

# Position Statement

## Physician Assisted Suicide

May 2011



Physician assisted suicide (PAS) refers to situations where doctors prescribe, but do not administer, lethal substances to competent, informed patients so that they may end their own lives at a time of their own choosing. Recent legislative debate in Australia and New Zealand has focused on the possibility of legalisation of PAS. This debate has prompted the release of this position statement.

There is no consensus within the College membership as to whether or not physician assisted suicide should be legalised. Nothing in this document should be taken as either an explicit or implied position for or against the legalisation of PAS. It is intended to assist College members who may want to participate in the current debate about PAS legalisation. It is also intended to assist all members if PAS becomes legal in any Australasian jurisdiction in the near future, and those members who find themselves practising in jurisdictions outside Australasia that allow PAS.

College members should note that legalising any activity does not make it ethically correct. There have been times in recent history when doctors have acted within the laws of a country, but well outside what would be considered ethical practice by the profession. Ethical values are set by the profession to protect all patients and preserve the trust in the profession. In this debate, there is a tension between what might seem right for an individual patient, and ethical principles that safeguard the community's trust in doctors through their social contract with the profession. The World Medical Association still condemns as unethical doctors' involvement in euthanasia and physician assisted suicide. This statement is not intended to bring any resolution to the ethical debate.

### Background

Physician assisted suicide (and euthanasia) were legalised in Australia's Northern Territory in 1995, by the Rights of the Terminally Ill Act. In 1997, the Northern Territory legislation was quashed by the Federal Parliament, using its power to overturn Territorial (as opposed to State) laws.

Currently PAS is a criminal offence in all Australasian jurisdictions. However the parliaments of numerous jurisdictions have debated Bills in recent years that would have allowed PAS if passed, and at the time of writing some of these legislative processes are ongoing. PAS currently may occur within strict legal parameters in some jurisdictions in the USA and Europe, notably in Switzerland and The Netherlands.

Public opinion is divided over physician assisted suicide in both Australian and New Zealand. A 2007 Newpoll found that 80 percent of Australians responded affirmatively to the question: "*Thinking now about voluntary euthanasia. If a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovering asks for a lethal dose, should a doctor be allowed to provide a lethal dose, or not?*" A similar survey conducted by Massey University in New Zealand in 2002 found a 73 percent affirmative response to the question: "*Suppose a person has a painful incurable disease. Do you think that doctors should be allowed by law to end the patient's life if the patient requests it?*"

### The role of the psychiatrist in legislation legalising physician assisted suicide.

Should legislation legalising PAS be introduced, it should require a mandatory independent psychiatric assessment. Under the quashed Northern Territory law, a psychiatrist was required to certify that the patient requesting was not suffering a treatable clinical depression or other mental illness which might have impaired their judgement. Current Australian efforts at legislative reform to legalise PAS have retained similar provisions requiring psychiatric review.

In The Netherlands and in Oregon, physicians generally refer the patient to a psychiatrist or psychologist only if they believe a psychiatric disorder may be present. Psychiatric assessment is requested for only a very small percentage of patients who request euthanasia in these jurisdictions raising the possibility that psychiatric disorder may be under-diagnosed in this population.[1, 2] Terminally ill patients with mental illness, especially depression, are more likely to consider PAS as an option, and therefore are particularly vulnerable to the misapplication of legislation allowing PAS.[3, 4]

Psychiatrists have specific skills to identify psychiatric illnesses and understand the aetiology of suicidal ideation in the terminally ill; thus any legislation allowing PAS should require a mandatory psychiatric review of the patient making the request before the request is acceded to.[5] However many psychiatrists may be cautious about taking an active role in the process. In one US survey, only 6 percent of psychiatrists reported confidence that a single assessment could enable them to decide whether or not mental illness is influencing a person's request.[6] A 1994 survey of UK psychiatrists found that while 64 percent agreed that psychiatric assessment should take place in all cases of PAS, only 35 percent would be willing to carry out such assessments.[7]

### **Physician Assisted Suicide and relevance in mental health**

The College does not support the provision of PAS in cases where a patient suffers psychiatric illness alone. The College believes that unrelievable psychiatric suffering is rare and the difficulties in ensuring capacity in these situations so great, that any putative benefits associated with the introduction of PAS for psychiatric illness, could not be outweighed by the associated risks.

Consideration needs also to be given to people suffering from dementia. As an age-related disorder, and because of the absence of effective prevention or treatment strategies, a significant consequence of an ageing population will be the disproportionate increase in the population with dementia. There is mounting evidence that those that develop dementia under the age of 70 are at increased risk of suicide and might possibly consider PAS. While this might be regarded as a form of 'rational' suicide, competence to make decisions is of particular importance in this risk group. Effective strategies for this group require further research into and evaluation of attitudes towards physician assisted suicide.

Should legislation be introduced, strict guidelines should be developed on circumstances which make it appropriate to allow for PAS. Competence of the person seeking PAS is a key factor [8]. Continuing support should be provided to anyone contemplating with PAS to ensure the correct process and decision is reached. This includes proper debate into the use of advance directives where significant concerns exist about the potential use of proxy decision makers.

A key role for health professionals is to enhance and impart knowledge about the availability of palliative care and other interventions that reduce perceived burdens on persons closest to them caused by disabling and distressing mental conditions.

### **Recommendations**

- College members should take no formal role in PAS whilst it remains illegal. There must be further open discussion about the ethical issues involved, including whether psychiatrists can ethically have any role in the process, even if it is legalised.
- Informed public discussion of issues surrounding the PAS should be promoted as a method of allowing Government and society at large to consider this controversial matter.
- The primary role of medical practitioners in end of life care is to facilitate the provision of good quality patient-centred care. Palliative care should strive to achieve the best quality of life during the final stages of their illnesses and allow patients to die with dignity. This should be adequately resourced and widely available.

- There is an important role for psychiatrists in the identification and treatment of mental illness in patients with terminal disease, including those who request to die. In the context of terminal illness, a patient's capacity to make decisions may be affected by both mental and physical illness.
- Should legislation legalising PAS be introduced, that legislation should include provisions that would exclude access to PAS for patients who may be incompetent as a result of a depression, delirium or other treatable psychiatric illness, and mandate independent psychiatric assessments to better ensure that such illnesses are detected and the patient's capacity to make the decision is assessed.
- The role of the psychiatrist in a PAS assessment should not be limited to a mere assessment of competence but also include, where relevant, a comprehensive clinical assessment and suggestions for broader management.
- The College does not support the provision of PAS by an advance health care directive compiled when an individual is competent with the intention to be implemented at a time when the individual is incompetent with or without proxy authorisation by the individual's next-of-kin or primary carer. Proxy authorisation of PAS is not acceptable in any circumstance due to the potential for abuse.
- All medical practitioners must have the right to choose whether they wish to take part in matters relating to PAS.

## References

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