Review Article | Ethics and Policy in Palliative Medicine and Palliative Care

Assisted suicide in persons with mental disorders: a review of clinical-ethical arguments and recommendations

Georg Marckmann[1]^, Thomas Pollmächer[2,3]^

[1]Institute of Ethics, History and Theory of Medicine, LMU Munich, Munich, Germany; [2]Center for Mental Health, Klinikum Ingolstadt, Ingolstadt, Germany; [3]Department of Psychiatry and Psychotherapy, LMU Munich, Munich, Germany

Contributions: (I) Conception and design: Both authors; (II) Administrative support: Both authors; (III) Provision of study materials or patients: None; (IV) Collection and assembly of data: None; (V) Data analysis and interpretation: None; (VI) Manuscript writing: Both authors; (VII) Final approval of manuscript: Both authors.

Correspondence to: Prof. Georg Marckmann, MD, MPH. Institute of Ethics, History and Theory of Medicine, LMU Munich, Lessingstr. 2, D-80336 Munich, Germany. Email: marckmann@lmu.de.

Abstract: Persons with mental disorders have the same right to self-determination as patients with somatic diseases, also regarding death and dying. However, there are several challenges that render persons with mental disorders especially vulnerable to inappropriate conduct of assisted suicide: their wish to die may be a symptom of their mental disease and not an autonomous choice, decision-making competence may be compromised by their illness and more difficult to assess, the severity of suffering may be more difficult to evaluate from an external perspective, the wish to die may be more variable over time and the prognostic uncertainty in mental illness makes it more difficult to determine whether the severe suffering is, in fact, treatment-resistant. After reviewing the clinical and ethical background of assisted suicide in persons with mental disorders, we assess each of these challenges to a medically and ethically justified practice of assisted suicide in mentally ill persons, based on relevant clinical and ethical literature. We conclude that the only ethically valid argument to exclude persons with mental disorders from suicide assistance is their potential inability to make a free, autonomous decision. However, the mentioned challenges should be taken into account in evaluating a person's request for assisted suicide and for promoting her well-informed and deliberated decision-making. In addition to assessing the person's decision-making capacity, the evaluation process should be guided by the goal to empower the person to make an autonomous choice between the available options. We conclude the paper with perspectives for a clinically and ethically justified practice of evaluating requests for assisted suicide in persons with mental disorders.

Keywords: Mental disorders; assisted suicide; ethics; regulation

Submitted Jul 01, 2023. Accepted for publication Mar 06, 2024. Published online Mar 25, 2024.
doi: 10.21037/apm-23-472
View this article at: https://dx.doi.org/10.21037/apm-23-472

Introduction

In recent years, assisted suicide has become a topic of major medical, ethical, legal and also public debates. Those debates seriously challenge the traditional Hippocratic request that no physician ever should "give a deadly drug to anybody if asked for it, nor … make a suggestion to this effect" (1). Nowadays, based on the claim that the right to self-determination and the obligation to respect persons' autonomy also extend to wishes to die, many countries around the world have introduced legal frameworks to

^ ORCID: Georg Marckmann, 0000-0002-6898-9500; Thomas Pollmächer, 0009-0008-1790-7588.

enable suicide assistance (2).[1] Such legal frameworks share a common goal: they seek to protect vulnerable people by allowing assisted suicide only if the request is voluntary, considered thoroughly and sustained over time by a well-informed person with full decision-making capacity. Furthermore, several regulations request that the wish to die is based on unbearable suffering which cannot be alleviated. In addition, regulations in some countries and federal states (e.g., in the US) require that the person suffers from a terminal illness, which usually refers to patients who are likely to die within the next 6 months (2). Most persons with mental disorders are thereby excluded from the possibility to receive medical aid in dying because they usually do not have such a limited life-expectancy. A unique position has been taken by the German Federal Constitutional Court which ruled in 2020 that a freely made suicide decision is the one and only legal prerequisite to legitimate suicide assistance (3,4).

From a medical point of view, people asking for suicide assistance can be divided into three sub-groups: healthy persons, persons with terminal or non-terminal somatic diseases and persons with mental disorders. Of course, somatic diseases and mental disorders can also occur in parallel. Assisted suicide in persons with mental disorders raises several complex issues (5-8). These issues arise especially from the following aspects: (I) there is a close reciprocal interaction between suicidal ideation and suicides on the one hand and mental disorders on the other, (II) mental disorders can compromise the decision-making capacity thereby raising the question whether the person's wish to die really constitutes an autonomous choice, (III) the wish to die can be more variable over time in persons with mental disorders making it more difficult to assess whether the request is really a stable and firm decision, (IV) unbearable suffering is often more difficult to comprehend in psychiatric patients than in somatically ill patients, and (V) it is more difficult to determine whether the mental disorder is really treatment resistant. Due to these issues, persons with mental disorders are an especially vulnerable group with regard to suicide assistance. As a consequence, assisted suicide for persons with mental disorders is especially controversial (9-13) and several regulations de jure or de facto exclude persons with mental disorders. While this shall provide special protection for this vulnerable group, it restricts their possibilities to end their life with appropriate assistance.

Based on a review of relevant clinical and ethical literature, this paper aims at exploring the complex relationship between mental disorders and the wish to die, elaborating the ethical foundations for suicide assistance in persons with mental disorders, discussing the special clinical and ethical challenges of assisted suicide for persons with mental disorders and providing some recommendations for an appropriate individual approach to the request for assisted suicide by persons with mental disorders. It thereby takes a systematic approach in starting with the fundamental right to self-determination, elaborating systematically the challenges in realizing this right based on the specific features of mental disorders and developing recommendations how these challenges can be met in order to develop a clinically and ethically justified practice of assisted suicide in persons with mental disorders. It should be noted that this paper does not address the fundamental question of whether assisted suicide in general can be ethically justified as such, but presupposes that this question has already been answered positively.

Medical background: the relationship between mental disorders and the wish to die

Suicides account for about 1.4% of all deaths worldwide (14). On average across European countries, about 10 out of every 100,000 people take their own lives each year, but rates differ by a factor of about 4 between countries (range, 5–20).[2] Up to 90% of suicides happen in persons with a psychiatric disorder (15), and a similarly high proportion of people with a psychiatric diagnosis is reported among those admitted to hospital after a suicide attempt (16). Although some claim that the association might be less tight (17), there is no doubt that, at least when drug and substance abuse disorders are included, the vast majority of people who are suicidal or who commit suicide have a mental disorder. However, this association does not in itself prove causality.

There are at least 3 different constellations in which suicidality and mental disorder coincide. The association can be accidental, but suicidality can also be a consequence or a symptom of a mental illness. In the first case, there

[1] In a number of countries, these frameworks also regulate requests for euthanasia. In this paper, however, we will only discuss assisted suicide.

[2] https://ec.europa.eu/eurostat

is no causal connection between the wish to die and the mental disorder. For example, when a person with a long-standing, but successfully treated obsessive-compulsive disorder wishes to end her life in the context of a serious, incurable physical illness with a limited life-expectancy.

A causal relationship exists, on the other hand, if the mental disorder is a necessary condition for the wish to die. Here, a further distinction must be made between two different constellations. First, suicidality can be a consequence of a mental disorder if a mental disorder leads to suicidality independently of the current symptoms. This refers to the situation of, for example, a person with bipolar disorder who has been ill for many years and who, in a current remitted state, is considering suicide because of the social consequences of the illness that have already occurred or because, in retrospect, she judges earlier phases of her illness unbearable and therefore is not prepared to endure future phases.

Second, suicidality can also be a symptom of the psychiatric disorder, e.g., if it occurs in the context of paranoid-depressive symptoms, an acute stress reaction or adjustment disorder or as a consequence of imperative voices in a hallucinatory syndrome. Suicidality in the context of acute intoxication with alcohol or drugs also belongs to this category.

Particularly if suicidality is a symptom of a mental disorder, the person may lack full decision-making capacity according to common standards for consent to treatment (18). These can also be applied to assess mental capacity in persons requesting assisted suicide (19). In these cases, the wish to die cannot be considered a free choice, because the disorder prevents the person in several ways (cognitively, emotionally, and/or effectively) from realistically assessing her situation and the prospects for success of treatment or other support. Suicidality as a symptom, in addition, is also typically characterized by considerable ambivalence rendering the wish to die unstable.

It should be noted that mental disorders frequently co-occur with severe somatic diseases. About one third of people in palliative care facilities suffer from depressive illness, adjustment or anxiety disorders (20) and neuropsychological deficits are even more frequent (21). However, cognitive impairment and psychopathology are often neither recognized nor adequately treated (22).

Hence, mental disorders have to be actively searched for in these people, particularly if they express a wish for dying and/or assisted suicide. Of course, suicidality and comorbid mental disorder in severely or terminally ill patients can coincide in the same three constellations just mentioned.

Although suicidality as a symptom of a mental disorder is particularly likely to compromise decision-making capacity, the question whether or not the wish to die can be considered a free decision must be asked and answered in every person individually.

Assisted suicides in persons with mental disorders

Of the 8,720 people who died by termination of life by request or assisted suicide in the Netherlands in 2022, 282 (3.2%) suffered from dementia and 115 (1.3%) from one or more psychiatric disorders. Hence, these persons only make up a relatively small proportion. However, this proportion more than quadrupled between 2011 and 2022, while the total number (only) doubled (23).[3] The proportion of people with a mental disorder thus increased significantly and disproportionately. This is not per se a proof for a slippery slope, but special caution and scrutiny seems to be warranted to ensure that the due care criteria are met in these cases.

Longitudinal data comparable to those from the Netherlands are not available for Switzerland. In 2014, 0.8% of assisted suicides were carried out in people with dementia and 3% in people with depression, although the documentation of diagnoses is patchy overall in Switzerland (24).

Data on individual psychiatric diagnoses over time do not exist for any of the countries mentioned. Samples from the Netherlands and Belgium show the following picture for patients with psychiatric disorders (without dementia), combined for assisted suicide and euthanasia: more than half of the patients are female, about half of them suffer from depression and the other half from personality disorders. Less than 20% suffer from schizophrenia and less than 10% each from anxiety disorders, trauma sequelae, addictive disorders, bipolar disorders or others. Comorbidities are common (25-27).

[3] https://english.euthanasiecommissie.nl/the-committees/annual-reports (access 10/07/2023)

Ethical foundations: right to self-determination and obligations of beneficence

Assisted suicide is usually ethically justified with reference to the individual's right to self-determination. This does not only include the right to refuse life-sustaining treatment but also the freedom to terminate one's life with appropriate assistance. While the possibility to receive suicide assistance allows individuals to exercise their right to self-determination, they must also be protected from inappropriate use of suicide assistance. This requires a thorough assessment whether the person has the required decision-making capacity (19,28) and whether the request is voluntary, i.e., free of undue external pressure or influences, thoroughly considered and stable. Interestingly, regulations often require unbearable and irremediable suffering caused by an incurable disease as a further condition for legitimate suicide assistance (2). Especially controversial is the requirement that the person must suffer from a terminal illness with death expected within 6 months (c.f. the Oregon Death with Dignity Act), because it excludes many persons with incurable illness and unbearable suffering from suicide assistance.

These additional criteria cannot be justified by the ethical obligation to respect the persons' autonomy. On the contrary, they could provide reasons to infringe the person's autonomy if they are used as a justification for not following a request for suicide assistance. Systematically, these criteria seem to be motivated by considerations of beneficence: accordingly, it is only compatible with an "objective" standard of well-being to commit assisted suicide if the person has a severe and incurable condition causing unbearable suffering which cannot be alleviated. We will argue in the following that these beneficence-based considerations are important for supporting the person's deliberation on the decision to commit assisted suicide but that they are not legitimate arguments to exclude persons from suicide assistance. Rather, ethical obligations of beneficence have an instrumental value for promoting the person's autonomy.

From the perspective of self-determination, persons suffering from a chronic mental disorder have the same right to request suicide assistance as persons with an incurable somatic illness. However, mentally ill persons are excluded if a terminal illness with a life-expectancy of less than 6 months is required for legal suicide assistance. This exclusion constitutes a considerable infringement of the individual's right to self-determination and therefore constitutes an unjustified discrimination of a group of patients who are often already disadvantaged in terms of access to effective treatment and support (7). But even in patients with somatic diseases, the requirement of terminal illness can hardly be justified, neither with reference to self-determination nor from a beneficence-based perspective (6): why should someone who experiences unbearable suffering for an even longer time not be granted the same possibility to die with medical assistance like a person whose suffering is expected to end by natural death within the rather short time of about six months? On the contrary: if unbearable and irremediable suffering is relevant from an ethical perspective, suicide assistance for persons who have no way out of their dire situation by natural death in the near future is supported by even stronger ethical arguments. This especially applies to persons with incurable psychiatric illness (but also to all patients with incurable, but not terminal illness): without the option of assisted dying, they are bound to continued suffering for years. This is another strong ethical argument not to exclude mentally ill persons categorically from assisted suicide (7).

Ethical challenges in requests for assisted suicide by persons with mental disorders

However, as already mentioned in the introduction, there are several aspects in persons with mental disorders that require special caution. First, the wish to die may be—as a symptom of the disease—caused by the mental disorder and therefore not be an expression of a well-considered free choice. In these cases, appropriate psychiatric treatment instead of suicide assistance would be the only ethically appropriate form of help. Second, the decision-making capacity may be compromised by the mental disorder and the competence assessment can therefore be more difficult. Third, unbearable suffering may be more difficult to determine in mental disorders, and fourth, the wish to die may be more variable over time. Fifth, prognostic uncertainty is often higher in mental disorders which makes it more difficult to determine whether the illness is really treatment resistant. Overall, these conditions make it more challenging to assess the standard criteria of ethical legitimacy and render persons with mental disorders more vulnerable to inappropriate conduct of assisted suicide. In the following, we will discuss whether these challenges constitute sufficient ethical arguments to exclude persons with mental disorders from assisted suicide. If this is not

the case, we will elaborate how these challenges can be managed in a responsible manner, thereby balancing the ethical obligations of respect for autonomy and beneficence towards persons with mental disorders.

Challenge 1: causal relationship between mental disorder and wish for suicide

As elaborated above, there can be three different kinds of relationships between mental disorders and the wish to die. Ethically rather unproblematic is the accidental coincidence of a somatic and a mental illness when the competent person's request for assisted suicide results from the impairments of the somatic illness. It is, however, important in the assessment of a mentally ill person's request for assisted suicide to distinguish whether the wish to die is a symptom of the disease—as it can be in severe depression—or whether it is a competent person's rational choice responding to the unbearable suffering caused by the mental disorder. In the first case, the wish to die is not an autonomous choice and therefore the request for assisted suicide should not be granted. In the latter case, the mentally ill person has the same right to access suicide assistance like persons with somatic diseases. In some cases, e.g., in chronic depression, it may be more difficult to decide whether the wish to die is a symptom of the illness or an expression of a rational, autonomous choice (29). The assessment requires specific psychiatric expertise and the evaluating psychiatrist should have longstanding experience in the specific mental disorder of the patient. In the assessment, it will be most important to determine whether the person's wish to die is related to concrete symptoms of the disorder like depressed mood, reduction in drive, paranoid thoughts and others. The assessment should be made by an independent specialist, not involved in the person's current treatment. In difficult cases, a further assessment should be performed by a second psychiatrist. If doubts remain, the request for assisted suicide should not be granted, further support must be offered, and it may even be considered to initiate a compulsory admission to a hospital. If in single cases with irresolvable uncertainty about the relationship between the mental illness and the wish to die the request is not granted, these unclear cases do not constitute a sufficient ethical argument to exclude persons with mental disorders categorically from suicide assistance.

Challenge 2: possible impairment of decision-making capacity due to mental disorders

Mental illnesses often involve an impairment of the person's decision-making capacity. However, the presence of a mental disorder does not necessarily lead to decisional incapacity. Even diseases like severe depression, in which the wish to die can be a symptom of the disease, may go along with phases of the disease in which the person has the ability to appropriately assess her situation, to evaluate the prospects of future treatment and make a stable decision according to her own values (18). Under these conditions, it would be ethically inappropriate to withhold the option of suicide assistance from these persons. However, the assessment of the decision-making capacity in mentally ill persons can be more difficult than in persons with somatic diseases (30,31). This especially applies to persons with severe depression who are able to understand their situation and the prospects of further treatment, but who may have difficulties to appreciate adequately the chances for improvement of the illness or other positive developments that could make their life worth living (6). Again, the difficulties that may arise in assessing competence in mental disorders do not appear to be a sufficient reason to exclude mentally ill persons completely from the option of suicide assistance because it would infringe the self-determination of too many persons with mental disorders who have decision-making capacity (32). Furthermore, it would be ethically inconsistent, as persons with mental disorders are granted the right to refuse life-sustaining treatment in situations in which the same uncertainties may occur in the competence assessment. Rather, psychiatrists with special expertise in the respective mental disorder should perform the competence assessment. In cases of persistent uncertainty about the person's decisional competence, suicide assistance should not be offered.

Challenge 3: difficulties to determine unbearable suffering in persons with mental disorders

The very expression "unbearable suffering" denotes a personal, subjective experience, because something can only ever be "endured" by the person from her internal perspective. From an external perspective, this suffering and its intolerability may or may not be comprehensible, but intolerable suffering can never be verified or falsified. While in the case of severe or even terminal physical

illnesses, objective findings, such as severe heart failure or proven bone metastases, facilitate the comprehensibility of suffering, such clues are typically lacking in the case of mental illnesses. The observer entirely depends on the information provided by the patient and/or her behavior.

In fact, people with mental illness frequently report unbearable suffering not being reflected in their obvious and observable behavior. Vice-versa, even acutely suicidal persons may appear completely balanced and unobtrusive immediately prior to committing suicide. Moreover, there are psychiatric patients who do not report suffering, but whose behavior suggests they are suffering intensely. This is especially the case in persons who present with severe formal or content-related thought disorders or who are unable to express themselves appropriately due to cognitive impairments. While the intolerability of suffering cannot be objectified, neither in somatic nor in psychiatric patients, the comprehensibility of this subjective feeling on the basis of a mental illness often seems to be clearly limited.

If unbearable suffering cannot be objectively assessed with sufficient validity, this calls into question whether it is an appropriate criterion for the legitimacy of providing suicide assistance (33). Actually, it seems that the criterion of unbearable suffering does not add much to the assessment of the person's stable wish to die which is usually an expression of the person's own subjective assessment that the illness-related suffering has become so unbearable for her that death appears to be the only way out. Instead of questioning whether the person's suffering is indeed unbearable, the assessment should focus on the person's decision-making competence and on assuring that all reasonable therapeutic options have been offered and considered seriously by the person requesting suicide assistance (see below).

Challenge 4: variability of the wish to die over time in persons with mental disorders

Although many risk factors are known for suicidality in persons with psychiatric disorders, individual prediction of suicides remains very difficult (34). One reason is that the wish to end one's life is mostly variable over time (35). This is related to variations in symptom load, to several external factors like distress or social support, but also to highly ambivalent thoughts balancing the wish to die against the wish to live on. Obviously, this instability renders it also very difficult to assess whether a request for assisted suicide is durable and stable, as requested for example by Germany's Federal Constitutional Court (4). As a consequence, procedures to ensure this kind of stability should include repeated psychiatric assessments.

Challenge 5: prognostic uncertainty and treatment resistance in mental disorders

Apart from a few exceptions, which include dementia in particular, mental illnesses often take a course that cannot be reliably predicted in individual cases (36,37). Both the observable symptoms and the subjective impairment can vary greatly over time, in some cases independently of one another. Many disorders, especially depressive disorders, even by definition take an episodic course with remissions and relapses. Even when depression becomes chronic, spontaneous remissions can occur after years. On the one hand, this is probably due to the complexity of the causes of the disease, which almost always represent a combination of biological, psychological and social factors. On the other hand, these different dimensions not only play a role in the development of the disorders, but often also show their own hardly predictable dynamics in the course, especially with regard to psychological and social factors.

Any type of psychiatric treatment interacts with the complex spontaneous course of the mental illness, which makes it difficult to assess the effectiveness or ineffectiveness of a treatment, especially in individual cases. These difficulties are also reflected in the fact that the concept of treatment resistance is intensively and controversially discussed in the field of psychiatry. As an example, consider the state of scientific discussion of treatment resistance in depression and schizophrenia (38,39). Treatment resistance in psychiatry is usually understood as a particular challenge to further therapeutic efforts, not as a reason for resignation.

Under no circumstances, however, should the concept of treatment resistance in the field of mental illness be understood to mean that there is definitely or with great certainty no longer any prospect of improvement or alleviation of the symptoms. This is all the more true because even severely mentally ill people still have their own resources and are accessible to psychosocial interventions that can significantly improve their situation and life satisfaction. Corresponding approaches are usually summarized under the term recovery-oriented or positive psychiatry (40). Furthermore, as mental illnesses are often not life-limiting, it cannot be excluded that some effective treatment for the person's condition will be developed in the future. At least, there is currently no empirically sound

basis for labeling the person's mental disorder as definitively treatment resistance[4] or even incurable, thereby questioning whether a lack of further or alternative treatment options is an ethically justified criterion for legitimate suicide assistance.

It appears to be rather unlikely that this prognostic uncertainty about the future course of mental disorders and the prospects of further and alternative treatment options can be eliminated (8). And even if it could be eliminated, we would not have universally accepted standards which likelihood of benefit justifies a—potentially—unsuccessful and often burdensome further treatment attempt.

How can we deal appropriately with this challenge in requests for suicide assistance? Considerable prognostic uncertainty also appears in decisions about life-sustaining treatment—and the solution is not to withhold persons the option to refuse life-sustaining treatment, but rather to let the person herself balance the benefits and risks of further treatment and decide whether the prospects are unfavorable and certain enough to stop or limit life-sustaining treatment. Uncertainty cannot be a justification to limit persons' freedom of decision-making.

Likewise, persons with mental illnesses should get the chance to determine themselves (6,7) how they evaluate the—probably small—likelihood of success of further treatment options, and the—likewise small—chance that an effective treatment will be developed in the not-too-distant future and how they balance these treatment prospects against the burden of enduring further suffering caused by their mental illness. Like in decisions about life-sustaining treatment, it seems ethically acceptable that mentally ill persons decide to forgo further treatment options even if they offer a (small) likelihood of improving the illness-related suffering. However, it is of utmost importance in these cases that the persons have full decision-making capacity (19), that they have been provided with unbiased, understandable information about their medical situation and the prospects of other available treatment and that they are supported in evaluating this information on the background of their individual life experiences and values. The thorough assessment of further available treatment options is especially important given the fact that persons with mental disorders may belong to disadvantaged groups with limited access to effective psychiatric treatments. This also includes the active search for mental disorders in patients requesting assisted suicide, because those remain undetected in many cases. Less than one third of mentally ill patients in Europe receive any treatment at all (41).

Conclusions: towards ethically justified assisted suicide for persons with mental diseases

Persons with mental disorders have the same right to self-determination related to death and dying as persons with somatic diseases. Hence, excluding these persons categorically from assisted suicide based on their diagnosis would constitute an ethically unjustified discrimination (42). There are mentally ill persons who are competent to make autonomous decisions to end their lives. However, there are several challenges that render persons with mental disorders especially vulnerable to inappropriate conduct of assisted suicide: their wish to die may be a symptom of their mental disease and not an autonomous choice, decision-making competence may be compromised by their illness and more difficult to assess, the severity of suffering may be more difficult to evaluate from an external perspective, the wish to die may be more variable over time and the prognostic uncertainty in mental illness makes it more difficult to determine whether the severe suffering is in fact treatment resistant. These challenges do not justify excluding persons with mental disorders from assisted suicide completely, as it is done in several countries, especially based on the criteria of unbearable suffering and treatment resistance of the mental disorder.

The only ethically valid argument to exclude persons with mental disorders from suicide assistance is their proven inability to make a free, autonomous decision. However, the mentioned challenges should be taken into account in evaluating a mentally ill person's request for assisted suicide and for promoting well-informed and deliberated decision-making on behalf of the person. In addition to assessing the decision-making capacity, the evaluation process should be guided by the goal to empower the person to make an autonomous choice between the available options, including further treatment, psycho-social support and suicide assistance.

To promote and respect mentally ill persons' autonomy and to protect this vulnerable group, we suggest the following points to consider in the process of evaluating a request for suicide assistance of persons with mental

[4] Of course, this does not include neurodegenerative diseases for which no primary therapy is available.

disorders [cf. (7,43)]:

- The wish to die should be evaluated by psychiatrists with a special expertise in the person's mental disorder. The assessment of decision-making competence and further available treatment options both require profound psychiatric knowledge about the mental illness, its relationship to suicidality and its possible impact on the person's ability to make autonomous decisions. At least in difficult cases with uncertainty about competence and available treatment options, an independent second psychiatric assessment should be conducted.
- Persons who are in an acute mental health crisis must be excluded from suicide assistance and offered appropriate treatment and psychosocial support.
- The assessment should include the mentally ill person's social circumstances to identify those cases in which contextual factors have compromised access to effective psychiatric treatment or may have influenced the person's wish to die [cf. (43)].
- Persons whose wish to die is a symptom of the mental disorder (and not an autonomous choice) must be excluded during the psychiatric assessment. In cases of doubt after second opinion psychiatric assessment, they should be offered best available treatment and support instead of suicide assistance.
- One—if not the—central task in the evaluation process is the assessment of the person's decision-making capacity. Again, psychiatric experience is essential to identify if the person's thinking, especially her appreciation of positive treatment perspectives, is distorted by the mental illness. Suicide assistance should be granted only if the person is able to make an autonomous choice about the available options. We suggest to build on established criteria to assess patients' competence for consent to medical treatment (18), because the decision about assisted suicide requires comparable competencies: understand the relevant information about the person's current situation, appreciate the situation, the available options and their consequences and finally make a choice according to the person's fundamental values and preferences [cf. also (19)]. This assessment should take into account the emotional and social dimensions of suicidality (28,44). In cases of doubt after second opinion psychiatric assessment, suicide assistance should not be offered at that time, but rather available treatment and support to improve the person's competence.
- The person should be supported adequately in the decision-making process and thereby empowered to make an autonomous choice among the available options including suicide assistance [cf. the shared-decision making standard (45)]. This must include information about the person's current medial situation and especially about further available treatment and support options that may improve the illness or at least reduce the suffering symptomatically. Within this communicative process, it seems appropriate to challenge the person respectfully with beneficence-based recommendations about alternatives to assisted suicide, thereby promoting the person's own value-based reasoning [cf. the deliberative model of the physician-patient relationship according to (46)].
- While treatment resistance should not be a criterion of ethical legitimacy, the process should include a thorough assessment of all further promising treatment options which could relieve the suffering (33,47). This assessment should be based on a review of all prior treatment attempts (43,48). The decision competent person herself should then make the final decision by balancing the prospects of treatment success against the continued suffering during a further therapeutic trial. Before granting a request for assisted suicide, it should have become clear that the person has given serious consideration to the available treatment options.
- Finally, the person's request should be consistent and stable over time. Therefore, at least 2 assessments appear necessary. There is no empirical evidence regarding an appropriate interval, but several months, e.g., 2–3, seem reasonable. In determining the appropriate time period, the intensity of subjectively experienced suffering should be taken into account. The person should be provided intensified support between the assessments.

As the assessment of the wish to die often will be more challenging in persons with mental disorders, the professionals involved should receive special training for the assessment. Furthermore, cases of remaining uncertainty especially regarding decision-making capacity should be decided by a cautionary principle: in cases of persistent

doubts, no suicide assistance should be granted. We suggest a sliding scale approach to the assessment of competence in cases of uncertainty about treatment resistance: the better the prospects of future treatment options are the stricter should be the competence assessment. The person should be able to argue understandably why she wants to die despite a rather positive prospect of treatment success. In difficult cases, a clinical ethics consultation can help to make a decision about the request for suicide assistance in the person's best interest. Overall, we hope that this evaluation procedure can help to achieve an appropriate balance on the thin line between respecting persons' autonomy and protecting a vulnerable group against ethically unjustified conduct of suicide assistance.

Acknowledgments

Funding: None.

Footnote

Provenance and Peer Review: This article was commissioned by the Guest Editors (Jan Gärtner and Manuel Trachsel) for the series "Ethics and Psychiatry Meet Palliative Medicine" published in *Annals of Palliative Medicine*. The article has undergone external peer review.

Peer Review File: Available at https://apm.amegroups.com/article/view/10.21037/apm-23-472/prf

Conflicts of Interest: Both authors have completed the ICMJE uniform disclosure form (available at https://apm.amegroups.com/article/view/10.21037/apm-23-472/coif). The series "Ethics and Psychiatry Meet Palliative Medicine" was commissioned by the editorial office without any funding or sponsorship. The authors have no other conflicts of interest to declare.

Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

References

1. Kass LR. Toward a more natural science. New York: The Free Press; 1985.
2. Mroz S, Dierickx S, Deliens L, et al. Assisted dying around the world: a status quaestionis. Ann Palliat Med 2021;10:3540-53.
3. Judgment of the Second Senate of 26 February 2020 - 2 BvR 2347/15 -, paras. 1-343, (2020). Available online: http://www.bverfg.de/e/rs20200226_2bvr234715en.html
4. Pollmächer T. Assisted suicide from a psychiatric perspective. Nervenarzt 2023;94:625-30.
5. Nicolini ME, Kim SYH, Churchill ME, et al. Should euthanasia and assisted suicide for psychiatric disorders be permitted? A systematic review of reasons. Psychol Med 2020;50:1241-56.
6. Steinbock B. Physician-Assisted Death and Severe, Treatment-Resistant Depression. Hastings Cent Rep 2017;47:30-42.
7. Schuklenk U, van de Vathorst S. Treatment-resistant major depressive disorder and assisted dying. J Med Ethics 2015;41:577-83.
8. van Veen SMP, Ruissen AM, Widdershoven GAM. Irremediable Psychiatric Suffering in the Context of Physician-assisted Death: A Scoping Review of Arguments: La souffrance psychiatrique irrémédiable dans le contexte du suicide assisté : Une revue étendue des arguments. Can J Psychiatry 2020;65:593-603.
9. Blikshavn T, Husum TL, Magelssen M. Four Reasons Why Assisted Dying Should Not Be Offered for Depression. J Bioeth Inq 2017;14:151-7.
10. Rooney W, Schuklenk U, van de Vathorst S. Are Concerns About Irremediableness, Vulnerability, or Competence Sufficient to Justify Excluding All Psychiatric Patients from Medical Aid in Dying? Health Care Anal 2018;26:326-43.
11. Appelbaum PS. Physician-assisted death in psychiatry. World Psychiatry 2018;17:145-6.
12. Sheehan K, Gaind KS, Downar J. Medical assistance in dying: special issues for patients with mental illness. Curr Opin Psychiatry 2017;30:26-30.
13. Grassi L, Folesani F, Marella M, et al. Debating Euthanasia and Physician-Assisted Death in People with Psychiatric Disorders. Curr Psychiatry Rep 2022;24:325-35.

14. Bachmann S. Epidemiology of Suicide and the Psychiatric Perspective. Int J Environ Res Public Health 2018;15:1425.
15. Bertolote JM, Fleischmann A. Suicide and psychiatric diagnosis: a worldwide perspective. World Psychiatry 2002;1:181-5.
16. Wolfersdorf M. Sind Menschen, die sich das Leben nehmen, psychisch krank? - Pro. Psychiatr Prax 2020;47:176-7.
17. Brieger P, Menzel S, Hamann J. Is the role of mental illness in suicide overestimated? Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz 2022;65:25-9.
18. Appelbaum PS. Clinical practice. Assessment of patients' competence to consent to treatment. N Engl J Med 2007;357:1834-40.
19. Stewart C, Peisah C, Draper B. A test for mental capacity to request assisted suicide. J Med Ethics 2011;37:34-9.
20. Mitchell AJ, Chan M, Bhatti H, et al. Prevalence of depression, anxiety, and adjustment disorder in oncological, haematological, and palliative-care settings: a meta-analysis of 94 interview-based studies. Lancet Oncol 2011;12:160-74.
21. Mehnert A, Breitbart W. Diagnostik und Behandlung psychischer Störungen in der Palliativmedizin. In: Koch U, Lang K, Mehnert A, et al. editors. Die Begleitung schwer kranker und sterbender Menschen: Grundlagen und Anwendungshilfen für Berufsgruppen in der Palliativversorgung. Stuttgart: Schattauer GmbH; 2006:90-122.
22. Durkin A. Incorporating concepts of end-of-life care into a psychiatric nursing course. Nurs Educ Perspect 2003;24:184-5.
23. van Veen S, Widdershoven G, Beekman A, et al. Physician Assisted Death for Psychiatric Suffering: Experiences in the Netherlands. Front Psychiatry 2022;13:895387.
24. Bartsch C, Landolt K, Ristic A, et al. Assisted Suicide in Switzerland: An Analysis of Death Records From Swiss Institutes of Forensic Medicine. Dtsch Arztebl Int 2019;116:545-52.
25. Thienpont L, Verhofstadt M, Van Loon T, et al. Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study. BMJ Open 2015;5:e007454.
26. Kim SY, De Vries RG, Peteet JR. Euthanasia and Assisted Suicide of Patients With Psychiatric Disorders in the Netherlands 2011 to 2014. JAMA Psychiatry 2016;73:362-8.
27. Calati R, Olié E, Dassa D, et al. Euthanasia and assisted suicide in psychiatric patients: A systematic review of the literature. J Psychiatr Res 2021;135:153-73.
28. Mrozynski H, Kuhn E. Reasoning for autonomous suicide? A qualitative approach to pre-suicidal decision-making. Soc Sci Med 2022;296:114764.
29. Berghmans R, Widdershoven G, Widdershoven-Heerding I. Physician-assisted suicide in psychiatry and loss of hope. Int J Law Psychiatry 2013;36:436-43.
30. Widdershoven GAM, Ruissen A, van Balkom AJLM, et al. Competence in chronic mental illness: the relevance of practical wisdom. J Med Ethics 2017;43:374-8.
31. Doernberg SN, Peteet JR, Kim SY. Capacity Evaluations of Psychiatric Patients Requesting Assisted Death in the Netherlands. Psychosomatics 2016;57:556-65.
32. Shaw D, Trachsel M, Elger B. Assessment of decision-making capacity in patients requesting assisted suicide. Br J Psychiatry 2018;213:393-5.
33. Trachsel M, Jox RJ. Suffering is not enough: Assisted dying for people with mental illness. Bioethics 2022;36:519-24.
34. Large MM, Ryan CJ, Carter G, et al. Can we usefully stratify patients according to suicide risk? BMJ 2017;359:j4627.
35. Morgan G. Predicting short-term suicide risk: allowing for ongoing variation in severity of intent. BJPsych Bull 2021;45:105-8.
36. Fusar-Poli P, Hijazi Z, Stahl D, et al. The Science of Prognosis in Psychiatry: A Review. JAMA Psychiatry 2018;75:1289-97.
37. van Veen SMP, Ruissen AM, Beekman ATF, et al. Establishing irremediable psychiatric suffering in the context of medical assistance in dying in the Netherlands: a qualitative study. CMAJ 2022;194:E485-91.
38. Sforzini L, Worrell C, Kose M, et al. A Delphi-method-based consensus guideline for definition of treatment-resistant depression for clinical trials. Mol Psychiatry 2022;27:1286-99.
39. Howes OD, McCutcheon R, Agid O, et al. Treatment-Resistant Schizophrenia: Treatment Response and Resistance in Psychosis (TRRIP) Working Group Consensus Guidelines on Diagnosis and Terminology. Am J Psychiatry 2017;174:216-29.
40. Bejerholm U, Roe D. Personal recovery within positive psychiatry. Nord J Psychiatry 2018;72:420-30.
41. Wittchen HU, Jacobi F, Rehm J, et al. The size and burden of mental disorders and other disorders of the brain in Europe 2010. Eur Neuropsychopharmacol 2011;21:655-79.

42. Braun E, Scholten M, Vollmann J. Assisted suicide and the discrimination argument: Can people with mental illness fulfill beneficence- and autonomy-based eligibility criteria? Bioethics 2024;38:61-8.
43. Expert Panel on MAiD and Mental Illness. Final Report of the Expert Panel on MAiD and Mental Ilness. Ottawa: Health Canada; 2022.
44. Kipke R. The denial of meaning in life. Why assisted sucide concerns us all. Ethik in der Medizin 2021;33:521-38.
45. Elwyn G, Vermunt NPCA. Goal-Based Shared Decision-Making: Developing an Integrated Model. J Patient Exp 2020;7:688-96.
46. Emanuel EJ, Emanuel LL. Four models of the physician-patient relationship. JAMA 1992;267:2221-6.
47. Hodel MA, Trachsel M. Euthanasia or Assisted Suicide in Patients With Psychiatric Illness. JAMA 2016;316:2153-4.
48. van Veen SMP, Evans N, Ruissen AM, et al. Irremediable Psychiatric Suffering in The Context of Medical Assistance in Dying: A Delphi-Study. Can J Psychiatry 2022;67:758-67.

Cite this article as: Marckmann G, Pollmächer T. Assisted suicide in persons with mental disorders: a review of clinical-ethical arguments and recommendations. Ann Palliat Med 2024. doi: 10.21037/apm-23-472

