Physician Aid in Dying and Mental Illness

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Scott Y. H. Kim, Raymond G. De Vries, & John R. Peteet, Euthanasia and Assisted Suicide of Patients With Psychiatric Disorders in the Netherlands 2011 to 2014, **JAMA Psychiatry** (2016).

The right to aid in dying (or physician-assisted suicide) has developed with different standards in the United States than in the Netherlands and Belgium, and a recent study suggests that the United States has gotten it right in a critical respect—on the criteria for eligibility. Patients can more easily qualify for aid in dying in the Netherlands and Belgium and that creates a potential for misuse that is not present in California, Oregon, Vermont, and the other American states that permit the practice. In particular, as a new study by Kim, De Vries, and Peteet indicates, the possibility that people with psychiatric disorders may choose aid in dying when treatment for their disorders might address their despair is a more serious problem in Europe than in the United States.

Concerns about psychiatric motivations give rise to a very important argument against a right to aid in dying. If people can choose aid in dying because of mental illness, people may opt for death when proper therapy would restore their desire to live. And anecdotal reports in both the United States and Europe reinforce this concern. In a *Frontline* report on underground aid in dying in the United States, filmmakers documented the death of a woman whose mental illness led her to harbor false beliefs about her health. Similarly, an article in *The New Yorker* described the troubling case of a Belgian woman who underwent euthanasia, which, like aid in dying, is permitted in Belgium, despite physician assessments that her psychiatric depression was not serious enough to make her eligible for assistance in dying.

Cases like this have not been described in Oregon, Washington, or the other states that have legalized aid in dying for a key reason—the right exists only for persons who are terminally ill. People exercising their right to aid in dying must have a serious and irreversible disease that will cause death within six months. As a result, in more than 75 percent of aid-in-dying deaths in Oregon, the patient had cancer, with most of the others suffering from neurologic, lung, or heart disease.

In the Netherlands and Belgium, on the other hand, the rules for aid in dying rely on a more subjective standard—people must be suffering unbearably from an incurable illness. Under this standard, psychiatric disease can provide grounds for aid in dying, and that allows for judgments that are more susceptible to error.

In the study by Kim, De Vries, and Peteet on aid in dying in the Netherlands, a number of observations are worrisome. In more than one-half of cases, social isolation or loneliness was a factor for the patients. As Paul Appelbaum observed in an editorial accompanying the study, aid in dying may have “served as a substitute for effective psychosocial intervention and support.” Indeed, in more than half of the cases in the study, patients refused treatment that might have helped, with lack of motivation a common reason for the refusals. In more than one-fourth of cases, aid in dying was provided by a physician who had not been involved previously in the treatment of the patient and might not have been able to fully understand the nature of the patient’s condition. This may help explain why in nearly one-fourth of cases, the independent physician reviewers disagreed whether the patients met the criteria for aid in dying. (In such cases, aid in dying can still take place since the treating physician has authority to decide whether to proceed.)

No study is perfect, and the authors acknowledge a number of limitations with their data. Still, the concerns raised by the findings of Kim, De Vries, and Peteet will reinforce the current reluctance to expand the right to aid in dying to patients who are not terminally ill.

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