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The Necropolitics of Psychiatric Euthanasia and Assisted Suicide (pEAS)

La nécropolitique de l'euthanasie et le suicide assisté psychiatriques

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Abstract
The thrust of this conceptual piece is to critique the State granting medical assistance in dying (MAiD) access to those whose sole underlying medical condition is a mental disorder through a necropolitical lens. First, I introduce Mbembe's (2003) Necropolitics as this paper's theoretical framework. Second, I argue how the State grants the psy-profession free rein to deploy its armory of necropolitical tactics to entangle the psychiatrized in its death-making, identity-devouring deathworlds. This paper will demonstrate how the MAiD process for pEAS keeps suicidal aspirants suspended in death-in-life involving silence, sacrifice, and stillness and waiting in protracted states of injury; additionally, it gives rise to a 'necroeconomy' demanding irregular mad body/minds be killed off so sane people can thrive and multiply.

Résumé
L'idée principale de cet article conceptuel est de critiquer l'État qui accorde l'accès à l'aide médicale à mourir (AMM) aux personnes dont le seul problème médical sous-jacent est un trouble mental, à travers une lentille nécropolitique. Tout d'abord, je présente la Nécropolitique de Mbembe (2003) comme cadre théorique de cet article. Deuxièmement, j'argumente sur la manière dont l'État donne carte blanche aux professions psychiatriques pour déployer son arsenal de tactiques nécropolitiques afin d'empêtrer les personnes psychiatrisées dans ses mondes morbides créateurs de mort et dévoreurs d'identité. Cet article démontrera comment le processus d'accès à l'AMM pour l'euthanasie et le suicide assisté psychiatriques maintient les personnes suicidaires suspendues dans une mort au sein de la vie qui implique le silence, le sacrifice, l'immobilité et l'attente dans des états de blessure prolongés. De plus, cette situation donne naissance à une « nécroéconomie » exigeant que les corps et les esprits fous/non normatifs soient tués afin que les personnes saines d'esprit puissent prospérer et se multiplier.

Keywords
MAiD, Psychiatric euthanasia, Necropolitics, Mad Studies, Mbembe

Mots clés
AMM, euthanasie psychiatrique, nécropolitique, études de la folie, Mbembe

Introduction

In February 2015, *Carter v. Canada* invalidated the prohibitions against medical assistance in dying (MAiD) as set out in the Criminal Code of Canada (Brodeur et al., 2022). The Carter decision extended MAiD eligibility to of-age Canadians physically or psychologically suffering. The Government of Canada (GOC), hereafter referred to simply as 'the State,' amended the Criminal Code through Bill C-14 to reflect the Supreme Court of Canada's ruling. The 'psychological' dimension of suffering spawned public outcry regarding the over-inclusive designs of the law and provoked Parliamentary debate; still, the nation outlawed euthanasia for those whose sole underlying condition is mental illness (Downie & Dembo, 2016; Nicolini et al., 2020a). In 2016, the first iteration of MAiD was enacted into law. In October 2020, Bill C-7: An Act to amend the Criminal Code regarding MAiD was tabled. The changes in C-7 culminated from the Superior Court of Quebec's 2019 Truchon decision, ruling the 'reasonable foreseeability of natural death' eligibility criterion unconstitutional (Rukavina, 2019). While repealed for its vagueness, this clause would have disqualified Mad applicants from eligibility (CCA, 2018). On March 17, 2021, Bill C-7 was codified into law, revising the eligibility criteria for securing MAiD and the assessment process (Komrad, 2021). The framework for extending MAiD to the mentally ill was installed; however, a last-minute amendment sunsetted the inclusion of mental ill-health for twenty-four months (Komrad, 2021). In February 2023, Bill C-39 temporarily extended the sunset clause to March 17, 2024 (Government of Canada, 2023).

Recent uptakes in requests by those with intractable mental illness(es) for euthanizing services in Benelux nations: Belgium, The Netherlands, and Luxembourg (Calati et al., 2021) begets a critical analysis of psychiatric euthanasia and assisted suicide (pEAS) in the Canadian context given that our sunset clause expires soon, after which Canada will become the most

MAiD-permissive jurisdiction the world over. Critical research on pEAS addressing the legal and ethical concerns germane to Canadian MAiD law is lacking (Trachsel et al., 2022). Few critical pieces discuss euthanasia and assisted suicide (EAS) (Braswell, 2011), and none exist to my knowledge critical of pEAS. Some pieces have evaluated the legal-ethical aspects of EAS through the prism of Mbembe's work on necropolitics (Grue, 2022; Kubiak, 2015; van Beinum, 2021); still, no papers interrogate pEAS through a necropolitical lens at all despite calls by Amado (2022) necessitating such inquests.

Half of the articles debating eligibility published between 2013 and 2019 were authored by credentialed psy-professionals with clinical backgrounds (Nicolini et al., 2020b). There is scant empirical research capturing the opinions of psychiatrized populations concerning MAiD eligibility (Grassi et al., 2022; Nicolini et al., 2023). Instead, the conversation centers on patients who suffer terminal physical illnesses in late stages (Varelius, 2023). Furthermore, the GOC fielded 300,000 surveys from Canadians in 2020 gauging how they felt about pEAS; however, respondents never answered if they identified as disabled/mad or were broken down by dis/ability status (Department of Justice, 2020, March). Additionally, the expert panel convened by the GOC on MAiD and mental illnesses involved no input from the wider Mad[1] community (Health Canada, 2022). This paper is written from the perspective of a consumer of psych services diagnosed with schizoaffective disorder. Throughout this paper, I use 'consumer' to refer to myself and others who consume mental health services and align with a 'choice paradigm' (Voronka, 2013) as opposed to the more common Mad Studies nomenclature of 'survivor' or

[1] In this paper, M/mad means two different things. The capitalized version of 'Mad' assumes "a more politicized notion of the ways in which mad subjects have been oppressed historically and into the present" (Cranford & LeFrançois, 2022, p. 71). Mad with a capital 'M' is "a signifier of a subversive standpoint" (Redikopp, 2021, p. 99) and will be used when discussing Mad people as a community. The smaller case 'm' is used instead to name the variability of experience, alternate realities, or distressing circumstances that the psychiatric complex has pathologized as mentally defective or 'brainsick.'

hybrid terms, e.g., user/survivor or consumer/survivor. Mad Studies as a field purports to draw on the knowledge(s) and perspectives of consumers, survivors, ex-patients, and 'the mad' (c/s/x/m) and citizens who have direct experiences with psy-oppression and sanism (McWade et al., 2015). This paper groups all those whose minds have been declared by psychiatric sciences as diverging from dominant mental and affective norms. While the acronym acknowledges their differences by using forward slashes, they have psychiatrization in common. 'Consumers use reclaimed terms such as 'mental illness,' whereas the radical branch of Mad Studies refuses to use the 'regime's' terms (Burstow, 2013). I am qualified to wade into this debate because schizoaffective sufferers constitute one of three psychotic groups successfully euthanized in Benelux jurisdictions (van Veen et al., 2018). Further, the ever-expanding biopolitical governance over mad peoples' life and death decisions concerns me. This debate, characterized by the back and forth of lawyers, professors, bioethicists, and physicians (Nicolini et al., 2020a), is fertile ground ripe for a mad analysis by someone irremediably 'schizoaffective.'

The thrust of this conceptual piece is to critique MAiD access to those whose sole underlying medical condition is a mental disorder through a necropolitical lens. My critique is approached through the lens of necropolitics to address questions regarding necropolitics and pEAS. For example, how does Canadian psychiatry ensnare c/s/x/m in its deathworlds? How does extending MAiD to the 'Mad' advance necropolitical harm against Mad populations deemed homo sacer? How is a necroeconomy created by demanding the processing of Mad folk for death so sane people can thrive? How do discourses of scarcity feed the necroeconomy with fresh sacrifices? How is the psy-profession given liberty to deploy its arsenal of necropolitical tactics to psychiatrically disable Canadians by entangling them in its death-making deathworlds? Implications of necropolitics and madness in pEAS contexts are offered in the conclusion.

Theoretical Framework: Biopolitics Becomes Necropolitics

Foucault (1978) described *biopower* as power over bodies; therefore, *biopolitics* is the politics of life. *Necropolitics* translates to the politics of death (Verghese, 2021, March 10). Biopower is about maximizing the life of citizens through modifying biological processes (Foucault, 1978); contrariwise, necropower minimizes life by terminating its biologized deviants whose bodies or minds stray from the healthy standard against which the State must defend its healthful body politic. Necropolitics is a revision of biopolitics (Puri, 2016).

Cameroonian philosopher Achille Mbembe (2019) posits necropolitics as "the capacity to define who matters and who does not, who is disposable and who is not" (p. 80). To Mbembe (2003; 2019), biopolitics entreats death as a necessary correlative or consequence of reproducing and optimizing the bio-potentiality of human existence (Foucault, 1978). In this way, necropolitics is the idea that sovereignty rests in the State's power and capacity to predispose swathes of undesirables to death to make desirables live/thrive (Mbembe, 2019). Said more grimly, Mbembe deploys necropower as a means to investigate "the purposes for which states turn people into corpses" (Grue, 2022, para. 19). As a framework, necropolitics sheds light on the State's life management policies that ascribe "differential value to human life" (Verghese, 2021, March 10, para. 3). Those valued less are often the sickly and ill, occupying the lower rungs of privilege and influence and are consigned to precarity under necropolitical logics (Iliadou, 2023). The more proximate subjects are to the dominant axes of power and privilege, the more their existence is valued as politically relevant (Grimaldi, 2022). This cleaving apart populations along biological lines of the 'killable' and the 'keepable,' according to their health statuses, is "a death pledge" underwriting society (Grimaldi, 2022, p. 23). The killable possesses lower protection

value and little political salience, whereas the keepable is accorded protections and promises of the 'good life.' The State makes martyrs out of subjects devoid of political status to officiate some symbolic social good (Verghese, 2021). The State rationalizes their death as conducive to the betterment of the lives of those valued most highly (Quinan & Thiele, 2020) as in Mbembe's words: "The calculus of life passes through the death of the Other" (Mbembe, 2003, p. 18).

The politics of death is situated in aspects of life that become threatening forces (Mbembe, 2003). Therefore, political power functions to effect figurative social deaths or literal deaths through necroharms. Social death refers to how the curtailment of civil rights diminishes and "even destroys one's status as a social actor and a full member of society" (Medina, 2013, p. 33). Necroharms are defined as direct intervention, (in)action, neglect, denial of provision, or abandonment of undesirables into a permanent state of injury, privation, pain, and suffering, that is, death-in-life, and into an 'informal existence' by exposing them to social death (Davies et al., 2017; Iliadou, 2023). Necropolitics enclaves the socially dead or biologic enemies whose life endangers the status quo into incomplete, liminal existences in 'worlds of death' (Quinan & Thiele, 2020). The State establishes 'deathworlds' where the worthless (undesirables, destitute, mad) are consigned to wither away a slow, social death (Zhang & Yang, 2024). For instance, those who sop up more than their fair share of healthcare resources make healthcare costs unmanageable. These biologized 'enemies' are so entrenched from within that they sicken the body politic's inner health (Wolframe, 2014). To Mbembe, the "desired perfect enemy does not and never will exist, so it must be continually invented. This cooked-up enemy is often an "Other" (Allen, N. D, para. 12). Mbembe's world of the dead is an extension of Agamben's (1998) notion of a 'state of exception' where necropolitics paves exclusionary spaces outside the permissible bounds of law, governance, and rules of life and death (Bicer, 2023). In states of

exception, undesirables are suspended half-alive in liminality somewhere in a zone of (non)existence between life and death. These deathworlds are where those imagined interlopers nearly alive live out the remainder of their days in "a liminal state of 'living dead'" (Mbembe 2003, p. 40). Similar to enslaved people on the plantation, the lives of the sickly and ill are suspended in a state of injury till slow death comes knocking (Mbembe, 2019). Here, "slave life, in many ways, is a form of death-in-life" (Mbembe, 2003, p. 21). Allen (N.D.) interprets "[t]his death-in-life turns the enslaved person into the "living dead" (para. 20). This is one tactic dispensed in death management whereby those ascribed non-human statuses are liable to become the living dead as a consequence of their preclusion from regular living society (Dalbem, 2022). These biologic enemies were never accurately alive (Allen, N.D.).

As biopower seeks to maximize life, I argue that MAiD, as a necropolitical weapon, minimizes (and cheapens) it by dispensing death.

A Necropolitical Critique of Psychiatric Euthanasia and Assisted Suicide (pEAS)

This section demonstrates how the MAiD process for pEAS keeps suicidal aspirants suspended in death-in-life involving silence, sacrifice, and stillness and waiting in protracted states of injury; additionally, it gives rise to a 'necroeconomy' demanding irregular mad body/minds be killed off so sane people can thrive and multiply.

Accessing Deathworlds

Rosas (2019) introduced the concept of '*necro-subjection'* to explore how necro-subjects are "those who are made—and who make themselves— dead—in order to live" (Rosas, 2019, p. 305). Rosas uses the exemplar of Mexican asylum seekers fabricating stories of state terrorism

endemic to Mexico to gain sanctuary in the United States (US). The US permits them egress to escape persecution in Mexico; however, this opens migrants up to abuses by border patrol agents or immigration and customs enforcement and locational imprisonment in migrant centers while their asylum applications are processed: a "process of 'making dead,' or rhetorically invoking death to reduce one's literal exposure to death" (Grimaldi, 2022, p. 8). Some Canadians enduring psychological suffering make themselves into necrosubjects by seeking out psychiatric relief from distressing 'symptoms.' They enter into this therapeutic relationship engaged in performativity - choreographing their performative script to cohere with DSM-diagnostic criteria - knowing which symptoms to play up to acquire a psy-diagnosis and access a quick pharmaceutical fix to expedite an officious end to their suffering. Their desire to band-aid over sadness with so-called chemical cures inflicts fresh physical and psychical wounds. One's DSM-assigned label becomes their ID badge in the pEAS deathworld; only those with one get access, and those without one are barred entry because their lives are considered 'salvageable' (Baril, 2023)[2] and still contain productive value. They enter here into a chemicalized death-in-life. Some are willing to exchange sadness for a medicated state that renders them a veritable corpse so long as their subjectively painful sorrow is subdued, illustrating the "agential power of the necro-subjected" (Grimaldi, 2022, p. 10). For example, the necro-subjected exercise agency when they select which harms are acceptable, e.g., adverse reactions from treatment such as weight gain,

[2] A similar thesis was posited in A. Baril's work (2023). Baril (2023) writes: "While some undesirable subjects—namely, visibly disabled/sick/ill/old people—are allowed (and sometimes even encouraged) to die in many countries, such as in the Canadian context in which I live, suicidal people perceived as 'salvageable' are forced to stay alive to become productive again in this neoliberal and capitalist world. In other words, while some citizens, deemed unproductive, are targeted to die, others are considered "salvageable" and are trapped in a process of "abledment," a term coined by disability theorist Fiona Kumari Campbell (2019), which consists of an active mechanism aimed at producing able-bodiedness through a variety of measures and procedures." This statement scaffolds Baril's (2017) comments on how MAID creates two classes of suicidal subjects: one targeted to die and the other forced to live.

and which collateral damages are not - will the benefits outweigh the side effects? Here, they'll swap "one form of necropolitical exposure for another such that their 'life' is still riddled with death … (yielding ameliorative effects both material and immaterial) in their death-making" (Grimaldi, 2022, p. 9).

Opting for Death-in-Life

The State demands conformism in life and death and makes examples of sufferers refusing pEAS and opting for death-in-life. Death-in-life prolongs patients' claim to State resources. They'll pay for the State's cost of caring for them with their pain. By selecting autonomously death-in-life to survive in some tragic, insufferable exclusionary zone by foregoing state assisted-suicide suspends them in states of injury. Here, psych patients assume the distinctive signification of the living dead. They are of no fixed address in the deathworld. The State lets them endure on their own in the liminality of itinerancy, drearily wandering in voids. There are two forms of death-in-life in the pEAS context: mental suffering and medical suffering.

Those opting for death-in-life assume what Grimaldi (2022) theorized as 'myriadic death' as "the perpetual subjection to non-lethal deaths" (p. 3). She argued that 'myriadic death' "encodes diffuse threats of death that are not wholly subordinateable by human efforts to order that death" (Grimaldi, 2022, p. 3). Necrosubjected pEAS aspirants replace one form of necropolitical violence, e.g., prescriptive violence, with exposure to another such that their abeyant 'life' was still suffused with a myriadic "death by [a] thousand smaller cuts" (Grimaldi, 2022, p. 9), such as poor access to health care, attitudinal barriers, structural sanism, and carcerality. They lack the necessities of a good life. These smaller 'cuts' (or non-lethal threats)

metastasize psychological suffering into mental suffering, which is thought to be without a diagnosable etiology or medical cause (Raus & Sterckx, 2015). Myriadic death results in 'slow death' or "the gradual wearing out of populations…." (Berlant, 2007 p. 754). However, the violence of 'slow death' or a thousand smaller diffuse threats "may well result in a life of living death that some would prefer literal death over" (Grimaldi, 2022, p. 9). For instance, austerity measures have been linked to arousing 'slow deaths' (Baril, 2020) in c/s/x/m communities that eventually kill them (Mills, 2020). In other words, people opt for pEAS "because austerity is killing them" (Mills, 2018, p. 317).

Suffering intolerably from adverse reactions arising from ongoing treatment amid the capacity assessment process can result in iatrogenic impairments - patients becoming disabled through methods of psychiatrization (Russo & Shulkes, 2015). Most psych interventions, precluding talk therapies, carry prescriptive harm(s) (Breggin, 2007). Necropolitics mobilizes 'debilitation' as another deliberate tactic for managing subjects' lives and deaths (Koivisto, 2019). The production of debility keeps half-living subjects in states of injury (Koivisto, 2019), which, in line with psychiatric death-making, debilitates medically suffering psych-patients toward inevitable death via an accumulation of intervention-induced necroharms reconstituting them into the Homo Sacer to justify murdering them. Others will exchange their chemicalized suffering death-in-life for literal death. Here, the patient trades a slow, social death, biochemically zombified[3] from brain-disabling pharmaceuticals, for, ironically, a shorter-lived death, a successful pEAS request. They make themselves dead through pEAS to not suffer degradation or eke out a (non)existence as the living dead. This recalls an analogy of the dancing

[3] While analogizing medicated c/s/x/m to automatons may be mistaken for reproducing ableist tropes, this is not the case and should not be perceived through that lens because many psychiatrized people describe their deadened medicated states as resembling being half-alive, half-dead (Schmitt, 2023).

dead: patients swap one deathly dance partner out for another – exposure to one dance with death, e.g., a chemicalized death-in-life, and partly alive with another, e.g., pEAS, and end-of-life service access. Psychiatrized patients who do swap death-in-life out for pEAS will riddle the remainder of their days with death-making assessments and different forms of assaultive violence in the form of treatment pushed on them, for instance, through a two-track approach, that is, while on a recovery track, patients are enlisted in recovery-oriented programs that run parallel with the euthanasia track, evaluating requests for pEAS access (Calati et al., 2021), until their end-of-life request is approved and they are scheduled for death.

Anemic Autonomy and Silence

Portraying one's request for MAiD as the patient's decision and theirs alone idealizes them as autonomous beings (Stahle, 2018). Two contrasting expressions of autonomy emerged from the debate over extending MAiD eligibility to psychiatrized populations: individualistic and relational autonomy (Widdershoven & van Wijk, 2016). Currently, section 241.2(c) imbues pEAS aspirants with the individualistic, subjective power to determine the extent to which their intractable madness causes them to endure psychological suffering that is intolerable to them and cannot be relieved under conditions they deem acceptable. Bill C-7 gives patients the sole discretion to independently determine, without any external compulsion, when and how their lives will conclude (CCA, 2018). Problematically, the subjective criteria set out in MAiD legislation get more sufferers to believe they are experiencing autonomous volition as autonomous and volitional subjects when they request pEAS. Individuals believe their decision to seek a diagnosis (and affirmation of difference) and treatments, including pEAS, was theirs and only theirs to make. Yet, psychiatrists will undermine patients' claims to subjectively know

the state of their decline through a series of rarefied determinations on capacity and irremediability of suffering. The relational view of autonomy is a 'broader conception' inviting the appropriate involvement of clinicians and canvassing input from family members in weighing treatment proposals (CCA, 2018). If patients select an individualistic approach, relationality will be thrust on them through their psychiatrists' subjectively biased capacity assessments. The relational aspect counters the subjective component (the individual element) by giving psy-professionals more opportunity to sway the subjectivities of the patient through claims to medical authority. Here, pEAS aspirants are silenced and cajoled into surrendering their rights of individualized autonomy for a relational autonomy schema.

Necropolitics advances autonomy rights discourses to displace responsibility from itself to the patient under the guise of honoring personal choice. Autonomy discourses are one necropolitical tool to control the flow of life and death. For necropolitical policies to gain traction, an illusion of individualized autonomy needs to be projected (Murray, 2022). Here, "the ruse of biopolitics" and the "liberal individual – the I – fed by a delusional sense of rationality, autonomy, and entitled agency, which together belies the fact that we are nonautonomous beings" (Murray, 2022, p. 24). Necropower uses sleight of hand to make autonomy appear and disappear to those desperately seeking an easy way out[4] of their pain. What remains of the patient's (autonomy) rights in the pEAS deathworld is an 'anemic autonomy' whereby autonomy is present, but it lacks vigor, vitality, and substantiative worth in life and death transactions. Relationality keeps 'Mad' MAiD applicants mindlessly hovering in a state of injury in constant hurt, in the belief that their autonomy will be respected; all the while, the State primes them for figurative death through afflicting myriadic harms. The patient decides when along the spectra of

[4] MAiD is depicted in this paper as an easy death/path. Death, even with MAID, is not easy for anyone.

symptoms (and treatment side effects) they've endured enough decline and anguish and can't brook anymore. The State then offers them an easy way out from their death-in-life through life-ending technologies. Then, it conceals its involvement, outcoming their death through diffusion of blame to patients who believe they were autonomously and volitionally exercising autonomy rights. Necropolitics portrays the deathworld as a world of the patient's own making to elide guilt. The elision of accountability is a moral disengaging maneuver to separate psychiatry from the atrocities it enacts (Stahle, 2018). If eligible, accessing end-of-life services will be their last autonomous act. Perhaps pEAS is sought after here to expend whatever anemic autonomy that may have survived the decimation.

Paternalism is grounded in the beneficence principle, where psychiatrists make decisions on patients' behalf pursuant to serving their objective best interests, similar to parenting kin. The necropolitical paternalism evinced by shrinks strips epistemic agency by convincing pEAS aspirants they know what's best, that their madness has sapped them of their decisional competence. They will choose the best course in life (and death) for pEAS aspirants requesting end-of-life services. They relegate this group to unintelligibility in death-in-life by branding them as irrational knowers, assuming their mental disorder clouds their better judgment (Baril, 2020). This epistemic asphyxiation culminates in silence and suicidism (Baril, 2020) in states of injury. Tarring pEAS aspirants as 'crazed' for choosing to terminate their lives evidences what Baril (2020) termed 'the injunction to live and to futurity.' This injunction argues that they must be intervened upon because preserving their lives should be prioritized at any expense except when the State deems them irrecuperable (Baril, 2020). Knowledge-power discrepancies between pEAS aspirants and assessor(s) culminate in epistemic necroharms or 'ontological erasure,'

which disputes that c/s/x/m have the mental wherewithal to know the world, where best they fit and not fit in.

Homo Sacer, Necroeconomy, and Sacrifice

There are no restrictions in Canada on physicians recommending euthanasia as a 'last line' of treatment to patients as medical advice or a reasonable clinical care alternative (Alexiou, 2022, August 15). Some expressed concerns that current MAiD eligibility will permit pEAS to aspirants who do not meet the due care criteria (Trachsel et al., 2022). Psy-physicians have faced little prosecution or consequences for over-including suicidal aspirants who did not meet the due criteria in Benelux jurisdictions (De Hert et al., 2022). Necropolitical states decide who to prosecute or who not to. Agamben (1998) designates those lives given negligible value as "homo sacer, i.e., a person who can be killed without the killing counting as homicide" (Le Theule et al., 2020, p. 527). Enemies locationally restricted in states of exception are reduced to 'bare life' (Agamben, 1998) shorn of political status (Bicer, 2023), approximating a master's power over those slated for slave life (McClellan, 2020). MAiD sunders the stratum of citizens with health wealth from the diseased classes, so the death of the diseased is acceptable and is also seen as progress (Nusbaum & Steinborn, 2019). This is precisely why the right-to-die legislation is enshrined in the Criminal Code of Canada and not human rights legislation. This sham accountability system has no designs to dissuade against prospective abuses. This system confers shrinks' carte blanche in over-including psych-patients, especially cases who "don't show themselves to be cooperative with the systems of power" (Wildhood, 2023, March 30, para. 9). Some authors acknowledge the difficulty of holding physicians accountable for inadequate assessments and have called for more stringent judicial oversight (Yarascavitch, 2017).

Worryingly, the Canadian Parliamentary Special Joint Committee recommended against establishing "a prior review system by a panel or judge … [and] suggested that a retrospective review system would be sufficient" (Kim & Lemmens, 2016, p. 338). Prosecutors retrospectively prosecute past harms because the patient is dead and can't seek legal relief given the finality of death. This system is not intended to gauge medicos' and nurse practitioners' strict compliance with the Criminal Code. Non-compliance, according to the committee, falls outside the scope of federal monitors and into the jurisdiction of local law enforcement (CCA, 2018).

Necroeconomy

Neoliberal cuts in public health, social and educative structures precisely define necropolitics (Gržinić, 2012). Then, when those retracted bureaucratic supports are even further rolled back to levels nowhere near enough to survive on, this results in psychosocial 'mental suffering.' This leaves one to wonder how deep the neoliberal State's knife cuts. Necropolitics embraces an economic model where suffering is calculable, like algorithms in calculus (Darian-Smith, 2021). Specifically, "living death or deadly living can be politically and economically profitable" (Clough & Willse, 2011, cited in Allen, N. D, para. 25). This underscores how necropolitics can be a productive force analogous to thanatopolitics. The literal death of the living dead is entreated as a commodity (Grimaldi, 2022) and profitable (Clough & Willse, 2011) resulting from necroeconomics or what Mbembe (2019) refers to as 'necroliberalism' "whereby the economic extraction of value relies on a diversity of deaths to generate surplus value through the destruction of lives whose welfare has been abandoned by the state…" (Grimaldi, 2022, p. 17). To reap cost savings, the State sanctions psy-powers to process the unsalvageable medically futile cases for pEAS to relieve them as drains on the government coffers. The State deploys a

fresh divide-and-rule tactic to bypass costs and mechanizes assisted death as a cost-saving measure. Additionally, necropolitics is transactional insofar as the State contracts psychiatry to keep c/s/x/m in chemicalized zones of existence to the degree that patients begrudgingly abdicate certain liberties, e.g., rights to self-determination over to the regime to end their life. This is a perversion of Rousseau's 'social contract,' where citizens enter into a 'social death contract,' relinquishing inalienable human rights for a protected death. Psychiatry wheedles these rights from individuals and hands them over to the State. To those entangled in death-in-life, psy-professionals may "deliberately mislead [patients] about what treatments they need" and "offer profit-making, long-drawn-out treatments that incur repeated charges" (Sociologymag.com, 2023, para. 8). Psychiatry has a vested profit interest in keeping mad minds suspended in a medicated death-in-life –creating an endless treadmill of consumers – furthering the State's necroeconomy. Cure is the antithesis of consumerism.

MAiD provision is "far more cost-effective than medical care to chronically ill patients" (Grassi et al., 2022, p. 328). Mental health clinicians "probably unconsciously, most or all of the time, will influence patients considering assisting dying in a way that is likely to free up scarce but much-needed resources like beds" (Bay, 2017, p. 6). When patients are cajoled into convincing themselves of their disposability, they may begin to feel guilty about being alive and have a duty to die (Grassi et al., 2022). Through necropolitical discourses of scarcity, "there are simply insufficient resources for us all, so some of us have to die" (Verghese, 2021, para. 8). Here, necropolitics fosters a 'sacrificial economy' (Murray, 2022). In this economy, "some will – and some must – die so that others may live: a condition of relational vulnerability or precarity that is structurally produced and inequitably distributed" (Murray, 2022, p. 24). Necroeconomics breeds internalized oppression in patients, weakening their sense of self-worth at the unconscious

level. This oppression makes bearers of mad minds further manipulable to the State's scarcity discourses. They interiorize the State's undervaluation of their lives. They share the state's view of them as economic drains leeching off an insufficiently resourced health care system (Reeve, 2015). That is, they cheapen their inherent value to fit usefully within the necroeconomy by serving themselves up for death –a reversed engineered eugenics of sorts, or a self-sacrificial economy - so others can live and benefit from the 'sacrificial economy' (Murray, 2022). For instance, some have argued that the still-alive bodies of assisted suicide or pEAS candidates have their organs harvested before termination (Stahle, 2018). Canada hasn't been spared this discussion. In other jurisdictions, mad bodies are being treated as "spare parts depot[s]" (Stahle, 2018, p. 15). Necropolitics views mad minds as waste, but the bodies casing them are apt for transplantation. In the economies of death, the organs from alive-bodies (and able-bodies) are extracted and sacrificed to sustain the living (Grimaldi, 2022). Skeggs (2021) referred to this breaking down of bodies in economies of death for commodity extraction as 'necrospeculation': "the ability to turn destruction into profit and produce new capitalist value" (p. 123). Cruelly, their organs are commodified to offset the costs incurred by the State to foot their healthcare coverage. The body becomes a site where the turf of the necropolitical State is expanded (Robertson & Travaglia, 2022). Koivisto (2019) posited that necropolitics "functions to convince its targets that they are already dead, that they were born dead, and that their existence was never, and will never be, endowed the status of human life" (p. 63). Their only value is to live vicariously through those they sacrificed themselves for.

Internalized oppression can mold mad mindscapes into deathworlds in which the psychiatrized retreat, locationally imprisoned in the maelstrom of distressing (and medicated) thoughts. These states of mind may sway the voluntariness of their pEAS request. Temporally,

the mind becomes a state of injury, inflicting and reproducing necroharms; more befittingly, the 'mental space' is a state of self-injury. They self-stigmatize themselves as blameworthy for their station in life, thereby making themselves into the Homo Sacer. Their mere existence divests the necroeconomy of resources. Through self-styled rituals of sublimation to the necroeconomy, their pain is currency, and every second suffered is an investment deposited in the sacrificial economy. This reaps dividends to the sane status quo and gets them closer to living the good life. They need to hemorrhage hurt, or die to grow the necroeconomy. Self-stigmatization evolves into a mind virus, nurturing their head space, a living dead space, or 'the hell inside the living dead.' Here, states of self-injury mirror Emerson's (2019) thoughts on necropolitics existing "beyond the limits of administrative or state power being imposed on bodies, but also becomes internalized, coming to control behaviors over fear of death or fear of exposure to deathworlds" (p. 2).

Hope, Spatially Stuck, and Waiting

pEAS aspirants cannot be coerced under criminal law into undergoing medical treatments, pharmaceutical or otherwise, even if qualified as curative or remedial (Downie & Dembo, 2016), and could prolong "their lives or even reverse the disease process" (Dembo et al., 2018, p. 454). Either treatments are ineffectively tried to the point that the patient experiences 'treatment fatigue' (van Veen et al., 2022), or they volitionally refuse treatments, citing medical futility in their decision. Those worn down from myriadic slow death, e.g., treatment-resistant bodies/minds, swap out being medicated, holding out for hope, with medicated holding out for pEAS approval.

When the prospect for symptom reduction is low, and the debility burden of extending psy-treatment to suicidal aspirants is high, this can lead to a feeling of spatial 'stuckedness' (Iliadou, 2023). Stuckedness was theorized initially to discuss the "protracted states of injury" keeping migrant border-crossers immobile in camps, as half living, half dead (Iliadou, 2023, p. 120). In these camps, migrant lives are made into disposable lives. They are immovable, stranded in a state of temporal stuckness lined with like-other somber-visaged beings with the exact status of the living dead destined for the same deathworld. I deploy 'stuckedness' here to refer to two spatial confinements in states of injury, such as psychiatric dis-citizens being spatially 'stuck' as occupants in some stygian asylum indefinitely cut off and denied intercourse with the living outside world (the sane body politic). Their interiors are cramped with like-situated hopefuls, life monotonous and regimented, where suffering is prospectless. Forensic facilities are the netherworld of psychiatric deathworlds – stratigraphically layering the least threatening crust of crazies above the most terrifying. Or they are chemically straight-jacketed within themselves in long-drawn-out medicated states of injury wedged between life and death, hopeful for succor. Differently, treating pEAS aspirants to the point of reaching medical futility, strewn with false promises, and distressing holdouts for a cure are multi-layerable 'necroharms' removing 'mad' subjects from the realm of 'possible' (possibly cured) and normalcy, into a seemingly endless state of necropolitical stuckedness (Iliadou, 2023). For example, holding out for a scientifically promising treatment suspends the pEAS aspirant equally betwixt life and death because recovery is never obtainable, nor is re-entry into the living world. It's hard to conceive of anyplace else being worse than 'stuck' in a state of injury where the living dead endure the cruelties of stillness.

Some may request pEAS because certain psychiatric services proposed are beyond their means, which leads to a form of diminished voluntariness; for instance, a "lack of choice constrains voluntariness of choice" (CCA, 2018, p. 166). More invasive therapies were deemed unacceptable to pEAS aspirants than non-invasive ones (Downie & Dembo, 2016). The privatization of certain forms of 'safe' mental health care is a form of necropolitics allowing the State to decide who gets to die (those who cannot afford, say, psychotherapy) and those who get to live (those who can afford psychotherapy). Some consumers are restricted in the choice of treatment modality they receive in Canada's socialized healthcare system that subsidizes certain consumers and forms of care and are priced out of accessing more costly treatments (Morrow, 2013). For instance, non-intrusive alternatives to care, e.g., psychotherapy, cost the end consumer the most because they are not covered in socialized medicine schemes. This further indicates how harm is privileged because it costs the State less to injure than to heal (Davis, 2004). The State knows which psych-patients will die through systemic barriers such as unaffordability assured of their continuity along the same destructive trajectory toward living death and becoming locatable in deathworlds – one foot in life, the other in death (SociologyMag.com, 2023). The structural violence drags on indefinitely the longer they are spatially confined in a state of possibility, with the treatment modality they deem acceptable being inaccessible. Lisa Walter, a panelist with lived experience, during a 2017 CAMH discussion on MAiD, remarked having spent two years trialing dozens of different medications, such as GBT, ECT, and various psychotherapies (CAMH, 2017, August 4). She claimed they all failed miserably: "The best ones didn't do anything, the worst kind made [her] want to kill [herself] even more" (CAMH, 2017, August 4).

When patients refuse or disrupt treatment proposals, their mental capacity may be questioned (Widdershoven & van Wijk, 2016). Capacity assessments are the principal safeguard for Canadian MAiD (CCA, 2018), ensuring that the end-of-life decisions of patients aren't nakedly carried out (Meynen, 2016), such as impulsive suicidality (Grassi et al., 2022). Canadian MAiD states two independent assessors must concur that a requestee meets eligibility for MAiD (CCA, 2018), precisely two psychiatrists in pEAS (Ramos-Pozon et al., 2023). The inclusion of an independent second or sometimes third opinion "provides a safeguard against possible arbitrariness and abuse" (Widdershoven & van Wijk, 2016, p. 1) and skirts accusations of bias in mono-disciplinary assessments (Hatchel et al., 2022). Eliciting more psychiatrists to partake in pEAS assessments is a continuation of the regime's necropolitical project to dispose of c/s/x/m through spatial stuckness –boundedness in systems – where disciplinary practices are doled out to keep those who are 'treatment-resistant' the 'living dead' and to defer their deaths to a later date when their valuelessness can be confirmed (e.g., pEAS assessors deem them incurable, non-productive) (Iliadou, 2023). Bogging the process down with multiple assessors increases the likeliness of disagreement (among them). As the State makes pEAS part of its healthcare culture, conflicts will inevitably become fewer. Before such a culture emerges, the drawn-out process will increase the duration medically-futile-consumers spend in unnecessary drug trials, exposing them to slow death and a slew of myriadic harms. The 'waiting' process proliferates human anguish in these bleak states of exception wherein waiting is marked by increased uncertainty of one's fate. They are ordered to these zones of exception to await their pEAS application outcome pending approval. Presently, Canadian MAiD law has a 90-day minimum assessment period. In the Benelux example, the application process can exceed 14 months (Verhofstadt et al., 2021). They become habituated to death-in-life enclosed in temporal landscapes, unveiling them to even

more necropolitical violence. Here, patients-in-peril are still, silent, and wait out their days neither dead nor alive. They are temporally stuck in an inescapable gloop of violence, motionless in the muck, enduring endlessly more necroharms as the applicant's death decisions are held in abeyance. Here, the necroviolence of stuckedness and waiting extends the "carceral continuum" (Foucault, 1978, p. 303) into an otherworldly elsewhere. The right to self-determined suicide is placed on administrative hold for permitting and processing. Waiting out excessive hurdles, such as safeguards, stricter thresholds, and second/third opinions, places pEAS requestees in a claustrophobic closeness to death (Hatchel et al., 2022). Increasing the assessment period to give the contrived appearance of objectivity will ultimately make patients engage in increased performativity to access rights-to-die, and they may become more dead set on death.

Hope (amid MAiD eligibility determinations) informs one's social death. The State's designs are to regress the patient to the terminal stage of medical futility until those quasi-alive cannot hope anymore. It keeps patients suspended, hopeless in some unknowable state of injury, where uncertainty is inevitable. Necropolitics sells them grandiose promises of a future shorn of suffering and that their prognostic outlook will straighten through evidence-based treatment. Hope is brainfood for the living dead. Not only does consumership line shrinks' pockets, but it also instills more hope in those holding out for it. Hope in an eventual cure withers the patients' psychological state down "from repeated disappointments" (Fuchs, 2017, p. 2). Chastened by slews of treatment errors, hope distresses these holdouts till they become debilitated. Their storehouse of hope is built on a tinder box made of easily ignitable fibers.

Research Implications

This paper warns of what "becomes possible when the medical profession[als] are functionaries of the state" (Burstow, 2015, p. 71). Psychiatry is less a 'regime of ruling' (Menzies et al., 2013) but a regime ruled. Once entered upon or institutionally captured and enclosed in the psychiatric deathworld(s) reserved for the mad-minded, it's challenging to escape under the weight of brain-disabling neuroleptics or wiggle free from duck cloth restraints. This widening-of-the-net of psy-powers to process the impending demand of pEAS requests from the living dead will lead to a meteoric slippery slope (Komrad, 2018, June 2), extending euthanizing services to those who are solely enduring mental suffering, e.g., psychosocial necroharms, whose suffering is not medical. Still, the scant critical perspective on state-assisted suicide advances necropolitical interests (Baril, 2020; Wedlake, 2020). These works cited roundly endorse the more problematic aspects of relational autonomy by opining that the State and its institutions should have the duty "to facilitate access to such [assisted suicide] services" (Baril, 2020, n. p.). Worryingly, their work on suicidality could be misconstrued as calling for a magnification of State necropower. Differently, since Canada regulated MAiD access, the number of completed suicide assists went from 1018 in 2016 to 10,064 in 2021 (Scopetti et al., 2023). Yet, while there is no data on the frequency of pEAS requests in the Canadian context, there is an underestimation of those in physically ill-health with a comorbid presence of madness (Scopetti et al., 2023).

Those for pEAS advocated growing the necroeconomy where pEAS is economical, cheaper to kill than cure (Maher, 2020), or extend life-long drug/treatment coverage. Davis (2004) maintains that the "supposed 'right to die' is a subterfuge for what is a 'duty to die' because society prefers not to provide appropriate support to help [them] to live with dignity, but prefers the cheaper option of killing…killing is cheaper than caring" (para. 9). The necropolitical tactic of killing the ill to skimp on costs will become standard fare for Canada's healthcare

culture (Wildhood, 2023, March 30). The vocabulary of capitalism has yet to filtrate, at least publicly, into the States' feasibility projections, justifying mortality through cost-benefit ratios calculating death-making and life-ending. Once the process is more formalized, stats on cost savings per successful pEAS may be made available.

Recommendations for Future Research

The pEAS debate never centers on the need to challenge the psy-professions' legitimacy claims to diagnose and treat patients' suffering. Considering the death-in-life perspectives from these subjects "may give us new insights into life, death, and the relationship between them" (Allen, N. D. para. 38). Secondly, how will MAiD affect future mental health care funding in Canada? Is an uptake in funding in response to treating the disease burden or cost burden? Are patients more vulnerable to incurring necroharms while awaiting a pEAS decision or on a two-way track? Thirdly, research is needed to determine how discourses of scarcity and insufficient resourcing fuel guilt (or a duty to die) in suicidal aspirants. Lastly, how do we deter psychiatrists from instigating suicidality through pEAS with coercive threats of lifelong medicalization and institutionalization? What will become of the pEAS requests by forensic mental health inmates whose stories of epistemic necroharms and rights restrictions rarely breach secured asylum walls? In Canada, a sliver of the reported 7,595 successfully euthanized MAiD cases in 2020 were related to people in detention: "As of August 2020, [incarcerants] in Canada had made 11 AD requests, three of which were granted" (Franke et al., 2022, p. 4). None were pEAS. The principle of equivalence of care states that Canada cannot refuse incarcerants the same health care provided to non-incarcerants (Franke et al., 2022).

Conclusion

MAiD is a structurally violent necropolitical system thrust on Mad citizens to control their biopolitical life and death. MAiD extends the reach of psychiatry into the affairs of death. This system proffers deficited patients-in-peril an easy way out from an anguished death-in-life. The analysis of pEAS through a necropolitical lens has shown that death-in-life for pEAS aspirants involves silence, sacrifice, stillness and waiting in protracted states of injury. This is done under the guise of autonomy rights discourses and democratizing access to death. Some bodies/minds must be killed so others may live prosperously (Essen & Redmalm, 2023) and proliferate (Braun, 2013). This marks the sundering of the living from the living dead (Özpolat, 2017). Namely, mad lives must be killed off so sane lives can thrive. The entire necropolitical economy of euthanizing c/s/x/m is grounded in its disposal of difference and the need to hasten the deaths of people deemed unviable or as non-durable commodities. The State's designs include expanding necropower by widening the psychiatric turf to proliferate pain and waylay more mad minds into demanding its euthanizing services. I anticipate the conditions for granting it will be enumerated in the DSM, along with procedures for processing hastened death requests of patients.

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