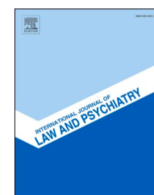
International Journal of Law and Psychiatry 87 (2023) 101871

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

journal homepage: www.elsevier.com/locate/ijlawpsy



Persons with mental disorders and assisted dying practices in Spain: An overview

Sergio Ramos-Pozón [a], Núria Terribas-Sala [b], Anna Falcó-Pegueroles [a,*], Begoña Román-Maestre [c]

[a] Faculty of Medicine and Health Sciences, University of Barcelona, Barcelona, Spain
[b] Fundación Víctor Grífols y Lucas, Barcelona, Spain
[c] Faculty of Philosophy, University of Barcelona, Barcelona, Spain

ARTICLE INFO

Keywords:
Euthanasia
Assisted suicide
Ethics
Psychiatry
Law

ABSTRACT

On 25 June 2021, the Law on Euthanasia in Spain came into force, providing for two modes of helping an individual end their life: euthanasia and/or medically assisted suicide. Among the requisites that a request for euthanasia has to fulfil are that the individual must be suffering a *severe, chronic and debilitating condition* or a *severe and incurable disease*, at the same time as that person shows the necessary *competence to decide*. The possibility exists that a patient suffering mental health problems submits such a request; however, the specific characteristics of a mental health disorder make such a request considerably more complex. In this article, based on a narrative review of the law itself and the related literature, the requisites established under the law are analysed from an ethical-legal perspective with the aim of defining when a request for euthanasia from a person with a mental health disorder may be deemed legitimate and in line with legal provisions. This should help clinicians make rational, reasoned decisions when dealing with a request of this type.

1. Introduction

Debates centred on the issue of euthanasia are gaining increasing importance in liberal societies. In Spain, although the fight for the decriminalization of euthanasia has been deliberated in public for decades, it was not until 25 June 2021 that Organic Law 3/2021 of March 24 regulating euthanasia came into force. This made Spain the fourth European country to draft legislation on euthanasia and the first to introduce an *ex ante* procedure, that is, a qualified assessment undertaken by a *Comisión de Garantías* (a so-called guarantee and evaluation committee) prior to euthanasia being performed. In this way, Spain introduced a procedure that is characterised by both guaranteeing citizens' basic rights (and ensuring due process), but one that is, at the same time, also more bureaucratic in its application. It is a law that prioritises the principle of patient autonomy, while also guaranteeing that healthcare workers can declare themselves conscientious objectors and, in this way, protect their right not to be involved in such procedures.

The law provides for two forms of assisted dying: euthanasia and medically assisted suicide; however, when a request for help to end a life is made on mental health grounds, various scenarios have to be carefully distinguished. A first possible scenario might be that of a person presenting comorbidity, that is, a mental disorder in conjunction with another serious somatic disorder. It could be the case that suffering from an incurable or debilitating cancer, or amyotrophic lateral sclerosis, for example, has led to depression and anxiety, but that the reason underpinning the request for euthanasia is not the mental health problem, but rather an inability to tolerate the suffering that this diagnosis supposes. In this case, it is the underlying diagnosis, not the mental illness, that moves the patient to seek assistance in ending their life. A second possible scenario might be that of a person suffering from a mental illness that causes intolerable suffering and which conditions all their activities of daily life, as well as their capacity for expression and relationship, and that such limitations will persist over time without any possibility of cure or improvement. It is this specific scenario that we wish to discuss in this article, one in which the basic diagnosis is psychopathology.

* Corresponding author at: Pavelló de Govern, Feixa Llarga Street s/n, 08907, L'Hospitalet de Llobregat, Barcelona, Spain.
E-mail addresses: sergioramos@ub.edu (S. Ramos-Pozón), nuria.terribas@grifols.com (N. Terribas-Sala), annafalco@ub.edu (A. Falcó-Pegueroles), broman@ub.edu (B. Román-Maestre).

https://doi.org/10.1016/j.ijlp.2023.101871
Received 29 November 2022; Received in revised form 21 February 2023; Accepted 21 February 2023
0160-2527/© 2023 The Authors. Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

2. Legislation regulating euthanasia in Spain

The new legal framework regulating euthanasia establishes a new individual right in the Spanish legal system. This right, as is stated in the preamble to the Organic Law, is linked to the fundamental right enshrined in the Constitution to life as well as to other rights, including the higher values of freedom, physical and moral integrity and dignity, among others. When analysing this new right in the specific case of a person with a mental disorder that requests help in dying, it is clearly relevant to know the essential requirements defined in this law, what role the attending and consultant physicians have, and what the legal reasoning is in other countries with greater legal experience in this field of assisted dying.

2.1. The requirements for receiving assistance in dying

Article 5 of Organic Law 3/2021 of March 24 regulating euthanasia establishes the requirements for requesting assistance in ending one's own life as follows:

a) Have Spanish nationality or legal residence in Spain, or a certificate of civil registration that certifies to a period of residence in Spanish territory of more than twelve months, be of legal age and fully capable and conscious at the time of the request.
b) Have, in writing, all relevant information about the medical condition, the various alternatives and possibilities for action, including that of access to comprehensive palliative care within the common portfolio of services and healthcare provisions to which that person is entitled in accordance with the rules of the care and protection of dependents.
c) Have, of their own free will, made two requests in writing, or by any other means that can be recorded, and which have not been induced by any external pressure, with a period of at least fifteen calendar days between the two requests.
d) Suffer a serious and incurable disease or a serious, chronic and incapacitating condition under the terms set out in this Law, as certified by the attending physician.
e) Give informed consent prior to receiving the provision of help to die. Such consent shall be incorporated in the patient's medical history.

To ensure the correct interpretation of Article 5 section d), the definitions contained in Article 3 of the Spanish legislation on euthanasia need to be taken into consideration:

1) *Suffering a serious, chronic and incapacitating condition*: refers to "those limitations that have a direct impact on the patient's physical autonomy and activities of daily life, preventing them from caring for themselves, as well as on their capacity for expression and relationship, and that are associated with constant and intolerable physical and psychological suffering, it being certain, or there existing a high degree of probability, that these limitations will persist over time without any appreciable possibility of cure or improvement".
2) *A serious and incurable disease* is "that which by its nature gives rise to constant and unbearable physical or psychological suffering without the possibility of obtaining a level of relief that the patient considers tolerable, with a prognosis of limited life expectancy, in a context of progressive frailty".

The patient, moreover, must be "fully capable and conscious", a critical condition that must be professionally evaluated in the case of any doubt. Indeed, the law defines the *situation of* de facto *incapacity* as "situation in which the patient lacks sufficient understanding and will to act autonomously, fully and effectively, regardless of the existence or adoption of measures of support for the exercise of their legal capacity".

Thus, it is possible that a patient with mental health problems might request assistance in accordance with these requirements.

2.2. The attending and consultant physicians

The attending physician is the "physician responsible for coordinating all the patient's medical information and healthcare, and for acting as the patient's primary interlocutor on all matters concerning their treatment and medical information throughout the care process, without prejudice to the obligations of other professionals involved in this provision of care", while the consultant physician is "a physician trained in the field of pathologies presented by the patient but who does not form part of the same team as that to which the attending physician belongs".

The attending physician is assigned the following functions:

1. To be present when the patient signs the request for assistance in dying, or to receive this document from another healthcare professional who indeed was present, a document that has to be included in the patient's medical record.
2. To provide the patient with all the information about their medical condition in writing, as well as about any therapeutic alternatives, including palliative care. The patient shall also be informed of the possibility of rescinding their request for assistance in dying at any time.
3. To certify that the patient complies with all legal requirements.
4. To carry out a process of deliberation with the patient throughout the aid-in-dying procedure.
5. To assess that the patient is competent to make healthcare decisions.
6. To consult with other professionals when deemed appropriate.
7. To contact the consultant physician so that he or she can carry out an assessment of the patient and verify that they fulfil all requisite criteria.
8. In the event that the request is denied, to inform the patient in writing of the decision and of the possibility of appealing the decision before the Guarantee and Evaluation Committee, and to submit the corresponding documents to this Committee.
9. To be present and to accompany the patient in the moment of assisting them to terminate their life. To certify the patient's death.

The consultant physician is an independent professional (i.e. he or she should not form part of the same team as that of the attending physician) with extensive knowledge about the underlying pathology presented by the patient and which has provoked the situation that has led this patient to seek help ending their life. If the underlying disease is of somatic origin (neurological, oncological, etc.), the physician must be a specialist in that field, even if the patient presents psychopathological symptoms. If the underlying cause is a mental illness that provokes great suffering, the consultant physician must also be an expert in mental health. This ensures a greater understanding of the patient's psychopathological condition and how the disease affects them. In making an assessment, the physician is required to verify if the symptomatology is a significant factor preventing the patient from being able to decide in an autonomous and responsible fashion. This information is essential in allowing the attending physician to verify whether or not the patient is fully capable and conscious. In addition, the consultant physician is assigned the following specific functions:

1. To verify that the patient has made two requests in writing and is acting of their own free will.
2. To verify that the patient complies with all the legal requirements.
3. To certify that the patient has all available information about their medical condition and therapeutic alternatives.
4. To verify that the patient has given their informed consent and that this has been included in their medical records.

2.3. An evaluation of the first year of legislation regulating euthanasia in Spain and a comparison with the situation in other countries

In the first twelve months since the introduction of this legislation in Spain, 336 individuals have requested assistance in helping them terminate their lives and 180 of these requests have been carried out. The region presenting most cases was Catalonia, where, as of June 2022 (Departament de Salut, 2022), 137 requests had been received, 68 of which were approved, 60 were carried out, five were pending, four postponed, and nine patients died before euthanasia could be performed. The most frequent illnesses presented by the patients in this region were neurological (neurodegenerative, neurological and paresis) disorders, oncological diseases and multimorbidity. More requests were received from men (77) than from women (60) and 49 requests were received from patients aged 51–70 and 75 from patients over the age of 71.

In the countries of the world in which euthanasia is decriminalized, individuals presenting problems of mental health can also request assistance in dying. Although statistically they represent relatively few cases, requests of this nature are increasing (Calati et al., 2021; Evenblij, Pasman, Pronk, & Onwuteaka, 2019; Perreault, Benrimoh, & Fielding, 2019; Verhofstadt, Van Assche, Sterckx, Audenaert, & Chambaere, 2019). In Belgium, Thienpont et al. (2015) studied 100 euthanasia requests from patients with mental disorders, of which 48 were accepted, although only 35 were carried out. Among these psychiatric diagnoses, depression and personality disorder were the most frequent. Likewise in Holland, requests are typically received from patients presenting a mood disorder, dementia, autism, anorexia and psychosis (Kim, De Vries, & Peteet, 2016; Dierickx, Deliens, Cohen, & Chambaere, 2016). In its annual report, the Dutch Euthanasia Committee (2019) identified 160 cases of dementia and 68 involving other mental disorders.

The legitimacy of the administration of euthanasia in patients with mental health problems generates considerable controversy. Debates centre on the assessment of a patient's capability, levels of suffering, the irremediability of the illness, the principle of self-determination and the authenticity of the decision (Nicolini, Kim, Churchill, & Gastmans, 2020). Several studies (Clarke, Cannon, Skokauskas, & Twomey P., 2021; Evenblij et al., 2019; Levin, Bradley, & Duffy, 2020; Pronk, Sindram, van de Vathorst, & Willems, 2021; Verhofstadt et al., 2020) show that psychiatrists who reject euthanasia in cases of patients presenting mental health disorders do so on the grounds that it is very difficult, if not impossible, to measure the intolerability of their suffering and to assess patient competence when it comes to distinguishing psychiatric symptoms from an autonomous decision. They also argue that an effective treatment for the disorder might be developed in the near term. In short, doctors are more likely to accept a request for euthanasia when it is made by a patient presenting with a somatic disease than with a mental pathology.

Ultimately, any analysis of the legitimacy of a person with a mental disorder to request assistance in ending their life under recent Spanish legislation requires an in-depth review of the key concepts underpinning this law – that is, *competence to decide*; *serious, chronic and incapacitating condition*; and *serious and incurable disease*.

3. Competence of patients with mental health problems

Article 5a. of the new legislation establishes that the patient "must be fully capable and conscious at the time of the request", that is, the patient must be fully competent of making the decision to end their life. This requirement is based on the premise that the decision to request euthanasia must be constant and coherent with the life project of the person requesting it.

To verify coherence, steps must be taken to ensure the patient has access to all available information about their condition, possible treatments, the inconveniences to which these might give rise, the resources that can be offered by way of support, etc. The request for euthanasia must be stable over time and reflect a rational line of argumentation. At the same time, steps should be taken to verify that this decision is not conditioned or coerced by third parties. The competence to take such a decision refers to the patient having sufficient psychological aptitudes and abilities to demonstrate that the decision is well argued, reasoned and reasonable.

There is a broad consensus that conducting such an assessment is based on cognitive criteria: *understanding, appreciation, reasoning and decision making* (Appelbaum, 2007). It requires verification that the patient has *understood* the pathology with which they present, what viable treatments can be offered, and what the associated risks and benefits of these treatments are, and the reasons why the patient opts to reject them. In addition, it is necessary to assess whether the patient *appreciates* the current status of their illness and what the purpose of the proposed treatment is. It is essential to understand the patient's *reasoning* in making their decision and, finally, whether they actually express that *decision*. This assessment concerns a specific task, undertaken at a specific moment in time and in a specific context.

In addition to these cognitive criteria, the assessment must also take into consideration the personal values of the person that requests assistance in dying, and the meaning they attach to their life and their quality of life (Palmer & Harmell, 2016). Any assessment of competence must be undertaken in a relational context that can provide the attending physician with an in-depth understanding of the patient's personal situation and the reasons why they request euthanasia. In a context of open dialogue, it is essential that the physician is able to interpret and endow with meaning the actions and words of the patient, leaving to one side their own prejudices and presuppositions (Kong, 2017).

To avoid accusations of discrimination or of incurring stigma, when a patient with mental health problems requests assistance in ending their life, their competence should be assessed in the same way as that of any other person. Working on the premise that such patients cannot decide is unjust and serves to strengthen the stigma that traditionally characterises mental health. But assessments of such cases are not exempt from added difficulties.

There are studies that examine the degree of *insight* (awareness of the pathology) and the ability to consent to medical treatment (Capdevielle et al., 2009). *Insight* has been analysed from several perspectives: in terms, that is, of levels of awareness, both of having a disease and of its symptoms, of the therapeutic need and its effects. Results point to a correlation between a poor degree of *insight* and a low appreciation of the risks and benefits of treatment, a decreased likelihood of comparing therapeutic alternatives, and a limited ability to express a choice. Cognitive impairment has also been found to be a conditioning factor for decision-making (Palmer, Dunn, Appelbaum, & Jeste, 2004).

Other studies conducting in-depth examinations of the competence of those with mental health problems conclude that many of these patients (including those with serious mental disorders such as schizophrenia or bipolar disorder) can make responsible decisions about their health status (y Calcedo et al., 2020; Vicens, Calcedo, Hastings, Männikkö, & Silvia, 2021). For this reason, there is no reason to rule out a priori a request for help in dying on the grounds that these patients are not competent to decide.

The therapeutic relationship – in such instances, more than ever – must be characterised by empathy and respect, avoiding at all times any preconceptions of the patient's situation, and seeking not to underestimate their suffering or devalue the narrative of their life. Considerable doses of compassion, humility and empathy are required for the physician to place themselves in the role of the patient and to look beyond what is "merely" seen or heard. Mental health professionals must have the skills and attitudes that allow them to explore the motives, values and desires of the patient and their family environment. And this also requires, when deemed appropriate, that they are willing to start conversations about the patient's desire to die as a reasonable decision to be assessed, conducting an exercise in hermeneutics in order to understand

in full the true sense of their suffering and how the disease conditions the daily life of the person with the mental disorder. Speaking about euthanasia at the request of the patient cannot be an *ipso facto* issue and considered just one more symptom of the pathology.

4. Serious, chronic and incapacitating condition

As is clearly set forth in the Spanish legislation, to request euthanasia, the patient must be experiencing constant and unbearable physical or mental suffering and this must be their main reason for seeking assistance in dying. It is worth reviewing here the definition of this suffering when it occurs within the framework of a serious, chronic and incapacitating condition, as provided for under Article 3 of the Law. As will become apparent, the interpretation of this definition in relation to the circumstances in which the patient with a mental disorder finds themselves may be critical in approving or dismissing the request for euthanasia.

Below, we consider some elements of this definition, beginning with an analysis of what is meant by "unbearable suffering". Some authors have sought to define unbearable suffering by considering it "a personal, subjective experience of an imminent, real or supposed threat to the integrity or life of the person, which has a significant duration and a central place in the mind of the person" (Dees, Vernooij-Dassen, Dekkers, et al., 2009). However, there is no consensus on its meaning (Murata & Morita, 2006; Rodgers & Cowles, 1997; Dees, Vernooij-Dassen, Dekkers, van Weel, et al., 2010), due doubtless to its inescapable subjective dimension.

Suffering can take on various dimensions, but it is possible to identify four elements that, on occasions, may even act together: medical elements, and psycho-emotional, socio-environmental and existential emotional factors (Verhofstadt, Thienpont, & Ygram, 2017; Verhofstadt et al., 2021; Dees, Vernooij-Dassen, Dekkers, Vissers, van Weel, et al., 2011; Evenblij et al., 2019; Stoll, Ryan, & Trachsel, 2021).

The medical elements include physical symptoms (fatigue, pain, problems of eating and drinking, etc.), cognitive symptoms (concentration problems, cognitive impairment, etc.), psychiatric symptoms (loss of emotional control, suicidal thoughts, addictions, identity crises, depression, etc.) and adverse reactions to treatment. Some authors have indicated that the suffering may also be related to the type of relationship a patient has had with their healthcare professionals. In the case of mental health, some patients claim that their suffering has been caused by their psychiatrist's difficulties in finding an effective treatment, because they have not been correctly diagnosed or because of the poor healthcare relationship they have experienced when admitted to hospital. All of these circumstances can result in a trauma, attributable equally to poor clinical management and to the lack of understanding demonstrated by healthcare professionals (Dees M., et al., 2011; Verhofstadt et al., 2021). The care relationship itself can give rise to feelings of additional suffering. On occasions, those who request help to die even claim that their doctors are unwilling to accompany them in this process. They might also identify obstacles to initiating a dialogue about, and discussing, euthanasia, creating the feeling that the doctors are not being altogether transparent when informing them about what to do and how to proceed. As a result, they may feel neglected and ignored and that the trust which should characterise the therapeutic relationship has been undermined (Verhofstadt et al., 2017).

Second, psycho-emotional factors may also intrude so that the person no longer identifies with who they used to be, having lost their autonomy as they face difficulties in carrying out daily activities and experiencing negative feelings (helplessness, sadness, etc.) and even the fear of future suffering.

Third, there are socio-environmental dimensions in which this suffering may be due to interpersonal experiences, such as the loss of loved ones or even psychological or sexual trauma (Verhofstadt et al., 2021). People with mental health problems may also have difficulty establishing interpersonal relationships, which can make them feel uncomfortable and distressed. Thus, poor social integration, the absence of economic support and help in the workplace, etc. may mean the family has to take responsibility for them. All this can cause the person to feel they have become a burden both for their family and for society in general, feelings that are exacerbated when they no longer want to continue living (Evenblij et al., 2019; Stoll et al., 2021; Verhofstadt et al., 2021).

Finally, it is also common to observe how people present symptoms of existential suffering, that is, a fear of continuing to live because of their poor quality of life, the absence of self-control and even the feeling of loss of self. All this adds up to their having a poor perspective of themselves, their needs, their future and their lives (Verhofstadt et al., 2017, 2021).

Similarly, it is known that the impact on the patient's family and friends depends on the severity of the patient's mental disorder, its evolution, symptoms, and their level of adherence and tolerance to treatment. Suffering can be attributed to a range of motives and severely condition the patient's daily life. The difficulty lies in determining whether this suffering can be alleviated by means of some type of treatment or therapy. The law regulating euthanasia does not state that all feasible lines of therapy for alleviating suffering have to be exhausted. Rather, it indicates that patients have to be duly informed about available treatments, their benefits, their contraindications, etc. It is not necessary to show that the patient would not accept a given type of treatment or medical procedure. People have the legitimate right to freely accept and/or reject a treatment, as long as they have the competence to take that decision. In fact, it might even be the case that they are suffering precisely because of the adverse effects of a treatment or therapy, thus further complicating the matter.

It is our belief that an individual's therapeutic trajectory should be evaluated for a period of at least 2 years, seeking the opinions of other professionals who have treated that patient, and attempting to verify whether their negative reaction to the treatment is due to a poor response or adherence to treatment. This would allow the acceptance of a patient with a brief therapeutic history. In our specific context, to proceed in this manner, we rely on the guidelines of the *Management Plan for Mental Health and Addictions, a proposal from the Department of Health of the Catalan Government (Spain)* (2023) for a training and study tool. This tool can be used to establish the guidelines for fostering, planning, coordinating and evaluating the actions carried out in the field of mental health promotion, and the prevention and treatment of mental disorders and addictions.

Clearly, the type of suffering must be assessed, and the causes of that suffering must be identified, in the person with a mental disorder who requests assistance in dying (Verhofstadt et al., 2019). This complex task also requires identifying the ethical values that the patient considers important, how these values affect their quality of life and the extent to which they consider their life worth living. Such an assessment, linked to the analysis of the psychic, neurological and somatic causes of suffering, can shed greater light on decision-making in the provision of care for these people.

5. Serious and incurable disease

The definition of serious and incurable disease as established by the Spanish euthanasia law is controversial when considered from a bioethical perspective, given that it appears to call into question a request for assistance in dying from an individual with mental health problems.

First, the patient's illness must cause them constant and unbearable suffering *without possibility of relief*. Here, the inherent difficulty is whether or not there are effective treatments that can address the patient's suffering and, hence, we need to consider the issue of 'futility' when treating problems of mental health. In this instance, it is the patient who must decide whether or not their suffering is unbearable and whether it is worth continuing to try potential treatments that might

eliminate that suffering. From a position of patient autonomy, the individual has to declare whether the relief provided by the treatment is sufficient or not. In the case of mental health, the complexity is considerable, because the hope of improvement that a certain treatment might bring depends on a set of factors that are not strictly clinical, such as the therapeutic alliance entered into with the professionals, and the social or economic situation in which the a patient might find themselves, etc.

The requisite of a prognosis of limited life expectancy makes it difficult for a patient with mental health problems to access euthanasia on these grounds as they are not usually in an end-of-life process. However, this would discriminate against all those without a limited life expectancy; for this reason, it is more reasonable to base a request on the assumption of a *serious, chronic and incapacitating condition*, where the requirement of a prognosis is not included.

Finally, the law provides for the "progressive frailty" of the patient. The term "frailty" has been frequently associated with the field of geriatrics; however, frailty is not synonymous with comorbidity or disability, rather, the latter are the result of the patient's frailty. One of the most important studies examining frailty is that conducted by Fried et al. (2001). The authors consider frailty to be evident in such clinical components as muscle weakness, low physical activity, self-reported exhaustion, slow walking speed and unintentional weight loss. Such an approach fits well with psychogeriatrics, including, for example, dementia, Alzheimer's, etc.; yet, it is of little use in other mental disorders in which the patients might be much younger. In the case of mental health, frailty defined in this way needs to be reviewed in the light of the patient's cognitive impairment or well-being (Jeste, 2019).

In the case of the concept of "incurable disease", various guidelines have been proposed (Tholen et al., 2009); thus, a disease can be considered incurable when:

1. There is no real prospect of improvement with current state-of-the-art treatments (periodic biological interventions, psychotherapeutic interventions and/or social interventions)
2. There is no possibility of administering an adequate treatment in a reasonable period of time (the patient's clinical history, the duration of the suggested treatments and the patient's age must be reviewed); and
3. No reasonable balance can be struck between the anticipated results of the treatment and the burden of the treatment for the patient (a review needs to be undertaken considering whether an improvement is plausible, and in which the nature and severity of the secondary effects and just how far the patient is willing to accept them are analysed)

If it is confirmed that a certain clinical situation is incurable because it does not meet the aforementioned criteria, the concept of futility – that is, the intrinsic relationship between an action and an expected outcome – as it applies to mental health must be reconsidered. Some studies distinguish three types of futility, namely: physiological (a treatment does not achieve the objective for which it was proposed), quantitative (when a clinician concludes, based on their professional experience or by examining empirical evidence, that in the last 100 cases in which a given treatment has been proposed it has not achieved the proposed objective) and qualitative (if it does not provide a substantial benefit to the patient as a whole) (Geppert, 2015). This categorisation, however, is not exempt from criticism (Aghabarary & Dehghan, 2016; Pies, 2015; Trachsel, Wild, Andorno, & Krones, 2015).

As discussed, the fact that the Spanish law regulating euthanasia focuses on a prognosis of limited life expectancy makes it difficult for a request for euthanasia from a patient with mental health problems to adhere to this definition of an incurable pathology, given that they are more likely to present a chronic course prolonged over a number of years. Frailty assessments are also unlikely to be appropriate for patients of this type. But there may well be requests for euthanasia from patients when the treatments adopted have had no positive effect on their state of health. Here, an extensive exploration of the patient and an evaluation of the therapeutic process would provide crucial information to understand the extent of their suffering and whether the treatment seems futile or not.

The patient has the right to refuse medical treatments, but they should have sufficient information in quantity and quality about all therapeutic options. This could provide information for the patient to assess whether they want to continue with a treatment or if they choose to seek help to die. If they decide to die, the healthcare professional should inform about the entire process set out by the legislation.

Indeed, some authors consider that the evaluation of this process should be at least one year long and comprise at least ten contacts with professionals (Vandenberghe, 2017, p. 162) to rule out any possibility that the decision is the result of resentment towards clinicians. An assessment by two psychiatrists has even been recommended, with prior discussions between all the health professionals involved in the case to remove any doubts about the legitimacy of the request (De Hert, Loos, Sterckx, Thys and Van Assche, 2022). Therefore, in order to understand and assess a request for euthanasia, it is necessary to consider not only the concept of unbearable suffering, but also that of incurable disease. This would enable physicians to determine whether or not the case is futile. The fact that there are no effective treatments does not imply that palliative interventions cannot be proposed, although these too might be rejected. In such a case, this would also be a sign of the patient's desire to end their life.

6. Conclusions

Spain's law regulating euthanasia provides for the possibility that a person, with the competence to make decisions, and who presents a serious, chronic and incapacitating condition or a serious and incurable disease can legitimately request aid in dying. The legitimacy of a person with a mental health disorder who wants to avail themselves of this new law should not be called into question by the fact of their suffering such a disorder, but rather they should enjoy the same right as any other person. And yet, given the difficulty in determining when a serious illness might be deemed incurable or not, it is apparent that any request for euthanasia on grounds of a mental health disorder does not readily fit into this category of *serious and incurable* disease. Rather, we believe that any assessment needs to be conducted in line with what can be understood as a *serious, chronic and incapacitating condition*, in line, that is, with the reality of people suffering mental illness.

Each case needs to be evaluated on its own merits, from a position of calm reflection, starting with a detailed assessment of the patient's competence to make the decision, followed by an analysis of whether the requirements of *serious, chronic and incapacitating suffering* are met. Dismissing this right a priori would be tantamount to incurring an act of discrimination, stigmatization and cruelty. Patients of this nature need to be treated with great caution, avoiding any kind of subjectivity both in the assessment of their competence and in the identification of whether or not their disorder is incurable or presents a prognosis for improvement and, of course, in the individual and subjective experience of unbearable suffering. In short, an unprejudiced assessment, an honest, transparent evaluation, one that is empathetic and respectful of the suffering of others, as carried out by healthcare professionals, could legitimize the request for euthanasia or medically assisted suicide made by those suffering mental illness.

Funding

Research Group APORIA. The philosophical gaze as a Medical paze. Project of the Ministry of Science, Innovation and Universities. Spanish Government (PGC2018–094253-B-I00).

References

Aghabarary, M., & Dehghan, N. (2016). Medical futility and its challenges: a review study. *Journal of Medical Ethics and History of Medicine, 2016*(9), 11.

Appelbaum, P. (2007). Assessment of patients' competence to consent to treatment. *The New England Journal of Medicine, 357*, 1834–1840.

Calati, R., Olíe, R., Dassa, D., Gramaglia, C., Guillaume, S., Madeddu, F., & Courtet, P. (2021). Euthanasia and assisted suicide in psychiatric patients: A systematic review of the literatura. *Journal of Psychiatric Research, 135*, 153–173.

Calcedo, A., Fructuoso, A., Martinez, J., Paz, S., Sánchez, M., & Vicens, E. (2020). A meta-review of literature reviews assessing the capacity of patients with severe mental disorders to make decisions about their healthcare. *BMC Psychiatry, 20*, 339. https://doi.org/10.1186/s12888-020-02756-0

Capdevielle, D., Raffard, S., Bayard, S., Garcia, F., Baciu, O., Bouziques, I., et al. (2009). Competence to consent and insight in Schizophrenia: Is there an association? A pilot study. *Schizophrenia Research, 108*(1–3), 272–279.

Clarke, C., Cannon, M., Skokauskas, N., & Twomey, P. (2021). The debate about physician assisted suicide and euthanasia in Ireland – Implications for psychiatry. *International Journal of Law and Psychiatry*. https://doi.org/10.1016/j.ijlp.2021.101747. Nov-Dec;79:101747.

De Hert, M., Loos, S., Sterckx, S., Thys, E., & Van Assche, K. (2022). Improving control over euthanasia of persons with psychiatric illness: Lessons from the first Belgian criminal court case concerning euthanasia. *Frontiers in Psychiatry, Jul 19*(13), 1–17. https://doi.org/10.3389/fpsyt.2022.933748

Dees, M., Vernooij-Dassen, M., Dekkers, W., et al. (2009). Unbearable suffering of patients with a request for euthanasia or physician-assisted suicide: an integrative review. *Psychooncology, 19*, 339–352.

Dees, M., Vernooij-Dassen, M., Dekkers, W., & van Weel, C. (2010). Unbearable suffering of patients with a request for euthanasia or physician-assisted suicide: An integrative review. *Psychooncology, 19*(4), 339–352.

Dees, M., Vernooij-Dassen, M., Dekkers, W. J., Vissers, K. C., & van Weel, C. (2011). 'Unbearable suffering' A qualitative study on the perspectives of patients who request assistence in dying. *Journal Medical Ethics, 37*(12), 727–734. https://doi.org/10.1136/jme.2011.045492

Departament de Salut. (2022). Press conference presentation: One year of the implementation of the Euthanasia Law. Available en: https://canalsalut.gencat.cat/ca/actualitat/notes-premsa/nota-premsa/index.html?id=434350#googtrans(ca|en).

Dierickx, S., Deliens, L., Cohen, J., & Chambaere, K. (2016). Euthanasia in Belgium: trends in reported cases between 2003 and 2013. *Canadian Medical Association Journal, 188*(16), E407–E414. https://doi.org/10.1503/cmaj.160202. Nov 1.

Evenblij, K., Pasman, R., Pronk, R., & Onwuteaka, B. (2019). Euthanasia and physician-assisted suicide in patients suffering from psychiatric disorders: a cross-sectional study exploring the experiences of Dutch psychiatrists. *BMC Psychiatry, 19*, 74. https://doi.org/10.1186/s12888-019-2053-3

Fried, L., Tangen, C., Watson, J., Newman, A., Hirsch, C., Gottdiener, J., et al. (2001). Frailty in older adults: evidence for a phenotype. *The Journals of Gerontology. Series A, Biological Sciences and Medical Sciences*. https://doi.org/10.1093/gerona/56.3.m146. Mar;56(3):M146-56.

Geppert, C. (2015). Futility in chronic anorexia nervosa: a concept whose time has not yet come. *American Journal of Bioethics, 15*, 34–43.

Jeste, D. (2019). Frailty and mental health: association with cognition, sleep, and well-being in older adults. *International Psychogeriatrics, 31*(6), 755–757. https://doi.org/10.1017/S1041610219000863. Jun.

Kim, S., De Vries, R., & Peteet, J. (2016). Euthanasia and Assisted Suicide of Patients With Psychiatric Disorders in the Netherlands 2011 to 2014. *JAMA Psychiatry*. https://doi.org/10.1001/jamapsychiatry.2015.2887. Apr;73(4):362-8.

Kong, C. (2017). *Mental capacity in relationship. Decision-making, dialogue, and autonomy*. Cambridge University Press.

Levin, K., Bradley, G., & Duffy, A. (2020). Attitudes toward euthanasia for patients who suffer from physical or mental illness. *Omega (Westport), 80*(4), 592–614. https://doi.org/10.1177/0030222818754667. Mar.

Management Plan for Mental Health and Addictions, a proposal from the Department of Health of the Catalan Government (Spain). Available: https://salutweb.gencat.cat/ca/el_departament/ambits-estrategics/atencio-salut-mental-addiccions/pla-director/, (2023).

Murata, H., & Morita, T. (2006). Conceptualization of psycho existential suffering by the Japanese Task Force: the first step of a nationwide project. *Palliative & Supportive Care, 4*, 279–285.

Nicolini, M. E., Kim, S. Y. H., Churchill, M. E., & Gastmans, C. (2020). Should euthanasia and assisted suicide for psychiatric disorders be permitted? A systematic review of reasons. *Psychological Medicine, 50*, 1241–1256. https://doi.org/10.1017/S0033291720001543

Palmer, B., & Harmell, A. (2016). Assessment of healthcare decision-making capacity. *Archives of Clinical Neuropsychology, 31*(6), 530–540.

Palmer, B. W., Dunn, L. B., Appelbaum, P. S., & Jeste, D. V. (2004). Correlates of treatment-related decision-making capacity among middle-age and older patients with schizophrenia. *Archives of General Psychiatry, 61*(3), 230–236.

Perreault, A., Benrimoh, D., & Fielding, A. (2019). Euthanasia requests in a Canadian psychiatric outpatient clinic: A case series part 2 of the McGill University euthanasia in psychiatry case series. *International Journal of Law and Psychiatry*. https://doi.org/10.1016/j.ijlp.2019.101464. Sep-Oct;66:101464.

Pies, R. (2015). Anorexia nervosa. Futility and category errors. *American Journal of Bioethics, 15*, 44–60.

Pronk, R., Sindram, N., van de Vathorst, S., & Willems, D. L. (2021). Experiences and views of Dutch general practitioners regarding physician-assisted death for patients suffering from severe mental illness: a mixed methods approach. *Scandinavian Journal of Primary Health Care, 39*(2), 166–173. https://doi.org/10.1080/02813432.2021.1913895. Jun.

Rodgers, B., & Cowles, K. (1997). A conceptual foundation for human suffering in nursing care and research. *Journal of Advanced Nursing, 25*, 1048–1053.

Stoll, J., Ryan, C. J., & Trachsel, M. (2021). Perceived Burdensomeness and the Wish for Hastened Death in Persons With Severe and Persistent Mental Illness. *Frontiers in Psychiatry, 11*(January), 1–7.

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). https://doi.org/10.1136/bmjopen-2014-007454. Jul 27. e007454.

Tholen, A. J., Berghmans, R., Huisman, J., Legemaate, J., Nolen, J., Polak, F., et al. (2009). Richtlijn verzoek om hulp bij zelfdoding door patienten met een psychiatrische stoornis. *Utrecht, 2009*. https://www.trimbos.nl/docs/feb35d93-7436-489f-af1e-4892fbaa57eb.pdf.

Trachsel, M., Wild, V., Andorno, N., & Krones, T. (2015). Compulsory treatment in chronic anorexia nervosa by all means? Searching for a middle ground between a curative and a palliative approach. *American Journal of Bioethics, 15*, 55–56.

Vandenberghe, J. (2017). Euthanasia in patients with Intolerable suffering due to an irremediable psychiatric Illness: a psychiatric perspective. In D. A. Jones, C. Gastmans, & C. MacKellar (Eds.), *Euthanasia and assisted suicide: lessons from Belgium*. Cambridge: Cambridge University Press.

Verhofstadt, M., Audenaert, K., Van den Broeck, K., Deliens, L., Mortier, F., Titeca, K., et al. (2020). Belgian psychiatrists' attitudes towards, and readiness to engage in, euthanasia assessment procedures with adults with psychiatric conditions: a survey. *BMC Psychiatry, 16;20*(1), 374. https://doi.org/10.1186/s12888-020-02775-x

Verhofstadt, M., Pardon, K., Audenaert, K., Deliens, L., Mortier, F., Liégeois, A., et al. (2021). Why adults with psychiatric conditions request euthanasia: A qualitative interview study of life experiences, motives and preventive factors. *Journal of Psychiatric Research, 144*(April), 158–167.

Verhofstadt, M., Thienpont, L., & Ygram, G. (2017). When unbearable suffering incites psychiatric patients to request euthanasia: qualitative study. *The British Journal of Psychiatry, 211*(4), 238–245. https://doi.org/10.1192/bjp.bp.117.199331. Oct.

Verhofstadt, M., Van Assche, K., Sterckx, S., Audenaert, K., & Chambaere, K. (2019). Psychiatric patients requesting euthanasia: Guidelines for sound clinical and ethical decision making. *International Journal of Law and Psychiatry, 64*, 150–161.

Vicens, E., Calcedo, A., Hastings, J., Männikkö, M., & Silvia, P. (2021). What is the capacity of individuals with schizophrenia and bipolar disorder to make healthcare decisions? An exploratory study of the views of patients, psychiatrists, and family caregivers—A survey on decisional capacity in mental health. *Psychiatry International, 2*, 127–144. https://doi.org/10.3390/psychiatryint2020010