

A rebuttal on externalism

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ABSTRACT

In a recent paper, I argued that an externalist understanding of mental disorder from the philosophy of psychiatry presents an ethical challenge to the practice of medical assistance in dying (MAiD) for psychiatric illness, because it highlights the ways in which the suffering associated with psychiatric illness is sustained by features of the external environment wherein the person is embedded, including social barriers and injustices. In a response to my paper, Harry Hudson argues that addressing social inequality lacks relevance to the immediate permissibility of psychiatric MAiD and that the issue of psychiatric MAiD should be informed by 'pragmatic politics' rather than by 'obfuscatory philosophy'. Herein, I contend that Hudson's response misconstrues my position and ascribes to me views I neither express nor endorse. My paper does not claim that psychiatric MAiD should be denied to people who are presently in intolerable distress. Rather, it suggests that the provision of psychiatric MAiD comes along with social responsibilities of the state to attend to the barriers and injustices that sustain and exacerbate psychiatric illness, as well as ethical responsibilities of clinicians to consider a wider range of presently available psychological and social interventions which may have been neglected under a traditional internalist approach.

I thank Dr Harry Hudson for his response, 'Dying in a Terminal Society', to my paper, 'Externalist Argument Against Medical Assistance in Dying for Psychiatric Illness'.^{1,2}

To clarify my position, I would like to draw attention to the final paragraph of my paper:

The argument I have presented here does not necessarily preclude the possibility of a situation where psychiatric MAiD is morally permissible. Nonetheless, it does indicate that the moral permissibility or impermissibility of MAiD is contingent on the range of resources that are made available to help people with persistent psychiatric illness, as well as on the wider sociopolitical context wherein the people are embedded ... This indicates the need for a serious ethical and political debate on the social responsibility to address these social harms and inequalities that contribute to the suffering associated with psychiatric illness.

My paper does not argue that psychiatric MAiD per se is unethical. Rather, it argues that an externalist understanding of mental disorder highlights ethical problems for the practice of psychiatric MAiD that are occasioned by certain contextual factors. Moreover, my paper focuses on the social and moral challenges raised by psychiatric MAiD, but does not draw any conclusions about its legal permissibility. Considering the above, I contend that Hudson's response to my paper ascribes to me claims which I neither make nor endorse.

RESPECT FOR AUTONOMY

Hudson suggests that my argument 'can be used to deny the agency of the mentally ill'. However, nowhere in the paper do I claim that MAiD should be denied to people with psychiatric illnesses who are presently in intolerable distress. Indeed, in a previous paper, I argue that an individual's request for MAiD should not be deemed illegitimate or inauthentic just because it involves a mental disorder.³ Hence, I am not arguing for the denial of the individual's right to use MAiD to escape intolerable and intractable suffering. Rather, my argument is predominantly a systemic critique. I argue that an externalist understanding of mental disorder highlights ethical challenges pertaining to the social and political responsibilities that come along with the provision of psychiatric MAiD by the state. If the state is neglecting these responsibilities, then there is something morally problematic about the way in which the regime of psychiatric MAiD is being implemented.

Such a critique of a system governing a practice is compatible with accepting that instances of that practice may be morally justified. To take an analogy, the system of plenary adoption in the USA has been criticised as an industry entwined with imperialism, trauma, poverty and exploitation, and so there has been a call to abolish the need for this system by addressing the injustices that result in families being unable to care for their children.⁴ However, it is entirely possible to endorse the aim of decreasing or abolishing the need for this specific system of plenary adoption while also acknowledging that there are children who presently need caring families, that there are circumstances where placing a child with adoptive parents is the ethically correct course of action, and that the adoptive relationship can be as authentic and as loving as any other familial relationship.⁵ Likewise, it is possible to criticise the way in which a regime of psychiatric MAiD is implemented and to endorse the aim of decreasing the need for such a regime while also acknowledging that there are circumstances where the provision of psychiatric MAiD is an ethical and compassionate course of action. By highlighting the ethical challenges and social responsibilities that come along with the state's provision of psychiatric MAiD, I am not in any way endorsing its legal prohibition or its denial to people presently in intolerable distress.

REASONABLE ALTERNATIVES

Hudson suggests that my argument 'connotes an arrogance, where someone is denied their agency until such a point that philosophers have decided that the world is fair enough for the person to choose whether to access MAiD'. He continues by proclaiming that 'forcing the suicidal individual to stay alive—to wait until we have the conditions of a just society in which they can make an informed judgement, re-evaluating their life—is immensely disrespectful'. Again, this misrepresents my position. I do not suggest anywhere in the paper that people seeking psychiatric MAiD should be forced to wait for some utopian future when society is more just. Rather, insofar as the externalist understanding of mental disorder is relevant to the clinical assessment for psychiatric MAiD, it underscores the responsibility to consider a wider range of presently available interventions which may have been neglected under an internalist approach. Accordingly, I write approvingly in my paper of the recommended changes to the practice of psychiatric MAiD proposed by psychiatrists and ethicists in Belgium, which include ensuring that all available medical, psychological, and social interventions have been considered before making a judgement

about irremediability.⁶ The standard here is that all presently available interventions are considered, not that potential future interventions are considered.

Perhaps Hudson misconstrues me on the above point because of my claim that ‘psychiatric MAiD may contribute to further social injustice by normalising death as an option for people from vulnerable groups when other alternatives may have been available under more just social conditions’. However, this passage does not suggest that the solution is to deny psychiatric MAiD to people presently in intolerable distress until more just social conditions have been achieved. Again, it is supposed to emphasise the responsibilities that come along with the provision of psychiatric MAiD by the state and the harms that occur if these responsibilities are neglected.

THE RELEVANCE OF INEQUALITY

Hudson claims that ‘understanding that mental illness has a social component, and that misery in general is socially constituted, does not give us a compelling reason to oppose MAiD: it gives us a reason to oppose socioeconomic inequality’. What this misses is the role that a MAiD regime can have in compounding such socioeconomic inequality. Consider, for example, the situation in Canada, where MAiD provision was recently extended to non-terminal suffering and is due to be extended to psychiatric illness.⁷ This extension of MAiD provision was implemented in the context of inequitable health funding policies and cuts to social welfare programmes. Accordingly, the government in Canada has been criticised for using MAiD as a convenient way to reduce costs by enabling more people to die instead of mobilising resources to improve health and social care services.⁸ Scott Kim notes:

The point is that these cases are a feature and not a bug of the current Canadian system, as reflected in the tepid responses they usually elicit from the government. The law explicitly makes room for the practice and the regulators say nothing to discourage it.⁹

This is an example of where a MAiD regime can encourage complacency and create an incentive not to oppose the socioeconomic inequality that contributes to people’s suffering. In this context, opposing socioeconomic inequality involves criticising the role that the MAiD regime has in incentivising the underfunding of health and social care services. Again, the point of mentioning this is not to deny MAiD to those presently in intolerable distress, but to emphasise that the provision of MAiD by the state comes along with responsibilities to provide decent care and improve social conditions.

Hudson maintains that ‘we need both MAiD and revolutionary change to conquer distress’. I don’t disagree. However, a lot hinges on the word ‘both’. As Hudson suggests, trying to address social injustice while denying MAiD to those in intolerable distress is unacceptable. I also contend that promoting a regime of psychiatric MAiD while neglecting or refusing to address the unjust social conditions and policies that exacerbate psychiatric illness is unacceptable. If these unjust social conditions and policies are worsening people’s mental health to the point where they are seeking MAiD, then we may need, as Kim suggests, to contend with the ‘recognition that MAiD for poverty-induced exacerbation of medical conditions is not really a medical act but a sociopolitical one’. Therefore, while the consideration of social injustice may not be of direct relevance to the immediate decision of whether a person in intolerable distress should be granted MAiD, it is certainly relevant to the way in which a MAiD regime is implemented by the state.

THE ROLE OF PHILOSOPHY

Hudson contends that ‘it seems at best unlikely and at worst arrogant to think that developments in the philosophy of psychiatry will fundamentally influence the lives of those who are suicidal’. I am not so naive as to think that philosophy of psychiatry on its own will improve things for people who are seeking MAiD. However, that does not mean that philosophical analysis is irrelevant. The ways in which we conceptualise and understand a problem have implications for what explanations and solutions are considered. An externalist understanding of mental disorder has implications for the sorts of factors and that are deemed relevant to address and the sorts of interventions that are deemed important to consider. Also, philosophical analysis can help to attain clarity about the myriad of values that are relevant to the debate and how these relate to one another. My paper is supposed to show that the debate about psychiatric MAiD involves, in addition to the considerations of individual autonomy and the alleviation of distress, social and political considerations pertaining to the harms of injustice and the responsibilities of the state. This is not ‘obfuscatory’, but is an important part of the process of assessing how these different considerations interact, how they come apart, and what ethical compromises are warranted.

Considering the above note on clarity, it is unfortunate that Hudson’s response to my paper ascribes to me views (deemed ‘arrogant’ and ‘disrespectful’) which I neither express nor endorse, because it seems that we may not actually be in disagreement on many of the substantive points of the debate.

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