From Mental Health Act Admission to MAID

Unravelling the conceptual questions

Marie Nicolini MD PhD

Introduction

Alan Nichols was a 62-year-old man with a cognitive disability and physical frailty, who was brought to a Canadian hospital in June 2019. Upon assessment in the emergency room, he was compulsorily admitted under the Mental Health Act after expressing suicidal ideation. He received medical assistance in dying (MAID) a few weeks later, in July 2019. Nichols' family "felt strongly that this was not assisted dying in Alan's case, but rather an assisted suicide" (1). Similarly, in the 2020 high-profile Belgian court trial about Tine Nys' death by euthanasia at age 38 - Belgium's very first euthanasia court case since the practice was legalized in 2002 - the family stated that "this is legalized suicide" (2), referring to her request as an expression of suicidality.

These cases illustrate an important issue in the MAID debate, namely the complex relation between MAID and suicidality, particularly in the context of non-terminal disorders: the clinical difficulty of distinguishing a MAID request from suicidal behavior, and the ethical difficulty of justifying different treatments for them. How to distinguish MAID from suicidality is of paramount importance for policy making: it determines whether providing MAID while preventing suicide makes sense, i.e. whether they are mutually compatible, from a public health perspective. We can only start examining the compatibility question if MAID and suicide prevention involve distinct evaluation processes and their underlying ethical justifications.

In the current state of affairs, however, we are still at the first stage: determining what a sound basis for distinguishing between a MAID request and suicidality might be. The two proposed bases for differentiation by existing guidelines, i.e. whether the request is "impulsive" vs. "non-impulsive", and "ill-thought of "vs. "well-thought of" (3,4), fail to provide an answer. The first fails due to a lack of positive empirical evidence, the latter due to a lack of a clear definition of what we mean by a well-thought of request for MAID. The next section will show how the Nichols case illustrates these questions, and identify venues for future research.

The Nichols case

Nichols' expressed suicidality coincided with his initial request for information about MAID. Indeed, on June 16, 2019, he was "admitted under the Mental Health Act for his own safety" after expressing suicidal thoughts. That is, he was admitted against his will. On June 17, after he "calmed down significantly and was no longer upset", Nichols "requested information about MAID". His official MAID request followed in the 10-day period between June 17 and 28, given that, on June 28, a psychiatric evaluation took place which "found that he was competent to make his own decisions, including his request for MAID". This series of events raises two main questions 1) Did his MAID request stem from suicidal behavior? and 2) What was he found competent *for*?

1) *Did his MAID request stem from suicidal behavior?*

The mere fact that Nichols was no longer agitated the next day does not, it seems fair to assume, exclude that he was still clinically suicidal. The question of whether his MAID requested stemmed from suicidal ideation or behavior is legitimate. Indeed, it constitutes a major dilemma for clinicians dealing with similar cases, as illustrated by this quote from the Dutch Psychiatric Association guidelines on euthanasia and assisted suicide: "Of particular note is the phenomenon that suicidal behavior is increasingly being articulated by the patient as a request for euthanasia or assisted suicide. After all, the term 'euthanasia' is becoming more common in the media and patients increasingly adopt this language in a completely different context. A request for assistance in terminating life that is in fact an expression of underlying suicidality may lead the physician astray" (3).

Hence, how to discern a MAID request from an expression of suicidal behavior, for which clinicians would typically propose treatment, is a recognized clinical and ethical dilemma. It is also one for which there is no clear solution. One main basis upon which professional organizations and their guidelines have considered a MAID request different from suicidality is impulsivity, whereby a MAID request is considered non-impulsive, carefully planned for action (3, 4). But the problem is that this misrepresents the heterogeneity of suicidal behavior, and the

complex and often lengthy thought process that precedes suicidal behavior (including suicide attempts). Furthermore, it reduces suicidality to one clinical characteristic, impulsivity, which, contrary to popular belief, is the exception rather than the rule. Impulsivity is neither necessary nor sufficient for suicidality, which makes it a bad candidate upon which to base the distinction with a MAID request (5). Complicating the matter is the finding that persons requesting MAID for mental disorders often show similarities with suicidal patients, such as their gender, risk factor like a history of trauma and previous suicide attempts (6).

The fact that there is no recognized evidence-based ground yet upon which to distinguish between MAID and suicidality means that, the shorter the period between an official request and implementation of MAID, the more difficult it is to rule out that the request stemmed from suicidality in the traditional sense. One way to address this issue is to include evidence-based treatment of suicidality as part of the evaluation process (5), in addition to allowing for sufficiently lengthy evaluation periods. Future research is needed to characterize those engaging in suicidal behavior versus those requesting MAID and what might indeed be an empirically sound basis for differentiation.

2) *What was he found competent for?*

If indeed impulsivity does not distinguish between MAID and suicidality, then it remains unclear what should guide clinicians. A second candidate is the "ill thought of" vs. "well thought of" distinction. This partially overlaps, conceptually, with the key legal criterion that the request be an informed and competent one (e.g. "well-considered" is the term used in the Netherlands and Belgium), conform the informed consent doctrine (7-9). Nichols was judged to have decision-making capacity to make a "well-considered request". But the fact that he was found "competent to make his own decisions, including his request for MAID" suggests that the competence assessment was a global one, not specific to MAID in particular. This is potentially problematic because it goes against standard understanding of capacity assessments, intended to gauge competence for a particular decision.

The question is not to dispute whether Nichols had decision-making capacity, but rather: do we have a clear account of what is required for a well-considered request for MAID? The current answer might be no. In practice, clinicians most often use global impressions of capacity rather than validated scales in such evaluations (10). In fact, psychiatrists and neurologists in Belgium performing evaluations of patients requesting euthanasia for psychiatric disorders have indicated that they often rely on personal experience and clinical intuitions in these evaluations, rather than on formal capacity assessments (11). This calls for a standardized well-defined definition of an informed request, one that is less likely to be based on subjective impressions. Major questions remain unsettled, such as: what should be the standards for such assessments, what threshold is desirable, how do we understand voluntariness (especially in the possible presence of suicidal ideation) and how do we value the outcome of death in MAID, as opposed to how we value it in in suicide prevention.

One thing is certain: the practice where one can, as in the Nichols case, be involuntarily admitted and soon after receive MAID, raises conceptual concerns. Either a person should not have been compulsorily admitted in the first place, or they should likely not have received MAID. As we have seen, the ethical justification for doing both things, especially when co-occurring in a short time span, is murky at best. This is because the underlying assumptions are contradictory: we *assume* the patient is incompetent when deemed suicidal, and we assume they are competent when making a request for MAID. If we want to make progress in delineating MAID from suicidality, we need to first define what we mean an informed, well-considered request for MAID.

Conclusion

The Nichols case illustrates some of the key broader ethical questions in the debate about MAID for persons with non-terminal disorders, particularly mental and cognitive disorders. It highlights the clinical difficulty of distinguishing MAID from suicidal behavior, and the ethical difficulty of justifying very different treatments. Further research is urgently needed in these specific areas. As Canada extends its MAID law to explicitly include non-terminal, mental disorders as of March 2023, these questions will become all the more pressing.

References

1. Lemmens T. Medical Aid in Dying in Canada: A Case Raises Questions About Its Use in Patients with Disability and Mental Illness. In: Controversies in the History of Neuropsychopharmacology. [Forthcoming]
2. Decré H. Geheime opnames die familie van Tine Nys maakte van dokters vrijgegeven op euthanasieproces [English: *Secret recordings made by family of Tine Nys of doctors released at euthanasia trial*] https://www.vrt.be/vrtnws/nl/2020/01/27/euthanasieproces-opnames/. VRT Nieuws. 2020.
3. NVVP. Nederlanse Vereniging voor Psychiatrie. Levensbeëindiging op verzoek bij patiënten met een psychische stoornis. [English: Termination of life on request in patients with mental illness.] https://richtlijnendatabase.nl/richtlijn/levensbeeindiging_op_verzoek_psychiatrie/startpagina_-_levensbe_indiging_op_verzoek.html 2018. (Accessed June 2019)
4. Creighton C, Cerel J, Battin M. Statement of the American Association of Suicidology: "Suicide" is not the same as "Physician aid in dying". https://suicidology.org/wp-content/uploads/2019/07/AAS-PAD-Statement-Approved-10.30.17-ed-10-30-17.pdf 2017. (Accessed Dec 2018)
5. Nicolini ME, Gastmans C, Kim SYH. Psychiatric euthanasia, suicide and the role of gender. British Journal of Psychiatry. 2021;220(1):10-3.
6. Nicolini ME, Peteet JR, Donovan GK, Kim SYH. Euthanasia and assisted suicide of persons with psychiatric disorders: the challenge of personality disorders. Psychological medicine. 2020;50(4):575-82.
7. Belgian Act. 28 MEI 2002. Wet betreffende de euthanasie. http://bit.ly/2jVFeS0. For an unofficial translation of the Act in English, see Jones et al. 2017 (Appendix III,pp.305-315). 2002.
8. Dutch Act. Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding. https://wetten.overheid.nl/BWBR0012410/2020-03-19. A translation of the due care criteria set out in the Act can be found in the EuthanasiaCode 2018 (p8). 2002.
9. CCA. Council of Canadian Academies. The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder is the Sole Underlying Medical Condition. https://cca-reports.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Medical-Assistance-in-Dying-Where-a-Mental-Disorder-is-the-Sole-Underlying-Medical-Condition.pdf. Ottawa, Canada. 2018. (Accessed Jan 2019)
10. Doernberg SN, Peteet JR, Kim SY. Capacity Evaluations of Psychiatric Patients Requesting Assisted Death in the Netherlands. Psychosomatics. 2016;57(6):556-65.
11. Schweitser F, Stuy J, Distelmans W, Rigo A. Assessment of patient decision-making capacity in the context of voluntary euthanasia for psychic suffering caused by psychiatric disorders: a qualitative study of approaches among Belgian physicians. Journal of Medical Ethics. 2020. doi: 10.1136/medethics-2019-105690. Epub ahead of print.