If Voluntary Assisted Dying is Available to those with Physical Disorder, It Should also be Available to those with Severe Mental Disorder – An Opinion.

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Abstract

Voluntary assisted dying (VAD) is now available in many countries around the world and the indications are that this option will soon extend into other countries. Some countries are permissive and allow VAD for most of those who argue that their life is not worth living. In other countries, such as the USA and Australia, eligibility criteria include that the individuals must be suffering a medical disorder and have a life expectation of less than six months. We argue that this discriminates against people with severe mental disorders who also find life not worth living. Throughout time suicide has been available and utilized by those facing painful, intolerable predicaments. Intractable mental disorder is painful and unalterable (given existing treatments. We argue people with chronic mental disorder suffering should not be discriminated against, and where VAD is available, it should be available to all types of suffering patient.

Key words: Voluntary assisted dying; mental disorder; freedom of choice; discrimination.

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If the law allows people suffering distressing terminal illness to access voluntary assisted dying (VAD), it should allow people suffering distressing, treatment resistant mental disorder to access that service.

Throughout history, people have looked to death as an escape from distress. Around 2000 BCE, Pyramus and Thisbe were lovers living in Babylon. They planned to meet in a park – Thisbe arrived first but was scared away by a lion. Then Pyramusarrived, saw the lion, assumed it had killed Thisbe, chose death over distress, and fatally stabbed himself. Thisbe returned, found his corpse, also opted for death over distress, and killed herself with the same weapon. Elements of this scenario are not uncommon - in 30 BCE, Anthony and Cleopatra were lovers in Egypt. Anthony incorrectly assuming Cleopatra was deceased and stabbed himself to death. Cleopatra consequently arranged her own death by holding a poisonous snake to her breast.

Distress of many types has led to suicide. Samson was an Israelite of great physical strength. In about 1078 BCE he was captured by the Philistines. He was blinded, tortured and humiliated in a temple. He said, "Let me die with the Philistines", and pushed down roof supports which caused his death (and that of many of his enemies). In about 33 CE Judas was feeling bad (we assume guilt was his dominant emotion) about having betrayed Jesus and hanged himself.

Many accounts of death being chosen as an escape from distress are detailed in folk and early literature, including Aesop's Fables, The Poetic Edda, The Kalevala, The Arabian Nights, and The Romance of the Three Kingdoms.

In the 20th century, Mao Zedong used the death of Miss Zho (21 years old, 1919, Changsha, China) to argue for political change. She was betrothed to a man she disliked. When she was placed in a capsule to be carried to his home, she cut her throat and died.

At the end of the Second World War, death was chosen over disappointment humiliation and retribution by many defeated Japanese and German commanders. Among defeated Germans, Hitler and Goebbels shot themselves and Himmler and Goring took cyanide.

Universally, people have choose death over long periods in prison. Harold Shipman was a medical practitioner convicted of killing approximately 250 of his patients. After all appeal options were exhausted, he hanged himself in Wakefield Prison (England, 2004). Jeffrey Epstein was a financier and convicted sex offender. He was rearrested in 2019 and hanged himself shortly after being reincarcerated (New York).

But, humans are hard to kill. Few people have a firearm, a noose that holds is not easy to construct and over-the-counter medication is annoyingly safe. Unless one has special training and facilities, choosing death may lead to a terrifying, failed attempt, a deeper sense of impotence and frequently, an additional physical disability.

Voluntary assisted dying (VAD) is available in certain countries. Should local applicants who wish to die satisfy all regulations, they are helped by trained clinicians to access painless, lethal medication(which they must self-administer). VAD providing countries divide into two groups, those with very broad and those with very narrow eligibility criteria.

The group with broad eligibility criteria includes Switzerland, the Netherlands, Belgium and Luxemburg. There are slight regulatory differences between these jurisdictions. Swiss case law is among the more permissive and may possibly make VAD services available to people who argue their life not worth living - there is no requirement that individuals must be suffering a particular type of disorder and there is no embargo against those suffering mental disorders.

The group with narrow eligibility criteria includes Canada, USA (12 states), Germany, Colombia, New Zealand, and Australia (Victoria, Western Australia, Tasmania, Queensland, with other states pending). Portugal and Spain are progressing legislation which is expected to place them in this group in the near future.

The narrow eligibility criteria contain two hurdles which discriminate against people with mental disorders. The first is a requirement that the individual must have a terminal illness, and death must be anticipated in a maximum of six or 12 months (depending on diagnosis). While mental disorders have destructive effects on the quality of life, they are not 'terminal'-they do not inexorably lead to death. The second is an explicit exclusion of mental disorder as justification for VAD. For example, the Tasmanian End-of-Life Choices Act states (Part 3. 9. (2)) "a person is not eligible" by reason only that the person (Part 3. 9. (2)(a)) "has a mental disorder".

The requirement for the presence of a terminal illness is a means of reducing risk and opposition. If the person will die within six months, the application of VAD will expunge six months of life, at most - averting the possibility of the loss of 20 years of happy times. From an ethical perspective, when death is imminent, the relief of suffering may be construed as superseding the responsibility to protect life.

The rationale for the embargo against mental disorder as a justification for VAD services is multi-headed. For some opponents, mental disorders are not legitimate disorders. Rather, they represent weakness of character, and would go away if only the so-called sufferers would pull themselves together. For others there is a philosophical concern that the mind and the body are different - the 'mind-body dualism' debate - which can be interpreted to mean mental and physical disorders cannot be managed in the same manner. This view is discounted by the fact that the mind is the function of the brain, which is part of the body – treatments of the mind are treatments of the brain - many mental disorders involve a genetic contribution and genes are of the body. Other opponents view people with mental disorders as not being 'normal', that is, as being unable to think clearly and give an account of themselves and the world, and thereby incapable of formulating a considered request. This is simple prejudice. The ability to make health decisions calls for similar skills as making a will or giving evidence in court - all are within the capabilities of many people with mental disorder. In fact, with certain safeguard, people with mental disorder are frequently required to make wills or and speak in courts.

Some opponents of VAD for people suffering mental disorderscontend such individuals are 'vulnerable' and if VAD was available, they would be irresistibly disposed of by those in power. However, VAD has been available in Switzerland for a century, the Netherlands for 40 years, Belgium for almost two decades and Luxemburg for more than one decade and there is no evidence whatsoever of focused extermination.

Other opponents make the excellent point that the wish for death could be an acute symptom of a mental disorder – such as, the delusion, "God wants me to kill myself". When people apply for VAD based on intractable mental disorder suffering, thorough psychiatric assessment is essential, and applications based on distorted thinking and beliefs would be identified. In some cases, treatment would eradicate this symptom/request and the request would lapse.

In all cases in which the request is an intrinsic symptom of mental disorder (a delusion for example), the patient would not have full insight into his/her circumstances and the request would not be legitimate and therefore not supported.Severe mental disorders which deserve VAD consideration are underpinned by well-established brain

changes both at the cellular level (size, shape and density of cell bodies) in specific regions, and the efficiency of connections between regions. These changes have been exhaustively demonstrated by imaging and electrical studies, and autopsy findings.

Mental disorders take many forms, some are little more than inconvenient, others destroy lives. Only the latter group might justify VAD. Disorders usually manifest acute, sudden, profoundly distressing episodes, which when actively treated with recommended methods, resolve and cease. Some episodes do not satisfactorily resolve (despite good treatment) and become chronic – with acute features reducing but dragging on and reoccurring over decades.

Some symptoms for which there is no effective treatment (loss of the ability to experience emotions; loss of drive and energy) cause gradual decline in the ability to function in work and family life.Acute phases of mental disorder are universally painful. In acute major depressive disorder, severe sadness is central - often accompanied by a strong a sense of (undeserved) guilt. There is often a desire for death, and usually slowing of movement and thinking, and loss of appetite, energy, and ability to sleep. In acute schizophrenia there are often threatening voices (hallucination) and the belief that one is in mortal danger from others (delusions) - loss of contact with reality is often intrinsically terrifying. Acute treatment may eradicate these symptoms.

People with chronic severe unresponsive mental disorder have accrued decades of loss. Many will have been unable to complete skills training or secure or sustain work. Frequently they have been unable to establish and maintain long-term relationships or marriage. Frequently, they will have lived on disability pensions and been unable to own their home. Extended and nuclear family relationships are often fractured by misunderstanding, frustration and disappointment affecting both the afflicted person and well-meaning family members. Afflicted people are generally aware of their disadvantage, their poor financial and social past performance, and prospects.

If the pain of a severe acute mental disorder is likened to the pain of a broken leg, the distress and discomfort of severe chronic mental disorder might be likened to the experiences associated with severe, painful congenital deformity.

Thus, it can be agreed that acute mental disorder is painful/distressing, to which may be added the torment of long-term illness, self-criticism and the disappointment of failed treatments. In the most comprehensive study of depressive disorder in history, 30% of people did not respond to any known treatment, and of those who did respond, 70% relapsed within one year. In schizophrenia, one bunch of symptoms (the positive symptoms) may respond relatively favorably to treatment, for another bunch (the negative symptoms) there is no effective treatment. In a recent study of people with acute schizophrenia, 70% of patients failed to achieve remission (complete cessation of positive, symptoms).

In a recent study of patients with mental disorder being considered for VAD in the Netherlands, 68% had been suffering for more than 11 years and 27% had been suffering for more than 30 years.

People with mental disorder should not be automatically excluded from VAD services. A first requirement would be for the individual to have ‘decisional capacity’ – ability to make their own legal health decisions. This ability is lacking in some individuals with mental disorders (and a surprising number of individuals without mental disorder) – the corollary being, that decisional capacity is possessed by many people with mental disorder. It is routine practice for trained experienced clinicians to accurately determine decisional capacity status. When decisional capacity is absent, it may be regained with treatment aimed at improving thinking ability, or it may simply return with the passage/vicissitudes of time. If decisional capacity is present or can be regained, the next step would be to determine whether the request for VAD is a symptom (a delusion for example) of a mental disorder. If so, it may be possible to successfully treat the symptom, which would change the puzzle and summon reassessment. If the patient has decisional capacity and the request is not a symptom of disorder, any request for VAD from a person with mental disorder should receive serious consideration.

People choose death (suicide) to avoid endless distress. But, suicide is frightening and technically difficult – attempts are demoralizing and may add physical handicap. VAD should be available to people with painful mental disorders which is unresponsive to treatment, just as it is to people with painful, intractable physical disorders. Their suffering is beyond question. The embargo against VAD for people with mental disorder is based on ignorance of the nature of mental disorder and concern that people with mental disorder are unreliable individuals who are being treated by uninformed professionals. There is no evidence to support the concern that people with mental disorder are ‘vulnerable’ and will be targeted for extermination under the mantle of VAD.