



The many different languages of assisted suicide

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Comment on: Rivest J, Chammas M, Desbeaumes Jodoin V, *et al.* Learning about psychiatric aspects of medical assistance in dying: a pilot survey of self-perceived educational needs among assessors in a Canadian academic hospital. *Ann Palliat Med* 2022;11:3123-34.

Submitted Oct 12, 2022. Accepted for publication Oct 31, 2022.

doi: 10.21037/apm-22-1156

View this article at: <https://dx.doi.org/10.21037/apm-22-1156>

The stoics regarded death as an “adiaphoron”, neither good nor evil, but morally value neutral (1). Providing perspectives on assisted dying (AD) does not mean staying in a comfort zone. AD is an ongoing social and medical debate, and a profound discussion requires a clear starting point. However, AD speaks many different languages: a legal language, a medical language, a social language, a personal language and a philosophical language. First, the terminology needs to be clarified. AD refers to both voluntary active euthanasia and physician-assisted death. Physician-assisted suicide (PAS) means support for freely responsible suicide, for example, by providing a lethal drug that the person who is willing to die takes oneself. In the United States, PAS is limited to people with a prognosis of six months or less to live. PAS is currently authorized in 10 states and Washington, D.C. To qualify for legal assistance, individuals who seek PAS must meet certain criteria, including having a terminal illness or the presence of intolerable suffering, proving that they are of sound mind, and voluntarily and repeatedly expressing their wish to die. Once this is assessed, the individual has to take the specified lethal dose by their own hand.

Laws vary in scope from place to place. A terminally ill person with the capacity to make this decision will then be able to self-administer barbiturates to end their life. Euthanasia, which is practised (status 2021) in Belgium, Canada, Colombia, Luxembourg, the Netherlands, New Zealand, Spain and several states of Australia, is a practice in which another person (generally a physician) acts to cause death. Euthanasia is illegal in the United States, as well as in

several European countries. In Canada, medical assistance in dying (MAiD) is a process through which a physician or nurse practitioner can prescribe a patient a substance that they can self-administer to cause their own death or a physician or a nurse practitioner assists an individual, at their request, with intentionally ending their life. In Canada, anyone with a disability qualifies to die by MAiD.

Much of the future generation seems to be in favour of AD. So, are we on the verge of cultural change as access to AD is progressively expanding? Physician involvement is not legalized in all countries and is viewed controversially (2). The topic of AD in general provokes strong feelings. It is not suitable for an elevator pitch but requires in depth-discussion (3). Beyond that, AD challenges physicians to address their own role.

Additionally, AD has cultural weight. Medical crimes from the National Socialist era still have consequences on how medicine is practised today. For example, the “euthanasia murders” saw around 200,000 people killed, including those with psychiatric and neurological diagnoses and those with disabilities.

Palliative care (PC) physicians and psychiatrists seem to approach AD with even more reluctance than the medical profession in general (4,5). PC physicians refer to the importance of symptom relief and the availability of palliative sedation, while psychiatrists state that suicidality should be recognized as a symptom of a depressive illness (6).

Debate has been raised about whether PC physicians and psychiatrists must face the truth that they are unable to alleviate all suffering, just as intensive care physicians must

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withdraw therapy in critically ill patients, for example, when catecholamine therapy is stopped and patients die.

The study by Rivest *et al.* aimed to explore physicians' self-perceived educational needs regarding the psychiatric aspects related to MAiD in Canada through a cross-sectional online survey in one academic tertiary care centre (7). The survey was completed by 19 physicians from different fields. In Canada, MAiD was legalized in 2016. The study data were collected a year and a half after the MAiD law was enacted in Quebec. At the time the study took place, MAiD was restricted to patients at their end of life (EOL). In 2019, the Superior Court of Quebec ruled that restricting eligibility only to EOL patients violated the Canadian Charter of Rights and Freedoms. This leads to the question of whether medicine follows the law, as society is changing at a rapid pace. How people die has radically changed and continues to change (8).

Rivest *et al.*'s study results revealed that Canadian physicians reported high levels of competency in managing psychiatric issues among MAiD requesters (7). The authors concluded that this may indicate overconfidence among the participants, as 95% of the participants reported providing EOL care on a regular basis, while 47% had never received any PC or EOL training (7). The authors stated that there is still very little postgraduate training on psychiatric symptoms in PC.

By granting individuals the right to die in a self-determined manner, the question arises of who is the right person to give advice and support to people with a wish to die. If "unbearable suffering with no prospect of improvement" is recognized as an "indication" of a rational wish to die, PC physicians in particular come into consideration due to their expertise in alleviating suffering. First, medical professionals should engage in building relationships and evaluating the patients' situation without imposing their own opinions on the patients. The fundamental principle of choice is that it must be well informed and thoughtful.

A physician-patient relationship is based on the premise of "first do not harm" (9). But, can death be a therapeutic goal? There is an ongoing debate as to whether psychological conditions and physical conditions can be equated in regard to AD (10). In medical practice, the issue of AD for mentally ill patients represents a challenging situation. The principles of preservation of life, on the one hand, and preservation of patient autonomy, on the other, are very likely to come into conflict. It is argued that severe psychiatric conditions compromise a person's decision-

making capacity and there is no certainty that a person's psychiatric condition is untreatable, which makes AD a moral risk.

However, it is also argued that the exclusion of persons with mental illness from access to AD is discriminatory if AD is available to persons with a somatic illness. Differentiation seems challenging, as AD requesters often present with both physical and psychological symptoms (11). The distinction between demoralization and mental illness is another important factor, as severe diseases might go hand in hand with "appropriate" sadness, existential distress, fatigue or subthreshold psychiatric symptoms (12).

Looking at the ethical principles, one also finds different approaches here. The autonomy-based approach assumes that AD is justified when a person has an autonomous desire to die irrespective of whether this is in the best interest of the person (13). Therefore, some argue that severe depression, possibly with previous suicide attempts, does not differ from a terminal somatic illness and could be considered an incurable disease state. In this case, the beneficence-based approach justifies AD because AD alleviates the suffering of a person who expresses a self-determined desire for AD (14). However, the counterargument states that AD also constitutes abandonment by the medical profession (15). This leads to the conclusion that there is not always a clear line between suffering and vulnerability.

The study by Rivest *et al.* must face the possible limitation of selection bias with regard to its small sample size of 19 participants, which might have a favourable opinion towards MAiD (7). However, the response rate of the survey was high and seemed to be representative of an attitude among Canadian physicians that MAiD has become part of medical practice. Interestingly, although the participants reported a lack of training concerning psychiatric issues and the need for additional training, a high proportion reported confidence in distinguishing a MAiD request from suicidal ideation. There was no psychiatrist among the participants, even though it is generally a central task of psychiatrists to assess mental health, clarify capacity and manage suicidality. A future multicentre study with a larger number of participants would be beneficial to study this topic more deeply.

Is society coming to the "new" conclusion that life itself can be a harm? Public opinion polls show a high number of people in favour of AD, but public opinion is a poor instrument for understanding complex topics, as terminology in regard to AD is complex. In a study

by Mangino *et al.*, 42% of respondents understood AD as the right of dying people to refuse life-prolonging measures (16).

As stated by Rivest *et al.*, there is a lack of training in medical education regarding PC and EOL issues (7). Furthermore, there is a lack of training regarding psychiatric issues and a lack of training regarding psychiatric PC and EOL issues. Do these facts represent good conditions for increasing the accessibility of AD? Should it not be considered the task of a developed society to provide alternatives to lonely, depressed or severely ill people who feel so hopeless as to request AD (17)? Data are emerging from Canada showing that MAiD requesters have high rates of psychiatric comorbidities (11). Rivers *et al.* reported that only 42% of the participants had provided PC in their practice, while 79% had provided MAiD at least once. Could this indicate that AD may be too readily available?

As the evidence concerning research on AD is sparse, we must prioritize research. We would never consider any other intervention based on the data available on AD. While provisions for PC are still inadequate, AD will not only affect the number of those who want AD, but will also affect the many living with a severe illness and the bereaved. A significant number of people who should be receiving PC do not have access to it (18). This particularly applies to non-oncological diseases, as patients with cancer receive more and earlier PC (19). PC needs will increase by up to 40% in 2040 (20). As dependence, fear, loss of mobility and social isolation are common reasons for AD, we must be aware of the existential dimensions of suffering (21). *Kodokushi* (Japanese meaning “lonely dying” or “lonely death”) refers to the deaths of mostly lonely persons when the passing goes unnoticed for an extended period of time and the person is not missed. In Japan and the UK, there are ministers for loneliness.

The availability of AD complicates the relationships between PC providers and their patients (22). The distinction between AD and PC might lead to confusion for patients and families. Therefore, education for healthcare professionals in dealing with patients with a wish to die seems to be crucial. This relates to Advance Care Planning and thinking about patients’ values and therapeutic goals. A wish to die can mean that someone does not want to live “that way”. Medical professionals should be aware of the ambivalence of a wish to die. AD should never be the immediate answer to a wish to die but should rather be regarded as an *ultima ratio* after all symptom-alleviating measures have been exhausted. As stated by Cicely

Saunders, we should make every effort “to give space” for something else to have a place apart from a disease and the burdens that come with it (23).

In the face of medical advances and an increasingly ageing society, it will be important in the future to train medical professionals in “unplugged” skills, such as conversation and listening. Regarding AD, we have to address numerous challenges and need to master different languages. To summarize, perspectives on AD will continue to be an ethical debate. It is always part of a physician’s duties to face the seriously ill and dying with respect, acknowledge the patient’s wishes and concerns and do everything in their power to alleviate their suffering. We need to emphasize further research and continue the dialogue.

Acknowledgments

Funding: None.

Footnote

Provenance and Peer Review: This article was commissioned by the editorial office, *Annals of Palliative Medicine*. The article did not undergo external peer review.

Conflicts of Interest: The author has completed the ICMJE uniform disclosure form (available at <https://apm.amegroups.com/article/view/10.21037/apm-22-1156/coif>). EKM serves as an unpaid editorial board member of *Annals of Palliative Medicine* from February 2022 to January 2024. The author has no other conflicts of interest to declare.

Ethical Statement: The author is 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.

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Cite this article as: Masel EK. The many different languages of assisted suicide. *Ann Palliat Med* 2022;11(12):3599-3602. doi: 10.21037/apm-22-1156