disorders such as phantom limb phenomena, in which strong predictions that a limb "is still there" outweigh sensory input to the contrary. Similarly, in functional paralysis, one hypothesis is that the brain predicts a limb that "is not there" (and thus cannot be moved) so strongly that it outweighs sensory input telling the brain that the limb is normal[4]. The predictive brain builds on older notions of "ideas" or "beliefs" being important in FND, or of conditioned responses to threat, illness or injury that operate below the level of awareness. Neurodevelopmental conditions – including autism spectrum disorder, attention-deficit/hyperactivity disorder, and joint hypermobility – may be more common in people with FND because of an impairment in this predictive and interoceptive machinery.

The first functional neuroimaging study of an FND patient appeared in 1997. The shock news was that FND could be seen in the brain. A number of networks have then been found to be relevant to FND, including those involved in attention, motor control, salience and emotion regulation[2]. Perhaps the most interesting and replicated finding is hypoactivation of the network involved in sense of agency – the parts of the brain that let you know that it is "you" who made a movement – including the right temporoparietal junction. Poor activation of this network is consistent with what we see clinically ("it looks like a voluntary movement") *and* what the patient is telling us ("it doesn't feel like under my control"). A diagnostic biomarker for FND may even one day become available[5]. For example, a study of resting state functional imaging was able to classify FND from healthy controls using brain scans alone with an accuracy of 72%[6].

If one considers FND a disorder of higher voluntary movement, it is hardly surprising that it has often been confused with wilful exaggeration or malingering. But a whole range of clinical and neuroscientific evidence, including geographical and historical consistency as well as remarkable responses to neurophysiological experiments, such as increased accuracy in tests of sensory attenuation, show that feigning offers a poor explanation for the clinical phenomenon of FND[7].

Treatment for FND reflects this new multidisciplinary approach, starting with an explanation of the disorder that emphasizes diagnosis by inclusion, mechanisms in the brain, but also relevant psychological risk factors when present. FND-focused physiotherapy promotes automatic over voluntary movement, has important differences to physiotherapy for recognized neurological conditions, and shows a lot of promise in randomised trials[8]. FND-focused evidence-based psychological therapy addresses adversity, but also recognizes the physiology of functional seizures and their similarity to panic[9].

The International FND Society, founded in 2019, embodies this co-operative approach, and is complemented by new patient-led organizations such as FND Hope and FND Action. Together they are defying the dualism which has prevented progress and understanding of this common disabling condition.

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DOI:10.1002/wps.21151

# Euthanasia for unbearable suffering caused by a psychiatric disorder: improving the regulatory framework

Medical assistance in dying (MAID) – defined as voluntary euthanasia and/or physician-assisted suicide – for people with a terminal illness is becoming available in more jurisdictions around the world. By contrast, MAID in people with a non-terminal illness and, more specifically, in people with a psychiatric disorder remains a controversial topic.

Belgium is one of the very few countries where euthanasia for unbearable mental suffering caused by a psychiatric disorder is allowed. According to the 2002 Belgian Euthanasia Law, the eligibility criteria are: a) the euthanasia request is made by a legally competent adult patient; b) the request is voluntary, repeated, well-considered, and not the result of external pressure; c) the patient is in a medical condition without prospect of improvement; d) the patient experiences constant and unbearable mental suffering that cannot be alleviated; and e) the suffering is the result of a serious and incurable psychiatric disorder. To assess the fulfilment of these criteria, the attending physician must consult two independent physicians, including a psychiatrist. At least one month should pass between the date of the patient's request and the performance of euthanasia. After the euthanasia is performed, the attending physician must report this to the Federal Control and Evaluation Commission for Euthanasia, which is tasked with the *a posteriori* control[1,2].

According to the official data in 2020, MAID accounted for 1.9% of all deaths in Belgium. Between 2002 and 2021, a total of 370 patients received euthanasia for unbearable mental suffering caused by a psychiatric disorder. This corresponds to 1.4% of the total number of euthanasia cases, although in recent years the incidence slightly decreased to between 0.9 and 1%. The most common diagnoses (data on 2002-2019, N=325) were mood disorders (55.7%) and personality disorders (19.4%), followed by psychotic disorders (6.2%), anxiety disorders and post-traumatic stress dis-

order (6.2%), autism spectrum disorder (4.6%), eating disorders (1.5%), and other and/or combination of disorders (6.5%).

Recently, the fundamental rights compliance of the Belgian Euthanasia Law, as applied to euthanasia for mental suffering caused by a psychiatric disorder, was scrutinized in two ground-breaking court decisions[3,4].

In the first of these, the European Court of Human Rights examined whether a euthanasia of a 64-year-old woman with treatment-resistant depression and a personality disorder had violated the state's responsibility to protect her right to life, as well as the right to respect for private and family life of her son, who had only been informed about the euthanasia after it had been performed[3].

The Court held that the Belgian legal framework governing euthanasia for mental suffering caused by a psychiatric disorder complied with the conditions set out in an earlier case law on end-of-life decisions. More specifically, it was argued that the Belgian law contains a procedure that can guarantee that a euthanasia request is voluntary. In addition, as required for MAID concerning particularly vulnerable persons, the law provides for increased protective measures for euthanasia in people with mental suffering. In this regard, the Court noted the importance of the obligation to consult two independent physicians, including one psychiatrist, as well as to observe a waiting period.

By contrast, the Court still found a human rights violation in the way the *a posteriori* control of euthanasia was regulated. In the case at hand, the physician who had performed the euthanasia was the chair of the Federal Commission. Since in monitoring the legal compliance of that case of euthanasia the Commission had relied completely on the anonymous part of the registration document, the chair had inadvertently taken part in approving the euthanasia case without anyone having noticed his involvement. However, as this monitoring should be independent, reporting should not be anonymous if physicians involved in euthanasia are allowed to sit on the Commission[3].

In the second case, the Belgian Constitutional Court was petitioned by a judge who was looking into the liability of a physician who had performed the euthanasia of a 38-year-old woman with a personality disorder[1-4]. As in previous rulings, the Court confirmed that the Euthanasia Law and its constituting elements and safeguards do not violate the constitution. Since the Belgian Euthanasia Law does not contain any sanctions, the Court was asked to shed light on the penalties that should apply. In accordance with the general provisions of the Criminal Code, any infraction, even of an administrative nature, could be considered murder by poisoning. The Constitutional Court held that this would be disproportionate for the physicians involved in euthanasia, as they would run the risk of being convicted for murder even for infringing upon a legal condition of minor importance. Ruling that this violated the principles of non-discrimination and equality, the Court instructed the Belgian legislature to diversify the applicable system of penalties, with lighter penalties for violations of procedural conditions that are less important to guarantee the fulfilment of the eligibility criteria.

The evaluation of a request for MAID in the context of a psychiatric disorder is clinically challenging. First, the assessment of the decisional capacity of psychiatric patients who request MAID may be more complex than for other patients[1,2,5]. It is emphasized by opponents of MAID in people with a psychiatric disorder that their competence can be severely impacted by the illness[1,6,7]. Although a cautious approach is therefore necessary, there is no reason to presume that people with a psychiatric disorder cannot possess the required decisional capacity. This capacity should be assessed case by case and held to a high standard, considering the nature and possible consequences of the request. In this light, it is highly advisable to conduct a formal evaluation of the capacity of psychiatric patients who request MAID.

Second, there is no consensus or authoritative guidance on how to define or measure unbearable mental suffering[1,7,8]. This entails a risk that unbearable mental suffering is too readily accepted. Although treatment refractoriness is a clinical reality, MAID should only be considered after all reasonable biological, psychological, social and recovery-oriented treatment options have failed. When a patient refuses such treatments, this should not lead physicians to conclude that the mental suffering cannot be alleviated and the psychiatric illness is without prospect of improvement. Hence, the request for MAID should not be granted.

In 2017, the Flemish Society of Psychiatry published recommendations to guide clinicians in these difficult decisions[7]. They recommend following a two-track approach in the evaluation of a euthanasia request by a psychiatric patient. One track should examine the fulfilment of the eligibility criteria. Importantly, it is suggested to always involve at least two psychiatrists, who preferably are experts of that specific psychiatric disorder. In the second track, the psychiatric patient should be actively supported in exploring all remaining therapeutic and recovery-based options. This two-track approach combines respect for the autonomy of the patient with the obligation to protect that person's right to life. It implies that, while the euthanasia request is being assessed, the psychiatric patient continues treatment and his/her psychiatrist remains involved.

These recommendations inspired the Belgian Order of Physicians to adopt more stringent deontological standards for physicians who consider a euthanasia request from a psychiatric patient. These physicians are now obliged to comply with additional due care criteria: at least two of the three physicians involved should be psychiatrists; the physicians should come to a jointly formulated opinion about the fulfilment of all due care criteria; euthanasia should not be performed unless all reasonable treatment options have been tried and failed; and patients should be encouraged to involve their relatives in the euthanasia procedure. Combined, the legal and deontological due care criteria help ensure that a euthanasia request for mental suffering caused by a psychiatric disorder is appropriately addressed.

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DOI:10.1002/wps.21152

# Physician-assisted death for psychiatric disorders: ongoing reasons for concern

Physician-assisted death (PAD) – i.e., the prescription and administration of lethal medications by physicians – is increasingly available as an option for people struggling with psychiatric disorders. Although PAD was initially promoted as a means of easing suffering for people with terminal conditions, a growing number of jurisdictions have extended access to all causes of intractable and severe suffering, including psychiatric conditions.

At present, Belgium, the Netherlands and Luxembourg, along with Spain and Switzerland, either explicitly authorize or *de facto* permit lethal assistance in such cases[1]. Canada is scheduled to join this group in March 2024. It is difficult to ascertain how often PAD is used for psychiatric disorders; however, among all PAD cases in Switzerland, 8% of those in Swiss residents and 17% of those in people traveling from other countries for this purpose had documented mental disorders[2]. Overall, available data suggest that the frequency of PAD use in people with psychiatric disorders is increasing[1].

A growing literature is debating the ethics of PAD in psychiatry. For jurisdictions that permit PAD in terminal illnesses, it is commonly argued that to preclude its use for non-terminal conditions that cause immense suffering, including psychiatric disorders, is discriminatory. To proponents of psychiatric PAD, it appears unquestionable that these conditions can cause severe suffering and may be resistant to available treatments, that most people with a psychiatric diagnosis are competent to decide that death is preferable to an indefinite continuation of their current state, and that clinicians can reliably ascertain whether these criteria have been met[3].

I have previously detailed in this journal[4] my concerns about PAD for people with psychiatric disorders. Among the reasons I noted for caution in embracing PAD are its application to disorders very different from treatment-resistant depression (which is often held up as the model of an intractable condition that causes great suffering), including autism, eating disorders, dissociative disorders, and personality disorders. The high proportion of patients with personality disorders seeking PAD, and the well-known reactivity of these conditions to environmental circumstances, raise the question of just how deeply rooted the distress being expressed by such patients might be. Whether a person is experiencing severe suffering, a key criterion for eligibility, is entirely subjective, leaving evaluators with little choice but to accept the patient's assertion that this is the case. Given that intractability is usually judged only by the lack of response to those treatments that a patient is willing to accept, it is common that potentially effective interventions have never been tried by patients seeking PAD. Finally, whether the underlying disorder is driving the person's choice is very difficult to ascertain, leaving the decisional competence requirement little role to play in these cases.

Here, I want to consider what we can learn from the experience with psychiatric PAD, primarily from reports published over the last five years. There has always been concern that PAD would become a replacement for the provision of psychiatric care, especially where such care is not easily accessed. Recent reports from Canada underscore this concern, as exemplified by the account of a woman who sought help at a hospital for suicidal ideation[5]. She was told that the mental health system was "completely overwhelmed", no inpatient beds were available, and she would have to wait six months to see a psychiatrist as an outpatient. At that point, the counselor assessing her asked if she had ever considered PAD, explained how it worked, and noted that it would alleviate her suffering. All this occurred even though PAD was technically not yet authorized in Canada for people with mental disorders, and reinforces reports from other Canadian jurisdictions.

Along with concern about PAD being used as a substitute for care are data suggesting that patients who are suicidal – and thus should be treated for their intention to end their lives – are disproportionately seeking PAD. A review of studies on the prevalence of personality disorders among PAD requesters noted that in several reports they represented more than 50% of the sample; the authors underscored the substantial frequency of suicidal behavior in personality disorders, its fluctuating nature, and the existence of evidence-based treatments to address it[6]. Another review focused on the disproportionate use of psychiatric PAD for women, who accounted for 69-77% of cases in several series[7]. The authors noted that women also attempt suicide more frequently and typically favor less violent means, such as medication overdose. Hence, they suggested that PAD may be serving as a substitute for self-inflicted suicide, especially for women, and encouraged further research on this question.

The momentous nature of a decision to seek PAD – an irreversible and final procedure – suggests the need for great care in evaluating whether the criteria for eligibility are met. However, this appears often not to be the case. A review of 66 cases of PAD from the Netherlands found that, in 55% of cases, documentation of decisional capacity was limited to a global judgment, without assessment of specific capacity-related abilities[8]. Moreover, there