Legal Implications of Psychiatric Assessment for Medical Aid in Dying

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In recent years, several jurisdictions have passed legislation to permit medical aid in dying (MAID) worldwide, with considerable expansion in the availability of this practice. MAID has been defined as the practice of a clinician prescribing lethal drugs in response to a direct request from the patient, with a shared understanding that the patient intends to use the medication to bring about the patient's death. Wider legalization of MAID has prompted debates and legal controversies regarding the extent to which MAID should be available and its application for people experiencing mental illness as the primary indication. This article examines shifting attitudes of professional medical organizations toward MAID. We discuss the existing statutory provisions for psychiatric assessment for MAID in the United States and the implications on such assessments should MAID be expanded to include mental illness as the primary indication. This article also assesses legal disputes concerning MAID regulations and explores the role of psychiatric experts in the practice of MAID.

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A growing number of jurisdictions have permitted access to medical aid in dying (MAID), defined in this article as the prescription of lethal drugs by a clinician with the mutual understanding that the patient intends to utilize the medication to end the patient's life. Just in the past few years, Spain, Austria, New Zealand, Colombia, and Australia expanded access to MAID.[1–5] This practice has been legal in Germany since 2020, although there have been more recent attempts to better regulate the practice.[6] Italy granted access to MAID for the first time in 2022 after legalization in 2019.[7] MAID was legalized in New Jersey and Maine in 2019, followed by New Mexico in 2021, bringing the total number of jurisdictions allowing it within the United States to 11.[8–11] As access to MAID has been increasing in a number of places around the world, questions have arisen regarding the consideration of mental illness as the primary criterion for MAID. This practice, legal in countries like the Netherlands, Belgium, and Luxembourg, is now being considered for implementation in other countries.[4] For example, in Canada, government officials were gearing up to authorize MAID for mental illness commencing in March 2024. In February 2024, legislation proposing an extension on the exclusion of this practice until March 2027 was introduced.[12,13] This proposed extension, informed by the findings of the Special Joint Committee on MAID,[13] underscores the necessity for informed guidelines and practices and the challenges of reaching this objective.

With wider legalization, MAID continues to attract debate regarding the extent to which it should be available, resulting in ongoing legal controversies. In this article, we examine existing statutory provisions for psychiatric assessment in MAID in the United States and analyze the language used. We consider the challenges in assessing MAID exclusively for mental illness and explore the concept of terminal mental illness. Finally, we review litigation surrounding MAID regulations and explore the role of psychiatric experts in this evolving landscape.

Shifting Attitudes

In the context of this article, we opt to use the term MAID to describe the practice of clinicians

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prescribing lethal medication for self-administration by patients, considering that, in certain jurisdictions, nonphysician advanced practice professionals are permitted to prescribe these medications.[14] It is crucial to differentiate this practice from euthanasia, which involves the administration of lethal medication by the clinician.[4] The shifting stances of organized medicine mirror the ongoing ethics discourse concerning MAID. The American Academy of Hospice and Palliative Medicine embraced a stance of studied neutrality in 2016.[15,16] In 2018, the American Medical Women's Association expressed support for the practice of MAID in their position statement, the American Academy of Family Physicians transitioned to a position of engaged neutrality, and the American Academy of Neurology reversed its longstanding opposition to MAID and instead left the decision to the conscientious judgment of its members.[17–20] In 2019, The American Medical Association's (AMA) Council on Ethical and Judicial Affairs (CEJA) undertook an analysis of the association's position on MAID, considering the changing landscape with an increasing number of American jurisdictions legalizing such practices.[21] The council acknowledged that both supporters and opponents of the matter share a dedication to values of care, compassion, respect, and dignity, but they differ in reaching distinct moral conclusions from these foundational values in equally sincere good faith.[21] While upholding its stance against MAID, the AMA modified its position by pairing it with Code of Ethics Opinion 1.1.7, which supports the individual conscience of physicians on this matter.[21,22]

Regarding the AMA's use of "physician-assisted suicide," CEJA acknowledged that choosing terms can convey unintended messages but opined that, despite its negative connotations, this term was the most precise at unambiguously distinguishing the practice from euthanasia.[21] At the time of this writing, the American Psychiatric Association is in the process of updating its 2016 position statement and resource document on this matter.[23,24] These various adjustments to long-held positions regarding MAID reflect the diverse perspectives within the medical community.

Statutory Provisions in the United States

As of 2023, 11 jurisdictions in the United States permitted eligible patients diagnosed with a terminal illness to access MAID.[11] In these jurisdictions, participating clinicians have the obligation to furnish patients seeking this option with comprehensive information, including their diagnosis, prognosis, the likely outcomes of prescribed MAID medication, and available alternatives.[25] Additionally, for a patient to meet typical eligibility criteria, the physician must ascertain that the patient is capable of making an informed and voluntary decision. These prerequisites align with established health care decision laws that mandate competent, voluntary, and fully informed decisions.[25] Statutory provisions for psychiatric assessments vary across jurisdictions, as summarized in Table 1.[8–10,26–43] In all of these jurisdictions, patients whose judgment is found by the mental health professional to be impaired are deemed ineligible to access MAID.[8–10,26,28,31,33,35,37,39]

In most jurisdictions, the obligation for a mental health evaluation distinctly mentions "psychiatric or psychological disorder," "depression," or "mental disorder" as the identified "cause" of impaired judgment.[27,29,34,38,40,41,43] The mere presence of a mental disorder, in and of itself, does not suffice for deeming patients as lacking decisional capacity under these statutes unless their judgment is demonstrably impaired. The presence of a mental disorder or another psychological condition, when referenced in these statutes, functions either as a catalyst for a more meticulous evaluation of capacity or as a contextual element when functional capacities are determined to be compromised. Phrasing used in MAID statutes that avoid excessive emphasis on diagnosing mental disorders may limit the probability of making broad assumptions about the connection between mental health conditions and capacity.[25] Additionally, such language alerts evaluators to the potential impact of factors beyond mental disorders on a patient's capacity. The wording within statutes can guide evaluators in centering their attention on the patient's evident functional incapacity rather than exclusively on the presence of a mental disorder diagnosis.[25]

Assessing MAID for Mental Illness

Several jurisdictions, such as the Netherlands, Belgium, Luxembourg, Switzerland, and Canada, have, to varying extents, moved away from a strict "terminal illness" criterion as part of their assisted death legislation.[4,44–47] In March 2021, Canada implemented Bill C-7, which introduced significant changes to the country's MAID legislation, such as broadening eligibility criteria by removing the requirement that a person's natural death be reasonably foreseeable, instead requiring that the individual have a

Table 1 Provisions for Mental Health Assessments in Medical Aid and Dying Legislation

Legal MAID	Year Effective	Mental Health Assessment Requirement
Oregon Death With Dignity Act[26]	1997	"If in the opinion of the attending physician or consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment."[27]
Washington Death With Dignity Act[28]	2009	"If, in the opinion of either the attending qualified medical provider or the consulting qualified medical provider, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment."[29]
Baxter v. Montana[30a]	2009	No legislation
Vermont Patient Choice and Control at the End-of-Life Act[31]	2013	"The physician either verified that the patient did not have impaired judgment or referred the patient for an evaluation by a psychiatrist, psychologist, or clinical social worker licensed in Vermont for confirmation that the patient was capable and did not have impaired judgment."[32]
California End of Life Option Act[33]	2016	"If there are indications of a mental disorder, the physician shall refer the individual for a mental health specialist assessment."[34]
Colorado Proposition 106 End of Life Options Act[35]	2017	"Refer the individual to a licensed mental health professional. . . if the attending physician believes that the individual may not be mentally capable of making an informed decision."[36]
DC Death with Dignity Act[37]	2017	"If, in the opinion of the attending physician or consulting physician, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment."[38]
Hawai'i Our Care, Our Choice Act[39]	2019	"The attending provider shall refer the patient for counseling. No medication . . . shall be prescribed until the person performing the counseling determines that the patient is capable, and does not appear to be suffering from undertreatment or nontreatment of depression or other conditions which may interfere with the patient's ability to make an informed decision."[40]
An Act to Enact the Maine Death with Dignity Act[9]	2019	"If, in the opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment."[41]
New Jersey Bill A1504 Aid in Dying for the Terminally Ill Act[8]	2019	"If, in the medical opinion of the attending physician or the consulting physician, a patient. . . may not be capable, the physician shall refer the patient to a mental health care professional to determine whether the patient is capable."[42]
New Mexico Elizabeth Whitefield End of Life Options Act[10]	2021	"If an individual has a current history of a mental health disorder or an intellectual disability that could cause impaired judgment. . . or if, in the opinion of the prescribing health care provider or consulting health care provider, an individual currently has a mental health disorder or an intellectual disability that may cause impaired judgment. . . "[43]

MAID, medical aid in dying. Data for this table were retrieved from the individual statutes.[8–10,26,27,29–33]

[a]In its 2009 decision *Baxter v. Montana*, the Montana Supreme Court ruled that assisted suicide did not violate Montana legal precedent or state statutes, but there is no legal protocol in place.[30]

grievous and irremediable medical condition.[47] To be considered as an individual experiencing a grievous and irremediable medical condition, one must have a serious disease or disability, must be in an advanced state of deterioration that cannot be reversed, and must experience unbearable physical or mental challenges as a result of an illness that cannot be alleviated under conditions that the patient deems acceptable.[48]

The application of the irremediability criterion to psychiatric distress poses several intricate challenges. Psychiatric distress is often inherently subjective, and determining when a mental illness reaches an irremediable state is a complex task.[49,50] A 2016 survey of 248 Dutch psychiatrists with practical experience in assessing irremediable psychiatric distress revealed that 56 percent believed it was possible to determine irremediability, whereas 44 percent either expressed doubts about its feasibility or considered it an impossible task.[51]

Although there is an abundance of theoretical literature addressing the concept of irremediability concerning MAID for mental illness, empirical studies on this topic are scarce. A qualitative investigation published in 2022, involving 11 psychiatrists in the Netherlands experienced in evaluating irremediable psychiatric distress in the context of MAID, revealed that most relied on retrospective criteria to define the prospective notion of irremediable psychiatric challenges.[52] Study participants acknowledged the inevitability of uncertainty in this context, and most of them felt that rejecting MAID solely because of uncertainty does not fully address a patient's request for it. The

authors of the study stressed the epistemological impossibility of attaining absolute certainty about the prognosis of any form of distress, suggesting that mental health professionals should aim for a balanced approach between the need for certainty and the duty to assist patients seeking relief from their challenges.[52] The primary diagnostic challenge identified by participants of the 2022 study of Dutch psychiatrists was the frequent co-occurrence of multiple psychiatric diagnoses. The study participants also highlighted treatment-related difficulties, including evaluating the effectiveness of prior treatments, determining when the limits of treatment had been reached, and managing cases involving treatment refusal.[52]

Multiple studies suggest that previous treatment failures often serve as a predictive factor for the chronicity of psychiatric illnesses.[53,54] Adopting a retrospective approach argues that, because a patient's medical history plays a pivotal role in establishing irremediability, the refusal of treatment may factor against irremediability when assessed by a mental health professional. In simpler terms, although clinicians in these contexts may not coerce patients into trying every available treatment, patients in turn cannot oblige clinicians to determine a condition as irremediable unless they are willing to explore an adequate array of therapeutic options. This retrospective outlook on irremediability supports a more stringent approach to treatment refusal in psychiatry that does not align with policies in jurisdictions such as Canada that do not require all reasonable alternatives be pursued prior to MAID eligibility.[55] This approach attempts to quantify and assess psychological challenges through measurable criteria; however, it overlooks the patient's personal experience of distress and does not take into account individual values and beliefs. Although grounded in principles of limiting MAID to situations with no viable treatment alternatives, safeguarding vulnerable individuals, and preventing MAID from replacing comprehensive mental health care, this approach may compromise individual autonomy. Striking a balance between these subjective and objective approaches underscores the inherent challenge of quantifying the nuanced nature of distress.

An approach that relies heavily on a history of robust mental health services utilization may lead to disparities in accessing MAID, as some individuals may lack the chance to explore all treatment options because of difficulties in accessing care. Denying access to MAID under the pretext of improving health care condemns potentially eligible individuals to prolonged distress.[56] Conversely, the argument that MAID could be seen as an alternative for those unable to access evidence-based treatments raises valid concerns.[57–59] MAID solely for mental illness can be viewed as conveying a perilous message to psychiatric patients, suggesting the existence of genuinely hopeless conditions that can only be alleviated by ending one's life.[58] This perspective can be seen as fundamentally contradictory to the role of psychiatrists considering the extensive training they undergo to prevent suicide. Another viewpoint argues that MAID could give patients hope that there is an end to their distress, thereby motivating them to pursue treatment.[51] In a study of psychiatric patients who were approved for MAID, eight of the 48 ultimately did not utilize it as merely having it as an option provided them with adequate peace of mind, enabling them to continue living.[51]

The consideration of patients declining specific treatments as experiencing irremediable distress is controversial and raises questions about the effectiveness of mandated treatments, especially psychotherapy.[51] Canadian law affords greater autonomy to the patient in the decision to decline treatments.[48] In the Netherlands, the law mandates a shared decision between patients and physicians regarding treatment refusal.[60] An examination of 66 Dutch psychiatric euthanasia and MAID cases from 2011 to 2014 found that 56 percent of patients had previously declined certain treatments for reasons such as lack of motivation, concerns about side effects or risks, doubts about treatment efficacy, or a combination of factors.[60] A 2022 study involving 53 experienced Dutch and Belgian psychiatrists aimed to establish consensus on criteria for characterizing irremediable psychiatric distress. Although there was agreement that there should be limits on the number of treatments patients must undergo, no consensus emerged on specific treatment refusal criteria. The criterion established in the study, that limits should exist, allows for differing interpretations.[60] An analysis of 35 Dutch cases involving psychiatric euthanasia or MAID revealed that physicians had disagreements about the concept of irremediable psychiatric distress in 11 percent of the cases.[51] These discrepancies in professional opinions underscore the potential ambiguity and subjectivity involved in the notion of irremediable psychiatric distress.

A 2020 comprehensive review suggests that up to three-quarters of psychiatric patients may possess the capacity to make health care decisions[61]; however,

the threshold for decisions regarding MAID should arguably be set higher.[47] Research reveals that a significant proportion of patients requesting MAID or euthanasia for mental illness endure extended courses of psychiatric conditions.[62] In such cases, the desire for death may be influenced by the enduring presence of the mental disorder, which can differ from an irremediable condition. For example, individuals experiencing depression typically pursue less information to aid in problem solving and utilize fewer resources.[63] These individuals also struggle with envisioning their future because of loss of hope, which can hinder their ability to make decisions oriented toward the future.[64,65] Although some have expressed concerns regarding the impact of symptoms such as hopelessness, helplessness, pessimism, and apathy on assessing the futility of additional treatment,[66,67] others suggest that the assessment of cognitive distortions and irrational health beliefs should be applied universally to all patients requesting MAID, regardless of whether they have somatic or mental disorders.[68–70]

The complexity of assessing capacity for patients seeking MAID solely for mental illness has led to differing expert opinions, with some advocating for the complete exclusion of psychiatric distress as a basis for MAID, whereas others deem such a blanket ban unwarranted.[68,69,71] Those in favor of inclusion contend that patients with mental disorders who do possess decisional capacity may unfairly continue to experience distress if excluded.[71] This perspective was illustrated when the Swiss court ruled in favor of an individual with a mental illness seeking access to MAID. The court ruled a distinction should be made between temporarily impaired individuals expressing a desire to die as a result of their treatable psychiatric condition and those with severe, enduring mental illness who have made rational and carefully considered decisions to alleviate their distress.[72] These diverse perspectives on decisional capacity are demonstrated in a 2017 survey conducted among Dutch psychiatrists, revealing that 65 percent believed they could determine a patient's capacity to make a competent assisted death request, 12 percent did not, and 23 percent had doubts.[73] Although there is ample research on the impact of cognitive distortions on decision-making capacity in general,[74] there is a notable scarcity of research regarding their influence on decision-making capacity within the realm of end-of-life decisions.

In regions where MAID is specifically designated for terminal conditions, the question emerges regarding whether mental illness can be classified as terminal based on the operationalization of the term within the jurisdiction. Medically futile treatment has been defined as a clinical intervention that lacks utility in achieving a defined goal for a particular patient.[75] The World Health Organization defines palliative care as, "an approach that improves the quality of life of patients and their families who are facing the problems associated with life threatening illness. It prevents and relieves distress through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual."[76] The discussion regarding palliative strategies in severe and persistent mental illness centers on exploring the potential advantages of recognizing the limitations of curative treatments for major psychiatric disorders.[77,78] It raises the question of whether prioritizing symptom alleviation and enhancing the quality of life might be a more practical approach in specific instances.[79]

In 2010, researchers proposed criteria for medical futility in anorexia nervosa, specifying poor prognosis, unresponsiveness to competent treatment, continued physiological and psychological decline, and an apparently inexorable terminal course.[80] They advocated for the utilization of palliative and hospice care as a last resort in managing refractory anorexia nervosa. As MAID becomes a more widely accessible option for end-of-life care, its potential role in treatment-refractory anorexia has garnered attention. In a 2022 article on the MAID process for three individuals with anorexia, the authors advocated for extending access to MAID to those facing terminal anorexia, marked by severe physiological deterioration and end-of-life challenges encompassing both psychological and physical distress.[81] They argued for this access in jurisdictions where MAID is legally permitted, aligning with the approach afforded to other patients with terminal conditions. Drawing from literature on the duration of life during hunger strikes,[82,83] the authors suggested that a prognosis of less than six months can be reasonably established when an individual with anorexia ceases participation in recovery efforts, meeting the eligibility requirement of MAID laws in the United States. Eligibility requirements, clinician requirements, and additional safeguards of MAID laws in the United States, compiled through a review of individual statutes, are summarized in Table 2.[8-10,26,28,30,31,33,35,37,39,84] Some experts have argued that individuals with anorexia may be deemed incompetent to refuse treatment

Table 2 Shared Characteristics of Medical Aid in Dying Legislation[a]

Characteristic
Eligibility Criteria
Minimum age requirement of 18 years
Residency requirement[b]
Able to independently formulate and convey healthcare decisions
Must be diagnosed with a terminal illness with an anticipated life expectancy of six months or less
Clinician Requirements
Licensed in the jurisdiction[c]
Provide a diagnosis for the patient indicating a terminal illness anticipated to result in death within six months or fewer
A clinician offering consultation is required to confirm both the terminal diagnosis and prognosis, in addition to ensuring that the patient has the capacity to make the decision
As necessary, a recommendation for consultation with a mental health professional must be initiated[d]
Must provide the patient with counseling regarding available alternatives
Additional Safeguards
Two oral requests with a time interval in between[e]
A written request with a witness present
The patient can withdraw the request at any given moment
Healthcare professionals are not under any obligation to engage or partake
The application of the law should not affect the standing of a patient's health, life, or annuity insurance policies

Data for this table were retrieved from the individual statu-tes.[8–10,26,28,31,33,35,37,39]

[a]Montana has legal MAID via court ruling, but there is no legal protocol in place, and therefore, the criteria in this table do not apply to Montana.[30]

[b]Oregon and Vermont do not have a residency requirement. There is ongoing litigation surrounding New Jersey's residency requirement.[26,31,84]

[c]In New Mexico (10), Washington (28), and Hawaii (39), non-physician advanced practice professionals are authorized prescribers. Colorado's statute, newly amended in 2024, will also permit this practice. once the amended law takes effect (35).

[d]Refer to Table 1.

[e]This time frame ranges from 48 hours to 20 days.[8–10,26,28,31,33,35,37,39] New Mexico does not have an oral request requirement.[10] Oregon specifies that patients with less than 15 days left to live can skip the 15-day waiting period.[26]

solely because of the nature of their mental illness.[85,86] Others contend that circumstances may warrant respecting anorexia patients' right to decline treatment, even if it potentially leads to death, and emphasize the importance of considering factors such as chronicity, severity, irreversible damage, the number of attempted treatments, and the patients' demonstrated competence to comprehend their situation.[87] This then raises the question of why when a competent individual with anorexia, facing a terminal illness expected to result in death within six months, is denied the option of MAID, whereas a competent cancer patient, opting out of experimental or novel chemotherapy because of a perception that enough has been tried or that the harm will outweigh potential benefits, is granted access to MAID.

Regions where MAID for mental illness is currently practiced and areas considering its implementation may find it beneficial to draw upon the latest research emerging from the longer standing practices in the Netherlands and Belgium. Empirical research, coupled with ongoing discussions among psychiatric professionals, has the potential to guide whether the establishment of criteria for determining irremediable psychiatric distress and terminal psychiatric illness is feasible.

Legal Controversies

Evolving societal attitudes toward end-of-life choices have resulted in litigation in recent years to expand the accessibility of MAID. In *Gideonse v. Brown* (2021)[88] and *Bluestein v. Scott* (2022),[89] plaintiffs challenged state residency requirements in MAID laws. In *Gideonse v. Brown*, the plaintiff contested Oregon's residency requirement, leading to a March 2022 settlement in which Oregon agreed to stop enforcing it and initiated legislative changes to abolish it. By July 2023, residency restrictions were fully removed from the Oregon Death with Dignity Act.[26,90] In *Bluestein v. Scott*, plaintiffs argued against Vermont's residency requirement, and in a March 2023 settlement, Vermont officials agreed not to enforce it, making Vermont the first state to eliminate this requirement.[32,91] The case of *Govatos v. Murphy*, which was filed in New York in August 2023, challenges similar residency requirements in New Jersey's MAID for Terminally Ill Act on constitutional grounds.[84]

Expansion of MAID in the United States has also raised ethics and moral dilemmas for clinicians and institutions with religious or conscientious objections to the practice. In *Glassman v. Grewal* (2019),[92] the plaintiff alleged that New Jersey's MAID legislation violated several rights, including the free exercise of religion. The case was dismissed, and the court clarified that, per the existing statute,[8] health care providers refusing MAID based on religious objections only needed to transfer medical records to another provider, which was consistent with existing regulations.[92] In *Christian Medical & Dental Associations v. Bonta* (2022), plaintiffs argued that requiring health care providers to document the patient's date of request for MAID in the medical record forced participation against their conscience.[93] They argued that documenting a patient's request for assisted death would fulfill the first of two oral requests required for a patient to undergo MAID in California. In May 2023, a settlement was reached, ensuring no enforcement of penalties for physicians who refuse to document MAID requests, provide information about it, or refer to

another physician.[94] Physicians would still be required to inform patients of their nonparticipation and transfer medical records. The plaintiffs were awarded $300,000 in legal fees.[94] In 2023, New Mexico enacted a bill permitting clinicians to refuse involvement in MAID referrals and the provision of MAID information because of conscientious or religious objections, a development stemming from the *Lacy v. Torrez* case.[95]

Global legal cases have underscored the concerns of health professionals and institutions that hold religious or conscientious objections to the practice of MAID. These concerns stem from a broader debate about the clash between religious freedom, evolving health care practices, and the principle of respecting the autonomy and values of clinicians while also ensuring patient access to legal health care options. St. Martha's Regional Hospital in Nova Scotia, Canada initially refused to provide MAID because of the institution's religious ties, but a 2019 ruling mandated that, although not required to perform MAID, St. Martha's Hospital must provide patients information and help transfer them to suitable providers or facilities.[96] Similarly, the Delta Hospice Society in British Columbia lost funding in 2021 for refusing to provide MAID, which violated federal law and provincial policy mandating access at nondenominational facilities that receive more than half their funding from the province.[97]

Amid growing availability of MAID, clinicians delivering these services may also face risks of legal action, a situation observed in jurisdictions where euthanasia is legally permitted. In 2018, a Dutch doctor was prosecuted for euthanizing a 74-year-old patient with Alzheimer's disease. The central problem was whether a prior choice for euthanasia remains valid if made while the patient was of sound mind but lost capacity later. The court ultimately acquitted the doctor in 2019, finding compliance with euthanasia legislation.[98] In 2020, a Belgian court held the first criminal case on euthanasia since its 2002 legalization.[99] Three doctors, including the one administering the lethal injection, the patient's former general practitioner, and a psychiatrist, were on trial. They were accused of performing euthanasia on a patient in 2010 who did not meet the eligibility criteria. Belgian law permits euthanasia for adults facing unbearable physical or mental distress from a serious and incurable disorder. The 38-year-old patient's family contended that she had not received psychiatric treatment for 15 years and was grappling with a relationship breakup when deemed incurably ill. Prosecutors argued that she did not have an incurable mental disorder, a necessary condition for euthanasia. The Belgian court acquitted all three doctors.[99] These cases underscore the need for clinicians to carefully consider legal frameworks, eligibility criteria, and potential ethics dilemmas when engaging in MAID practices, as legal actions can have profound implications for their professional roles and responsibilities.

The expansion of MAID raises concerns about potential risks and disparities, particularly for vulnerable populations like individuals with disabilities. Opponents argue that societal pressure could lead those with disabilities to see themselves as burdensome and opt for this choice.[68] This problem was central to a lawsuit in Canada, where a man alleged he had been denied proper home care and pressured to choose MAID over the necessary home care that would enable independent living.[100] In April 2023, a group of disability organizations, along with two individuals with disabilities, filed a federal lawsuit against the state of California. The plaintiffs allege that California's End of Life Options Act discriminates against individuals with terminal disabilities.[101]

In cases of mental illness, there is a risk that individuals with psychiatric conditions may request MAID without adequate evaluation of their condition or access to appropriate mental health care. This concern was highlighted in the case of a 61-year-old Canadian man with a history of recurrent depression, cognitive disability, and hearing loss.[49] He lived independently and was admitted to the hospital resulting from a wellness check and diagnosed with dehydration and suicidality. He underwent euthanasia 40 days after his admission, with the family being informed only four days before the procedure. During a final conversation, he was noted to be enraged and accused his biological family of not being his blood relatives. The family's complaint to British Columbia's College of Doctors and Surgeons required a police investigation, which confirmed the deceased met the criteria for euthanasia. Despite a request for a public investigation, the province's oversight unit found no need for further inquiry.[47,102]

Roles of Mental Health Experts

Although jurisdictions have varying legal requirements and safeguards for MAID, shared characteristics encompass the necessity for a voluntary, thoroughly contemplated, and sustained request over time.[103] In jurisdictions within the United States and Canada, it is mandatory for the prescribing clinician, a consulting

clinician, and sometimes a mental health expert to confirm the patient's capacity to make health care decisions before granting access to MAID.[8–10,26,28,31,33,37,39,48] A consultation may be sought in situations involving individuals with a prolonged history of mental illness and a concurrent terminal medical condition or in situations of new-onset psychiatric symptoms, as it is not unusual for such symptoms to emerge when individuals are confronted with serious medical conditions.[25,70] Recognizing that symptoms of mental illness can influence decisional capacity and voluntariness, a thorough evaluation of these aspects becomes essential.[63,67,104,105] The Canadian Psychiatric Association (CPA) has argued that, considering ethics principles and the protection of medical professionals, the capacity threshold for decisions as permanent and complex as MAID may be higher than the existing legal threshold in Canada. The organization has outlined clinical aspects of MAID capacity assessments in their position paper.[47] In the United States, jurisdictions have utilized varying language in statutory provisions concerning psychiatric assessments. For example, although several statutes make reference to "impaired judgment," only Vermont explicitly defines this term.[31] When referring to capacity or competency, most of the legislatures focus on patients' abilities to make and communicate a treatment decision whereas others make mention of the ability to understand the nature and consequences of the decision and its significant benefits, risks, and alternatives in their definition of capacity or competency.[8–10,26,28,31,33,37,39] This legislative variance does not indicate that validated factors of assessing capacity to make treatment decisions, such as reasoning and appreciating the nature and consequences of their choices,[106] are irrelevant to capacity determinations under statutes that do not mention them. Clinicians responsible for assessing the capacity to make health care decisions must fulfill this duty in accordance with ethics and professional standards.[25] It is important to highlight that, although informal tools for MAID consent are employed by certain hospitals and organizations, there are currently no standardized assessment tools validated with essential psychometric properties, such as inter-rater reliability or test-retest reliability, specifically designed for assessing capacity to consent to MAID.[47] Consequently, the CPA advises against relying solely on such tools or instruments for determining decisional capacity.[47] Specialized training could be argued for, considering the gravity of these assessments.[13,47]

Mental health professionals may be called upon to assess individuals for MAID solely for mental illness in jurisdictions that permit this practice. Under Canadian federal legislation, two independent assessors for MAID, who can be either physicians or nurse practitioners, must assess the legislated elements and verify that the person fulfills the eligibility criteria. If the person's death is not deemed reasonably foreseeable, at least one of the two assessors validating eligibility must possess expertise in the condition causing the patient's distress.[47] Although the federal legislation does not provide a specific definition for expertise, the stance of the CPA is that, when a mental disorder is the exclusive underlying factor driving the MAID request, it is recommended that one of the two independent assessors for MAID eligibility should be a psychiatrist.[47] In this role, the psychiatrist would be responsible for determining whether the mental illness meets the criteria for irremediable distress or terminal mental illness, both of which lack standardized criteria. A January 2024 report by the Canadian Special Joint Committee on MAID concluded that the problems around accurately determining irremediability and suicidality in the context of MAID solely for mental illness were unlikely to be resolved in the foreseeable future.[13]

Given the evolving landscape of MAID, forensic mental health professionals may play a role in legal proceedings concerning MAID, as these cases often revolve around multifaceted aspects of patient eligibility, decision-making capacity, and the ethics and legal nuances of the practice (Table 3). Disputes over decision-making capacity may require forensic mental health professionals to assess individuals' mental state and their ability to provide informed consent. Cases where allegations of coercion or undue influence are raised, particularly by family members or health care providers, may demand forensic psychiatric evaluations to determine the presence of external pressures. The forensic mental health professional may assess for any signs of coercion or undue influence by interviewing family members, health care providers, and others involved in the patient's care. They may evaluate the dynamics of the decision-making process and assess whether external factors are influencing the patient's decision. Wrongful death or negligence claims in MAID cases can also require forensic evaluation to assess the circumstances. In situations where clinicians, whether participating in MAID or abstaining from it, experience wrongful termination because of the

Table 3 Medical Aid in Dying Litigation and Forensic Psychiatry

Wrongful Death or Negligence Claims	
	Allegations that a healthcare provider failed to comply with the legal requirements or safeguards or that the patient's decision was influenced by coercion or mental incapacity. A forensic mental health professional may be asked to assess the deceased's mental state, decision-making capacity, and the circumstances leading to their choice.
Informed Consent Disputes	
	Disagreements regarding whether the patient was able to provide informed consent for MAID may call for a forensic mental health professional to evaluate the patient's capacity to make an informed choice.
Coercion or Undue Influence Claims	
	In situations where there are allegations of coercion or undue influence, a forensic mental health professional may be asked to assess the patient's vulnerability and the extent of external pressures, helping to determine the validity of these claims.
Compliance with Legal Safeguards	
	A forensic mental health professional may be called upon to evaluate whether healthcare providers or institutions followed the legal safeguards for MAID, ensuring that the process adhered to the law and ethical standards.
Wrongful Termination	
	In cases where clinicians face wrongful termination for their engagement in or avoidance of MAID, a forensic mental health professional may be called upon to assess the mental and emotional state of the terminated clinician and to determine whether the clinician's mental health was affected by the termination.

MAID, medical aid in dying.

interplay of personal convictions, institutional regulations, and external pressures, a forensic mental health professional may be enlisted to provide consultation in legal proceedings.[107] The forensic mental health professional may opine on the psychological and emotional toll of wrongful termination. As MAID laws evolve, legal challenges may emerge, making expert psychiatric assessments essential to address the interplay between mental health, ethics considerations, and evolving legal requirements in these cases.

Conclusions

Greater attention to MAID around the world has raised complex questions about the intersections of MAID and mental illness. In the United States, wider availability of MAID carries profound implications, not only for directly involved patients but also for the mental health professionals tasked with evaluating whether these individuals meet statutory criteria for MAID. In areas where MAID is being practiced or deliberated, the establishment of well-defined criteria, backed by empirical evidence, is necessary to provide sufficient safeguards. The evolving legal landscape underscores the intricate nature of these matters and highlights the need for greater research and scrutiny. As MAID laws have spread in recent years in the United States and elsewhere, there is little doubt that litigation, and the need for mental health professionals to provide input into these cases, will continue.

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