In late 2016 the American Psychiatric Association (APA) stated that psychiatrists ought not participate in physician aid in dying (PAD) or euthanasia for non-terminal illnesses. This practice already occurs in some European countries. As Mark Komrad, a psychiatrist on the APA’s national ethics committee, explained, the organization was concerned about this practice for multiple reasons: that it communicates that there is no hope for persons with severe suffering due to psychiatric illness, that persons with psychiatric illness have impaired decision-making capacity, and that judgments about whether suffering is interminable depend upon patients’ assessments of whether treatments like ECT are acceptable, even though these assessments could be controversial or misinformed. In effect, Komrad and the APA have opposed this practice because they are concerned that vulnerable psychiatric patients whose suffering might be treatable could instead receive aid in dying.

It would undoubtedly be a bad thing if that worry came to fruition. Still, we’re concerned that the APA’s opposition to PAD for non-terminal psychiatric illness is too facile. We’ll argue that the central justifications for PAD in cases of terminal illness also apply to some cases where people suffer only from non-terminal psychiatric illness. Moreover, we argue that the APA’s reasons for excluding persons with non-terminal illness from PAD are not compelling.

On the other hand, we are also sensitive to the APA’s concerns about PAD and euthanasia, and agree that many persons with psychiatric illness who suffer from suicidal ideation should not have access to PAD. Furthermore, we regard psychiatric practices like involuntary civil commitment and involuntary medication to prevent suicide as generally justifiable even though they are, as we will argue, deeply at odds with the rationale for PAD for non-terminal, psychiatric illness.

The result, we think, is a serious dilemma: how do we reconcile the idea that medicine should be empowered to prevent persons from attempting suicide with the idea that severe and intractable suffering, even when it is due to a non-terminal illness, can make death seem a reasonable option?

There are 3 short background readings: (contact linda.carrlee@hsc.utah.edu for copies)
- “Psychiatric evaluations for individuals requesting assisted death in Washington and Oregon should not be mandatory” by Linda Ganzini, MD, MPH (General Hospital Psychiatry 36 (2014) 10–12)