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# A licence to kill or to save lives

Said Shahtahmasebi & Saxby Pridmore
editor@journalofhealth.co.nz
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The ideas presented in this editorial are the outcome of collaborative work in progress with Professor Saxby Pridmore over the past few years. Some of the collaborative work can be found in the DHH's archives. Here, we present an alternative idea in line with the grassroots approach (Shahtahmasebi 2013a) for developing suicide prevention strategies.

In a recent referendum New Zealanders voted to legalise assisted dying under the End of Life Choice bill, allowing voluntary assisted dying (VAD) for those suffering a terminal illness. Adopting a VAD policy raises complex ethical, religious, cultural, legal, logistical and philosophical arguments against and for (assisted) suicide. In countries that have a VAD policy stringent rules and criteria apply –excluding people with mental impairment, see article by Pridmore et al in this issue.

"Death with dignity", "euthanasia", "right to die", "assisted suicide" and "choice" are among other terms which have been used to describe VAD. If VAD can offer the right to a dignified death then can the same philosophy be used to save lives as part of a suicide prevention strategy? This may appear controversial, i.e. how can suicide be prevented through a plan that offer VAD?

Under current policy, massive resources are allocated to suicide prevention and the end of life or VAD legislation can be construed (or misconstrued) as a 'licence to kill'. I will return to that point.

Suicide is promoted as a mental illness, and VAD as a choice. Importantly, recent acceptance of assisted suicide (I am conflating assisted suicide with VAD – a conflation I can confidently defend) indicates a change in public mindset, now associating suicide with solution to a problem.

Currently, worldwide, there is a major problem in suicide prevention policies. That is, globally, suicide prevention strategies are based on the erroneous belief that all suicide is the result of mental illness. This approach has failed to prevent suicide and reduce suicide rates (Shahtahmasebi, 2020). The reason for the failure is that this strategy denies the wish to die as a valid personal 'emotion' or 'feeling' or a potential solution to a problem in the process, the person is invalidated. .

This strategy relies on the 'diagnosis' of a mental illness in order to justify intervention with a psychiatric treatment. Anyone who may be feeling suicidal or commits suicide is automatically labelled mentally ill. This is probably the reason for why between half and three-quarters of all suicide cases do not come into contact with mental illness services -they

have no mental illness and do not want to be discounted in this manner (Shahtahmasebi, 2013a).

It is highly likely that potential suicide cases avoid service uptake knowing that their feelings and their desire to die won't be addressed and will be dismissed as a mental illness. For all intents and purposes this group can be described as an "invisible" terminally ill group - we have no way of knowing who they are.

It is apparent that VAD is socially formulated as the choice for a *dignified* death. To subscribe to it a certain set of criteria must be met, which means establishment of a dialogue about involving the individuals' network and those providing VAD. In this way, a VAD policy validates the individuals and their wish to die.

It can be argued that VAD should be extended to include suicidality - such programmes could be developed to engage suicidal cases in a dialogue *without prejudice* in order to address their circumstances/suicidality. Thus, suicide prevention strategies could be modified to adopt VAD. Such strategies would be better suited to respond to suicidality, will have a higher rate of subscription, and are more likely to have a better chance of engaging those who would have otherwise died (an undignified death) by suicide alone and in isolation (Shahtahmasebi, 2013b).

## References

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