psychiatric patients do not face a higher threshold to a finding of capacity, but that additional safeguards

⁹⁴ *ibid* [35], [37].

⁹⁵ *ibid* [115].

⁹⁶ *Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290.

⁹⁷ *ibid*.

⁹⁸ *Carter* (n 93).

⁹⁹ *ibid* [117].

capture the key risk surrounding competence in the psychiatric-specific context, which is that the desire to die may be unduly influenced by the disorder itself.

The threshold for a finding of capacity must be set at the same level for psychiatric patients as it is for physically ill patients. To set a higher threshold for psychiatric patients could amount to overturning the presumption of capacity, which applies equally to all patients under the current law and is a key tenet of patient autonomy. Two surveys of psychiatrists by Ganzini and others have found that many, and especially those with ethical objection to assisted dying, advocate a higher threshold for competence.¹⁰⁰ However, this argument assumes that psychiatric patients, as a category, are likely to be incapable of decision-making around assisted dying. It also contradicts the fact that capacity is assessed at the standard level for patients with psychiatric diagnoses who refuse life-sustaining treatment. Schuklenk and Vathorst argue that ‘it is simply a question of procedural justice to treat competence assessments affecting patients suffering from depression no different to competence assessments affecting other groups of patients’.¹⁰¹ To impose a higher threshold on all psychiatric patients would imply that they, as a category, have difficulties with decision-making capacity, which I have argued is false and discriminatory.

For similar reasons, the capacity threshold should not be varied according to which psychiatric disorder the patient suffers with. Evidence does suggest that certain disorders make it more likely that the patient will lack capacity. For instance, Owens and others found high rates of mental incapacity for people with mania and schizophrenia, compared with lower rates for people with depression and personality disorder.¹⁰² Therefore, it could be argued that patients with, for example, acute psychosis due to schizophrenia, should be required to meet a higher threshold for capacity. It is, perhaps, to ensure that only the most autonomous choices are actioned. However, from a parity perspective, this too would be unjustified. It would categorise all patients suffering with a particular

¹⁰⁰ Linda Ganzini, Darien S Fenn, Melinda A Lee, Ronald T Heintz, Joseph D Bloom, ‘Attitudes of Oregon psychiatrists toward physician-assisted suicide’ (1996) 153(11) *The American Journal of Psychiatry* 1469; Ganzini L, Leong G-B, Fenn D-S, Silva J-A, Weinstock R, ‘Evaluation of competence to consent to assisted suicide: Views of forensic psychiatrists’ (2000) 157 *The American Journal of Psychiatry* 595.

¹⁰¹ Schuklenk and Vathorst (n 85).

¹⁰² Owens and others (n 65).

disorder as incapable, rather than respecting each patient as an individual in their own right.

There are genuine concerns about capacity that exist only in relation to psychiatric disorders, namely that the disorder can have an undue influence on the patient's capacity to weigh information relevant to the decision. It would, therefore, be justified to impose an additional safeguard against this particular risk, in order to ensure that we are allowing access to assisted dying only for patients who can make an autonomous choice.

This safeguard could take the form of an additional question added to section 3(1)(c) of the capacity test (the ability to 'use and weigh' the relevant information). The clinician could consider the question: 'Has the disorder vitiated the patient's ability to discriminate between information relevant to the decision?'. As Cobb J highlighted in *The Mental Health Trust v DD*,¹⁰³ the key distinction between an unwise and an irrational decision, in terms of weighing and evaluating information, is 'the essential characteristic of discrimination'.¹⁰⁴ Alternatively, using the language of 'undue influence' to assess the authenticity of the patient's desire to die, the clinician could consider the question: 'Is the desire to die so influenced by the disorder that the request does not reflect the patient's authentic preferences?'. A third alternative can be found with the language of 'appreciation' in the Mental Capacity Act (Northern Ireland) 2016. This piece of legislation fuses the functional test under the Mental Capacity Act, but adds an additional test that the patient is able 'to appreciate the relevance of [the information relevant to the decision]'.¹⁰⁵ The government consultation outlined as an example that 'a person whose insight is distorted by their illness or a person suffering from delusional thinking as a result of their illness may not, therefore, meet this element of the test'.¹⁰⁶ These three additional tests move the capacity test beyond cognitive function to capture the concerns around capacity which are specific to the context of mental illness. Rather than raising the threshold for capacity, these questions rephrase the same test that applies to all patients, in order to get to the crux of the particular risk facing patients with psychiatric disorders. On a substantive

¹⁰³ *Mental Health Trust v DD* (n 70).

¹⁰⁴ *ibid* [54] (Cobb J).

¹⁰⁵ Gerard Lynch, Catherine Taggart, Philip Campbell, 'Mental Capacity Act (Northern Ireland) 2016' (2017) 41(6) *BJPsych Bulletin* 353 (accessed 02/05/2020).

¹⁰⁶ *ibid*.

understanding of equality, this additional test is justified in that it leads to psychiatric patients having the equivalent protection of their autonomy in real terms.

Alternatively, one could attach a list of factors to be considered in conjunction with section 3(1)(c), perhaps in the MCA Code of Practice, in order to draw the clinician's attention to the areas of risk in the psychiatric context. As noted, Berghmans and others highlight four factors that clinicians should critically consider: being afraid of what the future may hold; experiencing burnout from unrelenting disease; having the wish and need for control; and experiencing depression.¹⁰⁷ Clinical expertise would be needed to draft a complete list of factors. Given that the MCA already leaves clinicians wide discretion in relation to capacity assessments, this list of factors would not be exhaustive. Rather than creating an additional hurdle to a finding of capacity, psychiatric patients would receive the same protection of their autonomy, because these risks only exist in the context of a psychiatric disorder.

Finally, it must be noted that this places significant pressure on the capacity assessment as the threshold for access to assisted dying. Given that I noted above that some remain cautious about the clinician's ability to make a sound assessment of the authenticity of a psychiatric patient's request for assisted dying, there is a risk that, in practice, clinicians will take an overly cautious approach in order to avoid potential legal liability for a wrongful death. This poses a genuine practical risk to the autonomy of psychiatric patients, as many who are capable may be assessed as lacking capacity. To counter this problem, it is important that the law requires significant, albeit proportionate, oversight of capacity assessments, so that clinicians can feel confident that a false positive will be flagged up before a wrongful death occurs. The UK Assisted Dying Bills have proposed that requests for assisted dying must be agreed by two doctors and a High Court judge. In the Netherlands, capacity reports are reviewed by regional euthanasia review committees (Regionale Toetsingscommissies Euthansie), and the committees publish a significant number of case reports in the interest of transparency.¹⁰⁸ The

¹⁰⁷ Berghmans and others (n 82).

¹⁰⁸ Regional Euthanasia Review Committees, *Annual Report 2015* <<https://english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports>> date accessed 03 May 2020.

challenge for any oversight requirement, from a parity perspective, is that it does not amount to an additional hurdle to a finding of capacity.

However, it is also important not to overstate the practical challenges of these capacity assessments. A survey of physicians found that only 11.2% of physicians found capacity assessments to be ‘much more challenging’ than other tests.¹⁰⁹ Furthermore, Schuklenk and others highlight that there will only be a small patient group in practice. They give the example of the Netherlands, a country of 17 million people, where there were only 42 cases of psychiatric assisted dying in 2013, 41 in 2014, and 56 in 2015.¹¹⁰ Given the small patient group, a small number of highly trained and highly experienced professionals can conduct capacity assessments with reasonable confidence in their abilities. This is certainly the case in the Netherlands, where Support and Consultation on Euthanasia in the Netherlands (SCEN) physicians are specially trained to assist colleagues in the process.¹¹¹

In sum, I have argued that certain patients’ suffering with severe psychiatric illness will retain decision-making capacity to request assisted dying, and further that capacity in this context can be assessed to a sufficient degree of certainty. Therefore, there is no relevant difference between mental and physical illness, in terms of capacity, that justifies a blanket prohibition on access for the entire psychiatric patient group under the autonomy rationale. There are issues specific to the psychiatric context which need to be addressed when making capacity assessments, namely the influence of the disorder on the authenticity of the patient’s desire to die, but these risks can be accommodated by employing additional safeguards to achieve substantive equality.

¹⁰⁹ Seyfried, L, Ryan, K A, & Scott Kim, ‘Assessment of decision-making capacity: Views and experiences of consultation psychiatrists’ (2013) 54 *Psychosomatics* 115.

¹¹⁰ 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?’ (2018) 26(4) *Journal of Medical Ethics* 326.

¹¹¹ Scott Kim, Raymond De Vries, John Peteet, ‘Euthanasia and Assisted Suicide of Patients With Psychiatric Disorders in the Netherlands 2011 to 2014’ (2016) 73(4) *Journal American Medical Association* 362.

V. RATIONALE 3: TERMINAL ILLNESS, OR ‘INCURABILITY’

The third potential normative rationale for assisted dying may be justified in cases where the patient is terminally ill. It can be inferred that legislators behind the recent UK Assisted Dying Bills rely on this justification because each bill has proposed access only for patients with a terminal diagnosis of six months. Moreover, public opinion and the attitudes of medical practitioners are generally more favourable towards forms of euthanasia which hasten near and inevitable death rather than actively cause it.¹¹² I argue this can only provide a substantive moral justification for assisted dying if it is interpreted as meaning that assisted dying is justified where an illness is incurable. The illness does not also have to be terminal. On this analysis, the terminal diagnosis acts as a mere safeguard to ensure that an illness is incurable. As I will demonstrate in the context of extremely severe psychiatric illness, non-terminal illness may be considered incurable. The third rationale, therefore, extends to cases of non-terminal ‘incurable’ illness, such that a blanket prohibition on access to assisted dying for psychiatric disorders is not justified according to the incurability rationale.

The ‘terminal’ justification is commonly based upon a distinction on causation, whereby assisting a terminally ill patient to die would merely speed up inevitable death rather than cause the death itself.¹¹³ It is difficult to find coherence in this argument. As a moral rationale, it is difficult to see why it is more justified to offer death to someone suffering with a near death in sight, given that prolonged suffering is surely worse.¹¹⁴ Kioussis and Battin also note that it is problematic to assert that assisted dying does not really ‘cause’ death in terminal cases, because that would falsely imply that murdering a terminally ill person against their wishes does not cause their death.¹¹⁵ Furthermore, the benchmark for a ‘terminal’ diagnosis will always be arbitrary. The UK Assisted Dying Bills have each required a prognosis of six months, yet it is unclear from a moral

¹¹² Select Committee on Assisted Dying for the Terminally Ill Bill, *First Report, Appendix 7: Public Opinion on the Legalisation of Euthanasia/PAS* (December 2004).

¹¹³ Martin Benjamin, ‘Causation and Responsibility in Euthanasia and Assisted Suicide’ (1995) 20 *Midwest Studies in Philosophy* 431.

¹¹⁴ Sally Burgess, Keith Hawton, ‘Suicide, Euthanasia, and the Psychiatrist’ (1998) 5(2) *Philosophy, Psychiatry, & Psychology* 113, 123.

¹¹⁵ Kioussis and Battin (n 32) 32.

perspective why it would be less legitimate to offer assisted dying to a patient with seven or eight months to live. The diagnosis requirement is made more artificial given that clinicians can only loosely approximate how many months the patient has left to live.¹¹⁶ In and of itself, the terminal diagnosis requirement cannot therefore substantiate a coherent moral justification for assisted dying.

Another interpretation of this rationale is that assisted dying is only justified in cases where the patient's condition is incurable, such that assisted dying would not be justified where there is potential that the patient could eventually attain a sufficient quality of life. The normative rationale would be that assisted dying can be legitimate where the patient's condition is only going to be maintained or deteriorate further, so that, in assisting their death, we have not cut off the potential for a better quality of life. On this interpretation, the requirement of a terminal diagnosis acts as a safeguard rather than a normative rationale.¹¹⁷ If a patient has six months to live, we can be reasonably certain that they will not recover or find better quality of life. However, on this interpretation, it is not only terminally ill patients that could legitimately be assisted to die. This rationale would also capture those who have an incurable but non-life-threatening illness, where we can also be reasonably certain that their condition and suffering will only be maintained or deteriorate further, such as in the case of Tony Nicklinson's locked-in syndrome.¹¹⁸

In the next section, I will argue that a small number of severe cases of mental illness could also be considered 'incurable'. To the extent that one accepts this analysis, there exists no relevant difference between mental and physical illness which justifies excluding all psychiatric patients under the 'incurability' rationale.

A. Incurability, or 'irremediableness'

If it were the case that all patients with mental illnesses could recover, then assisted dying for psychiatric disorders would not be legitimate according to the incurability rationale. It would also be illegitimate according to the unbearable suffering rationale, because psychiatric patients' suffering could always be alleviated by appropriate treatment so that it would not be unbearable. However,

¹¹⁶ HC Deb 11 Sep 2015, vol 599, col 680.

¹¹⁷ Kious and Battin (n 32).

¹¹⁸ R (*Nicklinson and Another*) v *Ministry of Justice* [2014] UKSC 38 [2015] AC 657.

rare cases of severe psychiatric illness can be considered incurable (or ‘irremediable’, a term often used in the literature), such that a small number of psychiatric patients can legitimately access assisted dying under the incurability rationale. To be clear, mental illnesses are not equally likely to be incurable and there will only be a very small number of cases of severe mental illness that could be described as ‘incurable’. However, for that small number, they ought to be able to have access to assisted dying on equal terms to physically ill patients. I will make this argument by advancing two claims. Firstly, a parity perspective demands a qualitative understanding of incurability, according to which some especially severe cases of psychiatric illness could be defined as incurable. However, there are significant policy concerns associated with importing the logic of ‘incurability’ into the psychiatric context. I will therefore make the secondary claim that, from a proportional equality perspective, these risks can be sufficiently accommodated with appropriate safeguards, such that they do not justify a blanket prohibition on access to assisted dying for psychiatric patients.

Hereafter, the terms ‘incurable’ and ‘irremediable’ will be used interchangeably.

B. The concept of incurability

I am presenting an understanding of ‘incurability’ in the context of psychiatric illness as a qualitative concept, which focuses on what the patient can reasonably be expected to endure, rather than on the theoretical quantitative possibilities of recovery.

(1) The quantitative concept

Opponents to psychiatric assisted dying advance a quantitative concept of irremediableness. Authors such as Appelbaum argue that no psychiatric condition is truly incurable, given that it is possible to foresee new and more effective treatments becoming available within the patient’s lifetime, and that patients can and do make spontaneous recoveries.¹¹⁹ Ordinarily understood, psychiatric conditions are not terminal and, therefore, the patient has the rest of their life to pursue new treatment options. Seemingly ‘hopeless’ battles against psychiatric

¹¹⁹ Paul Appelbaum, ‘Physician-assisted death in psychiatry; (2018) 17(2) World Psychiatry 145.

conditions have been won, and future effective treatment can never be definitively excluded.¹²⁰ Alexander Simpson notes that '[n]ew treatments are possible, new types of therapy can assist, and new ways of thinking about someone living in recovery are always available'.¹²¹ Authors that conceptualise 'irremediableness' in this way therefore argue that no psychiatric patient's suffering is truly irremediable, so, according to the incurability and unbearable suffering rationales, they would not qualify for assisted dying.

(2) *The qualitative concept*

In contrast, I am advancing a qualitative concept of incurability in the context of psychiatric illness. This concept is more conducive to achieving parity of esteem and it sanctions psychiatric assisted dying. According to this concept, a disorder is 'incurable' where no available treatment is capable of providing a benefit which would allow the patient to resume a quality of life that they would consider worthwhile. This understanding reflects the idea that determinations of treatment 'futility' in psychiatric care depend, to some extent, on the patient's subjective experience of suffering. According to this understanding, a patient facing an extremely severe form of mental illness can reasonably conclude that their disorder is incurable.

A disorder is incurable if all available treatments are 'futile'. A treatment is 'futile' if the patient derives no benefit from it. That appears to be the view of Baroness Hale in *Aintree University Hospitals NHS Foundation Trust v James*,¹²² as interpreted in *United Lincolnshire Hospitals NHS Trust v N*,¹²³ where futility is described 'in the sense of being ineffective or being of no benefit to the patient'.¹²⁴ In the context of psychiatric illness, the purpose of treatment is to provide a

¹²⁰ Thomas Bilkshavn, Tonie L Husum, Morten Magelssen, 'Four Reasons Why Assisted Dying Should Not Be Offered for Depression' (2016) 14 *Journal of Bioethical Inquiry* 151.

¹²¹ Alexander IF Simpson, 'Medical Assistance in Dying and Mental Health: A Legal, Ethical, and Clinical Analysis' (2018) 63(2) *The Canadian Journal of Psychiatry* 82.

¹²² *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 [2014] AC 591 [38]-[44] (Baroness Hale).

¹²³ *United Lincolnshire Hospitals NHS Trust v N* [2014] EWCOP 16 [56].

¹²⁴ *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 [2014] AC 591 [38]-[44] (Baroness Hale); *United Lincolnshire Hospitals NHS Trust v N* [2014] EWCOP 16 [56].

benefit to the patient's comfort, well-being or general state of health.¹²⁵ If treatment for a psychiatric condition is futile, it means that it provides no benefit to the patient's comfort, well-being, or general state of health. This determination necessarily involves the patient's subjective experience of living with their condition and the way in which the proposed treatment could affect their quality of life. Baroness Hale appears to concur in *Aintree*¹²⁶ that the question of whether the patient derives a benefit from a proposed treatment ought to be judged from the perspective of the individual patient, where she asserts that a treatment will offer a prospect for recovery where it would resume 'a quality of life which the patient would regard as worthwhile'.¹²⁷ Therefore, a disorder is 'incurable' where all available treatments are not capable of providing a benefit to the patient that would allow the patient to resume a quality of life that they would consider worthwhile.

In reaching this conclusion, the patient must weigh the burdens of the proposed treatment against the benefits of continued existence. Lord Goff asserted in *Airedale NHS Trust v Bland*¹²⁸ that treatment may be considered 'overly burdensome' with regard to factors such as 'the intrusive nature of the treatment', 'the hazards involved in it', and 'the very poor quality of life which may be prolonged'.¹²⁹ In the psychiatric context, Cholbi notes that the assessment of the burdens of proposed treatment will depend to a large extent on the patient's 'narrative and historical judgment about their larger psychological engagement with their condition over time and its impact on the totality of their life'.¹³⁰ This subjective element is what distinguishes my understanding of incurability from the quantitative concept held by opponents to psychiatric assisted dying. In extremely rare and severe cases, the patient can reach a point at which all available treatments could only further decimate their quality of life. Where a patient has suffered unbearably for a long period of time, they consider that they have no quality of life left, and all available treatments would only maintain or deteriorate their condition by being overly burdensome, then that disorder could be

¹²⁵ Lawrence J Schneiderman, Nancy S Jecker, Albert R Jonsen, 'Medical Futility: Its Meaning and Ethical Implications' (1990) 112 *Annals of Internal Medicine* 949, 950.

¹²⁶ *Aintree* (n 122).

¹²⁷ *ibid* [115].

¹²⁸ *Airedale NHS Trust v Bland* [1993] AC 789 [1993] 2 WLR 316 (Lord Goff).

¹²⁹ *ibid*.

¹³⁰ Cholbi (n 38) 501.

considered ‘incurable’.¹³¹ No treatment option could provide a benefit to the patient. In these circumstances, according to my qualitative understanding of ‘curability’ in the context of psychiatric illness, a cure does not exist.

To illustrate this concept, it is useful to draw on the annual reports published by the Regional Euthanasia Review Committees in the Netherlands, which contain examples of real cases of irremediable psychiatric suffering. For instance, the 2015 Report describes the case of a woman in her 40s who, after being severely traumatised in her youth, had for years suffered from a suspected personality disorder with avoidant and borderline characteristics, which led to chronic depression and post-traumatic stress disorder.¹³² Her suffering preoccupied her thoughts all day long, and consisted of reliving traumatic events and dissociation, resulting in severe self-harm. She had tried all treatments proposed to her, including medication, outpatient psychotherapy, cognitive behavioural therapy, group therapy and trauma therapy, but none of them had a lasting positive effect on her mental state. Clinicians had determined thereafter that she could only be treated palliatively. After years of severe self-harm and suffering with no alleviation, the patient was tired, ‘could not see a single ray of hope’¹³³ and ‘could not bear the thought that she would be depressed for the rest of her life’.¹³⁴ In this case, it would appear that the patient’s suffering was incurable in the qualitative sense. All available treatment options were futile in that they could not provide a benefit to the patient and requiring her to endure any longer would only maintain or further decimate what was left of her quality of life. There was no ‘cure’.

(3) Why parity demands a qualitative understanding of treatment futility

This qualitative understanding of curability is important from a parity perspective because it focuses on maximising the patient’s subjective input towards an assessment of their therapeutic best interests. Where a patient faces an extremely severe and prolonged psychiatric illness, to the extent that further

¹³¹ Udo Schuklenk, Suzanne van de Vathorst, ‘Treatment-resistant major depressive disorder and assisted dying’ (2015) 41 *Journal of Medical Ethics* 577; Rooney and others (n 110); Tanner (n 43).

¹³² Regional Euthanasia Review Committees, Annual Report 2015 (n 108).

¹³³ *ibid.*

¹³⁴ *ibid.*

treatment would only maintain or increase their suffering, Ron Berghmans and others note that it would be an inadequate response to the patient's situation to refer them to a very small chance in the future that they could spontaneously recover.¹³⁵ Udo Schuklenk and Suzanne van de Vathorst similarly assert that it would be unreasonable to deny that patient their choice and ignore their lived experience with their illness based on a 'hunch' that successful treatment might come around soon.¹³⁶ When making the decision to request assisted dying, that patient should certainly be considering the possibility of new and better treatments becoming available, as well as the possibility that they may recover spontaneously. However, the patient will weigh those prospects against their own lived experience and quality of life to reach an informed decision about what they can endure.

Nevertheless, there is a risk that, in weighing up the efficacy of a proposed treatment against what they can endure, the patient's evaluation may be unduly influenced by their disorder. This risk is significant because psychiatric disorders such as depression are often associated with fatigue and a lack of optimism about the future.¹³⁷ It may be that the patient underestimates the efficacy of a proposed treatment because of the undue influence of the disorder itself. I would argue, from a parity perspective, that this risk does not justify a blanket prohibition on psychiatric assisted dying. Rather, this risk can be accommodated within the framework through appropriate safeguards and guidance for the clinicians conducting the discussion on treatment prospects. I will address this point in the next subsection.

Another reason why the qualitative concept of incurability is important from a parity perspective is that it recognises the harm that can be suffered by psychiatric patients who are required to wait for the theoretical possibilities of recovery to find fruition. This is important from a parity perspective because it accords greater respect to the inherent dignity of psychiatric patients. Schuklenk and Vathorst argue that there appears to be an assumption underlying the quantitative concept of incurability that the harm caused to the patient by requiring them to wait for future possibilities of a cure is zero, or sufficiently

¹³⁵ Berghmans and others (n 82) 440

¹³⁶ Schuklenk and Vathorst (n 85) 581.

¹³⁷ Alan D Ogilvie, S G Potts, 'Assisted suicide for depression: the slippery slope in action?' (1994) 309 *British Medical Journal* 492.

minor, that it ought to be borne by the patient in question.¹³⁸ They argue that this ignores the ‘unjustifiably high burden’ that is paid by patients who happen to wait unsuccessfully for a treatment that may not come about at all, or may come about too late to provide the patient with any benefit.¹³⁹ Again, these potential harms were starkly illustrated in *A Local Authority v E*.¹⁴⁰ The costs of E trialling one more treatment, in the form of force-feeding for at least a year, were to be profound. The treatment itself carried a very high risk to E’s physical health and mortality, and the psychological burden of the treatment amounted to the trauma of childhood sexual abuse. On a quantitative understanding, given that there existed a 20% statistical possibility that the treatment could work, this treatment was not considered ‘futile’.¹⁴¹ On a qualitative understanding of ‘curability’, it is likely that this treatment would be considered futile, given the profound likelihood that it would only maintain or further deteriorate the suffering borne by E. It can, therefore, be seen that the quantitative understanding of incurability places insufficient weight on the burdens that the treatment would cause for E. This case highlights that a qualitative understanding of incurability is important in the psychiatric context from a parity perspective, because it accords greater weight to respect for the inherent dignity of psychiatric patients in terms of what one can reasonably expect them to endure.

To be clear, there will also always be an empirical dimension to a determination that a treatment is futile. Medical prognoses work in probabilities, and never in absolutes. On either a quantitative or qualitative understanding, the determination that a treatment is ‘futile’ will not mean that the chance of the treatment working is 0%, but that it is highly unlikely to work based on available evidence about the patient and its previous efficacy. Therefore, any understanding of ‘futility’ has an empirical dimension in the form of a statistical cut-off point at which we can conclude that the chance of an available treatment working in the future is so low as to be effectively incapable of working. The question then arises of how statistically unlikely the success of a treatment must be to be deemed futile according to one’s qualitative understanding of futility. A thorough discussion around applying concepts of futility is beyond the scope of this essay. However, from a parity perspective, the key consideration must be to strike an appropriate

¹³⁸ Schuklenk and Vathorst (n 85).

¹³⁹ *ibid.*

¹⁴⁰ *A Local Authority v E* (n 41).

¹⁴¹ *ibid.*

balance between the burdens of treatment for the patient and the benefits of continued existence. The qualitative understanding of futility will place greater weight on the patient's subjective assessment of the burdens of treatment. In *A Local Authority v E*,¹⁴² the treatment was not considered futile because it had an estimated 20% likelihood of working. I would argue that, in the circumstances of that case, the statistical threshold for a finding of futility ought to have been lower given the overwhelming burden that treatment would have imposed on E. This is necessary to respect the inherent dignity of psychiatric patients on an equal footing with physically ill patients when reaching decisions about treatment futility.

In sum, I have proposed a qualitative understanding of irremediableness, under which a small number of severely mentally ill patients could qualify for access to assisted dying under the incurability rationale. I have argued that this understanding of incurability is necessary from a parity perspective, because it accords greater respect to the lived experience and inherent dignity of psychiatric patients.

However, if one accepts my conceptualisation, it may still be argued that the logic of 'incurability' should not be imported into the psychiatric setting. There are several important policy concerns associated with this. Some would assert that these risks are grave enough to justify a blanket prohibition on psychiatric assisted dying. In the following subsection, I will explore these concerns from a parity perspective and argue that they can be adequately accommodated within the legislative framework. Therefore, to impose a blanket prohibition in response to any or all of these risks would amount to disproportionate paternalism which would be unjust from a parity perspective.

C. Addressing policy concerns

(1) Therapeutic significance of hope

Many opponents to psychiatric assisted dying argue that no psychiatric condition should be considered irremediable because the element of 'hope' can contribute to the real prospect of recovery. For instance, Thomas Bilkshavn and

¹⁴² *ibid.*

others assert that positive expectations for recovery correlate with a positive alliance between the doctor and patient, and the element of hope gives power to the therapeutic relation.¹⁴³ If the clinician accepts the patient's loss of hope as reasonable, it may demoralise the patient, reinforcing and exacerbating their desperation and desire to die.¹⁴⁴ As a result of this demoralisation, the patient's cognition could become distorted and the patient may underestimate the efficacy of proposed treatment.¹⁴⁵

To be absolutely clear, in almost all cases it will be therapeutically necessary for the clinician and the patient to continue to hope for recovery. Even where suffering is extreme and prolonged, the clinician should continue to offer new treatment options and attempt to relieve suffering wherever possible, and it would be in the patient's best interests to hold hope themselves. However, if one accepts my analysis of incurability, then there will be cases, albeit a very small number, where the patient can reasonably make the subjective estimation that hope is illusory.¹⁴⁶ In those cases, it would be counter-therapeutic for the clinician to dogmatically impose a message of 'hope'. Berghmans and others argue that the existential despair which is expressed in that request for assisted dying would not be seriously addressed.¹⁴⁷ From a parity perspective, patients must be respected as individuals. Although fostering hope will be in the best interests of the vast majority of the patient group, the clinician should also consider the individual circumstances of the patient in front of them. Where that patient is very severely ill, and they have made a reasonable assessment that the available treatment options are qualitatively futile based on the factors discussed in the previous subsection, then the clinician ought to engage meaningfully with that patient's desire to die.

(2) Risk of countertransference

Countertransference refers to the therapist's unconscious (or conscious) reactions to the patient and to the feelings and wishes that the patient may

¹⁴³ Bilkshavn and others (n 120) 154.

¹⁴⁴ Berghmans and others (n 82) 439.

¹⁴⁵ Bilkshavn and others (n 120).

¹⁴⁶ Berghmans and others (n 82) 442.

¹⁴⁷ *ibid.*

project.¹⁴⁸ This is a standard risk that may arise in therapist-patient relationships.¹⁴⁹ In the context of therapist-patient discussions around ‘curability’ and assisted dying, there is a concern that the therapist may unconsciously influence the patient’s decision.¹⁵⁰ If the therapist has internally formed a belief that the patient’s condition has little substantive hope for recovery, the risk is that this will affect the patient’s subjective determination about the curability of their condition, so that the patient’s own estimation of their prospects for recovery may be inauthentic. This risk may be heightened by the fact that mental health professionals will be ‘shifting between such radically opposed attitudes as kindling hope and admitting hopelessness’.¹⁵¹ It could be argued that, because of this risk, notions of ‘incurability’ should not be invited into the psychiatric setting.

However, I would argue that this risk can be sufficiently mitigated with safeguards, such that a blanket prohibition would be disproportionate. Countertransference is a risk that arises in all therapist-patient relations, and it can be mitigated with appropriate oversight by independent clinicians. For instance, specific attention is paid to the risk of countertransference in the guidelines by the Dutch association of psychiatrists. They emphasise that the observations, feelings, and motives of the psychiatrist should be shared and discussed with the consulting colleague.¹⁵² Therefore, given that countertransference can be mitigated by appropriate oversight, the risk does not justify a blanket prohibition. From a parity perspective, that would be a disproportionate response.

(3) Socio-economic determinants of mental health

Certain disadvantaged groups are at a greater risk of being so severely mentally ill to qualify for assisted dying under the incurability rationale. It is widely documented that significant inequality exists in mental health care in terms of access to care and prospects for recovery. For instance, ethnic minorities are over four times more likely to reach a crisis point in their mental health and be

¹⁴⁸ American Psychological Association Dictionary, ‘countertransference’ <<https://dictionary.apa.org/countertransference>> accessed 03 May 2020.

¹⁴⁹ Berghmans and others (n 82) 441.

¹⁵⁰ Bilkshavn and others (n 120) 155.

¹⁵¹ *ibid.*

¹⁵² Berghmans and others (n 82).

compulsorily admitted to psychiatric hospital.¹⁵³ Once admitted, they are also likely to become stuck in a ‘revolving door’ of compulsory admissions, leading to more durable and severe long-term mental illness. Recovery rates following psychological therapies are, therefore, higher among white ethnicities compared to all other ethnicities, and deterioration rates are greater in non-white ethnicities compared to white ethnicities.¹⁵⁴ This inevitably means that certain disadvantaged groups are at a greater risk of reaching the level of severe and durable mental illness that could be described as ‘incurable’. If we are aiming to achieve parity and equality, it is difficult to conclude that equality demands access to assisted dying, because in real terms that may translate to equality demanding more people from disadvantaged groups end their lives. Policy changes can remedy the significant inequalities that exist in mental health care. It could be argued, therefore, that equality first demands policy changes to remedy the socio-economic determinants of severe mental illness before we move to legalising assisted dying for psychiatric disorders. Indeed, Anita Ho and Joshua Norman argue that no psychiatric disorder can be considered irremediable until the socio-economic determinants of that illness have been addressed.¹⁵⁵

However, it does not follow that, because inequality exists in mental health care, we should create another inequality while we wait (indefinitely) for the prior inequality to be remedied. It also does not follow that the severely mentally ill patients themselves should shoulder the burden of the prior inequality that society has created. It does not seem justified to require those patients to sit in unbearable pain and wait indefinitely for policy changes to be made. An essential aspect of parity is treating psychiatric patients as ends in themselves. Gerard Garbutt and Peter Davies note that the individual patient ought to be the focus of attention rather than the wider needs of the healthcare system.¹⁵⁶ Societal considerations should not determine whether psychiatric patients can access healthcare provision. That kind of utilitarian reasoning is directly opposed to our commitments to respect for the autonomy of psychiatric patients and, indeed, the

¹⁵³ National Collaborating Centre for Mental Health, *Advancing Mental Health Equality: Steps and Guidance on Commissioning and Delivering Equality in Mental Health Care* (London, National Collaborating Centre for Mental Health, 2019).

¹⁵⁴ *ibid.*

¹⁵⁵ Anita Ho, Joshua S. Norman, ‘Social Determinants of Mental Health and Physician Aid-in-Dying: The Real Moral Crisis’ (2019) 19(10) *The American Journal of Bioethics* 52.

¹⁵⁶ Gerard Garbutt, Peter Davies, ‘Should the practice of medicine be a deontological or utilitarian enterprise?’ (2011) 37 *Journal of Medical Ethics* 267.

primacy of patient autonomy in medical law. The individual's welfare, rather than society's welfare, should be the only determinant in granting or prohibiting access to legal healthcare provision.

(4) Institutionalisation of assisted dying within mental health care

Even if one accepts that patients should not be left to wait for better provision of mental health services, some argue that legalisation of psychiatric assisted dying would pose a further threat to the provision of those services, to the extent that more patients are likely to reach the severity of mental illness that could be described as 'incurable'. For instance, Bilkshavn and others argue that, when faced with an especially difficult case of psychiatric illness, the availability of assisted dying could be interpreted by some clinicians and struggling families as granting permission to give up on the patient.¹⁵⁷

Similarly, however, utilitarian societal considerations cannot determine whether psychiatric patients can access assisted dying. Parity demands that a blanket prohibition on assisted dying is only justified where the risks involved cannot be accommodated with appropriate safeguards. Professional guidance can emphasise the need to consider the patient as an end in themselves, and in the context of psychiatric assisted dying, it would certainly emphasise the need to only grant access where the disorder is genuinely 'irremediable'. In discussions with the patient, the clinician can also tease out the possibility that families have put undue pressure on the patient to consider their disorder incurable. Oversight by independent secondary clinicians can further ensure that the primary clinician has not unduly influenced the patient to consider their disorder incurable. Therefore, the risks posed to mental health care by the institutionalisation of assisted dying does not justify a blanket prohibition on psychiatric assisted dying, as they can more proportionately be accommodated within the legislative framework.

D. Safeguarding incurability within a parity-centred legal framework

The model for legalising psychiatric assisted dying must strike an adequate balance between respect for the autonomy of the patient as an individual and justified paternalism where genuine concerns exist in the psychiatric context. In

¹⁵⁷ Bilkshavn and others (n 120) 156.

relation to ‘incurability’, safeguards need to capture the key risks in the psychiatric-specific context, such as countertransference. As outlined above, these safeguards represent a proportionate response to the psychiatric-specific risks from the perspective of equal treatment, as opposed to a blanket prohibition which would amount to unjustified paternalism. Although safeguards are necessary, they must be counter-balanced against the need to respect the inherent autonomy of competent psychiatric patients. Patients should not face such high hurdles to a finding of ‘incurability’ that, in practice, no case would ever be considered incurable. Safeguards must be proportionate and balanced against respect for the patient’s own determination about their quality of life and what they can reasonably endure. It would not be advisable to set arbitrary thresholds for the duration of the suffering or the stability of the desire to die. From a parity perspective, it is more important that clinicians assess these factors on a case-by-case basis, bearing in mind the context-specific subjective determinations that patients will be making about the treatment options available, their quality of life, and what they can reasonably endure. The same can be said when determining the ‘temporal’ factor of incurability in terms of how long a treatment must be tried before it can be deemed futile. Clearly, the longer a treatment has been tried unsuccessfully, the more likely it is to be futile. However, that temporal consideration will also depend on context-specific factors, such as how long a proposed treatment usually takes to improve the patient’s condition, and how the patient has responded to that treatment so far.

An important question will be how refusal of (one or more) treatments should weigh on the assessment of incurability. On the one hand, only patients with extremely severe and irremediable disorders can legitimately access assisted dying according to the incurability rationale. On the other hand, respect for patient autonomy on equal terms with the physically ill means accepting that some refusal of treatment can be reasonable. Therefore, from a parity perspective, refusal of treatment should not automatically disqualify a case from being ‘incurable’, but a finding of ‘incurability’ can only be legitimate where the patient’s refusal of indicated treatment was reasonable. For instance, in the landmark Dutch case *Office of Public Prosecutions v Chabot*,¹⁵⁸ the patient’s refusal of mourning therapy was considered reasonable, given the length of time required to trial its

¹⁵⁸ *Office of Public Prosecutions v Chabot*, Supreme Court of the Netherlands, Criminal Chamber, 21 June 1994, nr 96.972.

efficacy balanced against the patient's profound suffering and desire to die.¹⁵⁹ Again, the determination of reasonableness will depend to some extent on the patient's own assessment of what they can endure, for instance which side-effects of a proposed treatments could further decimate their quality of life.

In conclusion, I have advanced a qualitative understanding of incurability and argued that, in certain very severe cases, a psychiatric disorder can be considered incurable to qualify for access to assisted dying under the 'incurability' rationale. There are important policy issues to be considered when inviting the logic of 'incurability' into the psychiatric setting. However, I have argued that these risks can be accommodated within the legislative framework. From a parity perspective, therefore, a blanket prohibition on access to assisted dying is unwarranted.

CONCLUSION

A commitment to parity demands that any attempt to legalise assisted dying in England and Wales must permit access for certain psychiatric patients. According to a parity perspective, there is no relevant difference between mental and physical illness which justifies a blanket prohibition on psychiatric assisted dying. There are risks specific to psychiatric assisted dying, in relation to determinations of curability and competence. However, these risks can be adequately accommodated with additional safeguards, so that the mentally and physically ill receive the same substantive equal protection and respect.

My hope is, paradoxically, that this process will save lives. Jennifer Hirsch notes from her own experience in clinical work that 'being able to hear an individual's desires and their unbearable anguish may foster greater trust and understanding between clinician and patient'.¹⁶⁰ Where a patient wishes to die, the clinician will be required to engage in a mature and thorough discussion around the prospective benefits that further treatment could offer, while also taking full account of the patient's lived experience, and at the end of that process the patient should be well-informed about their prospects for recovery. In nearly all cases, the patient and clinician will have reasonable hope for recovery. It is not irrational

¹⁵⁹ *ibid.*

¹⁶⁰ Jennifer Hirsch, 'The Wish to Die: Assisted Suicide and Mental Illness' (2016) 12(3) *Journal of Social Work in End-of-Life & Palliative Care* 231, 233.

to hypothesise that some patients who are suffering unbearably with mental illness who would ordinarily commit suicide, would instead opt to engage in a process to request assisted dying. By engaging in this process, rather than acting on the impulse to commit suicide, the patient may gain a broader perspective on their situation, may consider more thoroughly their treatment options, and in that process, they may find a reason to hope for recovery.

