

ARTICLE

Assisted Dying for Psychiatric Illness: An Ethical Analysis of the Law

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The End of Life Choice Act 2019 (the Act) legalised assisted dying in New Zealand on 6 November 2021. Although the Act only allows access to assisted dying for terminally ill persons, it was originally intended to include a broader category of patients. An explicit prohibition on assisted dying solely on the basis of age, disability, or mental disorder was introduced after numerous public submissions expressing concerns about the risks posed to these vulnerable groups. As a result, New Zealand does not allow assisted dying solely for psychiatric illness. Two jurisdictions that have taken a different approach are the Netherlands and Canada. The Netherlands was the first country to legalise assisted dying and has never distinguished between physical and mental suffering. Similarly, Canada, until recently, had been set to legalise assisted dying for psychiatric illnesses on 17 March 2024 when its prohibition on the practice was scheduled to expire. Despite moves towards legalisation, assisted dying solely based on psychiatric illness remains a controversial topic. Those in favour argue that mental suffering can be just as bad as physical suffering, meaning there is no reason to discriminate against patients with psychiatric illnesses. Opponents argue that discrimination is justified because psychiatric illnesses impair judgement and can be difficult to predict and diagnose. This article contains an ethical and factual legal analysis of this issue. It addresses the following key issues: incurability, mental capacity, structural vulnerability, and suicide prevention. The article ultimately argues that the legal regimes in the Netherlands and Canada cannot be ethically justified because they fail to mitigate the key risks associated with assisted dying for patients with psychiatric illnesses. The article also considers what procedural safeguards would need to be introduced should New Zealand decide to change its law in the future.

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I Introduction

In 2019, reports from the Netherlands emerged that a 17-year-old girl named Noa Pothoven had been euthanised on account of her unbearable mental suffering.¹ Ms Pothoven had suffered from anorexia nervosa, depression, and post-traumatic stress disorder after being sexually assaulted at the age of 11 and then raped by two men at 14.² She announced her plans to end her life on social media and sought permission to be legally put to death.³ In reality, the headlines were mistaken. Ms Pothoven had not received medical assistance in dying. Instead, she committed suicide by deliberately dehydrating herself in the presence of others.⁴ Despite the initial confusion, the subsequent criticism aimed at the Dutch Criminal Code was not entirely misdirected.⁵ After all, euthanising a psychiatrically distressed teenager is legal in the Netherlands.

Ms Pothoven's case raises several challenging questions. When the law expands to include patients whose illnesses may impact their ability to think clearly, can we really say that we are giving effect to their right to choose? Or has the law at that point evolved into something more sinister? Where does one draw the line between suicide, which society tells us ought to be prevented, and euthanasia, which society tells us ought to be facilitated? The following article argues that medically assisted dying solely on the basis of psychiatric illness is contrary to the established principles of medical ethics and that New Zealand is justified in maintaining its legal safeguards against it. Part II describes the current law in New Zealand, Part III describes the law in the Netherlands and Canada, and Part IV describes the key underlying ethical principles of assisted dying. Part V analyses the key issues related to assisted dying for psychiatric illnesses, and Part VI draws a final conclusion as to whether, and if so, how New Zealand should amend its current legislation.

A Terminology

The following terminology will be used throughout this article:

- **Psychiatric illness:** a psychiatric illness is any illness that is contained in the Diagnostic and Statistical Manual for Mental Disorders (DSM-V). This article uses the term “psychiatric illness” synonymously with the terms “psychiatric condition”, “mental illness”, and “mental disorder”.
- **Assisted dying:** assisted dying includes any form of legal, medically assisted death, whether by active or passive means. Synonymous terms used throughout this article include euthanasia, euthanasia and assisted suicide (EAS), and medical assistance in dying (MAiD).

II The Law in New Zealand

The End of Life Choice Act 2019 (the Act) legalised assisted dying in New Zealand on 6 November 2021. Prior to its enactment, assisted dying could be prosecuted under

1 Scott Kim “How Dutch Law Got a Little Too Comfortable With Euthanasia” *The Atlantic* (online ed, Washington DC, 8 June 2019).

2 At 2.

3 At 2.

4 At 2.

5 Wetboek van Strafrecht (NL) (translation: Criminal Code).

ss 160, 167, 173 or 179 of the Crimes Act 1961.⁶ The courts were resistant to the idea of relaxing sentences in cases that involved assisted dying or so-called “mercy killing” and consistently held that the key consideration in such cases was the sanctity of human life.⁷ This approach was challenged in *Seales v Attorney-General*, where it was argued that the criminalisation of assisted dying was contrary to the right to life under s 8 of the New Zealand Bill of Rights Act 1990.⁸ Ms Seales argued that the prohibition of assisted dying violated one’s right to life because, without access to assisted dying, a person might end their life sooner than they otherwise would have had medical assistance been available.⁹ This argument was rejected by the High Court, which confirmed that assisted dying was prohibited under the Crimes Act and that only Parliament had the power to amend the law.¹⁰ The End of Life Choice Act now specifically protects health practitioners who provide assisted dying from criminal liability.¹¹

A person is only eligible for assisted dying under the Act if they meet all of the following criteria:¹²

- They must be a citizen or permanent resident of New Zealand.
- They must be aged 18 years or over.
- They must suffer from a terminal illness that is likely to end their life within six months.
- They must be in an advanced state of irreversible decline in physical capability.
- They must experience unbearable suffering that cannot be relieved in a manner that they consider tolerable.

In addition to these specific eligibility criteria, there is also the more general requirement that the person must be able to make an informed decision about assisted dying. An “informed decision” can only be made under the Act if the decision-maker is able to:¹³

- understand information about assisted dying;
- retain information about assisted dying in order to make the decision;
- use or weigh up information about assisted dying when making their decision; and
- communicate their decision in some way.

Patients must request assisted dying; health practitioners are strictly prohibited from initiating any conversation about assisted dying while they are providing healthcare services.¹⁴ Once a request has been made, the patient’s attending practitioner is obliged to provide them with specific information—namely, the prognosis of their terminal illness, the irreversible nature of assisted dying, and the anticipated impacts of assisted dying.¹⁵ The attending physician is also subject to obligations related to information disclosure and communication outlined in s 11(2) of the Act requiring them to:

6 Culpable homicide, murder, attempted murder, or aiding and abetting suicide (respectively).

7 *R v Davison* HC Dunedin CRI-2010-012-4876, 24 November 2011, at [32].

8 *Seales v Attorney-General* [2015] NZHC 1239, [2015] 3 NZLR 556 at [151]–[161].

9 At [165].

10 At [13].

11 End of Life Choice Act 2019, s 37.

12 Section 5.

13 Section 6.

14 Section 10.

15 Section 11(2)(a).

- (a) ...
- (b) personally communicate by any means (for example, by telephone or electronic communication) with the person about the person's wish at intervals determined by the progress of the person's terminal illness; and
- (c) ensure that the person understands their other options for end-of-life care; and
- (d) ensure that the person knows that they can decide at any time before the administration of the medication not to receive the medication; and
- (e) encourage the person to discuss their wish with others such as family, friends, and counsellors; and
- (f) ensure that the person knows that they are not obliged to discuss their wish with anyone; and
- (g) ensure that the person has had the opportunity to discuss their wish with those whom they choose; and
- (h) do their best to ensure that the person expresses their wish free from pressure from any other person by—
 - (i) conferring with other health practitioners who are in regular contact with the person; and
 - (ii) conferring with members of the person's family approved by the person; and
- (i) record the actions they have taken to comply with paragraphs (a) to (h) in the first part of the approved form that requests the option of receiving assisted dying.

Once s 11 has been complied with, the patient must complete and sign an approved form. After the form has been completed and sent to the Registrar, the attending practitioner must give their opinion as to whether the patient meets the specific eligibility criteria and whether they have sufficient mental capacity to consent to assisted dying.¹⁶ The attending practitioner must then contact an independent practitioner who will be required to examine the patient and give their opinion on the same issues.¹⁷ If either the attending practitioner or the independent practitioner has doubts about the patient's mental capacity, a third opinion must be obtained from a psychiatrist.¹⁸ If either the attending practitioner or the independent practitioner is of the opinion that the patient does not meet the specific eligibility criteria, or the psychiatrist is of the opinion that the person lacks sufficient mental capacity to consent to assisted dying, then the patient's request will be denied.¹⁹ If the patient meets the specific eligibility criteria and is capable of giving consent, they must choose a date and time for the procedure to occur. The person may choose one of the following methods of administration:²⁰

- (i) ingestion, triggered by the person:
- (ii) intravenous delivery, triggered by the person:
- (iii) ingestion through a tube, triggered by the attending medical practitioner or an attending nurse practitioner: [and]
- (iv) injection administered by the attending medical practitioner or an attending nurse practitioner ...

16 Section 13.

17 Section 14.

18 Section 15.

19 Section 16.

20 Section 19(2)(a)(i)–(iv).

In addition to the eligibility criteria, s 5 also stipulates that a person does not become eligible for assisted dying by reason only that they are suffering from a mental disorder or illness, have a disability of some kind, or are of advanced age.²¹ The words “by reason only” mean that a person’s mental illness, disability, or age cannot be the sole basis for their request for assisted dying. People who have a mental illness or disability or who are of advanced age may still access assisted dying, provided that they are eligible and so long as their mental illness, disability, or age is merely incidental to their request.

The specific exclusion of mental illness as a basis for assisted dying was prompted by public concerns raised during the legislative process. The Justice Committee received over 39,000 written submissions from individuals and organisations, the overwhelming majority of which opposed the End of Life Choice Bill.²² Many submitters argued for the exclusion of mental illnesses on the basis that they can be temporary and difficult to diagnose, that people suffering from mental illness may not have sufficient capacity to consent to assisted dying, and that assisted dying was not an appropriate response to mental suffering.²³ The Royal Australian and New Zealand College of Psychiatrists supported the exclusion of mental illnesses.²⁴ Members of Parliament echoed many of these concerns during the Bill’s first and second reading.²⁵ In response to these concerns, ACT MP David Seymour introduced Supplementary Order 259, which made an amendment to s 4 specifying the exclusion of mental illness, disability, and age.²⁶

III The Law in the Netherlands and Canada

A *The law in the Netherlands*

The law on assisted dying in the Netherlands has been shaped by a number of influential court decisions from the 1970s and 1980s.²⁷ The first influential case was the *Postma* decision, which concerned a doctor who gave a lethal dose of morphine to her disabled and elderly mother.²⁸ Dr Postma was convicted of assisting suicide but was only given a nominal sentence. The District Court took the view that it was not necessary for a doctor to prolong a patient’s life at all costs and that administering pain relief, which had the effect of hastening death, was a legitimate medical practice. The Court’s only criticism of Dr Postma was that she administered a dose of morphine, which was immediately lethal, as opposed to one which merely hastened death. The next important decision was the *Wertheim* case, in which the District Court articulated specific criteria for determining whether or not assisted suicide was legally justified.²⁹ These criteria included that the patient’s suffering be enduring and unbearable, that the patient’s request to die be made

21 Section 5(2).

22 End of Life Choice Bill 2017 (269-2) (select committee report) at 9–10.

23 At 23–24.

24 At 11.

25 (13 December 2017) 726 NZPD 1036; and (26 June 2019) 739 NZPD 12350.

26 Supplementary Order Paper 2019 (259) End of Life Choice Bill 2017 (269-3) (explanatory note) at 6.

27 Jocelyn Downie “The Contested Lessons of Euthanasia in the Netherlands” (2000) 8 Health LJ 119.

28 *Postma* [1973] 183 Nederlandse Jurisprudentie (Leeuwarden DC) as cited in Downie, above n 27, at 121. This case was decided on 21 February 1973.

29 *Wertheim* [1982] 63 Nederlandse Jurisprudentie (Rotterdam DC) as cited in Downie, above n 27, at 122. This case was decided on 17 November 1982.

voluntarily and with sufficient mental capacity, and that a medical professional be involved in the final decision. The *Wertheim* criteria were elaborated on in the *Schoonheim* decision—the first case on euthanasia to reach the Netherlands Supreme Court.³⁰ In *Schoonheim*, the Supreme Court ruled that art 40 of the Criminal Code included a defence of “medical necessity”, which would apply in cases of euthanasia where there was a conflict between the doctor’s duty to alleviate suffering and their duty not to assist suicide. The test in *Schoonheim* was later applied in *Admiraal*, which was the first case in which a Dutch physician was acquitted after euthanising a patient.³¹

The rulings of the Netherlands Supreme Court were codified in 2002 when the Dutch legislature passed the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001. This Act introduced a new defence to the Dutch Criminal Code, which allowed physicians to end the lives of their patients upon request, provided that the patient was suffering “unbearably and hopelessly”.³² Physicians providing assisted dying must also comply with the legislation’s “due care” criteria, which include:³³

- (a) [being] satisfied that the patient has made a voluntary and carefully considered request;
- (b) [being] satisfied that the patient’s suffering [is] unbearable, and that there was no prospect of improvement;
- (c) [informing] the patient about his situation and his prospects;
- (d) [concluding], together with the patient, that there is no reasonable alternative in the light of the patient’s situation;
- (e) [consulting] at least one other independent physician, who must [see] the patient and [give] a written opinion on the due criteria referred to in (a) to (d) above; and
- (f) [terminating] the patient’s life or [providing] assistance with suicide with due medical care and attention.

Physicians are under an obligation to make sure that all reasonable alternative treatments have been seriously tried, and patients are unlikely to receive an assisted death if they refuse alternative treatments.³⁴ Unlike New Zealand’s legislation, the Dutch Criminal Code does not draw any distinction between terminal and non-terminal conditions, nor mental and physical suffering.³⁵ The Netherlands have also allowed access to assisted dying for children under the age of 12, with parental consent, and for people suffering from dementia who have been issued an advance directive.³⁶

30 *Schoonheim* [1985] 106 Nederlandse Jurisprudentie (Netherlands SC) as cited in Downie, above n 27, at 123. This case was decided on 27 November 1984.

31 *Admiraal* [1985] 709 Nederlandse Jurisprudentie (The Hague DC) as cited in Downie, above n 27, at 125. This case was decided on June 1985.

32 Jurriaan De Haan “The New Dutch Law on Euthanasia” (2002) 10 Med L Rev 57 at 57–60.

33 Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001 (Netherlands), s 2.

34 Brian L Mishara and Ad JFM Kerkhof “Canadian and Dutch doctors’ roles in assistance in dying” (2018) 109 Can J Public Health 726 at 727.

35 De Haan, above n 32, at 62–63.

36 BBC “Netherlands backs euthanasia for terminally ill children under-12” (14 October 2020) BBC <www.bbc.com>.

B *The law in Canada*

The Canadian Supreme Court decision in *Carter v Canada* initiated the legalisation of assisted dying in Canada.³⁷ Before *Carter*, aiding or abetting suicide was prohibited under s 241(b) of the Canadian Criminal Code and consenting to one's own death was prohibited under s 14.³⁸ The plaintiff in *Carter* argued that these provisions were in contravention of s 7 of the Canadian Charter of Rights and Freedoms (the Charter) to the extent that they prohibited medically assisted dying and were, therefore, unconstitutional.³⁹ Section 7 of the Charter protects the person's right to life, liberty, and security. The argument made in *Carter* was the same fundamental argument that was made in *Seales*, but unlike New Zealand's High Court, the Canadian Supreme Court accepted that s 241(b) was unnecessarily broad and that the provision need not apply to medically assisted dying.⁴⁰ The Court reasoned that the purpose of s 241(b) was only to protect vulnerable people who may be tempted to take their own lives in a moment of weakness, not people who had made a careful and reasoned decision to end their life as a cure for unbearable suffering.⁴¹

In response to *Carter*, the Canadian Parliament passed Bill C-14, which established Canada's assisted dying regime. The Bill allowed access to assisted dying for competent persons over the age of 18 who were suffering from a "grievous and irremediable" medical condition.⁴² The Bill provided for several important procedural safeguards, including that two independent medical practitioners assess every request for assisted dying and that every request be made in writing and signed in the presence of two independent witnesses.⁴³ The Bill defined a "grievous and irremediable" medical condition as one that makes the patient's death "reasonably foreseeable".⁴⁴ This limitation was later struck down by the Superior Court of Quebec in *Truchon v Canada* on the basis that it unfairly discriminated against patients with non-terminal conditions.⁴⁵ In response to this judgment, the Canadian Parliament passed Bill C-7, which introduced a separate regime for people whose deaths are not reasonably foreseeable, as well as making alterations to the existing regime for people whose deaths are reasonably foreseeable (for example, reducing the number of independent witnesses required from two to one).⁴⁶ Under the new regime for those whose deaths are not reasonably foreseeable, practitioners are required to consult an independent practitioner with expertise in the patient's particular illness and perform a minimum 90-day assessment period. Practitioners must also ensure that the patient has been informed of alternative solutions to their suffering, such as counselling and mental health services, and ensure that the patient has given "serious consideration" to such alternatives.⁴⁷ Section 6 of Bill C-7 repeals section 241.2(2.1) of the Criminal Code, the section which effectively excludes people with mental illnesses from

37 *Carter v Canada (Attorney General)* 2015 SCC 5, [2015] 1 SCR 331.

38 Criminal Code RS C 1985 c C-46.

39 Canadian Charter of Rights and Freedoms, pt 1 of the Constitution Act 1982, being sch B to the Canada Act 1982 (UK).

40 *Carter*, above n 37, at [90].

41 At [78].

42 An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying) SC 2016 c 3, s 241.2(1).

43 Section 241.2(3).

44 Sections 241.2(2) and 241.2(3).

45 *Truchon v Procureur général du Canada* [2019] QCCS 3792.

46 An Act to amend the Criminal Code (medical assistance in dying) 2023 (Bill C-39), s 1(4).

47 An Act to amend the Criminal Code (medical assistance in dying) SC 2021 c 2, s 3.

becoming eligible for assisted dying. Section 6 was originally scheduled to come into force on 17 March 2023, but on 9 March 2023, the Canadian Parliament passed Bill C-39, which delayed this event by an additional year.⁴⁸ At the time of writing, the Minister of Health has introduced legislation which would further delay implementation until 2027.⁴⁹

IV Underlying Ethical Principles

A *Autonomy*

German philosopher Immanuel Kant defined autonomy as “the property of the will by which it is a law to itself”.⁵⁰ In Kant’s view, the autonomous human will was central to morality and something that was worthy of great respect. He argued that because each individual possesses an autonomous will, human beings should never treat one another as simply a means to an end but always as an end in and of themselves.⁵¹ This idea has played an influential role in medical ethics. The requirement that all doctors first obtain their patients’ consent before performing any kind of treatment is a recognition of the patient as an autonomous being who has the right to choose what happens to their body.

There are three main exceptions to the general principle of bodily autonomy. The first is that people cannot use their autonomy in a way that causes harm to other people;⁵² the second is that people should not be allowed to exercise their autonomy where it is obvious that they lack sufficient mental capacity;⁵³ and the third is that people should not use their autonomy to inflict harm upon themselves.⁵⁴ An example of the third exception is if a patient asked their doctor to amputate their leg for no apparent reason. The patient may have sufficient mental capacity to make the decision, and they may not be harming any other person, but many doctors would nonetheless be justified in refusing to comply with their request. The second and third exceptions are most relevant to the legalisation of assisted dying for patients with psychiatric illnesses. The second exception is relevant because psychiatric illnesses can impair the ability to make rational decisions. The third exception is relevant because psychiatric illnesses are not fatal, so many doctors may have reservations about killing a physically healthy patient, even if the patient has sufficient mental capacity to consent to the procedure. These limitations on individual autonomy are normally justified in terms of paternalism or beneficence and nonmaleficence.

B *Paternalism*

The medical profession used to adhere to a strong paternalistic model. This model was predicated on the idea that a doctor’s superior knowledge and skill allowed them to make

48 An Act to amend the Criminal Code (medical assistance in dying) 2020 (Bill C-7), s 6; and Bill C-39, above n 46, at s 1.

49 Ismail Shakil “Canada to delay assisted death solely on mental illness until 2027” (2 February 2024) Reuters <www.reuters.com>.

50 Paul Guyer “Kant on the Theory and Practice of Autonomy” (2003) 20 Soc Phil & Poly 70 at 70.

51 Robert Johnson and Adam Cureton “Kant’s Moral Philosophy” (2022) The Stanford Encyclopedia of Philosophy <<https://plato.stanford.edu>> at 9–10.

52 John Stuart Mill *On Liberty* (Batchoche Books, Ontario, 2001) at 16.

53 Protection of Personal and Property Rights Act 1988.

54 See *R v Brown* [1993] UKHL 19, [1993] 2 WLR 556; and Annemarie Bridy “Confounding Extremities: Surgery at the Medico-ethical Limits of Self-Modification” (2004) 32 J Law Med Ethics 148.

unilateral decisions about their patient's treatment.⁵⁵ This model faced criticism in the second half of the 20th century as society developed a stronger idea of patient rights.⁵⁶ Opponents of the strong paternalistic model pointed to cases in which doctors had withheld important clinical information, such as cancer diagnoses, as evidence that strong paternalism inevitably leads to patient oppression.⁵⁷ In New Zealand, major reform was triggered by the Cartwright Report, which was published in 1988 in response to a medical trial that had taken place at the National Women's Hospital without patients' knowledge or consent.⁵⁸ The Cartwright Report highlighted abuses which led to the enactment of the Code of Health and Disability Services Consumers' Rights (the Code) in 1996—the world's first legislated code of patient rights. The Code ushered in a new, patient-centred approach to medical decision-making, largely replacing the old paternalistic model. Now, paternalism only exists in a much weaker form, mainly in relation to mentally incompetent people. Examples of paternalistic statutes include the Protection of Personal and Property Rights Act 1988 and the Mental Health (Compulsory Assessment and Treatment) Act 1992, although these Acts do try to acknowledge patient autonomy wherever possible. In relation to assisted dying, the term "paternalism" has largely fallen out of favour, and instead, the debate is often conducted in terms of beneficence and nonmaleficence.

C *Beneficence and nonmaleficence*

Beneficence and nonmaleficence describe two complementary ideas. Beneficence describes a doctor's positive duty to act in the best interests of their patients, whilst nonmaleficence describes a negative duty not to inflict harm.⁵⁹ Both concepts stem from the Hippocratic Oath, which states: I will use those dietary regimens which will benefit my patients according to my greatest ability and judgement, and I will do no harm or injustice to them.⁶⁰

Both concepts can be used to support or oppose assisted dying, depending on how one interprets their meaning. For example, supporters of assisted dying argue that beneficence calls for the alleviation of unbearable and incurable suffering, even if that involves actively ending a patient's life. At the same time, those who oppose assisted dying argue that it is more beneficent to preserve a patient's life and thereby protect them from the risk of premature death, even if there is no other way to end their suffering.⁶¹ The same applies to nonmaleficence. Those who support assisted dying argue that prolonging a patient's life and, therefore, prolonging their suffering is an act of maleficence, so the nonmaleficent thing to do is to end their suffering by withdrawing treatment or actively putting them to death.

55 JJ Chin "Doctor-patient Relationship: from Medical Paternalism to Enhanced Autonomy" (2002) 43 Singapore Med J 152 at 152.

56 At 152.

57 Allen Buchanan "Medical Paternalism" (1978) 7 Philosophy & Public Affairs 370 at 373.

58 Marie Bismark and Jennifer Morris "The Legacy of the Cartwright Report: 'Lest It Happen Again'" (2014) 11 J Bioeth Inc 425.

59 Bernadette Spina "Ethical Justifications for Voluntary Active Euthanasia" (1998) 3 Persp on L & Pub Int 71 at 73.

60 Michael North (trans) "The Hippocratic Oath" National Library of Medicine <www.nlm.nih.gov>.

61 Spina, above n 59, at 73.

On the other hand, opponents of assisted dying argue that nonmaleficence prohibits a doctor from killing their patients under any circumstances.⁶² The way in which one chooses to interpret these concepts will depend on whether one places more value on the duty to alleviate suffering or the duty to preserve human life. The fundamental difference between the two sides of the debate is that supporters of assisted dying would rather err on the side of alleviating suffering, even if this creates a risk of unnecessary death. Conversely, opponents of assisted dying would rather err on the side of preserving human life, even if this results in prolonged suffering.

Public opinion on this issue has shifted dramatically over time. For example, the Hippocratic Oath specifically prohibits the administration of lethal drugs on request, which shows that in 2000 BCE, medical practitioners valued the preservation of life over the alleviation of suffering.⁶³ This remained the prevailing view throughout the Western world until the late 20th century. Now, the public's current view on morality seems to have shifted. A recent survey showed that 87 per cent of Dutch people now support assisted dying, and only eight per cent of the population opposes it in all circumstances.⁶⁴ The same survey also showed that 55 per cent of Dutch people support assisted dying even for people who are not ill but simply "tired of life".⁶⁵ These results show that, at least in the Netherlands, a doctor's duty to alleviate suffering is now valued more highly than a doctor's duty to preserve life.

V Key Issues

In May 2022, Canada's Expert Panel on MAiD and Mental Illness (the Expert Panel) released its final report on assisted dying for people with "mental illness" in accordance with Bill C-7.⁶⁶ The Expert Panel identified that the main issues relating to assisted dying for people with mental illnesses were incurability and irreversibility, mental capacity, structural vulnerability, and suicide prevention.⁶⁷ The following section will address each of these issues, analyse the relevant ethical arguments, and consider how legal safeguards may address each issue.

A *Incurability and irreversibility*

It is a requirement in New Zealand, the Netherlands, and Canada that individuals must be suffering from an incurable and irreversible medical condition to be eligible for assisted dying. New Zealand's End of Life Choice Act uses the terms "irreversible decline in physical capability" and "suffering that cannot be relieved in a manner that the person considers tolerable".⁶⁸ In comparison, the Dutch due care criteria require that the patient's suffering be "unbearable" with "no prospect of improvement",⁶⁹ and Canada's Bill C-14 requires

62 At 72.

63 North, above n 60.

64 "Vast majority do not fundamentally reject euthanasia" (19 November 2019) Statistics Netherlands (CBS) <www.cbs.nl>.

65 Peter Cluskey "Right to euthanasia for people 'tired of life' supported by most Dutch" *The Irish Times* (online ed, Dublin, 19 November 2019).

66 Health Canada *Final Report of the Expert Panel on MAiD and Mental Illness* (13 May 2022) at 5.

67 At 9–11.

68 End of Life Choice Act, s 5.

69 Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001 (NL), s 2.

patients to be suffering from a “grievous and irremediable medical condition”.⁷⁰ The ethical implication of these provisions is that assisted dying is only ever justifiable as a last resort. Although the ethical basis of the irremediability requirement is not seriously disputed, the requirement does give rise to two key practical issues when applied to psychiatric illnesses.

The first issue is that it can be difficult, if not impossible, for psychiatrists to predict whether psychiatric illnesses will improve or deteriorate over time. This is because psychiatric illnesses do not always have clearly defined causes, they are not normally associated with any reliable biological indicators, diagnostic reliability is relatively low, and patient responses to treatment can be unpredictable.⁷¹ In Canada, this issue was raised by both the Expert Panel and the Special Joint Committee on Medical Assistance in Dying (Special Joint Committee). The Special Joint Committee heard from several expert witnesses who expressed opposing views on the nature of mental illnesses. On one end of the spectrum, Dr Tyler Black stated that “there are many psychiatric disorders that are not curable with present science”.⁷² However, on the other end of the spectrum, Dr Mark Sinyor was far more doubtful about psychiatrists’ predictive capabilities:⁷³

In medicine, we deal in probabilities. Doctors help patients make decisions in cancer treatment, for example, by sharing that chemotherapy might result in survival 90% of the time or only 10% of the time. In neither case do we know the outcome for certain, but those numbers are crucial in helping patients make informed decisions. In physician-assisted death for sole mental illness, we have no numbers at all. Neither we nor our patients would have any idea how often our judgments of irremediability are simply wrong. This is completely different from MAID applied for end-of-life situations or for progressive and incurable neurological illnesses, where clinical prediction of irremediability is based in evidence.

New Zealand, the Netherlands, and Canada have attempted to deal with this issue differently. The current position in New Zealand is that assisted dying solely on the basis of psychiatric illness should be completely prohibited because irremediability cannot be established with sufficient certainty. New Zealand’s legislation represents the strongest commitment to the preservation of human life. However, critics would argue that it fails to give enough respect to individual autonomy and that the risks associated with diagnostic uncertainty can be mitigated without imposing a complete prohibition. Diagnostic uncertainty is a problem with all medical conditions, not just psychiatric disorders, so assisted dying will always carry some risk of premature death.

In contrast to New Zealand, Canada and the Netherlands have attempted to mitigate the risk of premature death without imposing a complete prohibition on assisted dying for psychiatric patients. In the Netherlands, practitioners have developed a practice of assessing the incurability of psychiatric illnesses according to the patient’s treatment history. This process primarily involves analysing how many different kinds of treatment the patient has tried, how they have responded to past treatments, and how long they

70 An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying) SC 2016 c 3, s 241.2(1).

71 SMP van Veen and others “Physician Assisted Death for Psychiatric Suffering: Experiences in the Netherlands” (2022) 13 *Front Psychiatry* at 4.

72 House of Commons Canada *Special Joint Committee on Medical Assistance in Dying: Evidence Number 009* (44th Canadian Parliament, 1st session, 26 May 2022) at 16.

73 At 11.

have been in treatment.⁷⁴ Despite being the primary method used for assessing incurability, many psychiatrists in the Netherlands have expressed concerns about the validity of using retrospective signals to make predictions about the future course of an illness.

For example, in a qualitative interview study conducted in 2022, Dutch psychiatrists raised several issues in relation to assessing past treatments.⁷⁵ One of the major issues (also raised by Dr Mark Sinyor before the Canadian Special Joint Committee) was that there is an almost endless number of treatment combinations for psychiatric illnesses, so long-term irremediability can be difficult to determine. Another major issue raised was the possibility of unmotivated patients who might try a number of different treatments simply to “check the box” for becoming eligible for an assisted death.⁷⁶ Although Canada has not yet legalised assisted dying solely on the basis of psychiatric illness, the Expert Panel on MAiD and Mental Illness has recommended that incurability be assessed according to treatment history. Hence, practitioners in Canada are likely to face similar problems when this recommendation is implemented.

The second issue when applying the irremediability criterion to psychiatric illnesses is that the terms “irremediable” and “incurable” are legal terms that do not have settled scientific definitions. This means that a psychiatrist’s opinion on whether a mental illness is irremediable or incurable will depend on how they define those terms. Canada’s Special Joint Committee also raised this issue. The main disagreement between the expert witnesses was whether the terms “irremediable” and “incurable” had a strictly clinical definition or included situations in which a patient either refused an available treatment or was unwilling to wait for an available treatment. For example, Dr Ellen Wiebe was of the opinion that an illness could be considered irremediable if the patient was unwilling to join a five-year waiting list for treatment.⁷⁷ Dr John Maher, on the other hand, stated that the definition of “irremediable” should remain strictly clinical so as to prevent patients from giving up when treatment is difficult to access:⁷⁸

What this law is offering people is an opportunity to stop because the healing is hard and long, but recovery is always possible. I’ve surveyed my colleagues on this. We’ve talked about this. We have yet to find a case where treatment and recovery were not possible. The challenge is that 70% of all people with mental illness in Canada stop taking their medication, or they don’t want to continue treatment because of suffering. What you are saying is to give up before the remedy is provided, give up before the healing is possible, and it’s done under this guise that we have to relieve their immediate and horrible suffering ...

Dr Maher also pointed out that unlike many somatic illnesses, such as cancer, psychiatric disorders have hundreds of potential treatment options because psychiatrists are able to combine different medications. Dr Maher said that the longer a patient is sick with a psychiatric disorder, the easier it is to treat them because the list of potential treatments can be narrowed down over time.⁷⁹

74 van Veen and others, above n 71, at 5.

75 Sisco MP van Veen and others “Establishing irremediable psychiatric suffering in the context of medical assistance in dying in the Netherlands: a qualitative study” (2022) 194 CMAJ 485.

76 At 489.

77 House of Commons Canada, above n 72, at 8.

78 At 4.

79 At 4.

The Netherlands and Canada employ different procedural safeguards to deal with this issue. In both jurisdictions, it is accepted that patients cannot be forced to undergo alternative treatments against their will.⁸⁰ This means that neither jurisdiction adheres to a strictly clinical definition of “incurable”. However, in the Netherlands, practitioners are under a legal duty to come to a joint conclusion with their patients that assisted dying is the only viable treatment option. This means that where a patient refuses to undergo an alternative treatment, but the doctor still thinks the alternative treatment is preferable to assisted dying, the doctor may refuse to perform assisted dying. No equivalent duty exists in Canada, where practitioners only need to ensure that alternative treatments have been seriously considered. In Canada, a doctor cannot deny an application for assisted dying if the patient is adamant that no other treatment will work. In this sense, the Netherlands places more decision-making power in doctors’ hands than Canada, which takes a more patient-directed approach. When asked whether this respect for patient autonomy should outweigh the risks of premature death, Dr Mona Gupta, Chair of Canada’s Expert Panel, said:⁸¹

I think you’re asking about the very heart of MAID. I think the question is, who should decide whether that’s an acceptable risk? In allowing MAID in our country, we’ve said that is a choice for that individual to make that request.

Dr Gupta’s response highlights the main difference between Canada and the Netherlands. In Canada, the doctor is required to inform the patient of reasonable alternatives to assisted dying. If the patient refuses those alternatives, the doctor has little choice but to approve their request. By contrast, patients in the Netherlands are required to try alternative treatments. Although this does not mean that patients are forced to undergo treatment against their will, it does mean that patients who continually refuse alternative treatments are unlikely to access assisted dying. The obligation to try alternative treatments in the Netherlands is designed to ensure that those requesting assisted dying have made a rational and well-considered decision. This criterion is one of the main reasons why requesters of assisted dying in the Netherlands fail to meet the due care criteria. The fact that most people whose requests are denied on these grounds do not repeat their request for assisted dying after trying the recommended alternative treatment suggests that this may be an important and necessary safeguard.⁸²

B *Mental capacity*

(1) How mental capacity is assessed

Another major issue associated with assisted dying for patients with psychiatric illnesses is the assessment of mental capacity. New Zealand, the Netherlands, and Canada all have strict mental capacity requirements on the basis that without mental capacity, there can be no true autonomy. However, assessing mental capacity in patients with psychiatric illnesses poses a unique challenge to judges and medical practitioners. Historically, mental capacity was assessed broadly according to whether the patient had a “sound mind”.⁸³

80 Mishara and Kerkhof, above n 34, at 728.

81 House of Commons Canada, above n 72, at 30.

82 Mishara and Kerkhof, above n 34, at 728.

83 Scott YH Kim *Evaluation of Capacity to Consent to Treatment and Research* (Oxford University Press, New York, 2010) at 11.

Under this interpretation of capacity, patients were either competent or incompetent to make decisions for themselves, and the existence of a diagnosable psychiatric condition or intellectual disability created a strong presumption in favour of incompetence. This understanding of mental capacity stemmed from the paternalistic model of medicine. Under the paternalistic model, doctors' opinions were paramount, so patients were not required or expected to be able to make medical decisions for themselves.⁸⁴

In more recent years, the test for mental capacity has shifted towards a more functional definition due to the increasingly significant role of autonomy in medical law and ethics. The functional definition of capacity focuses on an individual's ability to perform certain tasks related to decision-making. This definition recognises that mental capacity can be both time and decision-specific, meaning that anyone can lack mental capacity temporarily and that even those with permanent mental impairments may still be capable of making some decisions—even if they are incapable of making others.⁸⁵ While the specific decision-making skills assessed under a functional definition of capacity vary between jurisdictions, the criteria listed in s 6 of New Zealand's End of Life Choice Act represent the general approach taken in most common law jurisdictions. The fundamental skills required for functional capacity are the ability to understand and retain information relevant to the decision, the ability to weigh information when making the decision and the ability to communicate the decision in some way. When a judge is assessing these skills, psychiatric evidence will often be highly persuasive, although not entirely determinative.⁸⁶

At the clinical level, functional capacity is normally assessed through an interview between the patient and their psychiatrist. Many jurisdictions, including Canada, use a standardised test called the MacArthur Competence Assessment Tool-Treatment (MacCAT-T).⁸⁷ During this test, the psychiatrist informs the patient of the nature of their disorder and then explains the recommended treatment, its risks and benefits, and the availability of alternative treatments.⁸⁸ The patient is then asked to express their preferred treatment option and explain their choice. The psychiatrist assesses the patient's fundamental decision-making skills throughout the interview process. For example, the patient's ability to understand the relevant information is assessed by asking the patient to paraphrase the information they have been given about their disorder. Reasoning is assessed by analysing whether the patient can draw logical conclusions based on the risks, benefits and consequences of receiving or not receiving treatment.

(2) Potential problems related to psychiatric patients

The critical question in relation to any patient with a psychiatric illness is whether their illness renders them incapable of consenting to assisted dying. The answer to this question is more complicated than a simple yes or no. Proponents of assisted dying for psychiatric patients argue that not all psychiatric conditions render one incapable of making important treatment decisions, so it would be unfair to deem all psychiatric patients

84 At 11.

85 Alex Ruck Keene and others, "Taking capacity seriously? Ten years of mental capacity disputes before England's Court of Protection" (2019) 62 *Intl J L & Psychiatry* 56 at 56–57.

86 *An NHS Trust v CS* [2016] EWCOP 10 at [8].

87 Health Canada, above n 66, at 32.

88 Thomas Grisso, Paul S Appelbaum, and Carolyn Hill-Fotouhi "The MacCAT-T: A Clinical Tool to Assess Patients' Capacities to Make Treatment Decisions" (1997) 48 *Psychiatr Serv* 1415 at 1415.

incapable of giving consent.⁸⁹ The problem with this view is that it relies on psychiatrists being able to distinguish between capable and incapable psychiatric patients with a high degree of certainty. If the methods for establishing capacity are unreliable, then we cannot say that we are truly giving respect to individual autonomy. Although many would argue that accurately assessing mental capacity in psychiatric patients is achievable, in practice, clinicians are faced with several problems.

The main problem is that capacity is not an entirely objective measurement. This is a problem which affects all psychiatric assessments because, unlike other fields of medicine, psychiatry is primarily concerned with ailments of the mind, and such ailments do not always leave a physical trace on the human body. As such, all psychiatric assessments involve some level of subjectivity. The United Nations Committee on the Rights of Persons with Disabilities made this criticism in a 2014 report:⁹⁰

Mental capacity is not, as commonly presented, an objective, scientific and naturally occurring phenomenon. Mental capacity is contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity.

This is especially true regarding mental capacity assessments, as their legal ramifications can heavily influence such assessments. For example, there is strong evidence to suggest that the opinions of forensic psychiatrists are influenced by whether they are working for the defence or the prosecution in a criminal trial, a phenomenon known as the “allegiance effect”.⁹¹ There is good reason to believe that similar considerations have an influence on psychiatric assessments for the purposes of assisted dying, as the results of the assessment have life-or-death consequences. The Dutch Psychiatric Association, for instance, explicitly maintains that not all the usual criteria for mental capacity need to be met when “the patient is clearly suffering so unbearably”.⁹² This indicates that the threshold used for assessing mental capacity in patients seeking assisted dying may change depending on how much the practitioner perceives the patient to be suffering. The decision of where to set the threshold for capacity is itself a subjective choice and is undoubtedly influenced by moral considerations. Doctors and lawyers often say that the graver the consequences of the decision, the more capacity the patient will need to make it.⁹³ However, critics have argued that this is simply a way of making it harder for patients to make decisions that doctors and the courts disagree with.⁹⁴ The main risk in this regard is that psychiatrists and judges may be influenced by their own ideas about what is right for the patient instead of thinking objectively about whether they are capable of making an autonomous decision.

89 William Rooney, Udo Schuklenk, and Suzanne van de Vathorst “Are Concerns About Irremediableness, Vulnerability, or Competence Sufficient to Justify Excluding All Psychiatric Patients from Medical Aid in Dying?” (2018) 26 *Health Care Anal* 326 at 336.

90 *General Comment No. 1 - Article 12: Equal recognition before the law* CRPD/C/GC/1 (19 May 2014) at 4.

91 Tessa MS Neal “Are Forensic Experts Already Biased before Adversarial Legal Parties Hire Them?” (2016) *PLoS One* at 2.

92 Samuel N Doernberg, John R Peteet, and Scott YH Kim “Capacity Evaluations of Psychiatric Patients Requesting Assisted Death in the Netherlands” (2016) 57 *Psychosomatics* 556 at 563.

93 Alec Buchanan “Mental capacity, legal competence and consent to treatment” (2004) 97 *J R Soc Med* 415 at 416.

94 At 416.

(3) How do Canada and the Netherlands mitigate this risk?

Canada and the Netherlands have taken the position that, despite the difficulties in assessing mental capacity, patients with psychiatric illnesses should be allowed access to assisted dying, provided that they meet all of the relevant criteria. The rationale behind this policy is that procedural safeguards can safely mitigate the risk of euthanising incompetent patients. The benefits of alleviating patient suffering presumably outweigh any residual risk. The critical question is: what procedural safeguards have been employed in these jurisdictions, and are they actually effective at minimising risk?

In the Netherlands, assisted dying legislation has never distinguished mental and physical suffering, so the same procedural safeguards are applied to both types of requests. This means that the same test for mental capacity is applied to all patients regardless of whether they suffer from a psychiatric illness or not. While practitioners are legally required to consult an independent practitioner about whether the requesting patient meets the eligibility criteria, the advice of the independent practitioner is non-binding. Further, there is no legal requirement for the independent practitioner to have expertise in the disorder that is causing the patient's suffering.⁹⁵ Nonetheless, both the Dutch Regional Euthanasia Review Committees and the Netherlands Psychiatric Association recommend that an independent psychiatrist be consulted in cases involving assisted dying solely on the basis of mental suffering.⁹⁶ Some researchers have expressed concern about the rigour of capacity assessments in the Netherlands; many reports only contain a short statement about the patient's mental capacity and lack a full description of how it was assessed.⁹⁷

Although Canada's assisted dying legislation for psychiatric patients has not yet come into force, Bill C-7 has already created a new set of procedural safeguards aimed at dealing with this type of request. The new Bill separates patients into two categories: those whose deaths are reasonably foreseeable and those whose deaths are not reasonably foreseeable. Additional safeguards apply to those whose deaths are not reasonably foreseeable, which includes psychiatric patients. The additional safeguards include a 90-day minimum assessment period, consultation with a practitioner with expertise in the person's condition, and providing information on available means to alleviate suffering.⁹⁸ Citing Thomas Grisso and Paul S Applebaum, Canada's Expert Panel recommends that practitioners conduct multiple capacity assessments to account for mental state fluctuations.⁹⁹ The Panel recommends using the MacCAT-T to assess psychiatric patients but recognises that this tool does not take into account factors such as emotional state or values.¹⁰⁰

95 Health Canada, above n 66, at 107.

96 At 107.

97 van Veen, above n 71, at 5.

98 An Act to amend the Criminal Code (medical assistance in dying) SC 2021 c 2, s 1(7).

99 Health Canada, above n 66, at 59 citing Thomas Grisso and Paul S Applebaum *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals* (Oxford University Press, New York, 1998) at 92.

100 Health Canada, above n 66, at 32.

C *Structural vulnerability*

In the context of healthcare, structural vulnerability refers to the impact of social, political and cultural forces on health outcomes for different social groups. As Canada's Expert Panel defines it:¹⁰¹

Structural vulnerability refers to the impacts of the interaction of demographic attributes (sex, gender, socioeconomic status, race/ethnicity, sexuality, institutional location) with assumed or attributed statuses related to one's position in social, cultural, and political hierarchies (including normality, credibility, and whether one deserves to receive care).

A clear example of structural vulnerability is the health disparity seen in many developed nations, such as New Zealand, Canada and Australia, between Indigenous and non-Indigenous populations. Indigenous populations experience worse health outcomes than non-Indigenous populations—not for biological reasons—but due to so-called “social determinants of health”, such as level of education, employment and income.¹⁰² These external social factors can directly and indirectly impact health outcomes and are often difficult for healthcare providers to address adequately.

Structural vulnerability is a major concern concerning assisted dying because it threatens to undermine the law's primary ethical justification—patient autonomy. The risk is that patients who belong to vulnerable social groups may be pressured into requesting assisted dying due to unfavourable social circumstances. These might include inadequate housing, unemployment, loneliness, or the inability to access alternative treatments. Structural vulnerability is related to the issue of mental capacity because it engages the principle of autonomy, but where mental capacity is concerned with the internal workings of the patient's mind, structural vulnerability is concerned with the influence of external social forces. For example, a patient may be mentally capable of making an informed decision about assisted dying, but they may nonetheless be unduly influenced by external factors that are not easily detected by the statutory criteria.

This issue is of particular concern to patients suffering from psychiatric illnesses because such patients are often among the most vulnerable members of society. Research shows that people with psychiatric illnesses are more likely to face discrimination as a result of their condition. This can have an impact on employment and housing opportunities, which in turn can have an impact on aggressive behaviour and criminality.¹⁰³ In addition, people with psychiatric illnesses are less likely to have a developed social network and are, therefore, less likely to receive social support when needed.¹⁰⁴ This kind of social vulnerability can be a direct cause of suffering, which may then lead people to request assisted dying instead of addressing the underlying social issues, which can be difficult to resolve.¹⁰⁵ Social vulnerability can also cause harm indirectly by making it more difficult for people to access the appropriate standard of care.

101 At 25.

102 Francis Mitrou and others “Gaps in Indigenous disadvantage not closing: a census cohort study of social determinants of health in Australia, Canada, and New Zealand from 1981–2006” (2014) 14 *BMC Public Health* at 2.

103 Fred E Markowitz “Mental illness, crime, and violence: Risk, context, and social control” (2011) 16 *Aggress Violent Behav* 36 at 39.

104 Jitske F Koenders and others, “Social inclusion and relationship satisfaction of patients with a severe mental illness” (2017) 63 *Int J Soc Psychiatry* 773, at 776–778.

105 Health Canada, above n 66, at 46.

For example, healthcare services may assume incorrectly that patients have access to transport and childcare arrangements in order to attend appointments. The treatment offered might focus entirely on medical interventions as opposed to other social services, and treatments might not be affordable or they might involve unreasonably long wait times.¹⁰⁶ Furthermore, people with mental illnesses may have negative past experiences with healthcare services that might deter them from seeking further treatment.

New Zealand's End of Life Choice Act already contains a safeguard to protect against structural vulnerability as an issue that affects all cases of assisted dying, not just cases involving psychiatric illness. Section 11(2)(h) requires physicians to:

- (h) do their best to ensure that the person expresses their wish free from pressure from any other person by—
 - (i) conferring with other health practitioners who are in regular contact with the person; and
 - (ii) conferring with members of the person's family approved by the person; ...

Section 11 is also supported by s 24, which provides that no further action is to be taken if, at any point in the process, the attending practitioner suspects on reasonable grounds that another person is pressuring the patient. Canada's Bill C-14 contains a similar protection. Section 241.2(1)(d) states that a person requesting assisted dying must "have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure". The same can be seen in the Netherlands, where the due care criteria require patients' requests to be "voluntary and carefully considered".¹⁰⁷ The word "voluntary" has been interpreted as meaning "free from external pressure".¹⁰⁸ Despite having the right intention, all of these provisions have faced serious criticism from lawyers and healthcare workers, who argue that they do not provide adequate protection in practice.

In New Zealand, such criticism came from Lawyers for Vulnerable New Zealanders (LVNZ), a group containing several high-profile lawyers and academics. Before enacting the End of Life Choice Act, LVNZ released an open statement arguing that the legislation was not fit for purpose and outlined several important criticisms.¹⁰⁹ First, LVNZ argued that s 11 sets a "hopelessly inadequate" standard of compliance because it only requires one doctor to perform two specific steps, neither of which requires any kind of actual assessment. Citing *R (Conway) v Secretary of State for Justice*,¹¹⁰ LVNZ argued that not even a lengthy court process could accurately detect external pressure, let alone a single medical practitioner.¹¹¹ Secondly, LVNZ pointed out that under s 11, practitioners would only be allowed to talk to family members that their patients allowed them to speak to, meaning abusive relatives could easily evade the provision.¹¹² Thirdly, the Act does not require any prior relationship between the practitioner and the patient, meaning that practitioners might be asked to detect external pressure in patients they know very little

106 At 46.

107 Termination on Request and Assisted Suicide (Review Procedures) Act 2002 (NL), s 2(1)(a).

108 Antina de Jong and Gert van Dijk "Euthanasia in the Netherlands: balancing autonomy and compassion" (2017) WJM 10 at 13.

109 Lawyers for Vulnerable New Zealanders "35 Fatal Flaws in the End of Life Choice Act" (14 April 2019) Lawyers for Vulnerable New Zealanders <www.lvnz.org>.

110 *R (Conway) v Secretary of State for Justice* [2017] EWHC 2447, [2018] 2 All ER 250 at [100]–[104].

111 Lawyers for Vulnerable New Zealanders, above n 109, at 2.

112 At 2.

about.¹¹³ LVNZ argued that this issue could be exacerbated by the fact that 52–58 per cent of GPs and 80 per cent of palliative care workers in New Zealand oppose assisted dying and are unlikely to participate in the process.¹¹⁴ Fourthly, s 11 only protects against coercion from another “person” and does not protect against other forms of social pressure, such as the inability to access palliative care or PHARMAC-funded medications.¹¹⁵ Finally, LVNZ criticised the fact that the Act does not require two independent witnesses to be present when the patient gives their request in writing, nor when the lethal injection is administered.¹¹⁶

In Canada, the Expert Panel recognised the increased risk for people in vulnerable social groups, particularly those with psychiatric illnesses, but nonetheless reached the following opinion:¹¹⁷

While structural vulnerability may contribute to a person’s experience of a chronic medical condition, the Panel does not believe persons in situations of structural vulnerability should be excluded systematically from access to MAiD. Rather, local MAiD coordinating services should ensure assessors are equipped to present requesters with a complete picture of any additional means available to relieve suffering and should make all reasonable efforts to ensure requesters have access to these means.

To address the issue of structural vulnerability, the Panel recommended that the term “community services” should be interpreted as including housing and income support as means available to relieve suffering and should be offered to patients requesting assisted dying where appropriate.¹¹⁸ The Panel also clarified that the term “serious consideration” should be interpreted to mean “genuine openness to the means available to relieve suffering” and “an ability to ‘try on’ different options and imagine how the means suggested might apply to the requester’s life”.¹¹⁹ But despite such protections, some evidence suggests that vulnerable members of Canadian society are already at risk of premature death. For example, in 2019, 80.5 per cent of assisted deaths were of elderly persons aged 65 years or over, and 13.7 per cent of those who received an assisted death reported “isolation or loneliness” as one of the main reasons for their request.¹²⁰ Furthermore, the media has reported several cases in which people have requested assisted dying due to poverty or inadequate housing.¹²¹

In the Netherlands, empirical evidence appears to go both ways. One study from 2007 that looked at assisted dying in the Netherlands and the United States found that there was no evidence of increased rates of assisted dying among vulnerable groups. The study defined “vulnerable” as including the elderly, women, people with low education, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses and

113 At 3.

114 Lawyers for Vulnerable New Zealanders, above n 109, at 3 citing Pam Oliver, Michael Wilson, and Phillipa Malpas “New Zealand doctors’ and nurses’ views on legalising assisted dying in New Zealand” (2017) 130 NZMJ 10 at 12.

115 At 3.

116 At 4.

117 Health Canada, above n 66, at 62.

118 At 9.

119 At 34.

120 Health Canada *First Annual Report on Medical Assistance in Dying in Canada* (July 2020) at 32.

121 Leyland Cecco “Are Canadians being driven to assisted suicide by poverty or healthcare crisis?” *The Guardian* (online ed, London, 11 May 2022).

ethnic minorities.¹²² More recent data indicated that rates of assisted dying were higher in relatively healthier districts with higher levels of income, which suggests that assisted dying is not disproportionately affecting poor people.¹²³ However, the same study conceded that much of the variation in rates of assisted dying between districts in the Netherlands remained unexplained and could potentially be related to access to palliative care.¹²⁴

Proponents of assisted dying argue that structural vulnerability can actually make it harder for vulnerable social groups to access assisted dying services, as opposed to pressuring them into requesting assisted dying. For example, Canada's Expert Panel stated in its Final Report:¹²⁵

At the same time, people with lived experience worry that if they do request MAiD, their requests may not be taken seriously. Persons with mental disorders may be assumed incorrectly to be incapable of consenting to receive MAiD. Their suffering may not be visible, and the severity or unbearableness of it may be underestimated by assessors. A request may be taken as evidence the person is suicidal and even lead to coercive measures such as involuntary hospitalization. Or, requests might be dismissed as a sign of manipulation or provocation, especially when associated with certain diagnoses such as borderline personality disorder or in the context of family or other social difficulties.

This statement is supported by other commentators, who argue that the so-called "slippery slope" argument is not supported by evidence and fails to recognise the lived experiences of vulnerable people.¹²⁶ Proponents of this view argue that access to assisted dying should be viewed as a fundamental right and that restricting access for vulnerable groups, such as the mentally ill, is itself a form of stigmatisation and discrimination.¹²⁷

D *Suicide prevention*

Another issue closely related to mental capacity is the issue of suicide prevention. This issue arises as a result of the fact that many psychiatric illnesses include suicidal ideation as a potential symptom. The traditional response from the medical profession to such illnesses was to prevent the sufferer from ending their own life, even if this involved compulsory treatment and hospitalisation.¹²⁸ Ethically, this response can be justified on the grounds of beneficence if one accepts that preserving the patient's life is the most beneficent thing to do or paternalism if one considers that suicidal patients lack the capacity to make decisions for themselves. However, now that some countries, such as the Netherlands and Belgium, have legalised assisted dying solely on the basis of mental suffering, the legal and ethical position has now changed. In those jurisdictions, the state

122 Margaret P Battin and others, "Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence concerning the Impact on Patients in "Vulnerable" Groups" (2007) 33 J Med Ethics 591 at 594.

123 A Stef Groenewoud and others, "Euthanasia in the Netherlands: a claims data cross-sectional study of geographical variation" (2021) BMJ Support Palliat Care at 6.

124 At 8–9.

125 Health Canada, above n 66, at 26.

126 Jocelyn Downie and Udo Schuklenk "Social determinants of health and slippery slopes in assisted dying debates: lessons from Canada" (2021) 47 J Med Ethics 662 at 666.

127 At 666.

128 Sascha Callaghan and Giles Newton-Howes "Coercive Community Treatment in Mental Health: An Idea Whose Time Has Passed?" (2017) 24 JLM 900 at 902.

has conceded that, in some cases, assisted dying is a legitimate response to psychiatric illness. From an ethical perspective, this law is based on a new understanding of beneficence. According to this new understanding, it is more beneficent to help somebody who is mentally ill to end their own life rather than force them to live in a state of unbearable suffering. The new policy can also be justified on the basis of autonomy—the idea that all citizens have a right to end their own lives on their terms, regardless of whether their suffering is mental or physical.

The difficulty with this new approach to psychiatric illness is that it appears to undermine the old public health message that suicide is something that ought to be prevented. The problem is that the old message is still being communicated in jurisdictions that have legalised assisted dying for psychiatric patients and is still supported by laws that criminalise assisted suicide outside of the official assisted dying regime. For example, assisted suicide is still a crime in the Netherlands and Canada, and both jurisdictions offer suicide prevention services. Advocates of assisted dying have tried to justify this apparent contradiction on the basis that legalised assisted dying will actually operate as an effective means of preventing suicide.¹²⁹ The logic behind this argument is that having the option of a legal, medically assisted death will reassure people that they will not have to take matters into their own hands and thus dissuade them from committing suicide. Advocacy groups and politicians worldwide have made this argument; it is also the argument that was accepted by the Canadian Supreme Court in *Carter v Canada*. In *Carter* the Supreme Court accepted that the prohibition on assisted dying was putting people at risk of premature death:¹³⁰

The trial judge found that the prohibition on physician-assisted dying had the effect of forcing some individuals to take their own lives prematurely for fear that they would be incapable of doing so when they reached the point where suffering was intolerable. On that basis, she found that the right to life was engaged.

We see no basis for interfering with the trial judge's conclusion on this point. The evidence of premature death was not challenged before this Court. It is, therefore, established that the prohibition deprives some individuals of life.

The argument in favour of legalising assisted dying is not simply that deaths by suicide will be replaced by medically assisted deaths post-legalisation but that legalising assisted dying will reduce both the number of assisted and unassisted suicides.

Opponents of assisted dying argue the opposite—that there is no meaningful distinction between suicide and medically assisted death and that legalisation of assisted dying will inevitably lead to an increase in both assisted and unassisted suicides. This argument was expressed by Dr John Maher, who gave the following statement to Canada's Special Joint Committee:¹³¹

Some of my patients are now refusing effective treatment to make themselves eligible for MAID. They have been susceptible to the perverse lie that it is not suicide. Suicide is always clinically defined as taking the steps to arrange your own death. The Canadian Association for Suicide Prevention has stated that all MAID for mental illness is suicide. The frankly

129 Yes for Compassion “Latest Suicide Stats Highlight Why The End Of Life Choice Act Needs To Pass” (press release, 24 August 2020).

130 *Carter v Canada*, above n 37, at [57]–[58].

131 House of Commons Canada, above n 72, at 2.

bizarre assertion that suicide is always an impulsive and unplanned act is not rooted in reality. Only 7% of people who attempt suicide in Canada actually die. I'm asking you, what will that percentage become? Likely number one in the world.

The empirical evidence on this issue is complicated. A 2015 study conducted by David Albert Jones and David Paton looked at suicide trends across the United States and concluded that legalising assisted dying was associated with a 6.3 per cent increase in total suicides (including assisted suicides). That legalisation was not associated with a reduction in non-assisted suicide rates.¹³² This study was later criticised in 2017 by Matthew Lowe and Jocelyn Downie in the *Journal of the Ethics of Mental Health*.¹³³ Lowe and Downie criticised the fact that Jones and Paton failed to control for two important predictors of suicide rates, namely, marriage rates and access to mental health services.¹³⁴

Lowe and Downie also criticised Jones and Paton for mistaking correlation with causation, and emphasised that data from one country was not necessarily applicable to other countries.¹³⁵ Lowe and Downie attempted to place Jones and Paton's study in a broader context by analysing data from the Benelux countries and concluded that "more research is required before definitive claims about the effects of legalization of medical assistance in dying on non-assisted suicide can be made".¹³⁶ However, in 2022, Lowe and Downie's criticism of Jones and Paton was itself criticised in a paper by David Albert Jones.¹³⁷ This recent paper compared the Benelux countries to similar neighbouring countries that had not legalised assisted dying. For example, the Netherlands was compared to Germany and Belgium was compared to France. The paper ultimately reinforced the pattern observed in the United States by Jones and Paton, concluding:¹³⁸

The data from Europe are not reassuring: The non-assisted suicide rates have not declined relative to comparable non-EAS countries, whereas there have been very large increases in suicide (inclusive of assisted suicide) and in intentional self-initiated death, especially among women.

Despite these concerns, Canada and the Netherlands remain committed to allowing assisted dying solely on the basis of psychiatric illness. In the Netherlands, mood disorders, such as depression, are a common reason behind assisted dying requests in people with psychiatric illnesses, even though suicidal ideation is a symptom of such disorders.¹³⁹ Furthermore, a history of attempted suicide does not prevent people from accessing assisted dying.¹⁴⁰ To prevent unnecessary suicides, the Netherlands appears to rely heavily on the capacity requirement and the obligation to try alternative treatments.

132 David Albert Jones and David Paton "How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?" (2015) 108 *South Med J* 599 at 599.

133 Matthew P Lowe and Jocelyn Downie "Does Legalization of Medical Assistance in Dying Affect Rates of Non-assisted Suicide?" (2017) 10 *JEMH* 1.

134 At 3.

135 At 4 and 7.

136 At 7.

137 David Albert Jones "Euthanasia, Assisted Suicide, and Suicide Rates in Europe" (2022) 11 *JEMH* 1.

138 At 28.

139 Scott YH Kim, Raymond G De Vries, and John R Peteet "Euthanasia and Assisted Suicide of Patients with Psychiatric Disorders in the Netherlands 2011–2014" (2016) 73 *JAMA Psychiatry* 362 at 364.

140 At 364.

Canada's Expert Panel takes a similar approach. On the issue of suicidality, the Expert Panel's recommendations include providing comprehensive capacity assessments and ensuring that the patient is aware of counselling and other mental health support services.¹⁴¹ The Expert Panel also recommended that if a requester has a history of suicidal ideation, then "suicide prevention measures can be mobilized as they are in usual clinical practice including involuntarily if the situation fulfils the criteria under mental health legislation".¹⁴² Although these recommendations seem to assume that practitioners can accurately distinguish between suicide and legitimate requests for assisted dying, the Expert Panel did recognise that there is considerable uncertainty on this issue:¹⁴³

While it may be more straightforward to rule out suicidality at the end of life, or for persons with no history of suicidality themselves, like Truchon and Gladu, this may be more difficult in persons with chronic suicidal thinking and behaviour who request MAiD. Whether there is a distinction between MAiD and suicide is a point of debate in the clinical literature, with some arguing these are two distinct phenomena (Creighton, Cerel & Battin, 2017), others arguing that they are not (Reed, 2019), and some claiming that even if they are distinct, in practice, practitioners cannot tell them apart (Nicolini et al., 2020).

The Expert Panel finally concluded that:¹⁴⁴

In allowing MAiD in such cases, society is making an ethical choice to enable certain people to receive MAiD on a case-by-case basis, regardless of whether MAiD and suicide are considered to be distinct or not.

By reaching this conclusion, the Expert Panel appears to accept the proposition that there may not be any meaningful distinction between suicide and medically assisted dying for mental suffering. If this is true, then it might make it difficult for the state to give clear guidance on when suicide prevention measures should be implemented and when the patient should be allowed to access assisted dying. It also sends a confusing message to the public about how they ought to deal with mental suffering, especially when assisted dying laws exist in unison with the criminalisation of non-medically assisted suicide.

VI Final Conclusions

Determining whether or not New Zealand should amend its current assisted dying legislation requires both an ethical and factual analysis. Ethically, a number of clear principles have been established. Firstly, the principle of bodily autonomy states that patients ought to be free to do whatever they want with their own bodies. This general principle is subject to three main exceptions. The first is that patients are not entitled to do anything which causes harm to others; the second is that patients should not be allowed to make decisions for themselves where it is obvious that they lack sufficient decision-making capacity; the third exception is that people should not use their autonomy to inflict harm upon themselves.

141 Health Canada, above n 66, at 32–38.

142 At 35.

143 At 35.

144 At 36.

The second and third exceptions are most relevant to the issue of assisted dying for patients with psychiatric illnesses. If a patient's psychiatric illness renders them incapable of making an informed decision about assisted dying, then it is clear that assisted dying should not be made available to them. Even when a psychiatric patient possesses sufficient mental capacity, it may still be possible to deny them access to assisted dying on the grounds of beneficence and nonmaleficence, depending on how one interprets the meaning of those concepts. One interpretation is that beneficence and nonmaleficence require doctors to preserve their patients' lives regardless of physical and mental suffering. Another interpretation is that beneficence and nonmaleficence permit the killing of patients in order to alleviate suffering. If one adopts the former interpretation, it is difficult to ethically justify assisted dying under any circumstances. Even if one adopts the latter interpretation, it still does not give patients an absolute right to die because it is still subject to the overriding principles of autonomy and the preservation of human life. Thus, assisted dying is only truly beneficent if it is performed with the patient's full and proper consent and in the absence of any reasonable alternative. These underlying ethical principles give rise to the main legislative requirements that we see in New Zealand, the Netherlands, and Canada, namely, incurability, mental capacity, and voluntariness (lack of external pressure). The relevant question, when it comes to law reform in New Zealand, is whether or not assisted dying for psychiatric patients complies with these criteria.

In terms of irremediability, the evidence indicates that it is difficult for doctors to reliably predict the future trajectory of psychiatric illnesses. This does not mean that all psychiatric illnesses are curable; it simply means that doctors cannot accurately distinguish between cases that are curable and incurable. This means that doctors will not know for certain whether the irremediability criterion has been met in any given case. This problem is particularly relevant for younger patients who potentially have many years of life still ahead of them. Ethically, if an illness is not irremediable, then assisted dying cannot be justified on the grounds of beneficence because it is not beneficent to end a patient's life when their condition may have improved in the future. Of course, there will always be some level of uncertainty attached to any medical assessment. However, in relation to psychiatric illnesses, the uncertainty is too high to justify the policy, especially given the grave consequences of the decision.

In terms of capacity, most psychiatric patients will likely be able to pass the standard tests for mental capacity, but the reliability of such tests is highly questionable. For example, the End of Life Choice Act sets a relatively low cognitive bar. Even patients with severe psychiatric illnesses are likely to be able to understand and communicate information and weigh up the relevant risks and benefits. The problem is that feelings of hopelessness, burdensomeness, and suicidal ideation are all symptoms of psychiatric illnesses. These symptoms can impair judgement without necessarily robbing someone of the ability to think and reason. Not all psychiatric illnesses include these symptoms, but it can be difficult for medical practitioners to distinguish between a genuine request and the symptoms of the psychiatric illness. Such illnesses affect the mind in ways that physical suffering does not, even though physical suffering can certainly impact peoples' judgement. There is sufficient evidence to support the conclusion that the impact on people's judgement cannot be reliably detected by standard capacity tests, which do not account for emotional states and cannot be extricated from the symptoms of the psychiatric illness itself.

In terms of involuntariness, some studies have shown that vulnerable people are not at an increased of premature death. However, there have been numerous reports in the media across multiple jurisdictions of people requesting assisted dying for non-medical

reasons such as inadequate housing or financial insecurity. As our population ages, health resources become scarcer, and assisted dying becomes more normalised, this might become more of an issue in the future. There are also concerns as to whether external pressure can be accurately detected. This is a problem with all forms of assisted dying, but it is particularly relevant to psychiatric illnesses because people with psychiatric illnesses are more likely to belong to vulnerable social groups.

In summary, legalising assisted dying solely based on psychiatric illness does not comply with the two ethical principles that are primarily used to defend it, namely, autonomy and beneficence. It does not empower individual autonomy due to difficulties assessing mental capacity and detecting social pressure. It does not constitute beneficent treatment because it creates a significant risk of killing patients who may otherwise have benefitted from alternative treatments. Furthermore, there is no strong evidence to support the claim that legalising assisted dying for psychiatric illnesses, or any illnesses, will act as an effective way of preventing suicides. If anything, there is a risk that suicides will increase as a result.

Despite these conclusions, a realist would recognise that any ethical debate ultimately comes down to a matter of opinion. No doubt, allowing assisted dying for patients with psychiatric illnesses gives rise to unique risks, but the question of what constitutes an acceptable level of risk ultimately requires a subjective decision based on one's values. Judging by the developments in the Netherlands and Canada, it would appear that many people currently believe the law should be expanded. For this reason, it is worth considering what procedural safeguards to employ in the event that New Zealand decides to expand its eligibility criteria in the future.

To address the concerns associated with the irremediability criterion, New Zealand should adopt the policy used in the Netherlands, requiring patients to try reasonable alternative treatments. A patient who does not genuinely consider reasonable alternatives should not be classified as being in an irremediable condition. To address the concerns associated with mental capacity and voluntariness, New Zealand should follow the recommendations of Canada's Expert Panel by requiring patients to be examined by an expert psychiatrist and to undergo rigorous capacity assessments over a prolonged period. New Zealand should also introduce an independent witness requirement to protect against coercion. Although not a perfect solution, these safeguards should at least provide some added protection to vulnerable patients should New Zealand choose to expand its eligibility criteria in the future.