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Essay

Physician-Assisted Death: Challenges in Mental Illness

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Abstract

Physician-assisted death (PAD) is being progressively implemented worldwide, but many important issues related to mental illness remain unclear. In this essay, the authors explore the historical, ethical, and legal evolution of euthanasia, tracing perspectives from Classical Greece to contemporary legislation. It is argued that the growing inclusion of mental patients in PAD across several countries has not solved controversial issues, such as the lack of consensus on eligibility criteria for psychiatric disorders and the difficulties in determining unbearable mental suffering, incurability and decision-making capacity. Furthermore, psychiatrization and overdiagnosis, as well as the insufficient availability of evidence-based psychosocial interventions, are not properly addressed when PAD is considered. It is, therefore, of the utmost importance, in countries where PAD is a possibility for mental patients, to establish interdisciplinary expert committees to rigorously evaluate the requests. These committees should apply clear, evidence-based, pre-defined criteria to prevent premature or inappropriate PAD decisions while protecting patients' autonomy.

Keywords: physician-assisted death; mental illness; legislation; evidence-based criteria; assessment

1. The Inevitability of Death

Death, due to the meaning of an inevitable end, has been a simultaneously disturbing and fascinating topic for humanity for millennia. Recently, the paradigm of the inevitability of death has been challenged, potentially radically transforming human nature and the way societies are organized around the finiteness of life. Biological ageing is defined as the progressive loss of cognitive and physical capacities towards death (Fulop et al., 2010). However, this conceptualization, especially among researchers dedicated to biochemical and cellular analyses, is changing, and ageing is increasingly perceived as a curable disease (Pereira et al., 2019). The "immortality" of certain living beings (Velasco-Muñoz et al., 2024), the knowledge that the adoption of various behaviors, such as healthy eating (Chen et al., 2026) and physical exercise (Qiu et al., 2025), can delay aging, the accelerated aging that occurs in Hutchinson-Gilford syndrome (Lamis et al., 2022) and genetic and molecular studies (Ribeiro et al., 2022) developed in the area have driven this revolutionary idea. Cell manipulation in mice increased survival by 25%, and several processes involved in ageing that can be "treated" have already been identified (Bi et al., 2025). In addition, the ongoing technological revolution, particularly in the field of artificial intelligence (AI), has crossed boundaries once thought insurmountable between reality and science fiction. This brave new world will necessarily incite a deep ethical, legal, social and clinical discussion about the nature and limits of mortality.

To this day, the innate and universal fear of death has driven human endeavors, contributed to the harmonious social organization of the species (Moore & Williamson, 2012) and promoted changes in social, philosophical and ethical thinking throughout the ages. The societies of Classical Greece, influenced by philosophers such as Democritus and Epicurus, approached the topic rationally, trying to overcome the fear of death. Democritus argued that accepting death as part of life was paramount,

and Epicurus focused on maximizing pleasure to achieve peace. During the Middle Ages, the influence of religious dogmas led to an obsessive fear of death. In the Renaissance, the classical ideas that people were responsible for their own destiny and death gave value to life were revived. It is interesting to note that, despite the dominant theistic views and religious explanations of the natural world, some philosophers approached the fear of death quite differently in antiquity. This was the case of Lucretius (99-55 B.C.), who, in Book III of *De Rerum Natura*, tries to convince readers that death should not be feared, presenting two main arguments: the argument of symmetry and the argument of the non-existence of harm (O'Keefe, 2003). In the first, Lucretius states that the infinite extension of postmortem non-existence is equal to that of prenatal non-existence. Thus, if we do not feel anguish about the latter, by analogy, we cannot fear the former. In the argument of the non-existence of damage, Lucretius says that death cannot be harmful to the person who died because the person ceased to exist.

Currently, with the sanitization of societies and the rapid development of technology and medicine, death and dying are removed from the public eye and have acquired a kind of aseptic meaning. Death is presented filtered by the media, and the rule is to die in a hospital, allegedly without or with minimal pain and anguish (Fulton, 1977). This notion of a peaceful and painless death may disregard the importance of debating topics such as euthanasia. The medicalization of death and the disregard for the topic by a culture obsessed with anti-ageing hinders an open and productive discussion about ageing and mortality. The literature advocates that death and dying should be addressed early in the life course to reduce fears, increase knowledge of healthy ageing strategies, and enable well-informed end-of-life decisions (Otto et al., 2023). Canada, for example, has already implemented an advanced care planning program in the school education curriculum (Canadian Hospice Palliative Care Association, 2020).

2. Euthanasia

In essence, the acceptance or rejection of euthanasia is closely related to the fear of death. When people deeply fear death and believe that Life, even under great suffering, is the supreme gift of humanity, they will find it difficult to accept that another person wants to die, even when suffering terribly from an incurable disease. On the other hand, people who face death without or with less fear see it as the ultimate palliative treatment for the relief of suffering and, therefore, accept more naturally that an individual in agony wishes to die.

The central position of societies in relation to euthanasia over time has been strongly influenced by governments, predominant currents of thought and the way living with dignity was interpreted. In Ancient Greece, the use of euthanasia was widely practiced and accepted. Socrates and Plato were advocates of ending a life whenever a serious illness caused long agony and suffering. Plato, in the book "The Republic", vehemently criticized those who advocated prolonging life through the overuse of ineffective treatments, a practice currently known as dysthanasia (Picón-Jaimes et al., 2022). However, there were dissonant voices, such as that of Hippocrates, the philosopher responsible for the oath that served as the basis for the ethical-deontological regulation of the medical profession (Bont et al., 2007). The generally accepted idea is that Hippocrates was firmly against euthanasia. However, some translators of Hippocrates' text suggest that his main concern was to prevent the possibility that, at a time when killing by poisoning was common, a doctor, through a privileged relationship of trust with a patient, would be instrumentalized to commit murder (Van Hooff, 2004). During the Middle Ages, Catholicism was the dominant force in the sciences, arts, and medicine. Based on the ideas of St. Thomas Aquinas and St. Augustine, suicide and the administration of a lethal substance to patients with terminal illnesses were prohibited. People who committed suicide could not be buried and given a proper funeral, and those who injected lethal substances into terminally ill patients were excommunicated and convicted. However, killing was permissible during the Crusades for religious expansion and conversion, and on the battlefield (Bont et al., 2007) a dagger could be used to kill seriously wounded enemies. In the Renaissance, science and philosophy became the engines of political and social organization. During this period, through the contribution of

thinkers such as Thomas More and Francis Bacon, the concept of euthanasia developed its current meaning: a means through which seriously ill people, at their own request, have a dignified death (Emanuel et al., 2016). The debate on euthanasia in the twentieth century was mainly influenced by the crimes committed by the Nazis during the Third Reich. Hitler's euthanasia program was a form of eugenics, in which individuals of particular ethnicities and people with physical or mental disabilities were deemed unworthy of living, including newborns (Von Engelhardt, 2002). These atrocities were the main responsible for the change from the paternalistic medical approach, which prevailed until then, to the full autonomy and self-determination of patients in decisions about their own health (O'Sullivan et al., 2020). The relatively consensual worldwide recognition, at least in the West, of the total autonomy and legitimacy of patients to freely decide on the treatments they wish to receive or not is at the basis of the progressive increase in countries that decriminalize physician-assisted death (PAD).

3. Physician-Assisted Death in the World Today

Euthanasia (the act of deliberately ending the lives of people, at their own request, who suffer from an incurable disease causing significant suffering) and assisted suicide have been progressively discussed and implemented in several countries (Mroz et al., 2021).

Euthanasia can be active, when a patient's life is ended by administering a drug, or passive (orthothanasia), by interrupting ineffective treatments that lead to death. Worldwide, some form of PAD (euthanasia, assisted suicide, or both) is legalized in the following countries (British Medical Association, 2024; Desk, 2024; Euthanasia and Assisted Suicide - Comparative Legislation, 2016; Maxim Institute, 2021; Mroz et al., 2021): Europe - Netherlands, Austria, Belgium, Luxembourg, Switzerland, Portugal, Italy, Germany, Spain, Sweden; North America - Canada; U.S. states of Oregon, Montana, Washington, Vermont, California, Colorado, Hawaii, New Jersey, Maine, and the District of Columbia; Oceania - New Zealand; Tasmania; Australian states of Victoria and Western Australia; South America - Colombia, Ecuador, Chile; Central America - Mexico; Asia - India.

Active euthanasia is allowed in Canada, Colombia, Spain, Belgium, the Netherlands, Luxembourg, Portugal, New Zealand and Australia. Seven countries currently offer assisted death to psychiatric patients (the Netherlands, Belgium, Colombia, Luxembourg, Spain, Canada and Switzerland). Finally, Belgium, the Netherlands, Colombia and Luxembourg allow minors to apply for PAD.

4. Physician-Assisted Death in Mental Illness

The so-called "physical" diseases have been the main reason for patients to request PAD. However, in countries where the procedure is legal, requests for PAD due to psychiatric illnesses have increased. A recent study revealed that, worldwide, end-stage cancers (45.4%), dementia (19.8%), treatment-resistant mood disorders (12.2%) and advanced cardiovascular diseases (12.2%) are the most common reasons for requests (Rahimian et al., 2024). Overall, chronic and debilitating physical illnesses are still the main reasons for applying for PAD. However, requests from patients with psychiatric disease who claim incurability and unbearable mental suffering are substantial, and the illnesses on which these requests are based are as varied as dementia, depression, personality disorders, generalized anxiety disorder or schizophrenia (Rahimian et al., 2024). This variability and the difficulties in clearly determining unbearable mental suffering and incurability reveal the absence of consensual eligibility criteria for psychiatric patients. The requirement of unbearable mental suffering for the granting of PAD is frequently reported and experienced by psychiatric patients at risk of suicide and/or suicidal ideation (Ducasse et al., 2018). In addition, there is no scientific support (Doherty et al., 2022) for the argument that the introduction of PAD reduces unassisted suicide rates, as advocated by some (Nicolini et al., 2020). The high percentage of patients who do not wish to die and give up the request for PAD demonstrates the complexity and possible transitory nature of unbearable mental suffering in many cases (Caceda et al., 2017). Some patients report that they suffer

more due to a persistently adverse personal context than due to a specific mental disorder (Verhofstadt et al., 2021). It may, in fact, seem a paradox that unbearable psychological suffering is both a target for suicide prevention strategies and a necessary criterion for PAD. The absence of ancillary diagnostic tests (Bohman, 2023), not only to make accurate diagnoses, but also to classify the severity of diseases; the heterogeneity of psychiatric evaluations and presentations of mental disorders, which lead several psychiatrists to assess the severity of illnesses differently (Newson et al., 2020; Saito et al., 2022); the fact that even mild psychiatric illnesses can lead to a poorer quality of life compared to healthy controls (Calcedo-Barba et al., 2020; Fonseca et al., 2024); and the inconsistency related to the definition of treatment-resistant psychiatric disorders (Howes et al., 2021) are some of the obstacles that hinder a concise determination of refractory illness and unbearable mental health distress. Furthermore, can a disease be said to be resistant to treatment and incurable when patients refuse treatment? (Calati et al., 2021). Won't serious mental distress secondary to severe psychopathology limit patients' ability to consider viable treatments? Does an absence of therapeutic response to at least two antidepressants, generally accepted to be considered a refractory depression (Steffens, 2024), in the absence of a pharmacokinetic profile and not knowing whether the drugs used reached the appropriate plasma dose for a therapeutic effect, guarantee that the antidepressants chosen were undoubtedly the most appropriate (Fonseca et al., 2024)?

Complex and very heterogeneous diseases, such as personality disorders, have been identified as the diagnosis of a large number of patients who have requested and received PAD (Mehlum et al., 2020). However, there are no specific criteria to define refractory disease and unbearable suffering in disorders characterized by rapid progression and unstable course, as happens, for example, in Borderline Personality Disorder. There is robust evidence that, with appropriate strategies such as structured psychotherapies, suicidal tendencies and disruptive behaviors can be effectively treated in these patients. Studies with Dutch psychiatrists show that the percentage of psychiatric patients with personality disorders who request euthanasia is 64% and that most refused several treatment options (Evenblij et al., 2019; Calati et al., 2021).

In general, when asked what could have prevented the request for PAD, adult patients mention the need to increase the accessibility, quality, and efficiency of mental health resources (Mistiaen et al., 2019). Most countries are still far from the percentage of the total health budget recommended by the Organization for Economic Cooperation and Development (OECD) to be invested in mental health (Verhofstadt et al., 2021). The OECD estimates that up to 13% of total health spending is allocated to mental health services. *Statista's* research shows that, for example, Portugal invested approximately 136.2 million euros in psychiatric hospitals (1.3% of total health spending) in 2019. 80% of total expenditure was related to hospitalizations and emergencies (Coelho et al., 2022), contrary to national (Law No. 113/2021, of 14 December) and international (World Health Organization, 2023) policies and recommendations on community mental health services, involvement of various social sectors (e.g., education, housing, law, industry, employment, transport, arts and culture, sport) in care and quality-focused investments (Lancet, 2020). It is undeniable that prevention and rehabilitation allow for better management of scarce resources.

In Portugal, despite the high prevalence of psychiatric disorders (the second highest at the European level), existing data suggest that a significant part of the population does not receive adequate mental health care (Coelho et al., 2022). The degree of severity of psychiatric disorders, as a whole, is distributed mainly between the groups of mild and moderate severity, 31.9% and 50.6%, respectively. Unfortunately, evidence-based non-pharmacological interventions are not widely available for use, either alone or in conjunction with psychopharmacology, with medication often being the only treatment implemented. In fact, Portugal has a high consumption of psychotropic medications, particularly anxiolytics, compared to other countries, which has been directly related to the significant prevalence of psychiatric disorders (OECD, 2023). The reasons are certainly diverse. However, two factors deserve special attention.

Firstly, the phenomenon of the psychiatrization of societies. It is extremely important to distinguish psychiatric illnesses from negative emotions. Sadness or anxiety, particularly in the

context of life events, are not necessarily symptoms of a mental health problem. Generally, these emotions are transient and do not require therapeutic intervention, even when they are part of a mild depression (Whiteford et al., 2013). In addition, if supportive interventions are recommended, non-pharmacological approaches may be effective (Malhi & Mann, 2018; Cuijpers et al., 2023). Psychiatrization has been defined as a “complex process of interaction between individuals, society, and psychiatry, through which psychiatric institutions, knowledge, and practices affect an increasing number of people, shape more and more areas of life, and consolidate the importance of psychiatry in society as a whole” (Beeker et al., 2021). One of the main concerns related to psychiatrization has been the contribution to lowering the threshold of what is considered abnormal, leading to an overdiagnosis of mental disorders, the prescription of unnecessary pharmacological treatments, and the inflation of epidemiological data (Beeker, 2022). With regard, for example, to depression, the most prevalent mental disorder worldwide (WHO, 2025), there has been a significant change in diagnosis with the criteria adopted in the DSM-3 (Horwitz, 2015). Symptom-based classification of the disorder and disregard of context led to a significant increase in the diagnosis of depression, a disease previously considered rare by clinicians. The DSM-5 went even further and removed the exclusion of grief from diagnostic criteria, eliminating the only reference to contextual grief and broadening the concept of illness (Horwitz, 2015). Misdiagnosing a normative emotional response as a disease is ethically pernicious, as it puts people in a vulnerable position of having to make decisions about an illness from which they do not suffer, contributing to an internalization of the role of the patient and harming personal dignity and expectations. In addition, it exposes healthy individuals to unnecessary risks, such as medications or stigma, and undermines the principle of equitable justice by diverting clinical and financial resources from those who truly need them. It is understandable and acceptable that a health professional, when encountered, for example, with a serious suicide attempt, in which several risk factors are present (e.g., older adult, male gender, unfavorable context, high lethality method used), takes the necessary measures to protect the person’s life. However, it must be known that this does not necessarily include making a diagnosis of mental illness or choosing a pharmacological approach. Suicide can occur in people without mental illness (Sher, 2023), and the elimination of *stressors* and/or the development of appropriate *coping* mechanisms, if necessary, through some psychological support, may be sufficient to resolve the situation, avoiding the diagnosis of psychiatric illness, unnecessary medication prescriptions, and stigma.

Secondly, inefficiencies in the mental health system and the insufficiency of non-medical professionals, such as psychologists, may be favoring a medication-centered approach and also justify the high rate of psychotropic drug use in Portugal. In fact, the data suggest that the ratio of psychologists (10.32/100,000 inhabitants) is below the recommended level of 20/100,000 inhabitants (OPP Opinion – Ratio of Psychologists, 2022). By contrast, the ratio of 15 psychiatrists per 100,000 population (Eurofound, 2025) exceeds the 10 psychiatrists per 100,000 population proposed by international organizations (WHO, 2020).

5. Physician-Assisted Death in Portugal

It is important to start by mentioning that there are already precedents from higher courts, such as the European Court of Human Rights, regarding the legitimacy of patients with psychiatric disease requesting PAD (De Hert et al., 2022). The Law does not even consider *ex post facto control* of the procedure adopted in countries such as Belgium to be illegal. Thus, it seems, therefore, that, currently, PAD and its regulation, under the eyes of the Law, is a choice that societies and their political representatives are free to make.

In Portugal, on May 29, 2018, several proposals for the decriminalization of PAD, presented by four political parties (Left Bloc, Socialist Party, People-Animals-Nature and Green Party), were rejected by parliament. A year and a half later, the same four parties and the Liberal Initiative presented five legislative initiatives on PAD, which were approved by parliament. The final vote at the global level took place at the end of January 2021 and culminated in the approval of a law. The President of the Republic (PR) would veto it, alleging “insufficient normative density”, but on

November 5, 2021, the decree would be approved again by parliament. However, a new veto would arise from the President due to contradictions in the diploma regarding concepts such as “serious disease”, “incurable disease” and “fatal disease”. During 2022, several definitions and conceptualizations were reformulated, and the law was finally approved in its current definitive form and published on 25 May 2023 in the Portuguese Official Gazette No. 101/2023, Series 1 (Assembly of the Republic, 2023).

So far, the law has not yet entered into force. Not only was the deadline for the regulation not met, but, in the meantime, in 2025, at the request of a group of members of the Assembly of the Republic and the Ombudsman, the Constitutional Court, while reiterating and improving its jurisprudence in the sense that the Constitution does not categorically impose or prohibit the legalization of assisted death, considered unconstitutional some provisions of the law (Constitutional Court of Portugal, 2025), namely: “a) several segments of the law that presuppose that the patient has the right to choose between the two methods of physician-assisted death – suicide or euthanasia –, when, in its current version, the law only allows euthanasia if the patient is physically unable to self-administer lethal drugs. In the Court’s view, these lapses by the legislator, in an extremely sensitive matter, may create unnecessary difficulties for the interpreter and generate an avoidable risk of misapplication of the law, offending the constitutional principle of legal certainty; b) the rule that regulates the method of intervention of the specialist doctor in the disease that affects the patient, by not requiring that the patient be examined, unlike foreign legislation that enshrines euthanasia regimes closer to the Portuguese one; and c) the rule that imposes on the health professional who refuses to perform or assist the act of physician-assisted death the burden of specifying the nature of the reasons of the objection, as it constitutes an inadequate, unnecessary and disproportionate restriction of freedom of conscience.”.

Thus, the diploma is pending analysis by the Assembly of the Republic, which is responsible for correcting the unconstitutionality pointed out by the Constitutional Court and moving forward with the regulation of the law, enabling its applicability, or repealing it.

Although oriented towards physical illnesses, the current legislation does not tacitly and explicitly exclude the possibility of a person applying for PAD on the basis of unbearable mental distress due to a psychiatric illness. The text states: “Death assisted by a doctor occurs by the will and decision of the person who is in one of the following situations: a) Permanent injury of extreme severity; and b) Serious and incurable disease. The law also does not refer to desires for PAD previously expressed by a patient in an advance directive (AD). This omission does not take into account conditions in which the patient, although fully conscious and cognitively competent, may not be able to communicate and, as such, will not be able to express the desire to die (e.g., *Locked-in syndrome*) or situations in which the person suddenly loses cognitive ability (e.g., after a severe ischemic stroke) but, in advance, expressed the desire to be submitted to PAD under these circumstances. It is surprising that ADs are not considered in a law regulating PAD, but are included in article 10 of the Mental Health Law (Assembly of the Republic of Portugal, 2023) as a possibility, establishing that citizens clinically capable of giving conscious, free and unambiguous consent can express their wishes in matters of mental health, including hospitalization, coercive measures, electroconvulsive therapy, transcranial magnetic stimulation and psychotropic medication. Article 10 establishes that the AD must not be complied with when there is a danger to the personal and patrimonial property of third parties. If patients with severe psychopathology resulting in loss of critical capacity have expressed in an AD the desire for PAD, alleging refractory disease and unbearable suffering, should the procedure be allowed?

The PAD law also stipulates that if an accompanied adult regimen (Law No. 49/2018, of August 14) is initiated, the procedure must be interrupted until the final judicial decision is rendered. However, the law does not set a deadline for completing the accompanying adult proceedings, nor does it clarify whether a third party (e.g., a spouse or children) can appeal the court’s decision. As the average time for the conclusion of an accompanied adult process is approximately six months

(DGPJ - SIEJ: Statistics of Justice, 2025), competent patients who request PAD may see their wish postponed indefinitely.

6. Challenges of Physician-Assisted Death in Mental Illness

In countries with PAD expertise in psychiatry, such as the Netherlands and Belgium, several studies have consistently reported that the diagnoses most commonly associated with requests are depression and personality disorders (Calati et al., 2021). Several limitations were pointed out at different stages of the process, particularly in the clinical assessment of patients, in the establishment of incurable disease and intolerable suffering, in the assessment (or lack thereof) of patients' decision-making capacity (Calati et al., 2021) and in the *a posteriori* control of the procedure (De Hert et al., 2022). It is also described that some patients undergoing PAD had complex and chronic psychiatric, medical and social disorders, and others showed highly questionable consent capacity, such as autistic patients with intellectual disabilities (Gallego et al., 2022). Can it be said that a psychiatric illness is incurable when about 49% of patients do not adhere to psychotropic medication (Ramamurthy et al., 2023)? In decades of experience in Belgium and the Netherlands, legislation has expanded the PAD criteria to somewhat unexpected limits: individuals with no apparent incurable disease (such as those suffering from treatable mental disorders), sick children, or people who have simply grown tired of living (Gallego et al., 2022). Under the arguments of self-determination and unbearable suffering, PAD seems to be beginning to be made available as an anticipation (albeit decades in advance) of inevitable death, exempting society and the State from the obligation to guarantee the support and social, economic and clinical conditions necessary for everyone to have a quality and meaningful life.

PAD of psychiatric patients in dubious conditions is already a reality these days, and the argument of "tired of living" has also been accepted as a reason. Thus, it is particularly relevant to include in the evaluation process of psychiatric patients who request PAD several measures that ensure, as accurately as possible, an adequate diagnostic assessment and an accurate determination of the severity of the clinical condition, rigorously ascertaining whether all available evidence-based treatments were implemented. To this end, if PAD becomes a reality for psychiatric patients worldwide, the inclusion in the law and in the respective regulations should consider the mandatory *a priori* evaluation of each case by a committee of experts composed of professionals from different areas of knowledge related to mental health. In such a heterogeneous and multidimensional field, where there are no ancillary tests for precise diagnoses and therapeutic responses are so variable and idiosyncratic, it is of paramount importance to ensure that the person who requests PAD suffers, in fact, from an incurable and disabling psychiatric disease causing significant mental suffering and a frank deterioration in quality of life.

Thus, based on the best scientific evidence and in order to safeguard the patient's best interests, it is essential that an interdisciplinary committee of experts evaluate each case in the following terms:

(1) the committee of experts must include, at least, the following professionals: a psychiatrist; a specialist in psychotherapies; a mental health nurse with relevant knowledge and experience in the treatment of severe psychiatric disorders; a social worker with specialized or relevant experience in mental health; a physician specialized in psychopharmacological and biological treatments of psychiatric disorders; a specialist in neuropsychology; and a lawyer specialized in mental health law and PAD. Competencies are not cumulative; that is, a professional cannot represent two or more areas of specialization. The committee of experts may have access to patients' medical records, if necessary, in accordance with legislation governing the privacy and confidentiality of personal and clinical information.

(2) several elements must be included in the application report for assessment by the expert panel of decision-making capacity, refractory disease and significant suffering, namely: all secondary medical causes for the psychiatric disorder must have been excluded; the international guidelines for biological prescription in Psychiatry must have been complied with, according to the best international scientific consensus (Ravitz et al., 2024; Taylor et al., 2025). The therapeutic rationale

must be described in detail; at least one evidence-based psychotherapy, delivered by a scientifically competent professional, accredited by official health entities, must have been implemented and completed. The rationale for treatment and the intervention steps should be described in detail; where available, patients' pharmacokinetic profiles and plasma concentrations of the chosen medication should have been used to guide prescribing and to monitor therapeutic plasma concentrations, respectively. The information must be included in the report. Public policies should strive to include these tools in the treatment of psychiatric patients, along with ancillary diagnostic tests, new treatments and biological markers, as soon as they become available; a detailed social report must be issued, including, among other information, data on the area of residence, domicile, living conditions, income, socio-family interactions and activities, professional history and the strategies proposed and implemented to improve the patient's social well-being; a comprehensive neuropsychological assessment of cognitive abilities and an assessment of the intelligence quotient must have recently been carried out; a statement from the attending psychiatrist attesting that the disease has caused a significant decline in the patient's level of personal, social, recreational and professional functioning, despite the treatments and social interventions implemented, must be included.

(3) patients (accompanied by the attending physician and/or lawyer, if they so wish) must present in person (or by validated telematic means) before the committee for the final confirmation of the will to PAD. The expert board should refrain from making any comments or questions based on personal beliefs that promote stigma and undermine the patient's dignity, confidentiality, privacy, and right, within the scope of the PAD legislation in effect, to the procedure. The committee may not, under any circumstances, object to the procedure if: all the criteria mentioned in point 2) confirm the patient's decision-making capacity, the existence of a refractory disease and a significant negative impact of the disease on the patient's level of personal functioning and quality of life; the legislation in force has been complied with; the patient confirms the will of PAD.

7. Artificial Intelligence in Physician-Assisted Death

In an Era of a new technological revolution, where AI has been the engine of profound change, it would, to say the least, be sloppy not to address the topic, even briefly. In fact, AI has significantly changed not only science in general, but also human nature, namely the behavioral, emotional, and cognitive patterns that have regulated the species' thought and action. Properties once considered exclusive to human beings, such as empathy, artistic gifts, or the capacity for reflective analysis, have also been attributed to AI (Föyen et al., 2025; Suleyman, 2026).

Throughout history, humanity seems to have maintained its behavioral and motivational nature, gravitating on a spectrum between evil and goodness, remaining territorial (Gómez et al., 2016), and driven by an avidity for knowledge that has allowed it to overcome, in some spaces, its own limits. The behavioral and emotional predictability of human beings has enabled psychiatric science to establish patterns, predict actions and consequences, and make prognoses. In this way, AI, through a learning process, can understand the human species and help or replace it across various domains. Today, AI is already capable of correctly analyzing a literary work in seconds (Mtotywa et al., 2026) and replacing human presence in various interpersonal interactions (Samuel & Schmiljun, 2021; Murray, 2025).

In the context of PAD in psychiatry, AI can also play an important role, specifically, contributing to the so-called Precision Psychiatry (Van Dellen, 2024). It can help mental health professionals to better understand diseases, improve diagnostic capacity, establish more accurate prognoses and therapeutic predictions, and implement personalized therapeutic approaches (Tahan & Saleem, 2024; Wiese & Friston, 2021). Notice how AI-generated psychological counselling is comparable to psychological counselling written by mental health experts in terms of scientific quality and cognitive empathy, while also outperforming the advice of emotional and motivational empathy experts (Föyen et al., 2025).

Thus, AI can be incorporated into therapeutic care processes and into the evaluation of criteria for accessing the PAD procedure in psychiatric patients, but only as an auxiliary means. At least for now, there is no evidence that current AI is capable of fully replacing professionals specialized in mental health in its most diverse valences, nor of issuing thoughtful and rigorous judgments, in line with the best evidence, within the scope of decision-making processes related to PAD.

8. Final Note

PAD in psychiatry presents unique challenges that should not be ignored. It is important to consider whether the *post hoc* control of the procedure will, in fact, be the most appropriate. Furthermore, considering the multidimensionality of mental illness, in countries where PAD is contemplated by law, there should be evaluation committees composed of professionals specialized in various areas of mental health. These committees should be tasked with assessing eligibility, ensuring that well-defined clinical criteria—aligned with the best current scientific evidence—are consistently applied.

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