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Medical Assistance in Dying for Psychiatric Disorders: A Critical Analysis of the Clinical, Ethical, and Societal Arguments

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Abstract: Medical assistance in dying has emerged as one of the most debated issues in contemporary bioethics, with growing attention to its extension beyond terminal somatic illnesses to include psychiatric disorders. While current discussions emphasize patient autonomy and the right to self-determination as fundamental principles, the application of assisted suicide in psychiatric contexts raises distinct clinical, ethical, and societal concerns. This article critically examines key arguments supporting physician-assisted suicide for individuals with mental illness, focusing on the challenges of determining irremediability, assessing decision-making capacity, and distinguishing autonomous choice from symptoms of the underlying disorder. Particular attention is given to the fluctuating course of psychiatric conditions, the absence of objective biomarkers, and the evolving landscape of therapeutic options, all of which complicate prognostic certainty. Finally, the analysis explores concerns related to vulnerability, social pressure, and the potential normalization of assisted death in contexts marked by stigma and structural inequities. The paper argues for heightened caution in extending medical assistance in dying to psychiatric populations given these unresolved complexities.

Keywords: Medical Assistance, Dying, Psychiatric Disorders, Psychiatric Conditions, Suicide

Introduction

The concept of 'death with dignity' has been the subject of sustained debate in recent years. Contemporary discussions surrounding medical assistance in dying increasingly emphasize patient autonomy and the right to self-determination as fundamental principles guiding end-of-life decision-making. Within this framework, the capacity of individuals to make voluntary and informed choices about the timing and manner of their death is often presented as a core expression of personal liberty and respect for human dignity (Marckmann & Pollmacher, 2024).

Euthanasia and physician-assisted suicide are frequently discussed under the broader framework of medically assisted dying, yet they represent two distinct practices differentiated primarily by the method of administration and the identity of the agent performing the final act. In euthanasia, the physician directly administers a lethal substance, most commonly through an intravenous route. This method is characterized by its high degree of pharmacological predictability and by the physician's continuous control over the procedure. In contrast, in the case of physician-assisted suicide, the clinician's role is limited to prescribing or supplying the lethal medication, while the patient is solely responsible for its administration. The method employed is almost exclusively oral ingestion, the physician does not perform the act that directly induces death, and the individual must retain sufficient physical and cognitive capacity to initiate the final step independently. Although both practices ultimately result in the patient's death, they diverge in ethically meaningful ways: euthanasia involves direct physician participation in the act that causes death, whereas physician-assisted suicide preserves a measure of patient agency through self-administration of the lethal medication. Despite their surface-level similarity, the distinction between the two procedures raises complex ethical considerations, particularly concerning the clinician's moral and professional responsibilities and the evaluation of autonomy and decision-making capacity in individuals with psychiatric disorders (Sulmasy & Mueller, 2017). In countries such as Belgium, the Netherlands, and Luxembourg, euthanasia may be allowed when a psychiatric disorder is the source of suffering, provided that stringent legal requirements are fulfilled. In Switzerland, assisted suicide is permitted when individuals demonstrate decision-making capacity and carry out the final act themselves, and, under certain conditions, this framework may also extend to persons with mental disorders (Grassi et al., 2022).

In Romania, discussions surrounding euthanasia and physician-assisted suicide reveal a consistent pattern of ethical caution and societal reluctance. Public opinion surveys indicate that laypeople generally regard assisted dying as largely incompatible with prevailing moral norms. Acceptance is even lower among health professionals, who tend to adhere more strongly to traditional medical principles that emphasize the preservation of life and the protection of vulnerable patients. These perceptions are strongly shaped by deeply rooted Christian-Orthodox beliefs and cultural values that emphasize the sanctity of life until its natural end, viewing life as a sacred gift and the timing of death as belonging exclusively to God. Although a modest tendency toward greater acceptance of assisted suicide can be observed among younger and more highly educated segments of the population—groups more receptive to notions of individual autonomy and increasingly influenced by Western liberal values—this openness remains limited. Even within these groups, assisted dying is only partially accepted in cases involving older adults, reflecting a culturally embedded distinction between the natural death of an elderly person and the premature death of a younger individual, the latter being widely perceived as contrary to the natural order. These perspectives collectively suggest that, in Romania, assisted dying is understood through an outlook that highlights responsibility, relational ethics, and social solidarity rather than individual autonomy alone, a view that helps explain the sustained resistance to its legal and clinical adoption (Teodorescu et al., 2019; Sârbu, 2022).

Most of the literature on medical assistance in dying has historically focused on patients with terminal somatic conditions such as advanced cancer, amyotrophic lateral sclerosis, and AIDS, where prognosis and suffering are more predictable and measurable. In contrast, relatively fewer studies have examined assisted dying in the context of primary psychiatric disorders (Grassi et al., 2022). The legislative and regulatory landscape surrounding physician-assisted suicide for psychiatric patients is highly contentious, with varying approaches across jurisdictions reflecting deeply divided ethical and clinical perspectives (Scopetti et al., 2023).

1. Impact of Mental Illness on Decision-Making

The legal and ethical frameworks surrounding decision-making capacity become particularly complex when applied to individuals with severe mental illness and suicidal ideation, requiring an approach that extends beyond formal diagnostic criteria and incorporates a nuanced understanding of their decisional vulnerabilities (Scopetti et al., 2023). Certain severe mental disorders, particularly those involving major depressive episodes or psychotic symptoms, may significantly impair the decision-making capacity of the individual, including the ability to make autonomous and informed choices about treatment (Olie et al., 2023).

The presence of suicidal intent itself, although not sufficient to establish a lack of decisional capacity, can strongly suggest the presence of underlying mental illness that may compromise the individual's ability to make fully informed decisions, especially with regard to life-sustaining treatments (Nicolini, 2020). Suicidal behavior can also be described as an obsessive concern of the individual over his existential failure and the lack of finding an alternative situation to solve the problems of his life (Tănăsescu, 2019, p. 210). However, it is crucial to recognize that a diagnosis of mental illness alone does not automatically imply a lack of decision-making capacity. Rather, capacity must be evaluated individually, assessing the extent to which the patient can understand relevant information, appreciate the consequences of treatment choices, reason through alternatives, and communicate a clear and consistent decision (Hatherley, 2019).

The refusal of psychiatric treatment by individuals with suicidal ideation can be understood not merely as a volitional choice but as a consequence of underlying neurobiological and neuroanatomical dysfunctions. Unlike patients with terminal physical illnesses, the decision-making capacity of individuals with mental health conditions is often compromised, raising concerns about the authenticity and voluntariness of their requests for physician-assisted suicide (Hatherley, 2019). Consequently, distinguishing between a deeply considered, autonomous decision and a manifestation of the illness itself becomes a clinical and ethical challenge for healthcare providers (Grassi et al., 2022). Neuroimaging studies suggest that suicidal behavior is associated with altered activity in brain regions critical for guiding decisions, evaluating consequences, and processing reward, including the ventromedial prefrontal cortex, orbitofrontal cortex, dorsolateral prefrontal cortex, and basal ganglia. These alterations may compromise decision-making capacity, often manifesting as an increased tendency for high-risk choices and reduced impulse control. Such neurobiological vulnerabilities can lead to difficulties in appreciating the long-term benefits of psychiatric treatment, particularly when immediate relief from psychological distress is prioritized over future well-being (Mann & Rizk, 2020).

In individuals with suicidal ideation, numerous studies have reported structural and functional alterations in regions such as the dorsal and ventral prefrontal cortex, the insula, and the anterior cingulate cortex. These regions support cognitive control, attentional processes, and self-regulation, and disruptions in their functioning can contribute to cognitive distortions, including an attentional bias toward suicide-related cues and reduced ability to generate alternative solutions to problems. This narrowing of cognitive focus may limit individuals' ability to recognize the potential benefits of psychiatric treatments or to develop insight into their condition, making treatment adherence challenging (Schmaal, 2020; Dobbertin et al., 2023).

Additionally, suicidal ideation is frequently accompanied by emotional dysregulation and a marked sense of hopelessness. Neurobiological mechanisms implicated in this vulnerability include abnormalities in serotonergic signaling, hyperactivation of the hypothalamic-pituitary-adrenal axis, and dysfunctions within the neuroimmune pathways. These biological alterations sustain persistent negative affective states such as severe depression, anxiety, and anhedonia, which tend to persist over time despite therapeutic efforts. Brain regions involved in emotion regulation, particularly the amygdala and hippocampus and their connections with the prefrontal cortex, show altered activity and connectivity in individuals experiencing suicidal thoughts. Such disturbances can intensify feelings of despair and reinforce beliefs that treatment is unlikely to be effective, contributing to treatment refusal. Hopelessness has been conceptualized as emerging from heightened stress sensitivity, persistent maladaptive beliefs, and a reduced sense of controllability, factors that can weaken motivation to participate in treatment (Pandey, 2013; Schmaal et al., 2019).

2. Questionable criteria

2.1. Irremediability

In several countries, including Belgium, the Netherlands, and Canada, the legal frameworks that *regulate* euthanasia or medical assistance in dying require that a patient's condition be *considered* 'irremediable'. While the precise meaning and clinical application of this criterion differ across jurisdictions, it plays a key role in determining eligibility, especially when requests are based on psychiatric suffering. Still, the application of irremediability to mental disorders remains widely *contested* (Nicolini et al., 2022).

Unlike many advanced somatic illnesses, which often follow relatively predictable and irreversible trajectories of decline, psychiatric disorders frequently involve symptom severity and subjective distress that are highly context-dependent and prone to fluctuation over time, including under the influence of environmental or psychosocial factors such as poverty or loneliness (Marckmann & Pollmacher, 2024).

Psychiatric disorders are inherently characterized by periods of relapse and remission, and a period of suicidal ideation may be followed by substantial improvement or even complete remission. This variability in clinical course is compounded by the absence of validated objective biomarkers for most psychiatric conditions, resulting in prognostic assessments that rely primarily on qualitative clinical judgment and the patient's subjective symptom reporting (Craine, 2023). These considerations complicate the assessment of whether a psychiatric disorder can be regarded as irremediable. Consequently, a significant ethical dilemma emerges: it is exceptionally difficult to determine to what extent a psychiatric patient's expressed wish to die is stable over time, and whether it genuinely reflects an absence of recovery potential (Nicolini et al., 2022).

2.2. Unbearable suffering

Several jurisdictions use eligibility criteria for medical assistance in dying that include formulations such as 'unbearable suffering' without the prospect of improvement, or even 'mental suffering'. These categories are often broadly defined and lack clear clinical criteria, which makes their application particularly challenging in cases involving psychiatric conditions (Nicolini et al., 2020). In terminal somatic illnesses, physical suffering arises largely from identifiable and progressive physiological deterioration, such as uncontrolled pain caused by tumor infiltration, irreversible organ failure, severe respiratory distress, or the loss of basic bodily functions. These manifestations have a clear biological basis and can be verified through objective clinical findings, lending a degree of predictability to the course of decline (Reid et al., 2017).

By contrast, the subjective and deeply personal nature of mental suffering makes it inherently difficult for external evaluators to assess or quantify with any degree of precision. Similar to the fluctuating course of psychiatric disorders, mental suffering is a dynamic and variable construct that faces comparable challenges due to the absence of standardized assessment tools. What a psychiatric patient may perceive at a given moment as 'unbearable suffering' can later diminish, either spontaneously or in response to appropriate treatment (Marckmann & Pollmacher, 2024). In this context, it becomes increasingly difficult for a mental health professional to rely exclusively on clinical judgment when encountering complex presentations such as personality disorders, in which emotional suffering may be intensified by maladaptive cognitive patterns, interpretive distortions, and difficulties in emotion regulation (Bersani et al., 2025).

2.3. Treatment options

One argument frequently invoked in support of medical assistance in dying is the claim that suicidal ideation may, in some cases, be resistant to treatment. However, the notion of 'treatment-resistant' depression, often referenced as a criterion for considering physician-assisted suicide, does not definitively rule out the possibility of future improvement or recovery, given that diagnostic categories for mental illnesses are descriptive constructs rather than reflections of underlying pathophysiological mechanisms. Consequently, determining with certainty when a psychiatric condition is genuinely refractory presents a significant ethical challenge for clinicians evaluating requests for physician-assisted death (Hatherley, 2019). This difficulty is further compounded by the issue of treatment refusal. Some authors argue that a condition cannot be classified as irremediable if the patient has not exhausted all reasonable therapeutic options, while other scholars warn that an overly patient-centered approach to treatment refusal may result in preventable deaths (Kim et al., 2016).

For individuals experiencing suicidal ideation, a wide range of evidence-based treatments is available and can substantially reduce suffering, promote stabilization, and support recovery, thereby potentially preventing requests for medical assistance in dying. Contemporary psychiatric practice includes pharmacological interventions, such as antidepressants, anxiolytics, and mood stabilizers-as well as psychotherapeutic approaches, including cognitive-behavioral, psychodynamic, and trauma-focused therapies. In addition to these established modalities, the field continues to evolve, with emerging interventions such as esketamine nasal spray, repetitive transcranial magnetic stimulation, and electroconvulsive therapy demonstrating efficacy for individuals with severe or treatment-resistant depression. The ongoing development of novel therapeutic strategies underscore that many patients who initially appear refractory may still benefit from alternative or innovative treatments, highlighting the importance of comprehensive and sustained therapeutic efforts before considering medical assistance in dying as an option (Bersani et al., 2025).

In many jurisdictions, legislation does not clearly specify the circumstances under which a patient seeking physician-assisted suicide must undergo a psychiatric evaluation, nor does it delineate which therapeutic options should be exhausted before eligibility can be established. The absence of well-defined eligibility criteria grounded in international diagnostic standards, together with the lack of protocols outlining the range of treatments that should be attempted prior to considering medical assistance in dying, may create the risk of premature and potentially avoidable deaths (Kim et al., 2016).

3. Societal and professional implications

3.1. Economic and social burden

The economic dimension of medical assistance in dying remains insufficiently analyzed in the context of psychiatric patients. In psychiatric care, the direct costs are often driven by repeated hospitalizations, long-term pharmacological management, psychotherapy, and the need for sustained psychosocial support. These clinical expenses are further compounded at the population level by the high prevalence of psychiatric disorders and the substantial indirect costs associated with early retirement, unemployment, and reduced occupational functioning. Currently, public health systems worldwide face substantial economic pressures, and mental disorders constitute a significant and growing component of this burden (Trautmann et al., 2016).

Because medical assistance in dying may, in some situations, cost less than the long-term treatment of chronic psychiatric disorders, some authors have raised concerns that financial considerations could subtly influence policy decisions. They caution that appeals to autonomy and patient choice might, at times, mask the extent to which economic pressures shape the broader policy context, even if direct evidence for such influences remains limited (Grassi et al., 2022). Such perspectives raise important questions about the potential desensitization of both the medical community and society at large to the implications of suicide, the importance of prevention efforts, and the ways in which the value of a human life may be assessed when viewed solely through the lens of individual contribution (Gopal, 2015).

The availability of physician-assisted suicide raises important ethical concerns regarding potential vulnerability among patients with dementia. These concerns arise from the complex interplay between progressive cognitive decline, fluctuating decision-making capacity, and broader societal attitudes toward dependency and aging. Individuals living with dementia frequently express fears of future deterioration and loss of autonomy, and some report concerns about becoming an emotional or financial burden on their families (Bravo, 2022). Some commentators caution that permitting assisted suicide in such circumstances may unintentionally contribute to a perceived ‘duty to die’ among vulnerable patients. This concern is particularly relevant in the context of chronic psychiatric conditions, where individuals may be more susceptible to internalizing societal attitudes related to dependency, cost, or perceived dependency (Verhofstadt et al., 2024). However, this deeply personal motivation also raises significant ethical concerns regarding the voluntariness and authenticity of such requests. It becomes challenging to determine whether the decision represents an autonomous choice or instead reflects internalized societal pressures and a perceived sense of obligation (Marijnissen et al., 2022).

Ultimately, the stigma and discrimination associated with mental illness, combined with limited access to mental healthcare and the profound sense of hopelessness that may arise from distorted perceptions and impaired decision-making, can contribute to a patient's wish to die rather than seek help. These factors are frequently described in the psychiatric literature as amplifying vulnerability and diminishing help-seeking behavior, which may influence how some individuals interpret the option of medical assistance in dying (Kious, 2025).

3.2. The therapeutic relationship

Suicidal ideation is regarded in psychiatry as a clinical emergency that requires active intervention to preserve the patient's life, even when doing so contradicts the patient's stated wishes. In this context, the extension of medical assistance in dying to psychiatric conditions may compromise the therapeutic relationship, as clinicians are placed in the dual position of both assessing suicide risk and, under certain circumstances, potentially facilitating a patient's death (Nicolini et al., 2020). As a consequence, the availability of physician-assisted suicide may be interpreted by some psychiatric patients as a sign of diminished therapeutic commitment or reduced investment in developing new treatments for treatment-resistant psychiatric conditions. Such perceptions can erode trust in mental health institutions and reinforce feelings of hopelessness, thereby weakening the expectation of future improvement and potentially discouraging engagement in life-affirming treatments (Grassi et al., 2022).

The relationship between the availability of physician-assisted suicide or euthanasia and suicidal behavior in psychiatric populations remains a subject of ongoing debate in the academic literature. While some proponents argue that access to medical assistance in dying may alleviate suicidal distress by providing a sense of control or psychological reassurance, empirical findings have challenged this assumption. For example, a systematic review by Doherty, Axe, and Jones reported that although some individuals withdrew their requests for euthanasia after finding reassurance in the availability of the option, a proportion of those included in the analyzed studies ultimately died by self-initiated death, whether through euthanasia, assisted suicide, or non-assisted suicide. These findings indicate that the availability of assisted dying does not consistently alleviate suicidal distress. The review ultimately found no empirical support for the substitution hypothesis, namely the claim that medical assistance in dying is associated with reduced rates of non-assisted suicide (Doherty et al., 2022).

3.3 The slippery slope argument

This gradual expansion of eligibility criteria, often described in the literature as the 'slippery slope argument', suggests that policies initially introduced as exceptions for cases of extreme suffering may progressively extend to broader categories of patients (Scopetti et al., 2023). Some scholars caution that expanding eligibility to psychiatric patients may contribute to a gradual widening of criteria, potentially encompassing other vulnerable populations or less clearly defined forms of suffering. Proponents of this view contend that such developments risk normalizing assisted death as a response to an increasingly wide range of human difficulties, raising concerns about the broader societal implications for how the value of life is conceptualized. In particular, within the critical literature, it has been argued that an expanded reliance on assisted dying may subtly shift attention away from robust mental health interventions toward the facilitation of premature death among vulnerable populations (Grassi et al., 2022). This debate also raises a more fundamental question: how can a just balance be maintained between collective welfare and individual rights within societies that are increasingly shaped by productivity-driven and profit-oriented priorities?

Conclusion

The legalization of physician-assisted suicide for psychiatric patients introduces profound societal and professional implications, necessitating a critical examination of its potential impact on healthcare systems, public trust, and the very definition of medical care. The difficulty in definitively establishing irremediability in psychiatric suffering, coupled with the potential for recovery, the emergence of new treatments, and the availability of palliative care approaches, underscores strong arguments against the provision of PAS for mental illness alone. Ultimately, death is not viewed solely as an escape from physical, mental, or existential suffering, but also as a way out of poverty and loneliness.

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