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Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

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Internal coercion and self-stigma

Professors Bhui and Malhi[1] ably describe some of the difficulties in constructing adequate protections around legalised assisted dying. Among those mentioned is the possibility of coercion from abusive (or simply exhausted) family and carers. These situations undoubtably exist, but a more common problem is a person within a loving family feeling pressure to pursue assisted suicide precisely because of the loving care they are being given and the impact of this on their family. In Oregon, 53% of people who requested assisted dying included 'feeling a burden' in their rationale.[2]

Our society generally looks down on those who are unable to work or who need care. People with severe enduring mental illnesses are particularly exposed to these negative beliefs, often shouted after them in the street. It takes a great deal of self-belief to avoid self-stigma, where the individual takes on society's stigmatising beliefs about their illness and devalues their own worth because of these.

Psychiatric review for capacity or treatment of depression will be essential to any legalisation. One problem is the impact of that association on the image new and potential patients hold of us. Those admitted with acute psychosis are often terrified that staff intend to kill them, while building up rapport with people affected by chronic persecutory delusions can be slow and difficult work. Neither of these will be helped by a genuine association between psychiatrists and killing (however voluntary and capacitous).

There is a large measure of agreement between both sides of the debate, No one on either side of this debate wants either for people to feel trapped in their bodies, fearful and lacking dignity, or for vulnerable people to feel pressure to opt for assisted suicide for the sake of others. Unfortunately, there is no way avoid both perils simultaneously. The argument for assisted dying is being championed by those who are educated and articulate, whereas the dangers affect those most marginalised and least eloquent. To protect those vulnerable and often voiceless people, we need to maintain the law as it stands.

Declaration of interest

J.B. is a member of the Our Duty Of Care steering group, part of the Care Not Killing alliance, is disabled, and has a strong interest in people not valuing the lives of people with disabilities or severe and chronic illnesses less than those of people who are (currently) able-bodied.

References

1 Bhui K, Malhi GS. Proposed Assisted Dying Bill: implications for mental healthcare and psychiatrists. *Br J Psychiatry* 2022; **221**; 374–6.

2 Public Health Division, Center for Health Statistics. *Oregon Death with Dignity Act 2020: Data Summary* (p. 12). Oregon Health Authority. Available from: https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf.

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RE: Proposed Assisted Dying Bill: implications for mental healthcare and psychiatrists

Optimal management of dying

The editorial by Gin Malhi and Kalmaldeep Bhui (1) discusses the challenges and supports around terminal illness especially that complicated by a mental illness. It seems there may be three scenarios. 1. People who do not receive optimal end of life care. They are suffering and appropriate palliative care has not been given. This may be the biggest group of people who find their final weeks and months difficult. The answer is to provide appropriate palliative care (and a recent law has made this a right), and not to assist their suicide. 2. Those with so called unbearable suffering. This terminology comes from Dutch/Belgian parlance and is unsatisfactory as a diagnosis and wide open to abuse and error. Many such people may have poorly managed care and optimal care would make their lives bearable. Those not adequately managed by optimal care may fit into category 3. 3. Those who cognitively, emotionally and philosophically want to end their lives regardless of symptoms or illness. Freedom enables people to do and choose what they want regardless of consequences to themselves, collateral damage and moral infringements. This however never means their choice has to be rolled out to the population and become law. People do all kinds of things and it is their own responsibility and not the basis of a cultural, legal , philosophical or moral change for anyone else. Incorrect laws and precedents can cause serious harm to the more vulnerable who cannot defend themselves as Professors Bhui and Malhi point out. Copy cat behaviour, Halo effect and social impact can all influence attitudes and as the Liverpool care pathway showed once started regulation and controls are sidelined.

Conflict of interest

None declared

Reference

1 Bhui K and Malhi GS. Proposed Assisted Dying Bill: implications for mental healthcare and psychiatrists. *Br J Psychiatry*. 2022; **221**, 374–376.

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RE: Proposed Assisted Dying Bill: implications for mental healthcare and psychiatrists

I write as Chair of the Royal College of Psychiatrists in Scotland and as a member of our Legislative Oversight Forum, who are leading

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the College's response to a draft Bill on assisted dying which will be put before the Scottish Parliament.

Although we are pleased to see this topic raised in a *BJPsych* editorial[1], there are factual and contextual issues within the article with regard to the Scottish context, to the extent that a misleading impression is given around developments in this area.

From the outset, it portrays the legislation being undertaken through the UK Parliament on making assisted dying available to patients who are terminally ill as applying to the entirety of the UK. It would instead only apply in England and Wales. As already noted, there is separate legislation in Scotland currently being developed, led by a Liberal Democrat MSP.

This failure to account for the Scottish legislation is in spite of the Scottish draft Bill being much more likely to progress. The bill in England and Wales has not yet left the House of Lords, whereas the proposed bill in Scotland has support from individual members of the governing party, the SNP, and has now reached the point of clinical guidance being drafted to support consideration.

The article also fails to provide additional context, including the six previous rejections of similar legislation since 2003 (four times in Westminster and twice in Holyrood). We are concerned that a prominent editorial on such an important subject, written by senior authors, has been published without accounting for the legislative process in Scotland. We would urge the journal to engage with researchers, clinicians and lived experience representatives in the devolved nations to ensure its processes for commissioning, peer review and approval in future accounts for each of the four nations of the UK. This would ensure that an accurate portrayal of such issues can be provided to members in future.

Declaration of interest

None

Reference

1 Bhui K, Malhi GS. Proposed Assisted Dying Bill: implications for mental healthcare and psychiatrists. *Br J Psychiatry* 2022; **221**: 374–6.

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Author's reply. RE: Proposed Assisted Dying Bill: implications for mental healthcare and psychiatrists

We thank Drs Findlay, Bryden and Breen for their comments on our editorial[1] on assisted dying. Dr Findlay rightly clarifies that even though the legislation we refer to is being considered by the UK parliament, it only applies to England and Wales. This error occurred inadvertently through successive revisions of an earlier draft. A synopsis of previous attempts to pass such a Bill was also suggested by one of the peer reviewers of our article, and we do refer readers to suitable literature. However, given space and reference limitations, we were unable to provide a reasonable history of assisted dying legislation, which is extensive and nuanced.

Instead, the substance of our editorial concerns issues of medical and psychiatric care that supersede regional and political systems and lie predominantly in the realms of medical ethics and comprehensive service provision. We believe patients and families are not best served if different jurisdictions adopt distinct procedures and processes for implementation and follow markedly different political processes for deliberation. Such an approach is likely to create inequalities of access and potential harms; therefore we advocate a broader consensus, and guidance needs to be achieved by health and social care professionals.

In addition, we allude to the failures of international implementations referred to in the House of Lords record. Given current variations in service provision and the challenges of regulation, we argue that safe implementation should, in the first instance, be coordinated at a national level, and that alongside this, careful surveillance and research of harms and benefits is necessary.

Drs Bryden and Breen both make compelling and compassionate arguments. For example, Dr Bryden's comments regarding the motivations of those seeking assisted dying and the stigma associated with those judged as not actively contributing to society are on point. We agree with their sentiments even though they arrive at somewhat different conclusions, but this further highlights the challenges we face. End-of-life care is personal, and each person will want a particular level of care and support, some moving towards assisted dying while others remain firmly against the possibility. This is where legislation will need to incorporate personalised options such as advanced directives and novel measures to assess capacity. However, given the many scenarios in which assisted dying may be sought and the likely complexities of each person's situation, any legislation will need to be flexible and accommodating while ensuring that choice and dignity are not compromised.

Declaration of interest

None

Reference

1 Bhui K, Malhi GS. Proposed Assisted Dying Bill: implications for mental healthcare and psychiatrists. *Br J Psychiatry* 2022; **221**: 374–6.

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