

## Correspondence

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

It was encouraging to see authors Bhui and Malhi and the *BJPsych* engaging with the topic of assisted dying and the implications for mental healthcare and psychiatrists. We welcome the authors' concluding four recommendations for implementation; however, there are a few points worth clarifying that we hope will add to the conversation.

The authors rightly highlight problems with current end-of-life care. Here in the UK, current end-of-life practices are not robustly reported on (e.g. withdrawal of life-sustaining treatment and DNACPR decisions). What is not emphasised is that assisted dying legislation, whatever people's views on it, would bring regulation and safeguards to a space that is currently lacking oversight.

Many of the complexities highlighted with assisted dying already apply to existing end-of-life practices (e.g. what is a psychiatrist's role if someone with life-limiting cancer and a diagnosed mental illness refuses chemotherapy that might extend their life?), so perhaps it is unnecessary to single out assisted dying as a novel problem for the specialty. We also challenge the claim that evidence from around the world shows that 'Patients may be coerced'. What is this evidence and how does it compare to the evidence of coercion in any other treatment decision, including refusal of life-sustaining treatment?

The role of doctors is also questioned. Yet, doctors are already required to make complex decisions about patients' end-of-life care, and the proposed Assisted Dying Bill includes a robust conscientious objection clause allowing doctors to choose not to participate.

Psychiatrists can have an important collaborative role to ensure that dying people receive the best possible care at the end of their lives, yet evidence shows even the highest quality is not always sufficient to relieve suffering.<sup>1</sup> Although it is essential that inequalities are addressed, anyone concerned that socioeconomic factors could influence a person's decision-making has to acknowledge that assisted dying legislation, with upfront safeguards, puts in place

protections that increase the likelihood of doctors detecting and addressing these concerns. Further, we should not ignore inequalities that the current blanket ban on assisted dying has created – those with the financial means to travel to Switzerland, the only country that allows non-residents to come to the country for an assisted death, currently have access to a greater degree of end-of-life choice than those who do not.

In addition to psychiatrists navigating the potential challenges of implementing an assisted dying law, it is vital they also play a part in considering whether the current law is fit for purpose. There is poignant evidence to suggest it is not, with people approaching the end of their lives often feeling they have no other option but to plan other ways to die on their own terms, whether this be an assisted death overseas<sup>2</sup> or a lonely, potentially violent death at home.<sup>3,4</sup>



In line with the authors' call for further research, having considered the experiences of people with terminal and advanced illness,<sup>5</sup> we suggest that research into the psychological harm inflicted by denying dying people the choice of assisted dying would be valuable to the debate. Ultimately, this is what is at the core of the proposed Bill, supporting individual choice.

### Declaration of interest

None

### References

- 1 Zamora B, Cookson G, Garau M. *Unrelieved Pain in Palliative Care in England*. OHE Consulting Report, London: Office of Health Economics. Available from: <https://www.ohe.org/publications/unrelieved-pain-palliative-care-england>.
- 2 Dignity in Dying. *The True Cost: How the UK Outsources Death to Dignitas*. Available from: [https://cdn.dignityindying.org.uk/wp-content/uploads/DiD\\_True\\_Cost\\_report\\_FINAL\\_WEB.pdf](https://cdn.dignityindying.org.uk/wp-content/uploads/DiD_True_Cost_report_FINAL_WEB.pdf).
- 3 Office for National Statistics. *Suicides among People Diagnosed with Severe Health Conditions, England: 2017 to 2020*. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesamongpeoplewithseverehealthconditionsengland/2017to2020>.
- 4 Wales Online. My dad shot himself to end his suffering from cancer, we should have been allowed to help him end his life. Available from: <https://www.walesonline.co.uk/news/wales-news/my-dad-shot-himself-end-23217368>.
- 5 YouGov. *What Matters to Me: People Living with Terminal and Advanced Illness on End-of-life Choices*. Available from: <https://www.dignityindying.org.uk/wp-content/uploads/What-matters-to-me-Dignity-in-Dying-Nov-2019.pdf>.

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### Authors' reply. RE: Proposed Assisted Dying Bill: implications for mental healthcare and psychiatrists

We thank the authors for their interest and offer some necessary clarifications. Assisted dying is an emotive and complex issue, and the aim of our Editorial<sup>1</sup> was to anchor the debate within a framework of sophisticated discourse. Some issues raised by our colleagues seem to lack reason and are somewhat speculative as they are based on assumptions of premises that are unlikely to be realised.

The inconsistencies in reporting current practice in end-of-life care are inevitable given the lack of guidance or standard reporting frameworks in most jurisdictions, and this is a prevalent problem worldwide. We concur that legislation may bring more oversight

of end-of-life decisions, yet it is not obvious that this would suffice, and significant concerns remain where legislation for assisted dying has been passed. For example, in jurisdictions such as Belgium and The Netherlands, where assisted dying is already available and seemingly extensive safeguards are in place, there are ongoing complaints voiced by relatives of patients and advocacy groups that are submitted to governing bodies with the responsibility of legal and professional oversight. These complaints question the validity of the decisions made by physicians and procedures used to consult family and friends.

We disagree also with the point made that 'perhaps it is unnecessary to single out assisted dying as a novel problem for the specialty', given that putatively psychiatry already has a role in the management of such requests made by patients suffering from terminal illnesses. There is no global or even national agreement as to what psychiatric care should be made available to those receiving end-of-life care. Consenting to assisted dying solely on the basis of suffering from a physical illness ignores the important psychological impact of a terminal physical ailment such as cancer. Having in addition a mental illness not only adds to the suffering but invariably complicates the evaluation of quality of life, as it may impair the individual's reasoning. Further, the comorbid mental illness may not be optimally treated, especially if the suffering is considered to be inevitable. Thus, the development of a mental illness or its existence concurrently generates a whole new and separate set of implications where psychiatrists must be centre stage. New proposed legislation also suggests that capacity should be assessed more comprehensively, in particular if there are complications; in these instances, psychiatrists might be engaged precisely for such purposes, rather than for the overall assessment of optimal care for mental illness and the ability to weigh up decisions in the absence of suffering.

We are also somewhat puzzled by the challenge to our claim that 'patients may be coerced'. We state quite clearly that this is a possibility that is evidenced in the original drafts of the proposed legislation. Coercion may come from all quarters, including in particular family and those that may have a conflict of interest. Procedures set up to monitor assisted dying in The Netherlands and Belgium, for example, which focus largely on the role of physicians, have regularly found procedural irregularities, with doctors often not following the stipulated steps. The insinuation in some of these instances is that physicians have a conflict of interest and are perhaps overly keen to facilitate the assisted dying pathway. We haven't commented on this specifically but have simply raised the concern that families and friends may also succumb to questionable practices. Again, this seems possible and needs safeguards, especially in those that are vulnerable such as the disabled, elderly, poor, and chronically and/or mentally ill.<sup>2</sup> These concerns are borne out by research. For example, studies in 2010 in Oregon and Washington (states within the USA that permit physician-assisted dying) have shown that nearly a quarter of those ingesting lethal drugs did so because they no longer wanted to be a burden on their family.<sup>3</sup> Furthermore, insurance companies were reported to favour funding for assisted dying rather than more intensive treatment.<sup>4</sup>

Therefore, it is perhaps better to examine practices in jurisdictions where legislation and procedures are already in place and construct a pathway that allows for close monitoring and measurement of any provisions made for assisted death. However, trials of 'denying' end-of-life care are highly implausible both where the legislation for assisted death is already in place and, similarly, where the legislation does not permit end-of-life care – as is the situation in the UK at present. Suggesting that it is unjust to not pass legislation, by invoking the false premise that if assisted death is not permitted then care is being denied, does not advance a moral or logical argument.

In the UK, and where legislation is not in force, we assert that the necessary preconditions for legislation are not yet in place. Better-funded end-of-life care generally and standards of care that apply to people with severe mental illness may achieve much, if not all, of what legislation might achieve. In addition, we need further research and trials with appropriate monitoring of processes and procedures – all under the umbrella of close careful legal scrutiny. Thus, our emphasis is on a much more considered approach that allows for further investigation while maintaining choice and dignity for those involved.

### Declaration of interest

G.S.M. is a deputy editor of *BJPsych*. K.B. is the editor-in-chief of *BJPsych*.

### References

- 1 Bhui K, Malhi GS. Proposed Assisted Dying Bill: implications for mental healthcare and psychiatrists. *Br J Psychiatry* 2022; 221(1): 374–6.
- 2 Battin MP, van der Heide A, Ganzini L, van der Wal G, Onwuteaka-Philipsen BD. Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups". *J Med Ethics* 2007; 33(10): 591–7.
- 3 Oregon Health Authority. *Oregon's Death With Dignity Act, 2010*. 2011. Available from: <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year13.pdf>.
- 4 Berger H. *When Insurance Companies Refuse Treatment "Assisted Suicide" Is No Choice At All*. Available from: <https://www.aapd.com/when-insurance-companies-refuse-treatment-assisted-suicide-is-no-choice-at-all/> [cited 9 Nov 2022].

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### RE: Effectiveness and cost-effectiveness of psychiatric mother and baby units: quasi-experimental study

*MBUs in the UK: value and cost*

As academics, clinicians and leaders of UK charity Action on Postpartum Psychosis (APP), we campaign for mother and baby units (MBUs) for women with postpartum psychosis. We hear daily of their importance and the devastating consequences of units not existing.

The methodological limitations of this study are laid out by the authors and must be borne in mind when interpreting the findings. Owing to the small sample, the control group consisted of women who received treatment from general psychiatric units (GPW) and women receiving home treatment, which typically provides care for women with less severe illness. Therefore, as the authors explain, the inclusion of home treatment is likely to mask differences between MBU and GPW care. This is confirmed by the study's findings showing differences between the home treatment group and in-patients: women with severe and relapsing illness are underrepresented. When these groups are examined separately, readmissions are in the expected direction (22% MBUs, 32% GPW, 21% home treatment).

Twelve-month relapse rates are a problematic outcome measure for several reasons. In patients with postpartum psychosis and pregnancy-triggered bipolar, relapses are common and represent the expected illness course rather than indicating care quality. MBUs have a lower threshold for readmission than GPWs. Women