

The social failure behind assisted suicide

Why are people in pain? Why are their illnesses incurable? Neither advocates nor opponents of PAS tend to ask these questions.

by [Lilia Ellis](#) in the [August 2026](#) issue

Published on July 31, 2026

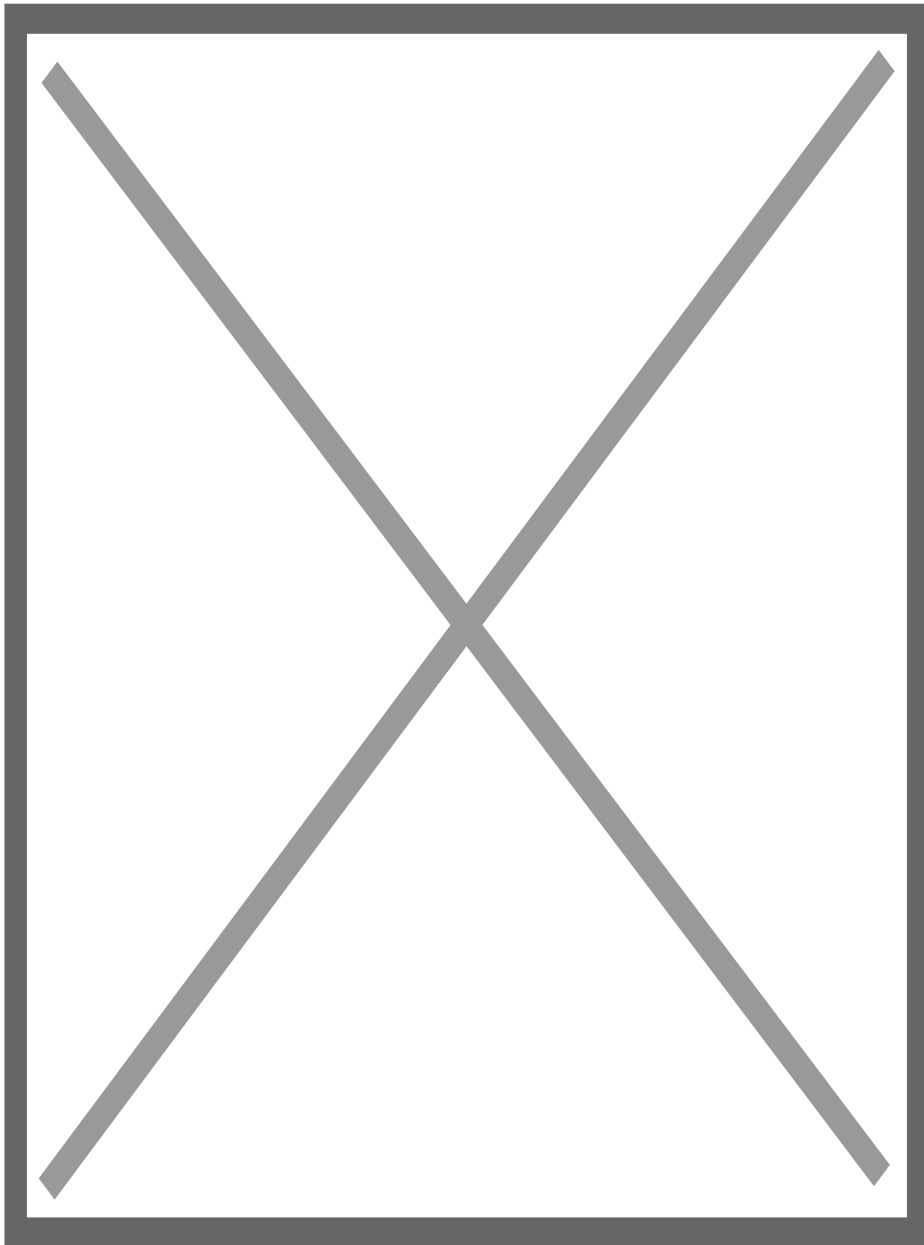


Illustration by Michael Morgenstern

The year I spent in bed, I often thought about dying. I was sick with Epstein-Barr virus and, subsequently, myalgic encephalomyelitis, a poorly understood neurological illness that sometimes follows viral infections and causes everything from intense nausea to debilitating headaches to difficulty speaking. Doctors had no real treatments to offer. No one could say if I would ever get better. I thought that I might die, or that at some point I would want to. Even as my health slowly improved, I was often in pain and struggled with basic daily tasks.

Before I got sick, as a dyed-in-the-wool Anglo-Catholic who believed life is an infinitely precious gift from God, I was convinced that physician-assisted suicide was immoral. Spending so much time seriously ill, in pain, thinking about death every day, and learning from chronically ill and disability communities only deepened my convictions. I'm not only opposed to PAS, I'm also convinced that our highly individualistic way of framing the issue is wrong altogether.

Both advocates and opponents of PAS tend to frame the debate as a question of agency or individual choice, the same way we think of abortion. But PAS is far more like other forms of suicide than we care to admit. With suicide in other contexts—say, the several thousand American teenagers who die by suicide each year—we recognize that a person's choice is influenced by social factors. Maybe a teen faced cruel, relentless bullying; maybe they were unable to get the mental health help they needed due to cost or stigma; maybe they were let down by their parents, mentors, and teachers. Survey data shows that LGBTQ teens who have an accepting adult in their life are 40 percent less likely to attempt suicide.

Social factors can shape community suicide risks, for good or for ill. The same can be true of PAS. We tend to see chronically ill patients who die by assisted suicide simply as people in great pain who are struggling with an incurable illness. Neither advocates nor opponents typically ask *why* people are in pain or *why* their illnesses are incurable.

These are crucial questions, and the answers are not straightforward. Many illnesses that are treatable today were a virtual death sentence decades ago. Publicly funded research is often the key that turns an untreatable illness into a treatable one, and discrimination influences which illnesses receive that funding. My illness, myalgic encephalomyelitis, is largely untreatable. Federal funding for research has been appallingly low for decades, amounting to a paltry sum of around five dollars for each American with ME. With no guarantee of profit, the private sector will not always act to fund research, and without funding, ME and other conditions like it will probably be untreatable for years to come. When people with ME die by assisted suicide, as some do, it looks as if society has succeeded in offering them a compassionate way out of an untreatable illness. But the untreatability of ME is not neutral: it is a social failure, not a biological fact.

Treatability is often entwined with oppression. ME disproportionately affects women, and illnesses affecting women routinely receive less research funding than illnesses affecting men, even when their symptoms are more severe. An enormous body of evidence shows that women's pain is routinely taken less seriously in health-care settings. The effect is greater still for illnesses that affect Black women disproportionately, and health care in the United States has long been characterized by vast racial inequities. Similarly, governments delayed and underfunded research during the HIV/AIDS epidemic—hardly ancient history—because they deemed gay lives less valuable. In the coming years, the Trump administration's reckless and malicious cuts to health care and research funding will only exacerbate such inequities.

Sick people also struggle to get adequate support. It is notoriously difficult to qualify for Social Security disability benefits. Only 21 percent of claims are granted, while another 10 percent eventually earn benefits after a costly and confusing appeals process. The vast majority of people who apply for disability benefits get nothing at all. Worse, the most any individual can receive in disability benefits is \$967/month. That's not enough for anyone to live on, let alone someone with heavy medical expenses.

Nor is support from family and friends guaranteed. Many sick people report being abandoned by family and friends upon falling ill, leaving them isolated and uncared for. Among cancer patients, for example, 75 percent report friends and family suddenly disappearing when they become sick. In Canada, where assisted suicide is legal, 13 percent of people who died by assisted suicide in 2019 indicated isolation or loneliness as reason for their death; by 2023 that rate had increased to more than 20 percent. Investigations have revealed cases in which Canadians were not terminally ill but chose death due to isolation and the fear of becoming homeless. As evidence from Switzerland has shown, women who live alone make up a disproportionate share of people who die by assisted suicide. In 77 percent of cases studied in the Netherlands, loneliness was cited as a reason for the suicide request—more often than pain, physical symptoms, or poor quality of life. Better social structures might lengthen some patients' lives and improve the quality of others' last days. We cannot celebrate the compassion of assisted suicide cases when a person's life was made so difficult not by illness but by social failures.

History is replete with examples of nondisabled people doing violence to disabled people under the guise of kindness, and today, many nondisabled people fear disability and dependence, struggling to imagine that disabled people could possibly be happy. But disabled people are capable of living thriving, rich lives—if they are fully accepted and accommodated by their communities. Discrimination and lack of social support can make the lives of disabled people difficult, and even outside PAS the suicide rate is several times higher among disabled people than among others. But when a disabled person's life is not worth living, is it because it is inherently painful, or because social exclusion has made it so? Even in the best of times, we can't trust the government or health care industry to make that determination. Dozens of autistic people and people with intellectual disabilities have been killed under PAS laws in the Netherlands. It is not merely a possibility that ableism will show up in assisted-suicide programs; it is a present reality.

For similar reasons, PAS raises serious concerns from a mental health perspective. Often, it is people with mental health disorders like depression and PTSD who feel like their lives aren't worth living, or who are made to feel that way by others. And in many countries, assisted suicide is legal for patients with mental illness. In the Netherlands, where PAS is permitted in almost any situation, 219 people were euthanized for mental health issues in 2024, a dramatic increase from just two people in 2010. (In 2025, it went down to 174 people.) At the same time, the underfunded Dutch mental health care system forces patients to endure inordinate wait times for care, with OCD patients, for example, waiting an average of 25 weeks to be seen. That euthanasia rates multiplied a hundredfold as mental health waiting lists ballooned ought to be a moral indictment of the Dutch government. In a just society, these people would get the help they need to live full and happy lives. What might appear to be compassionate serves to mask a much greater failure.

Many Western countries slashed mental health funding in the wake of the 2008 financial crisis, raising the prospect that many of those who were euthanized were not beyond help but simply never received it to begin with. In Canada, anonymous messages between doctors show that many believed their patients' deaths were avoidable, and yet they were approved for PAS by the state anyway. "I don't want [euthanasia] to become the solution to every kind of suffering out there," said one doctor.

In the United States, the majority of people with mental illnesses face substantial barriers to receiving care, and the more barriers a person faces, the worse their mental health tends to be. Mental health care remains out of reach for far too many people, and this is to say nothing of the quality of care patients receive when they can access it. In such a dilapidated mental health care system, some people inevitably will lose hope that things could get better. This, too, should be understood as a social failure: their communities could not get them the help they needed to flourish. When a mentally ill person dies by suicide, we rightly recognize it as a tragedy. Assisted suicide should not be treated differently.

But what about the textbook cases of PAS? What about terminally ill patients and patients with dementia or certain cancers, diseases that are terribly painful and, at least for the foreseeable future, truly incurable?

While advocates celebrate the agency of choosing how to die in these circumstances, many terminally ill people cannot choose how to live their last days on their terms. As health care costs continue to spiral out of control, driven by a profit-centered health care model and federal budget cuts, more patients are likely to consider PAS as a way to spare their families from labor or medical expenses. Likewise, many people lack access to caretaking services or palliative care that would help them live their last days as comfortably as possible. In Oregon, where PAS is legal only for those with six months or less to live, more than half of PAS patients cited feeling like a burden as a reason for choosing to die, a number that has doubled in the past decade.

Viewed narrowly, it may be compassionate to let a patient choose to die rather than endure the pain of loneliness and illness. But if we zoom out, we see individual patients embedded in a social web in which our collective decisions have real impact on their suffering. Sometimes, opponents of PAS bear more responsibility for this failure than advocates do: Many of them recognize the dignity of patients at the end of their lives and yet support the very sorts of spending cuts that make patients vulnerable to begin with. In much of the world, those opponents are “pro-life” Christians.

As Christians, we can and should stand up to the great moral danger posed by PAS. We can and should speak up for the disabled, chronically ill, and mentally ill people who have the most to lose from it. But we need to think beyond rigid individualism. Our focus on individual agency has not only failed to achieve compassion; it has obscured much deeper issues at play beneath the surface. This is precisely where Christian ethics can offer a way forward, boldly proclaiming that we are, as Paul says, “members one of another” (Rom. 12:4–5). That means providing funding for medical care and research, even if we have to pay higher taxes and have less left for luxuries. It means lessening the stigma on mental illness and working to promote full inclusion and support for disabled people. It means showing up for our friends and loved ones when they become disabled or seriously ill, and doing what we can to support the disabled and ill people already in our communities. Christian compassion should rewrite our entire way of seeing the world and each other, so that we leave hyper-individualism behind.

“Bear one another’s burdens,” says Paul, “and so fulfill the law of Christ” (Gal. 6:2). When I first fell ill, I could barely leave my childhood bedroom. I remember the cruelty of people who would not bear my burdens with me—longtime friends who abandoned me, colleagues who said terrible things. But I also remember the people who visited, who spent long hours talking with me on the phone when I could barely get through my sentences, who prayed with me and for me and held me across great distances. I remember how loved they made me feel.

I think of Jesus’ words from the Gospel of Matthew: “I was sick and you visited me.” Our compassion should guide us to care for and love our neighbors every day of their lives, not just their last.