

A Conceptual Framework for Thinking about Physician-Assisted Death for Persons with a
Mental Disorder

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Abstract

Physician-assisted death (PAD) has been enacted in a number of international jurisdictions, with several extending access to PAD for persons whose condition is not terminal, including those with a mental disorder. We argue that based on the state of the literature, it is too early to make well-defined recommendations on how relevant fields can proceed legally, ethically, and clinically, particularly in regard to PAD for persons with a mental disorder. The aim of this paper is to introduce a framework for further discussions on PAD for persons with a mental disorder to stimulate thoughtful and considered debate in our field. We provide a brief discussion of the principles that guide regulatory frameworks on PAD practices worldwide, including a discussion of jurisdictions in Europe and North America that allow PAD for those suffering from an incurable non-terminal disease, illness, or disability. Next, we present a conceptual framework as a series of questions that address legal, ethical, and clinical dilemmas arising from this trend. We conclude with a summary of guidelines on the practice of PAD from international jurisdictions in order to assist in the development of potential legal and professional regulations.

Keywords: international legislation, mental disorder, physician-assisted death, practice guidelines

A Conceptual Framework for Thinking about Physician-Assisted Death for Persons with a Mental Disorder

As a result of rapid advances in medical science, persons with incurable or degenerative diseases can live longer (Shrestha, 2005), even though their quality of life can be severely diminished (Breitbart et al., 2000). Concerns for personal autonomy (Boudreau & Somerville, 2014), coupled with limitations in palliative care for alleviating pain and suffering (Knaul, Farmer, Bhadelia, Berman, & Horton, 2015), have fostered supportive attitudes towards the use of assisted death among some practitioners in the fields of philosophy (Gill, 2009), medicine (Lee, Price, Rayner & Hotopf, 2009), and law (Hendry et al., 2013). Despite increased attention to assisted death in current academic discourse and policy-based literature, psychologists have been relatively absent in the discussion (but see Achille & Ogloff, 2004; Appel, 2007; Bergmans, Widdershoven, & Widdershoven-Heerding, 2013; Deschepper, Distelmans, & Bilsen, 2014; Johnson, Cramer, Conroy, & Gardner, 2014; Macleod, 2012; Parker, 2012; 2013; Schoevers, Asmus, & van Tilburg, 2014). However, given the shift in assisted death practice in some jurisdictions from persons with a terminal medical condition to persons with a mental disorder, we believe psychologists can and should re-enter the discussion.

Over the past few decades, laws legalizing assisted death for adults with a terminal or general medical condition have been enacted in a number of jurisdictions, including Canada, the Benelux countries of Belgium, Luxemburg, and the Netherlands, as well as several U.S. states. Some jurisdictions in Europe and North America have also extended access to assisted death to adults with a mental disorder or have left open the possibility that persons with a mental disorder may qualify for assisted death. Based on this shift in assisted death practices, further discussion is needed concerning whether assisted death should be approved when a mental disorder is the primary or sole medical condition and whether safeguards are needed to regulate assisted death for persons with a mental disorder separate from or in addition to regulations for persons with a terminal or general medical condition.

In 2000, *Psychology, Public Policy, and Law* published a Special Issue on physician-assisted death (hereinafter PADⁱ) with a specific focus on the implementation and implications of Oregon's Death with Dignity Act, adopted in 1997 (Benjamin, Werth, & Gosten, 2000). The Special Issue comprised 24 articles from various experts in the field who provided reviews and commentary on practice, policies, and empirical evidence on PAD (for a summary of the special issue see Benjamin, 2000). PAD for persons with a mental disorder as a sole diagnosis was not thoroughly debated in this special issue, perhaps because it was not permissible under Oregon law and there was an apparent consensus at that time that PAD is not appropriate for persons with a mental disorder (Baron, 2000; Burt, 2000; Illingworth & Bursztajn, 2000; Jamison, 2000; Kerkhof, 2000; King, Kim, & Cowell, 2000; Martyn & Bourguignon, 2000; Rosenfeld, 2000a, 2000b; Werth, Benjamin, & Farrenkopf, 2000; Werth, Farrenkopf, & Benjamin, 2000; Youngner, 2000). Things have changed. When the Special Issue was published, PAD for persons with a mental disorder was only permitted in Switzerland. Since 2000 seven additional jurisdictions permit PAD and three allow persons with a mental disorder to request assistance with death (see Table 1). There appears to be a movement to extend PAD generally, with some jurisdictions extending PAD to persons with a mental disorder, and thus there is a need to reopen the discussion from psychology.

-- Insert Table 1 about here--

PAD is controversial in the context of many different types of medical conditions, but in the context of a mental disorder discussion about PAD is especially fraught. On the one hand, one could argue that when available treatment has been found to be inadequate, persons with a mental disorder should have the same rights as persons with a terminal or general medical condition to receive relief from suffering and maintain self-determination and control over the circumstances regarding their death (Doyal & Doyal, 2001). On the other hand, it could be argued that the nature and origin of their suffering and longer life expectancy compared to persons with a terminal medical condition makes PAD for persons with a mental disorder problematic or unacceptable (Guedj et al., 2005; O'Neill, Feenan, Hughes, & McAlister, 2003). The desire for death may be a reflection of the complex nature of the mental disorder, in which a sense of hopelessness or suicidal ideation may be symptoms of or triggered by the underlying condition (Nock et al., 2008). In addition, PAD for persons with a mental disorder raises societal concerns, such as the fear of a gradual extension of PAD to persons who lack requisite decisional capacity or that persons with a mental disorder may be coerced into choosing assistance in death (Appel, 2007; Dembo, 2010; Kelly & McLoughlin, 2002).

We argue that based on the state of the literature, it is too early to make well-defined recommendations on how relevant fields should proceed legally, ethically and clinically in regard to PAD for persons with a mental disorder. The aim of this paper is to introduce a framework for further discussions on PAD for persons with a mental disorder to stimulate thoughtful and considered debate in our field. We begin with a brief discussion of international jurisdictions that currently allow PAD; we provide a slightly longer discussion of jurisdictions in Europe and North America that allow PAD for those suffering from an incurable non-terminal disease, illness, or disability. To be clear, this discussion is not a comprehensive review of relevant laws; rather it is an analysis of international principles that guide practices to legalize or decriminalize PAD.ⁱⁱ This review will demonstrate that PAD for persons with a mental disorder may be becoming more common. Next, we offer a conceptual framework, presented as a series of questions, to consider some of the legal, ethical, and clinical dilemmas arising from this trend. Each question is addressed in the context of legal principles, public policy, and psychological research. In developing this framework, it was not our goal to fully examine each issue or to address all questions related to the regulation of PAD for persons with a mental disorder. Rather, it is our goal to stimulate conversation on key issues related to this important issue. That being said, policy has been enacted internationally to allow for PAD and health care providers, policy makers, and legal professionals are required to make principled decisions that should be based on the best available evidence. In order to assist in the development of potential legal and professional regulations, we conclude with a summary of guidelines on the practice of PAD from international jurisdictions.

Development of PAD Worldwide^{iii,iv}

In at least 142 countries and 45 U.S. states assisted death is illegal, with laws stipulating punishments for aiding, abetting, or encouraging death (see Mishara & Weisstub, 2015). However, in at least twelve jurisdictions PAD has been decriminalized or legalized.^v Specifically, Colombia, Canada, Japan, South Africa, and the U.S. state of Montana have used

court rulings to decriminalize PAD in certain circumstances, whereas Belgium, the Netherlands, Luxembourg and the U.S. states of California, Oregon, Washington, and Vermont passed legislation to legalize PAD (see Table 1 for a summary of the important characteristics of the laws in these jurisdictions). As is clear from Table 1, there is variation in the conditions under which PAD may be requested.

Most jurisdictions that have legalized or decriminalized PAD require a terminal medical condition as a requirement to receive PAD and do not permit PAD for persons with a mental disorder. For instance, in five U.S. states, persons with a mental disorder are explicitly prohibited from access to PAD (*Montana Death with Dignity Act, 2010; Oregon Death with Dignity Act, 1997; Patient Choice and Control at End of Life Act, 2013; The End of Life Option Act, 2016; Washington Death with Dignity Act, 2009*). However, in Belgium, the Netherlands, Luxemburg, and Switzerland PAD is permitted for persons with an irremediable mental disorder, in the absence of another medical condition (e.g., Schizophrenia, Bipolar Disorder). In Belgium, PAD is legal if the individual is competent,^{vi} has unbearable suffering, and is suffering from a severe and incurable disorder (*The Belgium Act on Euthanasia, 2002*). In the Netherlands, a competent individual may be granted PAD if their request is voluntary, enduring, well considered, they have unbearable psychological or physical suffering, and other options for care have been exhausted (Royal Dutch Medical Association, 2002). In Luxemburg, PAD is permitted as long as the individual has a grave and incurable illness, unbearable physical or psychological suffering from a medically based condition, and their request for PAD is stable over time (*Law of 16 March 2009 on Euthanasia and Assisted Suicide, 2008*). In Switzerland, an individual requesting PAD does not need to have a terminal medical condition or be a Swiss Citizen; however, he or she must be experiencing unbearable suffering, a disability, and a consistent wish to die (Swiss Academy of Medical Sciences, 2012).

Although it is possible for persons with a mental disorder to request PAD in these jurisdictions, the practice is rare. Most requests from persons with a mood disorder in the Netherlands are declined (Field & Curtice, 2009) and no cases involving PAD on the basis of a mental disorder have been reported in Luxemburg to date (Luxembourg National Commission for Monitoring and Evaluation of Euthanasia, 2013). In Belgium mental suffering from either a mental disorder or other medical condition is explicitly acknowledged as a valid basis for PAD (Naudts et al., 2006); however, the number of persons that receive PAD on the basis of a mental disorder is small (Federal Evaluation and Control Commission of Euthanasia, n.d.). In Switzerland requests for PAD on the basis of mental disorder are granted only in a small proportion of cases (Swiss Federal Statistical Office, 2009).

PAD for persons with a mental disorder has primarily arisen in European jurisdictions; however, an important case in Canada represents the first case in North America in which PAD may extend to persons with a mental disorder. In Canada, PAD is currently prohibited under section 14 and section 241 (b) of the *Canadian Criminal Code*. However, on February 6, 2015, the Supreme Court of Canada decriminalized PAD in *Carter v. Canada (2015)*, ruling that “the prohibition on physician-assisted [death] is void insofar as it deprives a competent adult of such assistance where (1) the person affected clearly consents to the termination of life; and (2) the person has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances

of his or her condition” (para. 4).^{vii} The Supreme Court of Canada held that prohibiting a competent person from access to PAD infringes the individual’s right to life, liberty, and security of the person, rights guaranteed in section 7 of the *Charter of Rights and Freedoms*.

Importantly, access to PAD was not restricted to persons with a terminal medical condition; similar to Belgium the Netherlands, Luxemburg, and Switzerland, the Supreme Court of Canada stated that a competent individual suffering from any *medical condition* that, in the *individual’s opinion*, leads to intolerable physical or psychological suffering will be permitted to request PAD. This ruling certainly leaves open the possibility that persons with a mental disorder will qualify.

The major implication from this brief review of international practices generally and the recent Supreme Court of Canada decision in particular is that there are trends in PAD policy that are indicative of changes in attitudes regarding the availability of PAD, including the extension of access to PAD for persons with a mental disorder. The legislative trend to extend PAD to persons with a mental disorder make it imperative that issues related to PAD for persons with a mental disorder be principled and thoroughly discussed.^{viii}

A Framework for Extending Access to PAD for Persons with a Mental Disorder: Legal, Ethical, and Clinical Considerations

Given recent legal developments in Canada and other international jurisdictions, it seems evident that PAD is becoming available to a wider group of individuals. In this section, we present a series of questions for researchers, policy makers, and practitioners to consider when thinking about PAD for persons with a mental disorder (see Figure 1). Our objective is to present some (not all) of the key issues and to review relevant public policy and psychological research to inform continued discussion.

-- Insert Figure 1 about here --

PAD for Persons with a Mental Disorder

Should a Mental Disorder be a Ground for Requesting PAD? Changes in public policy that extend the right to request PAD on the basis of a mental disorder stem from our growing understanding of the biological basis of certain mental disorders (Goldberg & Goodyer, 2014). If PAD is a legal option for persons suffering from a medical condition, it is unclear why access to PAD should not be available to persons suffering from a mental disorder (Doyal & Doyal, 2001). However, the similarities between general medical conditions and mental disorders, though strong, are not complete. There is still a limited understanding of the underlying causes of common mental disorders (e.g., Depression, Schizophrenia) making the prognosis of mental disorders more difficult to ascertain (Kelly & McLoughlin, 2002). Moreover, there are important qualitative differences between requests for PAD between, for example, a person with a terminal medical condition who is likely to die in the near future and a request from an otherwise physically healthy person with Major Depressive Disorder (Cowley, 2013; Gopal, 2015). While some studies indicate that the acceptance rate of PAD for persons with a terminal medical condition among ethicists, medical professionals, and the general public

is high (e.g., Cohen et al., 2006; Inghelbrecht, Bilsen, Mortier, & Deliens, 2010), this is not the case for PAD on the basis of psychological suffering due to a mental disorder (Cowley, 2013; Kouwenhoven et al., 2012).

Despite its controversial nature, in Belgium, Luxemburg, the Netherlands, and Switzerland, the existence of a terminal medical condition is not necessary for PAD, rather it is considered to be less important than the presence of “intolerable and hopeless suffering” (Schoevers et al., 2014). Mental disorders can lead to intense suffering that may occur as a result of the mental disorder or symptoms of the mental disorder (e.g., anxiety, depression, disorientation, depersonalization, hallucinations), the prospect of living with a severe mental disorder (e.g., loss of identity, loss of purpose), psychosocial losses that are incurred by the recurrence of hospitalization (e.g., difficulty maintaining employment), or symptoms that result from long-term use of psychotropic drugs (e.g., weight gain, movement disorders; Berghmans et al., 2013; Hewitt, 2007). For these reasons, it has been argued that suffering from a mental disorder is not different from suffering from a terminal or general medical condition, and that, in some cases, providing PAD to persons with a severe mental disorder who have made well-considered and voluntary requests can be legally and ethically justified (Berghmans et al., 2013).

Should PAD be Available for All Types of Mental Disorders? Most debate on PAD and mental disorders has focused on requests for PAD from persons with Major Depressive Disorder (i.e., as a subgroup of persons to be excluded; Ganzini, Leong, Fenn, Silva, & Weinstock, 2000; but see also Schuklenk & van de Vathorst, 2015).^{ix} However, in most jurisdictions that include a mental disorder as a reason to request PAD, distinctions are not made across mental disorders.^x There have been controversial cases in the Netherlands, Belgium, and Switzerland in which PAD has been provided on the basis of other mental disorders (see Appendix A). The DSM-5 and ICD-10 list 157 and 99 forms of mental disorder (McCarron, 2013; World Health Organization, 1992), which fall into 20 and 10 general categories, respectively. While a clinical diagnosis of a mental disorder does not necessarily mean that an individual will meet criteria for PAD^{xi} without clear direction *all* DSM-5 (e.g., binge eating disorder, insomnia, caffeine withdrawal, premenstrual dysphoric disorder) or ICD-10 mental disorders (e.g., paedophilia, pathological gambling, transsexualism) could be considered when requests for PAD are made. A significant risk of permitting PAD on the basis of such a large range of pathologies is the high number of individuals that would qualify. Worldwide mental health concerns are common - approximately 30% of the population is estimated to experience at least one mental disorder in any given year – and are the leading cause of disability (World Health Organization, 2004). In the U.S. and Canada alone, approximately 10% to 25% of the population (~79 million and 3.5 million people in the U.S. and Canada, respectively) meets criteria each year (Kessler et al., 2009; Pearson, Janz, & Ali, 2012). As such, one needs to consider whether a person who receives any diagnosis from the DSM-5 or ICD-10 is *de facto* (i.e., in fact, but not determined by legal procedures) a person who can request PAD or if PAD should be restricted to only a subset of mental disorders, and if so, which disorders?

Defining Grievous and Irremediable Mental Disorder

Should Persons who Refuse Alternative Treatment Qualify for PAD? If a mental disorder is a valid basis on which to request PAD, careful diagnosis and evaluation of the

person's prognosis are required to determine whether the condition is grievous and irremediable (i.e., there is a lack of prospect of improvement, Berghmans et al., 2013). In jurisdictions that permit PAD, persons with a terminal medical condition are not required to undertake treatment that is intolerable to the individual to be eligible to receive assistance with death. Whether this should also be permitted in the case of a mental disorder raises many questions. What if it is a new diagnosis or there have been few attempts at treatment? What if the treatment option (e.g., Dialectical Behavioral Therapy) involves side effects that most would consider tolerable? Should we respect the rights of persons with a mental disorder to refuse treatment or should treatment be required before a request for assistance with death is considered? If some treatment is required, how much treatment and who should decide if treatment is successful? Should different requirements exist for individuals with no response to *one* treatment or no response to *all* available treatments?

In the U.S. and Canada as elsewhere, competent individuals have the right to refuse unwanted treatment for a general medical condition, even if the consequences of such decisions entail a serious risk of death or are contrary to medical advice (e.g., Title 42, *Code of Federal Regulations*; Section 7, *Charter of Rights and Freedoms*). Requiring competent persons with a mental disorder to undergo alternative treatments before a request for PAD is considered but not requiring the same of persons with a general medical condition may be considered discriminatory under human rights law (e.g., Title III, *Americans with Disabilities Act*; *Canadian Human Rights Act*, 1985). Indeed, some have argued that the right to make treatment decisions should be based on decisional capacity, not the presence of a mental disorder (Callaghan et al., 2013). Nevertheless, restricted access to PAD if the individual has refused psychiatric care may be required to ensure that persons with a mental disorder that has not been adequately treated do not prematurely receive assistance with death.

What if the Person has Been Successfully Treated or Has Had Their Symptoms Remit in the Past? For some mental disorders full remission of symptoms is possible with treatment; however, this is not a cure as symptom relapse is possible (Nierenberg et al., 2010) and persons may continue to experience residual impairment in psychosocial functioning and/or a diminished quality of life (Tranter, O'Donovan, Chandarana, & Kennedy, 2002). Further, some mental disorders are characterized by intermittent and short-lived episodes of mental impairment or acute symptoms, followed by periods where the individual is symptom free (American Psychiatric Association, 2013). Whether these types of mental disorders meet the legal definition of an irremediable medical condition is not clear. In the context of mental disorders, Switzerland requires that a distinction is made between persons who wish to have assistance with death due to temporary psychological impairment and persons with a chronic and severe mental disorder (Appel, 2007). However, it remains unclear for how long a person is required to endure the current level of severity of symptoms of their mental disorder and for how long should the periods of remission be for the suffering to be considered "intolerable" or "irremediable." It will likely be important to consider the history of treatment attempts and relapse.

What if there is No Treatment or the Individual is not Responsive to Available Treatments? While it is well-established that treatment helps alleviate symptoms of a mental disorder for the majority of people (Lambert & Archer, 2006), treatment is not always effective

and can be more challenging (or symptoms more resistant or irremediable) for some disorders, such as Personality Disorders, Delusional Disorder, and Chronic Depression than others (Nathan & Gorman, 2015). In the Dutch system, PAD is not permissible if, to current medical knowledge, “there is a reasonable chance of recovery, within a surveyable period of time, whereby the suffering caused by the treatment is not disproportionate to the expected outcome” (Royal Dutch Medical Association Special Committee on the Acceptability of Termination of Life, 1997). Although the Dutch medical guidelines broadly recommend that a mental disorder can only be considered irremediable if all applicable pharmacological and psychotherapeutic interventions have been tried (Tholen et al., 2009), there is no clear criteria (e.g., years with the mental disorder, different medications tried, and years in treatment) that can help determine whether an individual’s condition is considered irremediable (Campbell & Aulisio, 2012). The discovery of effective treatment for a mental disorder may take longer than for a general medical condition (Schoevers et al., 2014). When a request for PAD is made by a person with a mental disorder in the Netherlands, health care professionals have to declare that the individual fulfills the criteria for an irremediable medical condition if there is (1) no reasonable chance of improvement, (2) there are no available treatments or the treatments and other interventions are minimally effective, or (3) the side-effects of the treatment outweigh possible benefits (Berghmans et al., 2013).

How Should Intolerable Suffering be Assessed?

In Belgium, Canada, Luxemburg, the Netherlands, and Switzerland, intolerable physical or psychological suffering is specified as a necessary criterion for PAD. How “intolerable” is assessed deserves consideration. In the literature, the concept of “intolerable suffering” has not been adequately defined, and views on this concept are in a state of flux (Dees et al., 2009). Some scholars have opined that this concept is purely subjective, dependent on personal values, and determined by the patient (i.e., the individual experiences the suffering as intolerable, even if another would not). Research shows that persons with a mental disorder are able to make reliable self-reported quality of life judgments (Baumstark et al., 2013). However, in some cases, a mental health patient’s judgment may be temporally distorted (Deschepper et al., 2014). Other scholars (e.g., Berghmans et al., 2013) have suggested that the test contain both a subjective (i.e. what the individual believes is intolerable suffering) and an objective element (i.e., what a reasonable person would find intolerable in the circumstances) to ensure that the patient’s subjective assessment is not due to distorted judgment. However, there is no clear guidance on what objective standard to apply. By definition, psychological suffering has few outward signs. As such, it may be difficult to objectively measure intolerable psychological suffering and physicians may have to rely on patient self-report or make inferences from the individual’s level of impairment in functioning.

Researchers have developed several self-report tools to assess psychological pain (e.g., Holden, Mehta, Cunningham, & Mcleod, 2001; Olié, Guillaume, Jausse, Courtet, & Jollant, 2010; Orbach, Mikulincer, Sirota, & Gilboa-Schechtman, 2003). These tools focus on the frequency and the intensity of painful feelings, and not on the source(s) of psychological pain. When assessing the degree of suffering in the context of a mental disorder, one cannot ignore the contribution of external factors. Risk factors associated with suicidal ideation, suicide attempts, and completed suicide, such as hopelessness, financial problems, lack of caring relationships,

stigma, and social isolation, are more prevalent among persons with a mental disorder than the general population (Beck, Brown, Berchick, Stewart, & Steer, 2014; Maris, Berman, & Silverman, 2000; Rüsck, Zlati, Black & Thornicroft, 2014; van Orden et al., 2010). As such, a test of intolerable psychological suffering that ignores these causes could lead to PAD for potentially malleable external factors or adverse environmental conditions (e.g., social stigma, chronic poverty, intolerant family; Dembo, 2010). For instance, if a person with a mental disorder internalizes the negative stereotypes associated with having a mental disorder (e.g., dangerousness), hopelessness may follow (Livingston & Boyd, 2010). As such when determining whether to consider requests for PAD, it is crucial that the complex interplay between the mental disorder and social factors be considered to determine whether suffering can be treated or managed.

Although some external factors can be targeted for psychological interventions (e.g., stress, coping resources, self-stigma, social isolation; Chehil & Kutcher, 2012), others may be intractable or require long-term, population-level interventions (e.g., anti-stigma interventions to reduce the occurrence of discrimination against mental health populations; Rüsck et al., 2014). If an individual with a mental disorder requests PAD due to the effects of intolerable environmental factors that are not likely to change soon, is this grounds to allow or deny the request? If social stigma is an acceptable source of intolerable suffering, why would a person with a mental disorder be permitted to request PAD while members of other groups or communities who may also be the target of social intolerance (i.e., on the basis of age, disability, religion, ethnicity, social class, sexual orientation, indigenous background, national origin, or gender; Hays, 2001), not be permitted to make such a request? Although the request for PAD must be linked to a recognizable medical condition, cases in Belgium and the Netherlands suggest the possibility that the definition of intolerable psychological suffering may be extended beyond the intention of the legislation (Huxtable & Moller, 2007). For instance, in the Netherlands there was a case of an elderly man who requested and received PAD because he was tired of life and all his friends and relatives were dead (Cohen-Almagor, 2004).

If the external factors that cause intolerable suffering are remediable but there is little chance that the individual will have access to the remediation (e.g., residential care may be available to persons with financial means, but the state is unlikely to make it universally available), should PAD be permitted? Access to remediation may be possible in countries where there is universal health care (e.g., Canada, the Netherlands), but even then psychiatric treatment, especially long-term treatment with a clinical psychologist, may not be covered by freely available basic medical coverage. Without guaranteed access to treatment to alleviate psychological suffering, its availability to a few is of little comfort to those who suffer enduring psychological pain without access to help.

Mental Disorder and Competence

Should There be an Assumption that a Person Requesting PAD is Competent to Make Such a Request? Although the standards relevant to the assessment of decisional capacity vary from jurisdiction to jurisdiction based upon case law, relevant statutes, and/or procedural requirements (Leo, 1999), in general, it is presumed that every individual is competent to make medical decisions for themselves unless proven otherwise (Appelbaum &

Grisso, 1995). Some scholars have argued that a decision about death can never be made rationally by persons with a mental disorder (Zaubler & Sullivan, 1996) or that the presence of certain mental disorders (i.e., Major Depressive Disorder) should automatically render a person incompetent to request PAD (Ganzini et al., 2000). Symptoms of a mental disorder may impair an individual's judgement, awareness, and decision-making, such as the relative weight an individual gives to future outcomes and negative aspects of their current situation (Owen et al., 2008; Levene & Parker, 2011). Moreover, many individuals, including those with major mental disorders such as schizophrenia, have their symptoms effectively treated and managed (e.g., National Institute of Mental Health, 2009). A common concern is that extending PAD to persons suffering from a mental disorder may lead to death of persons suffering from a *treatable* mental disorder (Dembo, 2010).

Systematic research on the decisional capacity of persons with a mental disorder is limited; however, existing empirical evidence suggests that although a mental disorder may impair some of the abilities required for decision-making (Appelbaum & Grisso, 1995), decisional capacity is not always affected by the presence of a mental disorder (Grisso & Appelbaum, 1995). For instance, in a study of individuals with a mental disorder admitted to a psychiatric hospital, more than half (56.4%) of participants retained the ability to make rational decisions about their health care (Cairns et al., 2003). Moreover, although problems in decisional capacity have been demonstrated in those with a severe mental disorder, decisional capacity is relatively unimpaired in those with mild or moderate forms of mental disorders (Owen et al., 2013). Similarly, some individuals with a mental disorder may only have impaired decisional capacity when they are experiencing acute symptoms of their disorder and may otherwise be competent when experiencing a remission (Ventura et al., 2011). In a study of decisional capacity among different diagnostic groups of patients admitted to a psychiatric hospital, Owens et al. (2008) found that decisional capacity was higher in persons with a mental disorder characterized by fluctuating symptoms, such as Bipolar Disorder and Schizophrenia, and lower for persons with more chronic disorders, such as Depression and Personality Disorder.

Cognitive impairment alone cannot be determinative of decisional capacity to request PAD. Stewart and colleagues (2010) suggest that the presumption of competence should be maintained, but “a cautious and rigorous examination of the effect of the mental disorder on the person's competence” should be conducted (pg. 4). Some believe that a single independent evaluation to determine a person's decisional capacity to decide to request assistance with death is insufficient (Wenze, Gunthert, & German, 2012), particularly in the case of disorders with fluctuating symptoms; periodic re-evaluations are needed where decisional capacity is expected to change over time (Ventura et al., 2011).

When an individual is not currently suffering from symptoms of a mental disorder, the desire for death may represent a rational and well-thought out choice (e.g., Weinberger, Sreenivasan, & Garrick, 2014). Some psychiatrists and psychologists opine that persons with a mental disorder are capable of making rational decisions regarding the circumstances of their death (Shah & Mukherjee, 2003). Thus, although the presence of a mental disorder may raise concerns that the request for PAD is the result of distorted judgment, whether a person with a mental disorder is competent to make such a request likely needs to be assessed on a case-by-case basis rather than inferring from general features of a particular diagnosis. However,

important questions remain regarding how to determine whether a request for death is rational, who should determine this (e.g., the patient, the physician, psychologists, medical review boards, or the courts), and what criteria should be used to assess decisional capacity.

If Competence is to be Assessed, Should the Standard be Higher to Request PAD than Other Non-Lethal Medical Decisions? Assessments of decisional capacity in the context of end-of-life decision-making are focused primarily on whether individuals are legally competent to make decisions regarding treatment (Baron, 2000; Parker, 2000). The law recognizes numerous distinct competences (i.e., driving capacity, marriage capacity, testamentary capacity, financial capacity, criminal capacity) that differ based on the abilities required for the task and consequences of the decision (Grisso, 1996). Given the gravity of end-of-life decisions, should we set a higher standard of competence for PAD decisions than other routine health care choices? If so, what criteria or standards should apply? Are different criteria and standards of competence justifiable in cases where a mental disorder is the primary or sole diagnosis versus when the individual is not suffering from a mental disorder?

The standard of competence required to request PAD is heavily contested in the literature. If the bar is too high, an individual's decision-making autonomy is infringed upon. If the bar is too low, sufficient protection for incompetent decision-makers is not provided. Several scholars (e.g., Buchanan & Brock, 1989; Wilks, 1999; Zapf & Roesch, 2009) have argued that the standards for competence must vary according to the consequences of the decision (i.e., greater consequences require a higher the level of competence). Some health care professionals advocate for a relatively high standard of competence and an extensive review of the decision to request PAD (Ganzini et al., 2000). An inspection of the assisted death acts in Switzerland, Netherlands, Belgium, and Luxemburg, suggest that in the case of hopeless and intolerable suffering, death is not considered a more harmful outcome for an individual (Berghmans, et al, 2013). Moreover, some authors have argued that competence to request PAD should not differ from competence to refuse life prolonging treatment (Baron, 2000; Parker, 2000). The permanence of death, however, may warrant safeguards (Dembo, 2010). It may be reasonable to require a formal clinical assessment for every individual requesting PAD to ensure the absence of a treatable mental disorder influencing an individual's judgment (Werth et al., 2000). Reliable appraisal of decisional capacity will require a time-consuming clinical evaluation (Wenze et al., 2012). This option, however, raises concerns about ability to pay. A comprehensive clinical evaluation is likely to be expensive and may be out of reach for many individuals.

What Test Should be used to Evaluate Competence to Request PAD? Mental disorders compound difficulties in the assessment of competence (Akinsanya et al., 2009) and an inadequate assessment may attribute decisional capacity when it is absent, or fail to detect decisional capacity when it is present (Parker, 2013). Structured assessments would ensure that decisional capacity is accurately and reliably evaluated (Lamont, Jeon, & Chiarella, 2012). However, currently, there is no legally defined test of competence to request PAD. Several objective psychological measures are currently available to evaluate decisional capacity to consent to medical treatment, for example, the MacArthur Competence Assessment Tool – Treatment (Appelbaum & Grisso, 1995) and the Hopkins Competency Assessment Test (Janofsky, McCarthy, & Folstein, 1992). These instruments may need to be revised (or a new

measure developed) to include factors to be considered when evaluating decisional capacity to request PAD (e.g., the individual's psychological and emotional state, the importance of supporting factors in the environment) to ensure that the evaluator consistently covers all relevant areas of decisional capacity in end-of-life decisions.

Who Should Make the Determination of Competence? In most jurisdictions that permit assisted death, the involvement of a physician to assess patient competence and voluntariness is considered a necessary safeguard. However, the ability of physicians (with the exception of psychiatrists) to assess the presence and role of a mental disorder in health care decisions has been debated (but see also Appelbaum, 2007). Research shows, for example, that due to a lack of knowledge or a failure to properly screen patients (Farberman, 1997), mental disorders have often gone undiagnosed, undertreated, or inappropriately treated in health care settings (Kathol, Bulter, McAlphine, & Kane, 2010; Mitchell, 2013; Young, Klap, Shelbourne, & Wells, 2001).^{xii} If symptoms of an underlying mental disorder are recognized, physicians may fail to recognize that the mental disorder is impairing judgment (Levene & Parker, 2011). Consideration must be directed to who should assess decisional capacity in the context of requests for PAD, particularly when the individual making the request suffers from a mental disorder.

What is (or should be) the role of clinical psychologists?^{xiii} Clinical psychologists are trained to assess mental disorders and relieve mental suffering, and some are trained to evaluate decisional capacity; thus, it would seem that clinical psychologists and psychiatrists are in a position to protect patient autonomy by determining whether a requesting patient has an underlying mental disorder that impairs judgment (Niederjohn & Rogers, 2009) as well as to determine whether there are reasonable alternatives to relieve a patient's psychological suffering (Dees et al., 2013). Forensic clinical psychologists have expertise in evaluating decisional capacity in a variety of contexts (e.g., fitness to stand trial, criminal responsibility, civil forensic decision capacity; competency to be executed; Roesch & Zapf, 2013). Thus, psychologists with forensic training might be the most qualified to develop and administer measures to assess decisional capacity to request PAD.

While clinical psychologists may be in a position to assist with assessments of decisional capacity, there are ethical considerations for serving in this role. Within the field of clinical psychology, there is a general expectation for clinical psychologists to prevent harm among their patients (Bongar & Sullivan, 2013). For instance, in typical clinical practice, when a patient commits suicide, concerns may arise about the clinician's competence and the adequacy of their training (Schmitz et al., 2012). The participation of psychologists in PAD practices could be construed as a violation of the standard to avoid harm and the standard to intervene in cases of suicidal crises (American Psychological Association, 2010; Canadian Psychological Association, 2000; Johnson et al., 2014). One major concern of psychologists' involvement in evaluations of decisional capacity for assisted death is that their involvement would increase the potential for malpractice liability. Similar to competency to be executed evaluations, psychologists should consider whether participation would violate their professional responsibility to avoid harm (Johnson et al., 2014). If a psychologist feels that participation would violate professional ethics, he or she must decline involvement according to Standard 3.06 *Conflict of Interest* (American Psychological Association, 2010)/Standard III.35 *Conflict of Interest* (Canadian Psychological

Association, 2000). Further, some authors have raised concerns that psychologists may end up taking on a gatekeeping role for PAD requests (Ryan, 2012). Given that competence to request assistance with death could be challenging for an individual physician or psychologist to evaluate (American Psychological Association Workgroup on Assisted Suicide and End-of-Life Decisions, 2001; Dees et al., 2013), both professionals may be needed to independently and collaboratively assess decisional capacity.

What if a Person is Competent when Making a Request for PAD but Becomes Incompetent Before it is Carried Out? In contrast to some persons with a general medical condition whose decisional capacity is relatively stable over time, a mental disorder compromising an individual's decisional capacity can fluctuate (Larrabee, 2011). If a competent person with a mental disorder (e.g., someone suffering from a major mood or psychotic disorder) becomes incompetent before PAD is given it is unclear whether PAD should be administered. Issues that arise include: whether alternative provisions for end-of-life decisions among persons with a mental disorder should be enacted (for instance, a substitute decision maker), if competence should be a necessary condition to both request and *receive* PAD, and whether health care professionals will be required to restore competence to provide assisted death? Related to this, situations may arise in which an individual with a severe mental disorder develops a degenerative disease (e.g., cancer, ALS). If deemed incompetent, an individual with a mental disorder would not meet the requirements for PAD, even though he or she also has a terminal medical condition and is in intolerable physical pain.

An option considered in the literature is the use of advance directives. If a patient's decisional capacity to consent to medical treatment will be affected in the future, they can write an advance directive (or "living will") to set out the procedures and treatments they do and do not consent to (Irvine, Osborne, & Mary, 2013). Persons with a mental disorder can also write a psychiatric advance directive to declare their psychiatric treatment preferences in advance of onset of acute symptoms that may compromise decisional capacity (Srebnik et al., 2005; Swanson, Swartz, Ferron, Elbogen, & Van Dorn, 2006). Should it be possible for a person to include a request for PAD in an advance directive (i.e., "advance assisted death directive"^{xiv}) if their mental condition deteriorates? Research has suggested that persons with a mental disorder can have difficulty understanding how advance directives work, due to lack of experiences with laws, difficulty understanding abstract concepts (e.g., future states), and other cognitive limitations (Swanson et al., 2003). Moreover, although these directives reflect a person's desires at the time of writing, they are not legally binding. Mental health professionals may have concerns about the validity of these documents (e.g., whether an individual's wishes have changed from the time the advance directive was written; Lemmens, 2012) and thus have concerns about honoring requests. For example, in a survey of physicians, 54% reported that they would not perform PAD if requested in the form of an advance directive due to a lack of knowledge about interpretation of the law (Rurup, Onwuteaka-Philipsen, van der Heide, van der Wal, & van der Maas, 2005).

To what Extent Should a Person's Family be Involved in PAD Requests? An individual should be allowed to exercise self-determination over the circumstances regarding his or her death (e.g., Doyal & Doyal, 2001). However, the individual is not the only person affected by a decision to seek assistance with death; parents, spouses, children, and other loved

ones may be adversely affected by the decision (Bostwick & Cohen, 2009; Maris et al., 2000). Current policy in the U.S., Canada, and abroad does not require family members' involvement in health-related decisions made by competent persons due to the need to uphold medical confidentiality, unless an individual is at risk to harm themselves or others (e.g., *Freedom of Information Protection of Privacy Act*, 1996; *Health Insurance Portability and Accountability Act of*, 2010). However, in European jurisdictions failure to consult family members before proceeding with PAD for persons with a mental disorder have resulted in malpractice claims or physicians being physically threatened by family members (Deschepper et al., 2014).

Research conducted over the past decade has shown that a patient's outcome improves when family members are involved in treatment-related decisions (Dixon et al., 2014). Moreover, survey data of the general public suggests that a majority favor family involvement in PAD decisions, especially when the patient is suffering from a mental disorder (Frey & Hans, 2015). Family involvement, however, may also make patients more vulnerable to pressure from family members to choose PAD. Family members involved in the lives and care of persons with a mental disorder often provide case management, financial assistance, and housing (Dixon et al., 2014). This imposes considerable burdens (Schulze & Wulf, 2005) and family members may encourage persons with a mental disorder to opt for an early death due to burnout or for financial reasons. Conversely, a person's ability to make treatment-related decisions may be questioned when the family does not agree with the choice (Winter & Parks, 2008). If and how family members should be involved in PAD decisions is unclear at this point.

A Summary of Internationally Developed Guidelines

Based on the analysis above, we strongly encourage jurisdictions that are considering extending (or have extended) PAD to persons with a mental disorder to implement additional safeguards and procedures, otherwise persons with a mental disorder may not be thoroughly assessed or adequately treated before decisions regarding PAD are made. There are two types of safeguards: direct (i.e., legislation) and indirect (i.e., professional guidelines). Given that legislation is not always effective or followed (Ganzini et al., 2008; Pereira, 2011), it is critical that professional bodies develop comprehensive professional guidelines for PAD for persons with a mental disorder. One of the most helpful discussions of the professional and legal issues faced by mental health professionals for PAD was fleshed out in guidelines recommended by Werth, Benjamin, and Farrenkopf (2000) and commentaries on these guides^{xv} in the 2000 special issue of *Psychology, Public Policy, and Law*. Werth et al.'s (2000) guidelines concerned assessing competence and impaired judgment in decisions related to PAD in the context of the Oregon law. In brief, the guide specified that assessment should include: (1) a review of previous and current medical records for psychiatric and physical issues, including opining whether the medical issues satisfy the requirements of the Oregon Death with Dignity Act; (2) the administration of psychological tests and questionnaires related to competence, mental status, cognitive functioning, depressive symptoms, and attitudes toward PAD; (3) a comprehensive clinical interview with the patient (see p. 367-370 for components of the interview); (4) collateral interviews with the patients' significant others; and (5) a written report that details the assessment of decisional capacity and includes an opinion regarding the patients' decisional capacity to make decisions related to PAD.^{xvi} As discussed earlier, this could be expensive and questions of who will carry the financial burden and the implications thereof must be considered.

Three commentaries from legal professionals (Baron, 2000; Burt, 2000; Martyn & Bourguignon, 2000) and one from a psychiatrist (Youngner, 2000) provided critiques of the guidelines. Baron (2000) recommended that rather than the *a priori* recommendations (i.e., based on logical necessity, rather than actual experience), there is a need for guidelines and criteria for competence assessments in this area to be drawn from case law which would indicate what issues need to be evaluated in such an assessment. Baron also recommended that evaluations be recorded to be used as evidence for legal decision-makers if that becomes necessary. Burt's (2000) reply stated two criticisms of the Werth et al.'s (2000) guidelines: (a) "The proposed guidelines would require detailed, probing inquiry into motivations for choosing assisted [death]. This is an appropriate requirement in principle. In practice, it will be virtually impossible to carry out this inquiry within the likely statutory time limits" (p. 382) and (b) "The guidelines provide false comfort that physician-assisted [death] can be carried out with adequately sensitive monitoring of voluntariness and mental competence" (p. 382). Martyn and Bourguignon (2000) similarly argued that the guidelines would do little to aid in legal decision-making for PAD because, despite guidance for best practice, physicians' judgments will remain subjective and influenced by their own values. Further, the use of physicians in competence determinations would place the decision-making power in the hands of physicians for PAD, rather than the courts. Finally, Youngner (2000) stated that the guidelines are limited by (a) the lack of a clear definition and consistent use of the term decisional capacity, (b) the values and bias of clinicians making determinations of decisional capacity, and (c) a lack of detail on the relative importance and limitations of the psychological tests and questionnaires recommended by Werth et al. (2000).^{xvii}

In crafting policies on PAD it is essential to take into account what current legislative frameworks have found to be effective. Since the 2000 special issue of *Psychology, Public Policy, and Law*, the Netherlands, Belgium, and Switzerland have accumulated at least 10 years of experience with PAD for persons with a mental disorder. Professional practices adopted in these countries may be useful in providing direction for regulating such practices in Canada and other jurisdictions who have recently introduced or are in the process of tabling PAD legislation, as well as jurisdictions that plan to extend PAD to persons with a mental disorder. For several jurisdictions, including the Netherlands, Belgium, Luxemburg, and Switzerland, the relevant assisted death acts and any professional guidelines on PAD are listed in Table 2 and summarized in Table 3. This discussion of international guidelines is not restricted to PAD for persons with a mental disorder; however, we clearly identify additional criteria that must be met if a request for PAD is from a person with a mental disorder.

-- Insert Tables 2 and 3 about here--

Grievous and Irremediable Medical Condition

In all jurisdictions, a second opinion from an independent physician or specialist is required to verify the irremediable nature of the patient's medical condition (i.e., there is no reasonable chance of recovering within a non-specified period of time). If other eligibility requirements are satisfied, patients can refuse alternative treatments. In all jurisdictions, there must be extensive documentation of the diagnosis, prognosis, and attempted treatments by the attending and the consulting physicians.

Intolerable Suffering

In all jurisdictions the attending physician must reasonably conclude that the patient's suffering is intolerable and irremediable. In the case of psychological suffering, the Acts of Belgium, Luxemburg, and the Netherlands require that a psychiatrist or psychologist conclude that there are no feasible alternatives to relieve the patient's suffering. To ensure an objective evaluation, Dutch medical guidelines instruct that great care is taken in assessing whether the psychological suffering is unbearable. In all jurisdictions, the patient and doctor/psychiatrist must arrive at a joint decision that death would be preferable to ongoing suffering.

Competence

In all jurisdictions the individual requesting PAD must possess decisional capacity at the time of the request. In Switzerland and U.S. jurisdictions the standard of competence required to request PAD is similar to competence required for other medical decision-making (i.e., the individual must be able to understand treatment options, weigh information, and communicate a choice). In Belgium, Luxemburg, and the Netherlands a definition for competence/decisional capacity is not specified in the Acts or professional guidelines. No jurisdiction requires a psychiatric assessment to confirm decisional capacity for every patient making a request. However, in Belgium, Luxemburg, and the Netherlands, where a mental disorder may be the primary medical condition, both a doctor and a psychiatrist/psychologist are required to evaluate whether the requesting patient has the decisional capacity to request PAD. In Switzerland, medical guidelines specify that decisional capacity be evaluated by a third health care professional who is not necessarily a physician, which may include a psychiatrist. In U.S. jurisdictions if the attending physician believes that a terminal patient has a mental disorder causing impaired judgement, the physician must consult with a licensed psychiatrist, psychologist, or social worker and refer the patient to counselling. In all jurisdictions, health care professionals, including psychiatrists/psychologists, are not required to participate in PAD. However, they must refer the patient to another health care professional who is willing to fulfill the request. PAD cannot be included in advance directives in U.S. jurisdictions, however, in Belgium, the Netherlands, and Switzerland, if all other standards of legally sufficient care are met (e.g., voluntariness, competence) an individual is allowed to make a formal request for PAD in the form of an advance directive to be carried out if the individual becomes incompetent.

Voluntariness

In all jurisdictions decisions must be well-considered and persistent over time. For instance, in Oregon at least two requests more than 15 days apart must be made by a patient stating his or her wish to die. Patients should also have adequate time to change their mind (e.g., at least a month from when the initial request was made), and any sign of ambivalence or uncertainty should abort the process. In all jurisdictions, family members can be involved in the decision-making process at the patient's request. However, caution should be used, as it is important to determine whether family members are supporting PAD for selfish gain (e.g., financial gain, caregiver burnout) or are trying to override well-thought-out requests. In addition, U.S. jurisdictions require a witness who is not a relative, entitled to the estate of the patient, or affiliated with a health care facility in which the patient is receiving care to verify a

patient's voluntary request.

Concluding Remarks

The aim of this paper was to stimulate discussion on key issues that may arise in extending PAD to persons with a mental disorder, so that we as a field can have a thoughtful and considered discussion. It is important to note that there are a number of complexities that were not sufficiently addressed in this paper. For instance, ensuring that some persons requesting PAD are seen by two doctors, receive a comprehensive battery of tests, and have their competence restored to receive PAD have major resource implications that we were not able to comprehensively consider. Further, concerns remain regarding whether the legalization of PAD for persons with a mental disorder may divert attention and resources from suicide prevention. Additional commentary from mental health professionals, as well as lawyers, ethicists, and philosophers, would be helpful in determining whether more harm is being done by not respecting an individual's autonomous wishes or failing to engage in suicide prevention. Each topic addressed in this paper (and others) warrants full discussion and we encourage our colleagues internationally to join us in this discussion.

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Conflict of Interest

The authors declare that they have no conflict of interest.

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Tables and Figures

Table 1.

Jurisdictions in Which Physician-Assisted Death (PAD) is Currently Legal, Decriminalized, or Practiced

Jurisdiction	Date Entered Into Law	Terminal Medical Condition Necessary Condition for PAD	PAD Permitted When Mental Disorder is the Sole Medical Condition
Switzerland ^{1, a}	1937	No	Yes
Japan ^{2, b}	1962	Yes	No
Oregon ^{3, a} (United States)	1996	Yes	No
Colombia ^{4, b}	1997	Yes	No
The Netherlands ^{5, b}	2001	No	Yes
Belgium ^{6, c}	2002	No	Yes
Luxemburg ^{7, b}	2008	No	Yes
Washington ^{8, a} (United States)	2008	Yes	No
Montana ^{9, a} (United States)	2009	Yes	No
Vermont ^{10, a} (United States)	2013	Yes	No
South Africa ^{11, b}	2015	Yes	No
Canada ^{12, a}	In Effect 2016	No	Not Specified
California ^{13, a} (United States)	In Effect 2016	Yes	No

Note. Jurisdictions are presented in chronological order with respect to the date that PAD became possible. Not Specified = Restrictions have not yet been placed on which disorders do or do not qualify for PAD. ¹ Article 115, *Swiss Criminal Code* (1937). ² Hoshino (1993, 1996); but see also Article 202, *Japanese Penal Code* (1907). ³ *Oregon Death with Dignity Act* (1997). ⁴ Colombia Constitutional Court (1997). ⁵ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* (2001). ⁶ *The Belgium Act on Euthanasia* (2002). ⁷ *Law of 16 March 2009 on Euthanasia and Assisted Suicide* (2008). ⁸ *Washington Death with Dignity Act* (2009). ⁹ *Baxter v. Montana* (2009);

Montana Death with Dignity Act (2010).¹⁰ *Patient Choice and Control at End of Life Act* (2013).¹¹ *Stransham-Ford v. Minister of Justice and Correctional Services and Others* (2015).¹² *Cater v. Canada* (2015).¹³ *The End of Life Option Act* (2016).

^a Physician-assisted suicide but not physician-assisted euthanasia permitted. ^b Both physician-assisted euthanasia and physician-assisted suicide permitted. ^c Physician-assisted euthanasia but not physician-assisted suicide permitted.

Table 2.
Acts and Professional Guidelines of Jurisdictions that Permit Physician-Assisted Death (PAD)

Jurisdiction ¹	Name of Act (Year)	Name of Professional Guidelines (Year)
Switzerland	Not Available ²	Guidelines on End-of-Life Care, Swiss Academy of Medical Sciences (2012) ²
Oregon (United States)	Oregon Death with Dignity Act (1997)	Oregon Death with Dignity Act: A Guidebook for Health Care Providers, Task Force to Improve Care of the Terminally Ill
The Netherlands	Termination of Life on Request and Assisted Suicide (Review Procedures) Act (2001)	Standpoint on Euthanasia, Royal Dutch Medical Association (2002); Guidelines for Dealing with the Request for Assisted Suicide in Patients with a Psychiatric Illness (2009), Dutch Psychiatric Association
Belgium	The Belgium Act on Euthanasia (2002)	Not Available ³
Luxemburg	Law of 16 March 2009 on Euthanasia and Assisted Suicide (2008)	Not Available ³
Washington (United States)	The Washington Death with Dignity Act (2008)	Not Available ³
Montana (United States)	Montana Death with Dignity Act (2010)	Not Available ³
Vermont (United States)	Patient Choice and Control at End of Life Act (2013)	Not Available ³

Note. ¹ In Colombia, Japan, and South Africa there are no acts or official guidelines on PAD, thus, these jurisdictions were not included in this Table. ² Switzerland does not have any formal legislation on PAD in place; however, the Swiss Academy of Medical Sciences has put forth recommendations for physicians to follow when performing PAD. ³ Additional professional guidelines were not available or could not be obtained.

Table 3.
Summary of International Practices for Determining Whether to Grant Requests for Physician-Assisted Death (PAD)

	Jurisdiction				
	Switzerland	Oregon, Washington, Vermont, and Montana (United States)	The Netherlands	Belgium	Luxemburg
Criterion of Legally Sufficient Care					
<u>Grievous and Irremediable Condition</u>					
At least two health care professionals required to confirm diagnosis/prognosis	Yes	Yes	Yes	Yes	Yes
Refusal of alternative treatments permitted if other eligibility requirements satisfied	Yes	Yes	Yes	Yes	Yes
Treatment attempts well documented	Yes	Yes	Yes	Yes	Yes
<u>Intolerable Suffering</u>					
Subjective-objective standard applied	Yes	No	Yes	Yes	Yes
Suffering cannot be relieved by other reasonable or available means	Not specified	No	Yes	Yes	Yes
Psychologist required to confirm psychological suffering irremediable	No	No	Yes	Yes	Yes
<u>Competence</u>					
Higher threshold of competence than other medical decision-making	No	No	Not specified	Not specified	Not specified
Mandatory psychiatric exam for every individual	No	No	No	No	No
Psychologist/psychiatrist can serve as an additional expert/specialist	Yes	Yes	Yes	Yes	Yes
PAD can be requested in form of an advance directive	Yes	No	Yes	Yes	Yes
<u>Voluntariness</u>					
Decision persistent over time	Yes	Yes	Yes	Yes	Yes
Adequate time to change mind	Yes	Yes	Yes	Yes	Yes
Family involvement at request of the patient	Yes	Yes	Yes	Yes	Yes

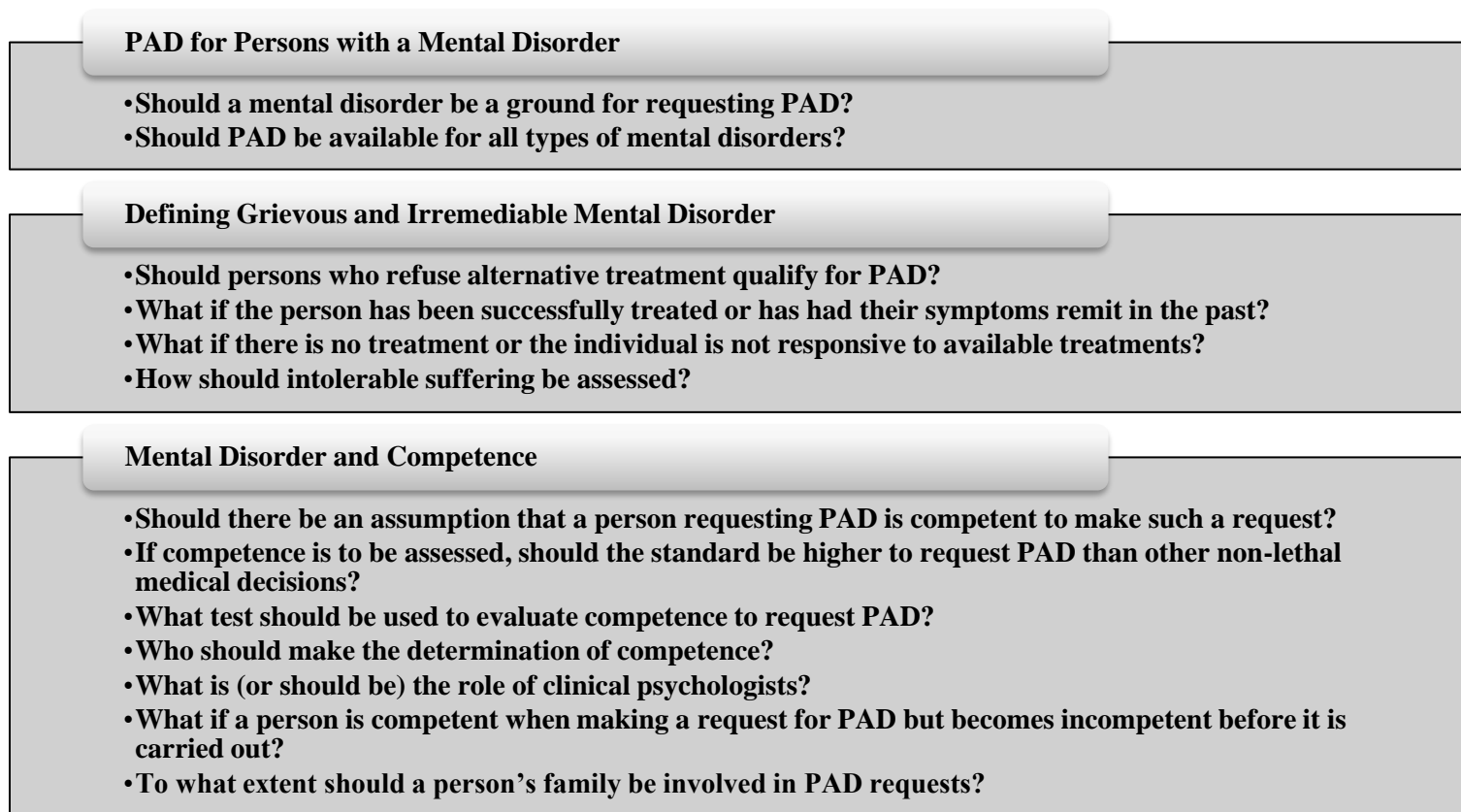


Figure 1. A Framework for Extending Access to Physician-Assisted Death (PAD) for Persons with a Mental Disorder: Legal, Ethical, and Clinical Considerations

Appendix A: International Cases of Physician-Assisted Death (PAD) on the Basis of a Mental Disorder

Anorexia Nervosa: In the Netherlands, a 48-year old woman with a 30-year history of Anorexia Nervosa and depression obtained PAD after both her husband and mother died (Cohen-Almagor, 2008).

Antisocial Personality Disorder: In Belgium, a 50-year old man serving a life prison sentence for sexual assault and murder, was found eligible for PAD on the basis that he “would never be able to overcome his violent impulses and that his life was not worth living due to unbearable psychological suffering in prison”. However, no doctors were willing to provide PAD (Scutti, 2014).

Bipolar Disorder: In Switzerland a 56-year old man with a 25-year history of Bipolar Disorder obtained PAD after deciding during a period in which his condition was stable that life was no longer worth living (Douez, 2011).

Gender Dysphoria: In Belgium, a 44-year old man with Gender Dysphoria received PAD after a sex-change operation was unsuccessful (Gordts, 2013).

Schizophrenia: In Switzerland, PAD was made available to a man with Schizophrenia who had been attempting to obtain PAD from other right-to-die organizations over the past 10 years (McKay, 2003).

Endnotes

ⁱ Not all jurisdictions require that the person offering assistance with death be a physician. However, as discussed below, physician-assisted death (PAD) is the most common model and so that is the label we use throughout the balance of this paper.

ⁱⁱ These discussions should not be relied on as current or absolute explication of law. For additional information, we refer readers to the legal materials cited in Tables 1 and 2.

ⁱⁱⁱ Throughout this paper we use the term *terminal* or *general medical condition* to refer to medical conditions that exclude mental disorder (e.g., Amyotrophic Lateral Sclerosis [ALS], Multiple Sclerosis, Cancer, Human Immunodeficiency Virus [HIV]; American Psychiatric Association, 2013). The DSM-5 defines a mental disorder as a “clinically significant disturbance” in “cognition, emotional regulation, or behavior” that indicates a “dysfunction” in mental functioning that is “usually associated with significant distress or disability” in major life domains (e.g., work, relationships, or other areas of functioning; American Psychiatric Association, 2013, pg. 20). Similarly, the ICD-10 defines a mental disorder as “a clinically recognizable set of symptoms or behaviours associated in most cases with distress and with interference with personal functions” (World Health Organization, 1992, pg. 11).

^{iv} Physician-assisted death is a model that includes both physician-assisted euthanasia and physician-assisted suicide. Physician-assisted euthanasia and physician-assisted suicide are often used interchangeably. However, in medical practice and under the law they are treated differently. *Physician-assisted euthanasia* involves the direct administration of life-ending drugs by a physician, whereas *physician-assisted suicide* involves the provision of life-ending medication by a physician that a person will self-administer (Materstvedt et al., 2003).

^v In their review of the criminal and penal codes of 192 countries and 50 U.S. states, Mishara and Weisstub (2015) found that 30 jurisdictions had no provisions in their criminal or penal codes regarding assisted death. In these jurisdictions assisted death can be practiced because there are no laws rendering the practice illegal. However, because there are no guidelines regulating the use of assisted death practices, it is not clear if assisted death is practiced by physicians in these jurisdictions.

^{vi} Throughout this paper we use the terms competence and decisional capacity interchangeably because the distinction between them is not consistently reflected in medical usage (Appelbaum, 2007). *Competence* is a legal term that is determined by the courts and refers to the ability of an individual to make autonomous decisions that are sufficiently valid (Leo, 1999). In contrast, *decisional capacity* refers to an assessment made by a medical or mental health professional of an individual’s abilities to understand, appreciate, and manipulate information, form rational decisions, and communicate choices that are consistent with the legal standard for the task in question (Appelbaum, 2010).

^{vii} The effect of this decision was suspended for 12 months to give the Canadian Parliament an opportunity to develop a legislative framework for PAD that is consistent with this

decision. If the Canadian Government remains silent on this issue, physicians will be left to decide if and how to respond to requests for PAD.

^{viii} Another implication worth mentioning specific to *Carter v. Canada* (2015) is that the Supreme Court of Canada did not restrict access of PAD in Canada to Canadians. Recall that the law prohibiting PAD was held to be invalid in certain circumstances because it is contrary to section 7 of the *Charter*. Section 7 of the *Charter* applies to “everyone;” it is possible, therefore, that anyone who is on Canadian soil could have access to PAD. This could lead persons with a non-terminal medical condition from other countries, including the U.S., to travel to Canada to die.

^{ix} Major Depressive Disorder is the most common mental disorder that is comorbid with suicidal ideation (Nock et al., 2008). For example, for an individual’s symptoms to meet criteria for a Major Depressive Episode in DSM-V five or more symptoms need to be present, one of which may be recurrent thoughts of death, or recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. However, an individual may still meet criteria for a Major Depressive Episode in the absence of suicidal ideation.

^x For instance, in a review of requests for PAD among 100 persons with a mental disorder in Belgium (some had more than one mental disorder), 50 had a personality disorder (e.g., Borderline Personality Disorder, Dependent Personality Disorder, Histrionic Personality Disorder, Avoidant Personality Disorder, Narcissistic Personality Disorder, Personality Disorder Not Otherwise Specified), 14 had Schizophrenia or another psychotic disorder, 13 had Post-Traumatic Stress Disorder, eleven had an anxiety disorder, ten had an eating disorder, ten had a substance use disorder, ten had Bipolar Disorder, nine had a Somatoform disorder, eight had a pervasive developmental disorder (Asperger’s Syndrome, Attention Deficit Hyperactivity Disorder), seven had Obsessive Compulsive Disorder, and seven had a dissociative disorder (Thienpont et al., 2015).

^{xi} Not all mental disorders are alike in their intensity, recurrence, and duration of symptoms (American Psychiatric Association, 2013; World Health Organization, 1992), making it difficult to establish a standard set of disorders that would meet criteria for PAD. Decisions may need to be made *ex post facto* (i.e., after the fact) regarding when persons with mental disorder meet the criteria for PAD.

^{xii} For instance, in some U.S. jurisdictions when an individual with a terminal medical condition requests PAD, the attending physician is required to present feasible alternatives (e.g., palliative care). However, physicians are not required to be knowledgeable about how to relieve emotional suffering, thus their ability to recommend effective treatment alternatives to persons with a mental disorder is limited (Dilworth, Higgins, Parker, Kelly, & Turner, 2014).

^{xiii} Although this paper has focused on the role of psychologists in relation to PAD for persons with a mental disorder, this is not to suggest that psychology is reducible to mental disorder nor that psychologists should only be interested in PAD when it involves persons with a mental disorder. Psychologists can and should become more active in other areas, such as

research, assessment, counselling, and advocacy related to end-of-life decisions and quality of care issues of persons with a terminal or general medical condition (see American Psychological Association Working Group on Assisted Suicide and End-of-Life Decisions, 2000).

^{xiv} This raises questions about physician-assisted suicide versus physician-assisted euthanasia. Recall that physician-assisted suicide involves providing a person with a means to commit suicide whereas physician-assisted euthanasia involves administering the life-ending substance to the individual. If a person's condition has deteriorated to a point that he or she cannot self-administer a substance, physician-assisted euthanasia is the only alternative to fulfill the person's wish to die.

^{xv} Jamison (2000) also provided guidance on factors medical professionals should consider in the context of PAD, many of which echo the guidelines by Werth, Benjamin, & Farrenkopf (2000). Kerkhof (2000) also provided guidelines for PAD within the context of assisted death in the Netherlands. Kerkhof's (2000) review focused on guidelines for PAD for persons with unbearable mental suffering.

^{xvi} The authors recommended that the report also included any other concerns arising from the assessment and treatment recommendations to restore judgment should it be determined that judgment is impaired.

^{xvii} For a response to these commentators by the authors' of the guidelines see Werth, Farrenkopf, and Benjamin (2000).