

Should euthanasia and assisted suicide for psychiatric disorders be permitted? A systematic review of reasons

Review Article

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Abstract

Background. Euthanasia and assisted suicide (EAS) based on a psychiatric disorder (psychiatric EAS) continue to pose ethical and policy challenges, even in countries where the practice has been allowed for years. We conducted a systematic review of reasons, a specific type of review for bioethical questions designed to inform rational policy-making. Our aims were twofold: (1) to systematically identify all published reasons for and against the practice (2) to identify current gaps in the debate and areas for future research.

Methods. Following the PRISMA guidelines, we performed a search across seven electronic databases to include publications focusing on psychiatric EAS and providing ethical reasons. Reasons were grouped into domains by qualitative content analysis.

Results. We included 42 articles, most of which were written after 2013. Articles in favor and against were evenly distributed. Articles in favor were mostly full-length pieces written by non-clinicians, with articles against mostly reactive, commentary-type pieces written by clinicians. Reasons were categorized into eight domains: (1) mental and physical illness and suffering (2) decisional capacity (3) irremediability (4) goals of medicine and psychiatry (5) consequences for mental health care (6) psychiatric EAS and suicide (7) self-determination and authenticity (8) psychiatric EAS and refusal of life-sustaining treatment. Parity- (or discrimination-) based reasons were dominant across domains, mostly argued for by non-clinicians, while policy reasons were mostly pointed to by clinicians.

Conclusions. The ethical debate about psychiatric EAS is relatively young, with prominent reasons of parity. More direct engagement is needed to address ethical and policy considerations.

Introduction

Euthanasia or assisted suicide (EAS) primarily on the basis of psychiatric disorders (psychiatric EAS) is permitted in some European countries such as the Netherlands and Belgium (Table 1). In these countries, the number of cases has been slowly but steadily increasing since 2010 and empirical papers on the topic have rapidly increased since 2015 (De Hert et al., 2015; Dierickx, Deliens, Cohen, & Chambaere, 2017; Doernberg, Peteet, & Kim, 2016; Kim, De Vries, & Peteet, 2016; Miller & Kim, 2017; Nicolini, Peteet, Donovan, & Kim, 2020; RTE, 2017; Thienpont et al., 2015; van Veen, Weerheim, Mostert, & van Delden, 2019; Verhofstadt, Thienpont, & Peters, 2017). In Canada, the 2016 medical assistance in dying law, limited to those whose natural death is ‘reasonably foreseeable’, engendered an ongoing controversy about whether access should be extended to the non-terminally ill (CCA, 2018). A recent Quebec court ruling declared the proximity to death requirement unconstitutional, raising important implications for psychiatric EAS in the country (Rukavina, 2019).

But even in the European countries where psychiatric EAS has been legal for years, the practice remains controversial (Griffith, Weyers, & Adams, 2008; Jones, Gastmans, & MacKellar, 2017; RTE, 2018) and some cases have led to court cases (Cheng, 2019; Day, 2018). Attitudes among professionals vary: a 2016 Dutch survey indicated that 37% of psychiatrists found it conceivable to provide psychiatric EAS, compared to 47% in 1995 (Onwuteaka-Philipsen et al., 2017). Similarly, Belgian mental health professionals have been divided over the issue (Bazan, 2015; Claes et al., 2015; Haekens, Calmeyn, Lemmens, Pollefeyt, & Bazan, 2017). Perhaps as a consequence of this, various guidelines by major healthcare institutions and professional organizations have been written and revised, especially over the last few years to guide and regulate the practice (EuthanasiaCode, 2018; NVVP, 2018; Orde der Artsen, 2019; Vandenbergh et al., 2017; Verhofstadt, Van Assche, Sterckx, Audenaert, & Chambaere, 2019).

Although the landmark Chabot case in the Netherlands occurred over 25 years ago (Griffith et al., 2008), a systematic review of the literature on the ethical reasons for and against the practice

Table 1. Comparison of psychiatric EAS practice across jurisdictions^a

Country	Year	Voluntary/ well-considered request criterion	Unbearable suffering criterion	Irremediability criterion	Specific waiting period	Psychiatric consult required	Guidelines for psychiatric EAS practice
The Netherlands	2002 ^b	Voluntary and well-considered ^c	Unbearable suffering without prospect of improvement	No reasonable alternative	No	No ^d	Berghmans et al. (2009), Swildens-Rozendaal and van Wersch (2015), EuthanasiaCode (2018), NVVP (2018)
Belgium	2002	Voluntary, well-considered, repeated, and without external pressure	Constant, unbearable physical or mental suffering that cannot be alleviated	No reasonable alternative Serious and incurable nature of disorder	Yes, 1 month (for all non-terminally ill patients)	Yes	Brothers of Charity (2017), Vandenberghe et al. (2017), Gastmans (2018), Orde der Artsen (2019)
Luxembourg	2009	Voluntary, deliberate and repeated and without external pressure	Constant unbearable physical or mental suffering without prospect of improvement	Incurable medical situation	No	No	No
Switzerland	1942	None	None ^e	None ^e	No	No ^d	SAMS (2018)
Germany	2015	None	None	None	No	No	No
Canada	2016 ^f	Voluntary request, without external pressure	Enduring physical or psychological suffering that is intolerable and cannot be relieved under conditions the person considers acceptable	Grievous and irremediable condition	Yes, 10 days (for all EAS cases)	No	No

^aRefers to psychiatric EAS in persons who are not at end of life (due to other medical conditions). The Benelux countries allow for both euthanasia and assisted suicide. The Belgian Act does not explicitly mention assisted suicide but it is allowed in practice. Switzerland and Germany do not have a specific EAS law but decriminalized-assisted suicide (not euthanasia) under certain conditions, regardless of proximity to death and there have been cases of psychiatric EAS in these countries (Black, 2012; Bruns, Blumenthal, & Hohendorf, 2016; Griffith et al., 2008).

^bPsychiatric EAS in particular became effectively legal following the 1994 Chabot court case involving the assisted suicide of a 50-year old woman with complex bereavement who refused treatment (Griffith et al., 2008).

^cWhile the law does not mention it, the Euthanasia Review Committees (EuthanasiaCode, 2018) add in their definition of the requirement that it be 'without external pressure'.

^dA psychiatric consultation is not stated in the law but is required by the Euthanasia Review Committees in the Netherlands (Berghmans et al., 2009; EuthanasiaCode 2018) and by the Swiss Federal Supreme Court following the 2006 Haas case ruling in Switzerland (Black, 2012).

^eAlthough the Swiss law does not have an unbearable suffering or irremediability requirement, the guidelines by the Swiss Academy of Medical Sciences do (SAMS, 2018).

^fThe 2016 Medical Assistance in Dying law (MAID) applies to persons whose natural death is 'reasonably foreseeable'. Hence, it allows for EAS on the sole basis of a psychiatric disorder only if the person is deemed to have a 'reasonably foreseeable death' (CCA, 2018). However, a recent Quebec court case ruling that this requirement is unconstitutional and suggests that psychiatric EAS will likely become legal in all of Canada (Rukavina, 2019).

is lacking. Systematic reviews of ethics literature are intended to inform bioethics argumentation, but also policy-making (McCullough, Coverdale, & Chervenak, 2007; Sofaer & Strech, 2012; Strech & Sofaer, 2012). We performed a systematic review of reasons, a specific type of review for bioethical questions which identifies and extracts all published reasons for or against a contested policy or practice. Its purpose is to provide a comprehensive and systematic descriptive overview of the ethical debate rather than a philosophical evaluation of the reasons (McDougall, 2014; Mertz, Strech, & Kahrass, 2017; Strech & Sofaer, 2012). The aims of our review were twofold: First, to identify what reasons have been provided for why psychiatric EAS should or should not be permitted as a practice or by law. Second, to describe and characterize notable trends in the debate and identify current gaps and areas for future research.

Methods

Search strategy

We used the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) flow diagram (Liberati et al., 2009; Moher, Liberati, Tetzlaff, & Altman, 2009) (Fig. 1).

One author (M.N.) searched, from inception until 6 November 2018, the following databases: PubMed/MEDLINE, Web of Science (Core Collection), PsycInfo, Philosopher's Index, Embase, Scopus, and CINAHL. A search strategy used keywords from three groups: mental illness; euthanasia and assisted suicide; and ethics and philosophy. The full search strategy (Appendix A) was reviewed and validated by an independent librarian from the National Institutes of Health. The search was updated to 12 June 2019. Finally, we used the snowball method and our own experience to add publications that was not detected in the seven databases. EndNote X9 was used to manage and screen citations.

Inclusion and exclusion criteria

We included a publication if:

- (1) It focused on psychiatric EAS defined as EAS in which mental illness is the primary reason for the request.
- (2) Its primary aim was to provide ethical reasons why psychiatric EAS should or should not be permitted (as a practice or by law).

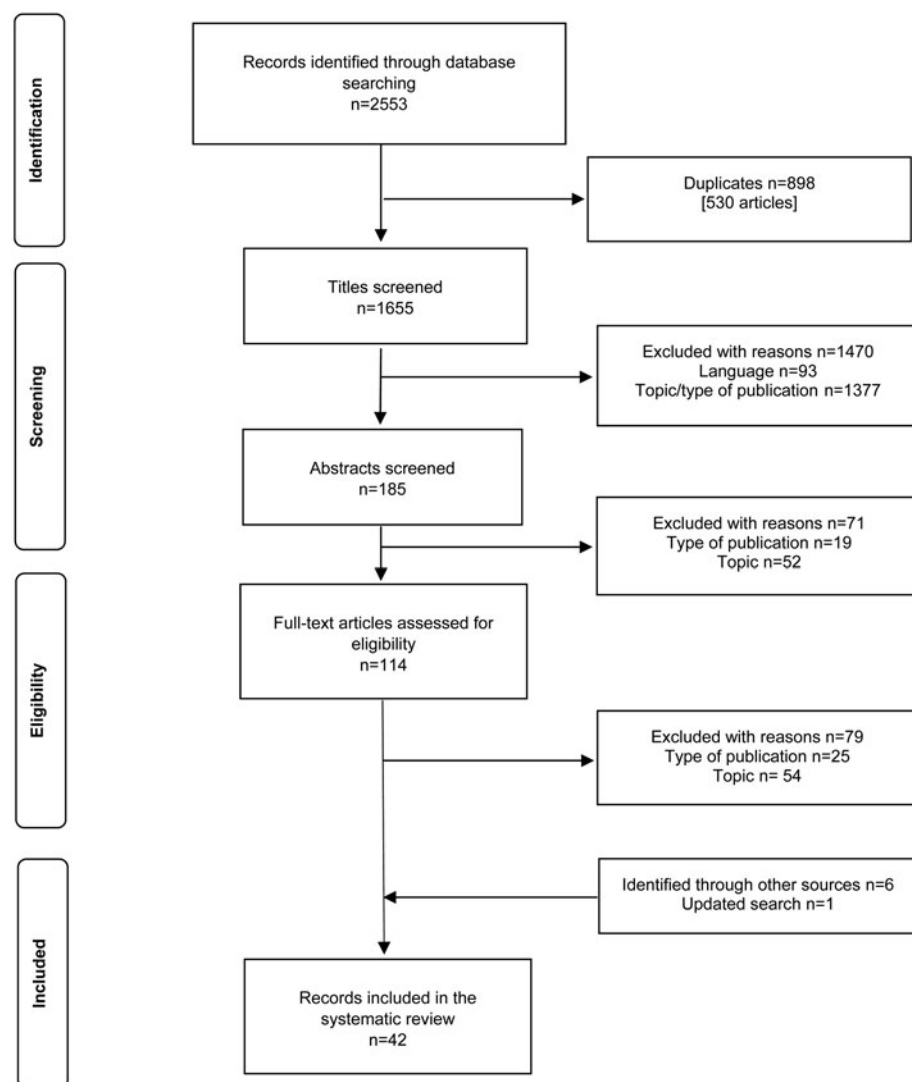


Fig. 1. PRISMA flow chart of the selection process.

- (3) The publication was peer-reviewed.
- (4) The publication was written in English, Dutch, Italian or French.

Condition (I) excluded papers focusing on EAS in: persons with neurodegenerative diseases (e.g. dementia); terminally ill persons with a psychiatric disorder, where the primary reason for requesting EAS was the physical condition and not the psychiatric disorder and persons without medical conditions (e.g. 'tired of living' or 'completed life' cases). It also excluded papers about the ethics of suicide rather than assisted death and 'euthanasia' of the mentally ill in the context of historic eugenic practices.

Condition (II) excluded empirical studies, purely descriptive clinical or legal – rather than normative – case analyses, and articles mainly providing an overview of the reasons for or against psychiatric EAS rather than defending one's own position. Articles in which the overall position was taken was less clear but where the authors directly responded to others' positions were included because responding to an argument implies taking a position. Finally, we included case discussions only if they contained ethical arguments, principles or

recommendations. Condition (III) excluded non-peer reviewed articles, newsletters, guidelines and textbook chapters. We included letters, commentaries and editorials only if they were peer-reviewed. When it was not clear from the journal's website whether a publication was peer-reviewed, we contacted their editorial office.

Study selection and data extraction

Two readers (M.N.; M.C.) independently performed the title/abstract screening following the predefined inclusion and exclusion criteria. Full-text screening and data extraction were independently performed by two readers for English articles (M.N.; M.C.) and non-English articles (M.N.; C.G.). Discrepancies were resolved through discussion involving an additional reader (S.K.). We identified and extracted reasons using the following steps. First, we identified the reasons for and against psychiatric EAS. Second, we included a passage as a reason for or against psychiatric EAS if the author proposed the reason directly as an argument for or against, or if the context made it clear that it fell within their overall argument. If the authors discussed an idea but not clearly as a reason for or against, we did not include it.

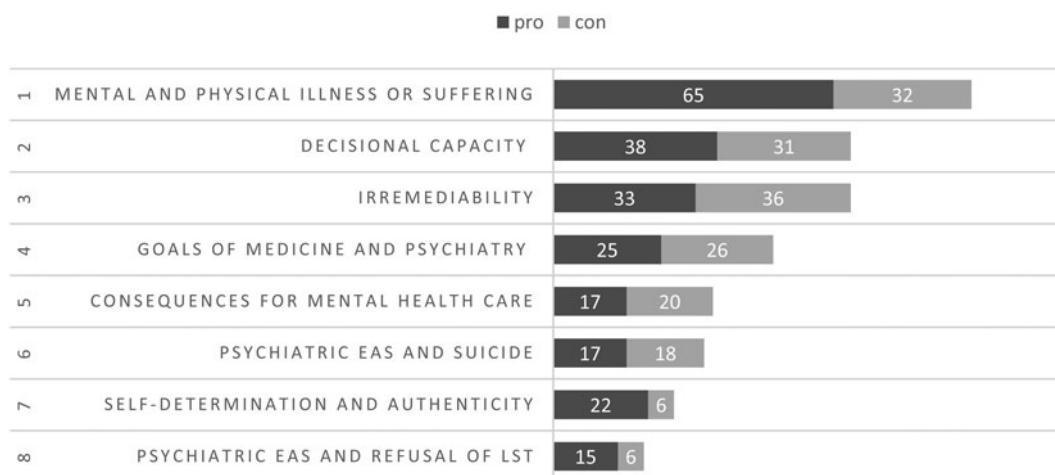


Fig. 2. Number of mentions per content domain.

Third, we grouped the reasons into content domains by qualitative content analysis. This was done by multiple readings, highlighting the meaningful units (passages of reasons), labeling them (codes), and grouping them into content domains using a combined deductive and inductive method (Elo & Kyngas, 2008; Graneheim & Lundman, 2004; Mertz *et al.*, 2017).

Results

The systematic search yielded 2553 articles (Fig. 1). Of those, 35 were eligible for inclusion. We identified six additional eligible articles pursuing reference lists and included one article from the updated literature search, for a total of 42 articles.

Publication characteristics

The dates of publication ranged from 1998 to 2019, but 81% (34/42) were published in 2013–2019. Articles were published in the following fields: medicine (52%), bioethics (40%), law (5%) and social work (2%). Based on the corresponding author's credentials, half of the articles were written by authors with a clinical background (e.g. psychiatry, palliative care, geriatrics, social work). Virtually, all clinicians were physicians (95%, 20/21), mostly psychiatrists. The other half were written by authors with a background other than medical (e.g. philosophy, bioethics, law). When an author had both clinical and non-clinical credentials, they were counted as clinicians. Overall, most (71%, 30/42) articles were written by authors in a country where EAS of some type has been legalized (in the country or in some jurisdictions within it). Over half (52%) were from a country where the eligibility for EAS is tied to its proximity to natural death (Appendix B). Of the total, 90% of articles (38/42) were written in English, four were written in Dutch or French.

The articles were nearly evenly distributed with regard to their overall position (48% articles in favor and 52% against). The authors' position was determined by their conclusions and whether the majority of arguments given were in favor or against psychiatric EAS. For example, some authors presented mostly arguments against or in favor of psychiatric EAS, even though they also expressed reasons for the other side – in which case we classified them according to their predominant position (den Hartogh, 2015; Steinbock, 2017; Vandenberghe, 2018;

Vink, 2012). The position taken varied depending on the corresponding author's background and the article type. Most articles in favor of psychiatric EAS were full-length articles written by non-clinicians (75%, 15/20). Publications against psychiatric EAS tended to be shorter, commentary-type pieces written by clinicians (73%, 16/22).

Reasons for and against psychiatric EAS

We identified 107 reasons (62 pro, 45 con) which were mentioned 407 times (232 pro, 175 con mentions) (Fig. 2). We categorized reasons into eight content domains as shown in Table 2, using the following labels and listed in descending order of frequency: (1) mental and physical (illness and suffering) (2) decisional capacity (3) irremediability (4) goals of medicine and psychiatry (5) consequences for mental health care (6) psychiatric EAS and suicide (7) self-determination and authenticity (8) psychiatric EAS and refusal of life-sustaining treatment (LST) (Table 2). Within each domain, we described the reasons according to the specific topic of disagreement they related to. Of the total, 9% of mentions (36 of 407) directly responded to another paper included in this review; this direct engagement between authors started only in 2013.

Mental and physical illness or suffering

Within this domain (65 pro and 32 con mentions), two main areas of discussion emerged: parity (non-discrimination) between mental and physical illness or suffering (59 mentions) and policy concerns (38 mentions). Parity reasons, mostly raised by non-clinicians, stated that if EAS is permitted in persons with terminal, physical illness, differential treatment in persons with mental illness is not justified, based on the parity of mental illness and suffering from physical illness and suffering. Assertions of parity between mental and physical *suffering* (24 mentions) were the most frequently cited parity reasons in favor of psychiatric EAS, followed by reasons of parity between mental and physical *illness* (20 mentions). Responses against parity which focused on differences between mental and physical *illness*, such as the often poorly understood etiology of mental illnesses, were raised by clinicians only. Non-clinicians arguing against parity instead pointed to the fact that there are morally relevant differences

Table 2. Domains, subdomains and their reasons

Domain	Side	Subdomain and reasons	N	Reference	
Mental and physical		Parity between mental and physical illness or suffering	59		
		<i>Mental and physical illness</i>	34		
Mental and physical	Pro	What justifies EAS in the terminally, physically ill (autonomy, irremediable suffering) can be present in mental illness too, hence excluding the mentally ill is discriminatory	8	Tanner (2018), Steinbock (2017), Schuklenk and van de Vathorst (2015b), Schuklenk and van de Vathorst (2015a), Rooney et al. (2018), Provencher-Renaud, Larivée, and Sénéchal (2019), Dembo et al. (2018), Cholbi (2013)	
		Excluding the mentally ill forces patients to suffer for much longer than those who are terminally ill	5	Steinbock (2017), Schuklenk and van de Vathorst (2015a), Rooney et al. (2018), Varelius (2016a), Sagan (2015)	
		Excluding the mentally ill based on 'vulnerability' is discriminatory and stigmatizing	5	Rooney et al. (2018), Dembo et al. (2018), Sagan (2015), Hirsch (2016), Reel (2018)	
		Since there are no logical differences between physical and mental illness, there is a strong case for the acceptability of psychiatric EAS	1	Parker (2013)	
		Mental illness can also be terminal (i.e. what makes a person's condition terminal is whether a decision about ending one's life would have occurred were it not for the person's condition)	1	Cholbi (2013)	
	Con	Mental illness is distinct from physical illness because its etiology is poorly understood and diagnosis is purely descriptive, hence predictions are less reliable than for physical illness	6	Pearce (2017), Kelly and McLoughlin (2002), Kelly (2017), Naudts et al. (2006), den Hartogh (2015), Blikshavn, Husum, and Magelssen (2017)	
		Mental illness (and suffering) is more multifactorial in nature than physical illness (e.g. poor social conditions), hence we should not treat them in the same way	5	Pearce (2017), Kelly (2017), Naudts et al. (2006), Schoevers, Asmus, and Van Tilburg (1998), Simpson (2018)	
		Unfair discrimination only applies if there are no relevant differences between two groups, but there are differences (e.g., elevated risk of incapacity, greater risk of error)	2	Steinbock (2017), Jansen, Wall, and Miller (2019)	
		There is an accepted differential treatment already since we restrict EAS in the terminally ill to only persons who have capacity	1	Jansen et al. (2019)	
			<i>Mental and physical suffering</i>	25	
	Mental and physical	Pro	Mental suffering can be as bad as or worse than physical suffering	10	Tanner (2018), Steinbock (2017), Provencher-Renaud et al. (2019), Dembo et al. (2018), Cholbi (2013), Sagan (2015), Hirsch (2016), Parker (2013), Dembo (2010), Varelius (2016b)
			Excluding the mentally ill is unjust because it amounts to discounting their pain	4	Tanner (2018), Schuklenk and van de Vathorst (2015a), Provencher-Renaud et al. (2019), Cholbi (2013)
			It is up to the patient to determine what unbearable suffering is, regardless of whether the suffering is physical or mental	4	Tanner (2018), Dembo et al. (2018), Cholbi (2013), Player (2018)
Mental and physical suffering cannot be disentangled			2	Tanner (2018), Cholbi (2013)	
Mental suffering can be unbearable or rob an individual of a future life of value			2	Tanner (2018), Cholbi (2013)	
Persons typically ask for EAS for reasons other than physical pain (e.g. loss of dignity), so the reasons already include psychological states of mind			1	Schuklenk and van de Vathorst (2015a)	
The suffering of incapacitated persons can be worse than that of persons with capacity			1	Varelius (2016b)	
Con		In mental illness, the perceived intolerability of suffering may be a symptom of the disorder	1	Appelbaum (2018)	

(Continued)

Table 2. (Continued.)

Domain	Side	Subdomain and reasons	N	Reference
		Policy concerns	38	
	Pro	The possibility of error (i.e. false positives) can be reduced by adopting rigorous safeguards (e.g. use of reliable tools to assess eligibility, prospective review process, a parallel focus on treatment)	9	Schuklenk and van de Vathorst (2015b), Schuklenk and van de Vathorst (2015a), Rooney et al. (2018), Provencher-Renaud et al. (2019), Dembo et al. (2018), Sagan (2015), Player (2018), Vandenberghe (2018, 2011)
		The possibility of error (i.e. false positives) is present in any medical regimen, we should tolerate a number of false positives to reduce overall suffering	7	Tanner (2018), Schuklenk and van de Vathorst (2015b), Rooney et al. (2018), Provencher-Renaud et al. (2019), Cholbi (2013), Sagan (2015), Reel (2018)
		Greater prognostic uncertainty in psychiatric illness is not a sufficient justification for excluding the mentally ill	3	Steinbock (2017), Schuklenk and van de Vathorst (2015a), Player (2018)
		Patients should not bear the consequences of lesser diagnostic reliability in mental illness compared to physical illness	2	Schuklenk and van de Vathorst (2015a), Parker (2013)
	Con	Policy considerations require that we err on the side of safety because the risk of false positives is greater than false negatives in non-terminal illness (e.g. due to broad eligibility requirements, capacity assessments not always carried out rigorously)	10	Steinbock (2017), den Hartogh (2015), Schoevers et al. (1998), Jansen et al. (2019), Appelbaum (2018), Vandenberghe (2018), Miller and Appelbaum (2018), Cowley (2015, 2013), Kim and Lemmens (2016)
		Whether restricting access to EAS to the terminally ill is justified also depends on policy considerations such as the potential for error	5	Steinbock (2017), Jansen et al. (2019), Appelbaum (2018), Kim and Lemmens (2016), Miller (2015)
		Improving the effectiveness of safeguards to reduce false positives may not be feasible	2	Steinbock (2017), Jansen et al. (2019)
Decisional capacity		Existence, nature and determination of competent requests	33	
	Pro	Not all patients with mental illness lack decisional capacity	9	Tanner (2018), Steinbock (2017), Schuklenk and van de Vathorst (2015a, 2015b), Provencher-Renaud et al. (2019), Dembo et al. (2018), Hirsch (2016), Player (2018), Frati, Gulino, Mancarella, Cecchi, and Ferracuti (2014)
		A death wish can be a competent wish even in persons with mental illness	5	Tanner (2018), Schuklenk and van de Vathorst (2015b), Hirsch (2016), Dembo (2010), Berghmans, Widdershoven, and Widdershoven-Heerding (2013)
		Excluding the mentally ill amounts to presuming they are incompetent	3	Rooney et al. (2018), Dembo et al. (2018), Dembo (2010)
	Con	Some patients with mental illness have impaired capacity and clinicians may not be able to reliably determine whether the request is part of the disorder or not	13	Steinbock (2017), Pearce (2017), den Hartogh (2015), Blikshavn et al. (2017), Schoevers et al. (1998), Jansen et al. (2019), Miller and Appelbaum (2018), Kim and Lemmens (2016), Frati et al. (2014), Olié and Courtet (2016), Broome and de Cates (2015), Appelbaum (2017, 2018)
		Not all the mentally ill lack decisional capacity, but we should be extra cautious	3	den Hartogh (2015), Jansen et al. (2019), Frati et al. (2014)
		Evaluation of decisional capacity	25	
	Pro	Capacity assessments for psychiatric EAS are not different than other capacity assessments (e.g. assessing capacity to refuse life-sustaining treatment)	4	Tanner (2018), Steinbock (2017), Rooney et al. (2018), Parker (2013)
		We can use trained clinicians or tools to limit the margin of error in capacity assessments	3	Tanner (2018), Rooney et al. (2018), Cholbi (2013)
		A capacity assessment should be unrelated to whether the clinician endorses the decision	2	Hirsch (2016), den Hartogh (2015)
			2	Steinbock (2017), Parker (2013)

(Continued)

Table 2. (Continued.)

Domain	Side	Subdomain and reasons	N	Reference
		Clinicians, not the patients, should bear the burden of proof for incapacity (i.e., look for positive evidence of capacity)		
		A cooling off period will ensure a person's request is persistent	2	Provencher-Renaud et al. (2019), Player (2018)
		Not acknowledging the potential benefits of treatment should not by itself be considered a failure to appreciate	1	Player (2018)
	Con	Persons with mental illness may often change their minds about the request	5	Kelly and McLoughlin (2002), den Hartogh (2015), Jansen et al. (2019), Frati et al. (2014), Olié and Courtet (2016)
		Persons with mental illness may not meet the 'appreciation' requirement for capacity (i.e. how information applies to oneself in estimating their chances of recovery)	3	Steinbock (2017), Blikshavn et al. (2017), Broome and de Cates (2015)
		Affective states can influence capacity	2	den Hartogh (2015), Frati et al. (2014)
		Persistence over time does not guarantee a competent request	1	Schoevers et al. (1998)
		Threshold for evaluation of decisional capacity	10	
	Pro	The standards of decisional capacity should be independent of the stakes	4	Tanner (2018), Schuklenk and van de Vathorst (2015a), Parker (2013), Player (2018)
		Applying a higher threshold to decisional capacity is better than banning psychiatric EAS altogether	2	Rooney et al. (2018), Player (2018)
		In extreme cases, it may be permissible to lower standards of decisional capacity	1	den Hartogh (2015)
	Con	The standard of decisional capacity should be higher because the stakes are higher	3	den Hartogh (2015), Cowley (2015), Frati et al. (2014)
		Voluntariness of request	1	
	Con	There can be undue external pressure influencing a person's choice	1	de Kort (2015)
Irremediability		Existence, nature, and determination of irremediable cases	39	
	Pro	In some cases, mental illness or suffering is indeed treatment-refractory or incurable	8	Tanner (2018), Schuklenk and van de Vathorst (2015a), Rooney et al. (2018), Sagan (2015), Reel (2018), Dembo (2010), Player (2018), Vandenberghe (2018)
		We can reliably determine irremediability and prognosis in psychiatry	3	Tanner (2018), Rooney et al. (2018), Provencher-Renaud et al. (2019)
		Prognostic uncertainty is not specific to psychiatry	1	Steinbock (2017)
	Con	We cannot reliably determine irremediability and prognosis in psychiatry	18	Steinbock (2017), Kelly and McLoughlin (2002), Kelly (2017), Naudts et al. (2006), Blikshavn et al. (2017), Schoevers et al. (1998), Simpson (2018), Jansen et al. (2019), Vandenberghe (2018, 2011), Cowley (2015, 2013), Kim and Lemmens (2016), Miller (2015), Olié and Courtet (2016), Broome and de Cates (2015), Appelbaum (2017), Kissane and Kelly (2000)
		Recovery in psychiatry can also depend on patient, therapist or external factors, making determination of irremediability difficult	8	Pearce (2017), Kelly (2017), Blikshavn et al. (2017), Schoevers et al. (1998), Miller and Appelbaum (2018), Cowley (2013), Kissane and Kelly (2000), Jansen et al. (2019)
		Given the prognostic uncertainty, hope has important therapeutic value	1	Blikshavn et al. (2017)
		Patients' subjective v. clinicians' objective judgment of irremediability	18	
	Pro	Patients can and should be able to make their own reasonable judgment about chances of	10	Tanner (2018), Steinbock (2017), Schuklenk and van de Vathorst (2015a), Rooney et al. (2018), Dembo

(Continued)

Table 2. (Continued.)

Domain	Side	Subdomain and reasons	N	Reference
		recovery (e.g. what treatment should be considered futile)		et al. (2018), Cholbi (2013), Reel (2018), Parker (2013), Dembo (2010), Berghmans et al. (2013)
		Feelings of hopelessness and demoralization are not necessarily part of the mental disorder	1	Berghmans et al. (2013)
	Con	We should not only rely on patient judgment in determining irremediability	5	Jansen et al. (2019), Vandenberghe (2018), Cowley (2013), Appelbaum (2017, 2018)
		Feelings of hopelessness and demoralization can be part of the mental disorder	2	Kim and Lemmens (2016), Appelbaum (2017)
		Waiting for new treatments	8	
	Pro	The possibility of future treatment options does not mean patients should wait indefinitely	6	Tanner (2018), Steinbock (2017), Schuklenk and van de Vathorst (2015a), Dembo et al. (2018), Varelius (2016b), Berghmans et al. (2013)
	Con	New treatments may be discovered in the near future (e.g. ketamine)	2	Simpson (2018), Broome and de Cates (2015)
Goals of medicine & psychiatry		Patient–physician relationship in psychiatry	27	
	Pro	An open attitude towards psychiatric EAS can in itself be therapeutic for patients	5	Provencher-Renaud et al. (2019), Hirsch (2016), Reel (2018), Player (2018), Vandenberghe (2018)
		A psychiatric EAS request should be explored on its own terms and not be interpreted as a cry for help only	4	Parker (2013), Naudts et al. (2006), Vandenberghe (2011), Vink (2012)
		A physician's attitude of unconditionally preserving life may not foster good care	2	Dembo (2010), Vandenberghe (2011)
		Physicians can give up on patients even when psychiatric EAS is not allowed	1	Rooney et al. (2018)
		A physician's excessive identification with the patient can be avoided	1	Berghmans et al. (2013)
	Con	A psychiatric EAS request can carry other meanings than a wish to die that can be responded to without endorsing psychiatric EAS	5	Blikshavn et al. (2017), Schoevers et al. (1998), Vandenberghe (2011), Miller (2015), Olié and Courtet (2016)
		Allowing psychiatric EAS might cause physicians to give up on their patients	4	Blikshavn et al. (2017), Miller and Appelbaum (2018), Appelbaum (2017, 2018)
		Allowing psychiatric EAS can negatively impact the patient–physician relationship, e.g. by undermining hope	3	Blikshavn et al. (2017), Schoevers et al. (1998), Vandenberghe (2011)
		Allowing psychiatric EAS may reinforce avoidance rather than coping with psychological pain	1	Blikshavn et al. (2017)
		A physician's excessive identification can impact the evaluation process	1	Schoevers et al. (1998)
		Compatibility with the goals of medicine & psychiatry	24	
	Pro	Physicians including psychiatrists have an obligation to relieve their patients' suffering, hence compassion can justify psychiatric EAS	7	Tanner (2018), Schuklenk and van de Vathorst (2015b), Hirsch (2016), Parker (2013), den Hartogh (2015), Dembo (2010), Berghmans et al. (2013)
		Providing psychiatric EAS can be compatible with the goals of medicine and psychiatric practice	5	Steinbock (2017), Parker (2013), den Hartogh (2015), Vandenberghe (2018), Berghmans et al. (2013)
	Con	Providing psychiatric EAS is not compatible with the goals of medicine and psychiatric practice	11	Kelly (2017), Naudts et al. (2006), Schoevers et al. (1998), Simpson (2018), Jansen et al. (2019), Kim and Lemmens (2016), Miller (2015), Olié and Courtet (2016), de Kort (2015), Kissane and Kelly (2000), Vink (2012)
		A right to medical treatment does not entail a right to assistance with suicide	1	Jansen et al. (2019)
Consequences for mental health care		Effects on mental health care	19	

(Continued)

Table 2. (Continued.)

Domain	Side	Subdomain and reasons	N	Reference
	Pro	Allowing psychiatric EAS and improving mental health care (e.g. improving funding and access to mental health care, reducing stigma, improving prevention) are not mutually exclusive	7	Tanner (2018), Schuklenk and van de Vathorst (2015a), Rooney et al. (2018), Provencher-Renaud et al. (2019), Sagan (2015), Reel (2018), Vandenberghe (2011)
	Con	Allowing psychiatric EAS will have negative consequences for mental health care policy (e.g. it may reinforce poor expectations towards mental health care)	8	Naudts et al. (2006), Blikshavn et al. (2017), Simpson (2018), Appelbaum (2018), Miller and Appelbaum (2018), Olié and Courtet (2016), Appelbaum (2017, 2018), Kissane and Kelly (2000)
		Allowing psychiatric EAS should depend on whether other factors can be addressed first (e.g. improving funding and access to mental health care)	4	Pearce (2017), Simpson (2018), Appelbaum (2017), de Kort (2015)
		Consequences for vulnerable populations	18	
	Pro	There is little empirical evidence that psychiatric EAS will have negative consequences for vulnerable populations	5	Steinbock (2017), Dembo et al. (2018), Cholbi (2013), Varelius (2016a), Dembo (2010)
		Allowing psychiatric EAS will not necessarily negatively impact families	3	Rooney et al. (2018), Provencher-Renaud et al. (2019), Sagan (2015)
		Expansion of psychiatric EAS to other conditions or existential suffering is an inevitable, but not necessarily bad, consequence	2	Steinbock (2017), Provencher-Renaud et al. (2019)
	Con	Allowing psychiatric EAS may have negative consequences for vulnerable populations or suggest that their situation can be hopeless	6	Schoevers et al. (1998), Simpson (2018), Jansen et al. (2019), Appelbaum (2018), Kim and Lemmens (2016), Frati et al. (2014)
		Allowing psychiatric EAS may negatively impact patients' families	2	Pearce (2017), Appelbaum (2017)
Psychiatric EAS & suicide		Compatibility with the duty to prevent suicide	26	
	Pro	Psychiatric EAS is a more humane alternative to suicide and hence can prevent violent or lonely suicides	10	Steinbock (2017), Schuklenk and van de Vathorst (2015b), Provencher-Renaud et al. (2019), Dembo et al. (2018), Sagan (2015), Reel (2018), Naudts et al. (2006), Dembo (2010), Vandenberghe (2011), Berghmans et al. (2013)
		Denying access to psychiatric EAS forces people to attempt or commit suicide	2	Provencher-Renaud et al. (2019), Sagan (2015)
	Con	Psychiatric EAS conflicts with the duty to prevent suicide	6	Pearce (2017), Naudts et al. (2006), Simpson (2018), Vandenberghe (2011), Miller and Appelbaum (2018), Frati et al. (2014)
		Just because suicide is no longer illegal does not mean there is a right to assistance with suicide	5	Simpson (2018), Jansen et al. (2019), Cowley (2015), de Kort (2015), Vink (2012)
		The likelihood or threat of a suicide attempt is not a reason to provide psychiatric EAS	2	Cowley (2015, 2013)
		Denying EAS to the mentally ill does not force these patients to commit suicide	1	Cowley (2015)
			Ability to end one's own life	9
	Pro	Patients should not be denied access to psychiatric EAS just because they are able to end their own lives	3	Dembo et al. (2018), Reel (2018), Player (2018)
		Not all patients are physically able or have the means to commit suicide	2	Schuklenk and van de Vathorst (2015b), Sagan (2015)
	Con	If persons have other ways to end their lives, assistance of physicians is not needed	4	den Hartogh (2015), Simpson (2018), Jansen et al. (2019), Vink (2012)
Self-determination & authenticity		Self-determination	22	
	Pro	Persons, including those with mental illness, can have a rational wish to die	9	Tanner (2018), Steinbock (2017), Schuklenk and van de Vathorst (2015b), Provencher-Renaud et al. (2019), Parker (2013), Dembo (2010), Vandenberghe (2018), Frati et al. (2014), Berghmans et al. (2013)

(Continued)

Table 2. (Continued.)

Domain	Side	Subdomain and reasons	N	Reference
		Persons are free to make their own choices, even if these are irrational	6	Steinbock (2017), Provencher-Renaud <i>et al.</i> (2019), Cholbi (2013), Hirsch (2016), Parker (2013), Varelius (2016b)
		Autonomy should be respected provided the person has capacity	3	Steinbock (2017), Rooney <i>et al.</i> (2018), Frati <i>et al.</i> (2014)
	Con	Respect for autonomy by itself does not justify psychiatric EAS	3	den Hartogh (2015), Simpson (2018), Jansen <i>et al.</i> (2019)
		The meaning of 'rational' is problematic when applied to a wish to die	1	Broome and de Cates (2015)
		Authenticity & personal integrity	6	
	Pro	Not being able to live up to our goals and values (loss of integrity) due to mental illness can make life not worth living	2	Dembo (2010), Wijsbek (2012)
		A person's values are what matters in a personal choice	1	Cholbi (2013)
		Depression can be a part of one's authentic self	1	Schuklenk and van de Vathorst (2015a)
	Con	Depression may not be compatible with an authentic choice	1	Cowley (2015)
		Personal integrity does not solely depend on whether or not we are able to live up to our goals and values	1	Cowley (2013)
Psychiatric EAS & LST refusal		Moral relationship between EAS and refusal of LST	21	
	Pro	If we allow refusal/withdrawal of LST in psychiatric patients, we should allow psychiatric EAS too	7	Tanner (2018), Dembo <i>et al.</i> (2018), Varelius (2016a, 2016b), Reel (2018), Parker (2013), Player (2018)
		If refusal/withdrawal of LST in psychiatric patients and psychiatric EAS are morally equivalent, the same conditions should apply (e.g. whether other treatments exist or whether the patient suffers should not matter)	3	Steinbock (2017), Varelius (2016b), Player (2018)
		Potential negative aspects of psychiatric EAS (e.g. danger of hasty decision, futility, false positives, degree of physician involvement) also apply to refusal/withdrawal of LST	2	Varelius (2016a, 2016b)
		Since we allow withdrawal of LST after a suicide attempt, we should allow psychiatric EAS too	1	Varelius (2016b)
		Denying access to psychiatric EAS based on vulnerability would justify denying the right to refuse LST	1	Rooney <i>et al.</i> (2018)
		Respect for refusal of LST is better justified in terms of well-being and autonomy than bodily integrity	1	Varelius (2016a)
	Con	The negative right to refusal of LST (a physician's obligation to respect a patient's bodily integrity) is not the same as a positive right to assisted death	3	Steinbock (2017), Jansen <i>et al.</i> (2019), Miller (2015)
		The distinction between acts and omissions does not apply in psychiatry and suicide prevention (i.e. allowing a patient to commit suicide amounts to being guilty of medical misconduct)	2	Frati <i>et al.</i> (2014)
		The doctrine of double effect is not helpful in psychiatric disorders, i.e. we do not treat mental distress with drugs that could hasten death (as an indirect effect)	1	Kelly and McLoughlin (2002)
		EAS is different than the refusal of LST because it requires physician assistance	1	Jansen <i>et al.</i> (2019)

that could justify differential treatment in EAS between mental and physical illness. Only one author argued against the parity of mental and physical *suffering*, that the intolerability of suffering may be a symptom of the disorder.

Policy considerations largely focused on the issue of ‘false positives’ (the ending of lives in persons who in fact do not meet the criteria). Some authors, from different backgrounds, focused on the increased risk of error (i.e. diagnostic or prognostic) in psychiatric disorders and the unfeasibility of implementing rigorous safeguards. Others, mostly non-clinicians in favor of psychiatric EAS, noted that the risk of false positives is not sufficient to justify prohibiting psychiatric EAS or that the risks could be adequately addressed by implementing rigorous safeguards.

Decisional capacity

The domain of decisional capacity figured prominently in the debate (38 pro and 31 con mentions). In the major disagreement (17 pro and 16 con mentions), those arguing for psychiatric EAS, mostly non-clinicians, emphasized that some persons with mental disorders seeking psychiatric EAS are decisionally capable (e.g. arguing that not permitting psychiatric EAS would amount to presuming incompetence). Others argued that the main issue is the difficulty of reliably determining capacity and the need for extra caution. The second point of contention (14 and 11 mentions) regarded evaluations of decisional capacity in psychiatric EAS requests. Authors in favor, largely non-clinicians, stated that capacity evaluations for psychiatric EAS should not be different than any other capacity evaluation in health care. Others, both clinicians and non-clinicians, argued against this and focused on the impact a psychiatric disorder might have on specific abilities for capacity (i.e. on the ability to appreciate how a decision applies to oneself). A third theme (7 pro and 3 con mentions) focused specifically on the threshold for capacity assessment. Some non-clinicians argued it should be independent of the stakes or should be low in order to err on side of self-determination. Other authors argued that the threshold should be high to minimize false positives. Finally, one reason against the practice, with no corresponding reason in favor, related to voluntariness (i.e. that undue external pressure can influence a person’s choice).

Irremediability

The irremediability domain (33 pro and 36 con mentions) contained reasons relating to the irremediability of mental disorders. However, authors sometimes used the term to also mean irremediability of mental suffering. The main area of disagreement (12 pro and 27 con mentions) related to whether truly irremediable cases exist in psychiatry and whether they can be reliably identified. The most common reason in favor was the view that mental illness or suffering can be truly irremediable. Responses, raised by authors from different backgrounds, pointed to practical challenges in reliably determining irremediability, such as difficulties in predicting prognosis or the lack of a unified interpretation of ‘treatment-refractory’. Only a few, non-clinicians, responded that we can reliably interpret irremediability, e.g., with the help of statistical tools. In the second dispute (11 pro and 7 con mentions), some authors in favor, mostly non-clinicians, argued that judgments about irremediability should not merely depend on statistical chances of recovery but instead on the person’s own judgment. Others responded that determinations of irremediability should be made by both patient and clinician. Within this

dispute, reasons in favor partially overlap with (and respond to) some reasons against the practice raised in the domain of decisional capacity, namely that a mental disorder can influence the cognitive aspects of a patient’s judgment about their chances of recovery. The third subdomain (6 pro and 2 con mentions) involved the question of whether waiting for possible new treatments, such as ketamine for treatment-resistant depression, is or is not justified.

Goals of medicine and psychiatry

This fourth domain (25 pro and 26 con mentions) contained reasons focusing on the impact of psychiatric EAS on medical and psychiatric practice. The main dispute (13 pro and 14 con mentions) was whether permitting psychiatric EAS would positively or negatively affect the patient–physician relationship. Reasons against were largely raised by clinicians, responded to by authors from different backgrounds. The second dispute (12 pro and 12 con mentions) was whether psychiatric EAS is compatible with the goals of medicine and psychiatry, involving even engagement from authors from different backgrounds. Authors in favor argued that it can be compatible with physicians’ role (e.g. consistent with professional integrity and physician’s role as gatekeepers of lethal drugs) and duty to relieve suffering. Authors responded that the two are incompatible (e.g. pointing to professional integrity, the social meaning of medicine or the duty to preserve life) and that there is a normative difference between a right to treatment and a right to psychiatric EAS.

Consequences for mental health care

In the fifth domain (17 pro and 20 con mentions), potential consequences of allowing psychiatric EAS for mental health care more broadly were raised. The first point of contention (7 pro and 12 con mentions) was about the effect of psychiatric EAS on mental health care policy. Clinicians argued that it may negatively impact mental health care and that other factors need to be addressed first. Authors from different backgrounds responded that the two are not mutually exclusive. The second disagreement (10 pro and 8 con mentions) concerned the potential consequences for vulnerable populations. All authors arguing that consequences could be negative were clinicians. Authors in favor responded with empirical reasons (e.g. that there is little evidence for this concern) or normative ones (e.g. that expansion of EAS to other populations is not necessarily a bad outcome).

Psychiatric EAS and suicide

This domain focused on the tension between psychiatric EAS and suicide prevention policies (17 pro and 18 con mentions). Within the main disagreement (12 pro and 14 con mentions), authors in favor, mainly non-clinicians, argued that psychiatric EAS can prevent suicides and that denying access to psychiatric EAS forces persons to commit suicide. Others, from mixed backgrounds, pointed to the conflict with the duty to prevent suicide and argued that there is no duty to provide, nor a corresponding right to receive, psychiatric EAS. The second disagreement (5 pro and 4 con mentions), largely argued for by non-clinicians, related to whether patients’ eligibility should or should not depend on their physical ability to end their lives.

Self-determination and authenticity

Reasons about self-determination and authenticity (22 pro and 6 con mentions) were, like decisional capacity, closely related to the general concept of autonomy. However, we categorized them separately as they addressed concerns distinct from decisional capacity. Reasons in this domain were raised by authors from different backgrounds. Most reasons related to self-determination (18 pro and 4 con mentions) and whether persons with a psychiatric disorder can have a rational wish to die or make their own free choices. Some responded that respect for autonomy is not sufficient grounds for psychiatric EAS. A second disagreement (4 pro and 2 con mentions) related to authenticity and the impact of psychiatric disorders on the ability to live up to one's goals and values.

Psychiatric EAS and refusal of life-sustaining treatment (LST)

Within this last domain (15 pro and 6 con mentions), the main disagreement related to the relationship between EAS and refusing LST. Some non-clinicians in favor of psychiatric EAS argued that there is no morally relevant distinction between refusing LST and psychiatric EAS. Authors against psychiatric EAS, from different backgrounds, instead claimed that the justifications for respecting a person's refusal of LST do not provide justifications for psychiatric EAS.

Discussion

Rational and informed policy-making about psychiatric EAS requires a systematic understanding of the reasons for and against the practice. We conducted a systematic review of reasons, a special form of review for bioethical questions, for this purpose. Its secondary aim was to describe and characterize notable trends in the debate and identify current gaps and areas for future research.

Main findings of reasons for and against the practice

Parity arguments figured prominently in the debate, taking the form of 'If EAS is permitted for X, then it should be permitted for Y since there is no relevant difference between X and Y'. This may be because arguments in favor of psychiatric EAS were mostly conditional upon EAS for the terminal, physical illness being legally permitted. This was true for 80% (16/20) of publications in favor of psychiatric EAS, largely (87%) written from countries where some form of legal EAS exists for physical disorders, such as the USA, Canada and Australia. Most authors who argued for parity between mental and physical illness were non-clinicians also arguing for parity between mental and physical suffering (Cholbi, 2013; Dembo, Schuklenk, & Reggler, 2018; Hirsch, 2016; Player, 2018; Provencher-Renaud, Larivée, & Sénéchal, 2019; Sagan, 2015; Schuklenk & van de Vathorst, 2015a; Steinbock, 2017; Tanner, 2018; Varelius, 2016a). Parity reasons largely relied on the assumption that suffering is the justification for EAS in terminal, physical illness.

Some of these authors also made parity arguments elsewhere, for example by stating that prognostic uncertainty can be present in physical illness as well, and hence does not justify excluding persons with mental illness. Similarly, some reasons in the domains dealing with psychiatric EAS and LST refusal and with decisional capacity were parity-based (e.g. whether capacity

assessments for psychiatric EAS should be different than for refusing LST) and conditional upon the right of persons with psychiatric disorders to refuse life-saving or other high-stake interventions.

The policy implications of parity reasons were disputed by both clinicians and non-clinicians. Some authors in favor, mostly non-clinicians, argued that parity requires extending EAS laws to include persons with mental illness as a matter of principle. Hence, the possibility of false positives should be tolerated to reduce overall suffering (Cholbi, 2013; Provencher-Renaud et al., 2019; Reel, 2018; Rooney, Schuklenk, & van de Vathorst, 2018; Sagan, 2015; Schuklenk & van de Vathorst, 2015a; Tanner, 2018). Other authors in favor of the practice instead raised policy concerns (Steinbock, 2017; Vandenbergh, 2018). These authors raised similar concerns about whether decisional capacity and irremediability can be reliably identified.

Other disagreements were not parity-based. Some depended on empirical assumptions which will need further testing, such as the dispute about prognosis prediction in psychiatry. For example, machine learning methods to predict prognosis at the individual level are being developed (Chekroud et al., 2016; Dinga et al., 2018) and may further inform the psychiatric EAS debate. Other empirical questions include the effects of psychiatric EAS on mental health care and the patient-physician relationship. Although there is some literature on the potential problem of (counter-)transference in the context of EAS and psychiatric EAS in particular (Berghmans et al., 2009; Groenewoud et al., 2004; Hamilton, Edwards, Boehnlein, & Hamilton, 1998; Jones et al., 2017), other effects on the patient-physician relationship are unknown.

Some normative disputes resulted from different underlying premises or philosophical assumptions. For example, whether irremediability should be defined by 'objective' clinical judgment based on prevailing evidence or by the requestor's own, 'subjective' judgment is not an empirical question. Thus, it appears disputes about irremediability trace back to larger conceptual disputes. Notably, no author explicitly argued that autonomy is a sufficient condition for permitting psychiatric EAS. Similarly, the normative question of what *threshold* should be used in evaluating decisional capacity will partly depend on how one weighs the relief of suffering against the unwarranted ending of an incapacitated patient's life. Some have pointed to this tension (den Hartogh, 2015) or argued explicitly that the relief of suffering should prevail regardless of decisional capacity (Varelius, 2016b).

Finally, whether psychiatric EAS is compatible with the duty to prevent suicide partly depends on whether one relies on a view that challenges, or instead relies on, current ways of conceptualizing suicide prevention. For example, current practices allow involuntary commitment to prevent suicide. Furthermore, while some argued that psychiatric EAS could prevent suicides, the underlying debated question of whether psychiatric EAS should be considered a form of suicide or not (CCA, 2018; Creighton, Cerel, & Battin, 2017) was rarely addressed explicitly. This could be because the broader literature on the issue of EAS and suicide was excluded by our search criteria, or it could be a gap in the current debate.

Trends in the debate and future directions

The debate over EAS in persons with psychiatric disorders is likely to continue, as it started to intensify only fairly recently. We found that most articles (81%) were written in 2013 or

later, despite the fact the Chabot case occurred over 25 years ago. This may reflect the relatively recent increase in the number of psychiatric EAS cases since 2011, with empirical papers providing a more detailed account on the practice raising rapidly only since 2015. Psychiatrists remain divided over the issue in the Netherlands and Belgium (Haekens et al., 2017; Pronk, Evenblij, Willems, & van de Vathorst, 2019). This could relate to our finding that the *ethical* debate is in its relatively early stages. In fact, the low overall direct engagement between authors (9% of mentions) suggests more time and research is needed for the debate to develop further.

Current controversies place parity at the center of an international debate (North-America, Europe and Australia) involving scholars from both clinical and nonclinical backgrounds. If parity arguments rely on physical and mental disorders being similar, some questions will need further study, such as whether mental disorders differ from physical ones, and if so how. There is a longstanding and ongoing dispute about psychiatric diagnosis and prognosis prediction, including in countries allowing for psychiatric EAS based on parity (Allsopp, Read, Corcoran, & Kinderman, 2019; Insel et al., 2010; Kendler, 2019; van Os, Guloksuz, Vijn, Hafkenscheid, & Delespaul, 2019; Vanheule et al., 2019). However, conceptual questions of parity may not be sufficient grounds for a safe practice, as suggested by the fact that guidelines developed in the Netherlands and Belgium often contain additional and more stringent criteria than the law itself. Other important empirical, policy questions of parity need further study, e.g., whether diagnosis and prognosis in psychiatry can, similarly to staging systems in physical illness, be valid and reliable. Furthermore, how some of the consequences of allowing psychiatric EAS may play out (on e.g. the patient–physician relationship, mental health care practice and policy, or suicide rates) needs more research, including monitoring of the practice of psychiatric EAS and some of its policy considerations pointed to by both sides of the debate.

Finally, we found that reasons provided by non-clinicians, mostly in favor of psychiatric EAS, have been laid out in more full-length articles, while clinicians have expressed their view more commonly in shorter, reactive articles. It could be that authors against the practice writing longer articles argued against EAS in general (therefore against psychiatric EAS as well) were excluded by our search criteria. However, surveys show that among clinicians, e.g. in the Netherlands and Canada, there is significantly more support for EAS in terminal and physical illness than for psychiatric EAS (Bolt, Snijdewind, Willems, van der Heide, & Onwuteaka-Philipsen, 2015; Rousseau, Turner, Chochinov, Enns, & Sareen, 2017). Our review suggests more thorough input, perhaps through full-length publications from this group, may further inform the debate about issues that are currently only briefly addressed. Both sides of the debate may benefit from more engagement by mental health professionals other than physicians. Finally, more input from patients e.g. through empirical research focusing on their perspectives is needed to further inform the ethical debate.

Limitations and strengths

Because articles specifically engaged in the psychiatric EAS debate tended to make conditional arguments (i.e. assuming that EAS is permissible for terminal and physical illness), our review does not speak to reasons that are more generally applicable to EAS *per se*. But this is a feature of the current literature on psychiatric EAS

rather than a limitation of our methods. Second, qualitative coding requires judgment. We recognize that others might have grouped the domains differently: e.g. parity-type reasons occurred across domains. Instead of creating one very large domain, we chose to group the most prominent of these (parity of mental and physical) in order to highlight the different topics per content domain. Hence, there may be some overlap between domains. Another example is the notably rare issue of voluntariness, which we subsumed under the decisional capacity domain, even though it is part of the broader concept of an informed request, as this is where it fit more closely. Furthermore, voluntariness and decisional capacity are often considered together in psychiatric EAS laws and guidelines (EuthanasiaCode, 2018; Griffith et al., 2008; Jones et al., 2017). Hence, the process of categorization was the result of interpretation. However, strength was that the systematic search strategy covered bioethics literature written by both clinicians and non-clinicians, and data extraction was performed by two independent reviewers. Finally, we did not provide qualitative judgments of the reasons, as the primary intent of a systematic review of reasons is to provide a descriptive overview of the debate (Sofaer & Strech, 2012). Therefore, the most commonly presented reasons are not necessarily the strongest or soundest arguments; however, they are likely to have had a greater presence in the debate.

Conclusion

Psychiatric EAS continues to pose important ethical and policy challenges. This review shows that the current debate is in its relatively early stage. As the number of cases increases in countries allowing the practice, with more empirical data becoming available, more direct engagement is needed to address conceptual questions and public policy considerations. This, in turn, will inform policy-making for jurisdictions that consider legalizing the practice.

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