

Correspondence

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

Internal coercion and self-stigma

Professors Bhui and Malhi¹ 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 undoubtedly 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 capacious).

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