COMMENTARY

INVITED SUBMISSION

Medical Assistance in Dying as an Adaptive Preference in Individuals with Mental Illness

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Commentary in Response to: "Decision-Making Capacity to Consent to Medical Assistance in Dying for Persons with Mental Disorders" by Charland, Lemmens, & Wada

Introduction

We offer this essay as a reply and addendum to Charland et al.'s extensive conceptual survey of the questions related to the extension of medical assistance in dying (MAID) to patients with mental illness (1). As the authors rightly point out, we must be especially diligent in ascertaining capacity for mentally ill individuals who wish to access medical assistance in dying and proceed with caution. We acknowledge that patients with severe mental illness may meet the basic criteria of the standard model of autonomy. However, we agree that this is not enough. Instead, in ways similar to Charland et al., we advocate for a return to an understanding of bioethical autonomy that more closely reflects its conceptual origins found in the Belmont Report: the principle of respect for persons.

Severe psychiatric illness can lead to a form of desperation, which can become utter demoralization in the face of unrelenting illness. While other medical conditions also involve such desperation, this form of distress is combined with an illness that affects cognitive process. This renders this form of desperation particularly powerful. Such a combination can wield undue influence over treatment preference ranking. It compromises the ability to effectively weigh options, which is a cornerstone of informed consent. To fully actualize the principle of respect for persons, we must acknowledge that individuals with severe mental illness are a uniquely vulnerable population. Along with limited access to psychosocial interventions, their ability to clearly see that there are other options besides death may potentially be compromised.

SMI's Interference with Consideration of Alternatives

We know that patients with severe mental illness often retain a level of capacity to make particular medical decisions. Central to informed consent is the ability to consider various options, their risks, benefits, and alternatives. Severe mental illness, however, can narrow the perception of what options are available. Even if other options are presented, they may be dismissed out of hand rather than carefully considered. The illness itself can exercise a controlling influence external to the patient's true desires, making death a particularly salient and over-valued option. Chronic and severe mental illness can warp perception of the future, making the patient feel like their current state is how life always was and will always be.

In a sense, this situation is similar to what Nussbaum and Sen have called an 'adaptive preference'. An adaptive preference is when someone "does not desire some basic human good because they have been long habituated to its absence or told that it is not for such as them." (2) Borne out of a form of oppression caused by an unrelenting disease that deprives patients of hope, happiness, satisfaction, or a vision of a future life, the desire for death may be an adaptive preference for a patient seeking relief from severe mental illness. In this case, pursuit of MAID may actually be

driven by a deformed desire, further exacerbated and reinforced by societal and self-stigma, lack of effective psychosocial support, and the challenge of finding and accessing treatment.

An important part of capacity determination is an earnest assessment of the forces that shape how these preferences are ranked. Thus it falls to institutional safeguards to ensure that the process of choosing between treatment options is intact and reflective of true desires, not symptomatic of pathology or the false belief that no other options are attainable.

Borderline Personality Disorder

Take for example the case of borderline personality disorder (BPD). A patient with BPD may believe that MAID is the only solution to end her suffering. She's sick of a life in shambles punctuated by stormy, unstable relationships. Her interactions with her health care providers are not an exception, undermining the otherwise protective nature of the physician-patient relationship. She may not be directly flirting with death, but engages in acts of self-mutilation. She has an unaddressed desperation and feels isolated, rendering her particularly vulnerable.

One might argue that an individual with BPD may deem herself legitimately ready to die, after having rejected or failed other treatment options. At face value, she may even meet criteria for capacity. However, her illness has narrowed the options in her view. This narrowing may be further exacerbated by a pervasive clinical misconception that BPD is incurable and unmanageable. This narrowing may be even further intensified by the lack of effective social supports and access to psychosocial interventions.

Unfortunately, this is not just theoretical. One study found that among Belgian patients who requested euthanasia for psychiatric conditions, 50% had a personality disorder (3). A Dutch study of patients who successfully completed MAID for psychiatric conditions found that 52% had a personality disorder or prominent character trait difficulties and 56% specifically mentioned social isolation or loneliness (4). These statistics should raise concerns among MAID advocates that patients are not being provided the necessary psychosocial supports they may need.

Conclusion

In contrast to a patient with a terminal illness such as advanced cancer or ALS, mental illness short circuits a patient's personal narrative in a unique way. Mental illnesses directly affect belief, value, desire, cognition, and emotion, in a way that a terminal disease such as cancer may not. In fact, some serious mental illnesses are in part defined by a lack of stable self.

In such cases, adaptive preference may take hold and a patient may wish to die, but be unaware or unconvinced that there really are other ways to ameliorate suffering. Unlike in patients seeking MAID in the context of terminal illness, death still represents a preference rather than an imminent inevitability. Thus, how the patient arrives at the preference must be carefully considered. Choosing MAID may result from a lack of recognition and consideration of other options, which is crucial to informed consent.

We are concerned about the policy implications of allowing access to MAID for relief from mental illness, as in the Benelux countries and now considered in Canada. We assert that individuals with SMI comprise a particularly vulnerable population who require heightened oversight. These individuals have a deeper set of vulnerabilities that may compromise their ability to make a truly informed decision. We must adopt a broader view of respect for persons, rather than focusing on an impoverished view of individual autonomy.

Endnotes

1. Charland, L. C., Lemmens, T., & Wada, K. (2016). Decision-Making Capacity for Medical Assistance in Dying for Persons with Mental Disorders. *Available at SSRN 2784291*.

2. Nussbaum, M. C. (2001). Symposium on Amartya Sen's philosophy: 5 Adaptive preferences and women's options. *Economics and Philosophy, 17*(01), 67-88.

3. Thienpont, L., Verhofstadt, M., Van Loon, T., Distelmans, W., Audenaert, K., & De Deyn, P. P. (2015). Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study. *BMJ open, 5*(7), e007454.

4. Kim, S. Y., De Vries, R. G., & Peteet, J. R. (2016). Euthanasia and assisted suicide of patients with psychiatric disorders in the Netherlands 2011 to 2014. *JAMA psychiatry, 73*(4), 362-368.

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