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Playing the ferryman: Psychiatry's role in end-of-life decision-making

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I had barely sat down to write this piece when I was called to see Miss Haros, urgently.

Sixty-five, always single and suffering end-stage congestive cardiac failure, Miss Haros had been admitted semi-electively 3 weeks prior in an attempt to better control her cardiac function and thus avoid nursing home placement. Three days ago her cardiologists had told her they could make her no better than prior to admission and that a nursing home could not be avoided. Two days ago Miss Haros had told her cardiologists she had decided to die and promptly refused all her medications. Attempts to convince her to change her mind had failed.

In Sandy MacLeod's review of the psychiatric aspects of legally sanctioned physician-assisted dying (PAD) in various jurisdictions across the world, he concludes, rightly in my view, that in these jurisdictions there are 'psychiatric concerns about euthanasia and physician-assisted suicide, yet psychiatry is infrequently consulted and involved in the decision-making processes' (MacLeod, 2012). 'Psychiatry', he asserts, 'needs to play a greater role in the assessment processes', though he worries that 'psychiatry does not have the expertise ... to "select" those whose wish for a premature death is rational, humane and "healthy"' (p. 942). He is right again, on both counts, though his final concern, it turns out, is irrelevant to the issue.

In this viewpoint, I briefly outline existing Australasian law around PAD and highlight its paradoxes. Next, I

overview the ethical arguments that support the introduction of legislation permitting PAD. Finally, drawing on those arguments and following MacLeod's lead, I suggest that any legislation permitting PAD should mandate a psychiatric assessment, though the aims of that assessment should be far more modest than those that trigger MacLeod's final anxieties.

The law

No Australasian legislation sanctions PAD, and though the Northern Territory *Rights of the Terminally Ill Act 1995* remains on the statute books, it was struck down by overriding Commonwealth legislation in 1997 (*Euthanasia Laws Act 1997* (Cth)).

Further, although suicide and attempting suicide are no longer crimes, assisting suicide remains an offence throughout Australasia (*Crimes Act 1900* (NSW) s 31C; *Crimes Act 1958* (Vic) s 6B(2); *Criminal Code* (Qld) s 311; *Criminal Code* (Tas) s 163; *Criminal Law Consolidation Act 1935* (SA) s 13A(5); *Criminal Code* (WA) s 288; *Crimes Act 1900* (ACT) s 17; *Criminal Code* (NT) s 168; *Crimes Act 1961* (NZ) s 179). There have been numerous convictions for assisting suicide (*R v Maxwell* [2003] VSC 278; *R v Hood* [2002] VSC 123) and people who have claimed to have assisted a suicide have been prosecuted for manslaughter (*R v Justins* [2008] NSWSC 1194; *R v Raymond Douglas Sutton*; *R v Margaret Ellen Sutton* [2007] NSWSC 295), attempted murder (*DPP v Rolfe* [2008] VSC 528) and murder. Nonetheless, the law is not

insensitive to the idea of mercy killing and the majority of those prosecuted for assisting the suicides of people in dire circumstances are either not convicted, or, if convicted, are given light or suspended sentences (*Kerridge et al.*, 2009; *R v Maxwell* [2003] VSC 278). In addition, many people who are known to have assisted suicide are simply not prosecuted. Several Australian doctors who have assisted in mercy killings have essentially challenged authorities to take action against them without result (Skene, 2008).

On the other hand, the last 2 years have seen Australian courts clearly uphold the rights of patients to refuse medical treatment (mechanical ventilation and dialysis (*Hunter and New England Area Health Service v A* [2009] NSWSC 761)) and food and water, even though these refusals would bring about the patients' deaths (*Brightwater Care Group Inc v Rossiter* [2009] WASC 229; *H Ltd v J* [2010] SASC 176). In these cases, and similar cases overseas (*Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All ER 449), the courts have been keen to ensure that the person had the capacity to make the decision to die and

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have heard expert opinion to help make that determination.

Presented this way, it is apparent that the law presents a paradox. If a competent patient requests that a doctor act to turn off a ventilator or cease life-preserving interventions, the doctor must do so even though that may result in death by hypoxia, starvation or dehydration. If, though, a competent patient requests that a doctor act to provide a lethal dose of medication to allow a comfortable death at a chosen time, then any doctor willing to comply must either try to avoid detection, hope that if detected they will not be prosecuted or trust that the justice system will be merciful.

In all such circumstances it would be wise to seek expert psychiatric opinion upon the person's capacity. Capacity is vital to ensure an apparent decision to die is validly made, but capacity can be eroded by delirium or depression, which are so common at the end of life and so frequently missed by non-psychiatrically trained physicians (Ryan, 1995). When life-preserving treatment is refused, psychiatric consultation is routinely sought, as it was for Miss Haros. Currently, though, when euthanasia or PAD is contemplated, there is no realistic avenue for expert assessment of capacity.

Ethics

No one suggests that a legally correct position is necessarily congruent with an ethically correct one. Nonetheless, a series of ethical arguments are sometimes raised to support the legal distinction between assisting in the death of a competent person and letting such a person die. These arguments are not strong.

Some proponents of the distinction argue that there is a morally relevant difference between deciding to do something and deciding either to do nothing or to stop doing something. This distinction is very difficult to maintain though, when both the act

and omission involve conscious decisions and both will have the same result – the death of the person competently requesting it (Kuhse and Singer, 1995). In a famous rejoinder to this acts and omissions fallacy, Rachels asks us to consider two evil uncles, each of whom set out to murder their respective young nephews in their baths. Both sneak into the respective bathrooms. Once inside, the first holds the boy underwater, but the second, seeing the boy slip and hit his head as he enters, stands idly by while his nephew drowns. Rachels contends that uncle 2 is no less morally reprehensible than uncle 1 despite it being his inaction, not his action that caused the hoped-for death (Rachels, 1975).

A second distinction often advanced, suggests that there is something morally superior about a 'natural' course and that treatment withdrawal is morally different to PAD because it is simply 'letting nature take its course'. There are several problems with this line of reasoning. The boundaries of 'natural' are not clear and even to the extent that they are clear, there is no reason to suppose that natural is better. There are obvious counter-examples to the moral supremacy of the natural. No one suggests that otherwise healthy diabetics ought be deprived insulin because it is morally superior to let nature take its course (Hopkins, 1997).

Finally, and perhaps most commonly, those who oppose the legalisation of PAD employ one of two types of slippery slope argument – ideological and psychological – to suggest that legalisation would be dangerous.

'Ideological' slippery slope arguments hold that allowing PAD, means abandoning the only logical distinction that can be drawn between PAD and other varieties of active killing, such as involuntary euthanasia – killing people against their will (Hendin and Klerman, 1993; Peretz, 1981; Singer and Siegler, 1990; Weber, 1988). This argument is easily countered. The fact that we find practices like involuntary euthanasia

morally repugnant suggests that there must be important differences between it and PAD. PAD is voluntarily, involuntary euthanasia is not, so there is one clear logical dividing line.

'Psychological' slippery slope arguments are more difficult to dismiss. These admit that logical distinctions can be drawn, but claim instead that once PAD is legalised, psychological and social factors will trample over the niceties of these distinctions and feared, unintended and possibly unforeseen, consequences will inevitably result. The exact nature of these consequences is usually left vague. There might be a lessening of palliative care services or a contraction of mental health facilities (Pollard and Winton, 1993). Perhaps vulnerable members of society (such as the terminally ill or mentally retarded) will be pressured to take up PAD to relieve the burden on their family, or perhaps there will be increases in non-voluntary or involuntary euthanasia (Doerflinger, 1989; Saunders, 1992; Schetky, 1992; Siegal, 1982; Siegal and Tuckel, 1984; Weber, 1988).

Despite its superficial appeal, the psychological slippery slope does not stand up to close scrutiny either. Many societal practices and laws could be abused, but that does not imply that they will be. Nor can the mere possibility of abuse be taken as a reason for prohibiting an otherwise moral pursuit. We allow scientific experimentation involving humans, despite the real possibility (and occasional actuality) of abuse (Mayo, 1983). The psychological slippery slope is not an argument for banning PAD; it is an argument for constructing stringent safeguards that minimise the risk of abuse.

The role of psychiatry in end-of-life decisions

Numerous surveys have suggested that around 85% of Australians and 70% of New Zealanders support the

legalisation of some form of medically assisted dying (Gendall, 2010; Robotham, 2011). With such strong public support it is no surprise that in recent years numerous Australasian legislatures have debated bills aimed at sanctioning voluntary euthanasia or PAD (Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2010 (Cth); Death with Dignity Bill 2003 (NZ); Voluntary Euthanasia Bill 2010 (SA)). It seems inevitable that one such bill will eventually become law.

Even a person implacably opposed to assisted-dying legislation, perhaps for religious reasons, would, presumably, still want to ensure that any legislation adopted be the best legislation possible.

MacLeod is right to be concerned about the shape of some law reform in overseas jurisdictions. PAD and euthanasia legislation seeks to support the autonomous decisions of dying people to end their lives at a time of their choosing. However, those most likely to ask for PAD or euthanasia are also those most likely to suffer a depression or delirium that may erode their autonomy. Non-psychiatrically trained doctors are not well placed to recognise the presence of these conditions in the medically ill population, nor are they often expert at determining a patient's capacity to refuse treatment or request an earlier death.

Given these facts, it is extremely concerning that psychiatrists are so rarely consulted in cases of PAD or euthanasia in The Netherlands and Oregon. In neither jurisdiction is psychiatric consultation mandated and this legislative oversight seems extremely unwise.

There is a strong argument for mandatory psychiatric consultation to be included in any future legislation authorising PAD or euthanasia. Such consultation was mandated in the ill-fated Northern Territory act (Ryan and Kaye, 1996) and in the New Zealand bill referred to above, but was not a part of the South Australian

bill nor a proposed bill for debate in New South Wales (Rights of the Terminally Ill Bill 2011 NSW). Lawmakers do not have medical, let alone specialist psychiatric, expertise and it is unreasonable to assume that they will be familiar with the prevalence and possible effects of psychiatric disorders in the terminally ill. Psychiatrists should actively participate in the drafting of such legislation and argue for mandatory psychiatric review to ensure, as much as possible, that a terminally ill person's request for an early death truly represents an autonomous choice.

Miss Haros was already quite breathless as I spoke to her. She was sad but sanguine and certainly not depressed. She said that she had no desire to go to a nursing home and that she knew that she was to die soon anyway. She had considered this course of action for some time. 'Better I die now on my own terms.' My efforts to persuade her to, at least, take the diuretic frusemide so that she might be more comfortable were politely rebuffed. Her mind was made up. Though I could not agree with her decision there was no reason to displace the presumption of capacity that is afforded us all (*Hunter and New England Area Health Service v A* [2009] NSWSC 761 [23]). She understood her circumstances and the consequences of her actions. There was no cognitive impairment and she could weigh the information at hand to come to a decision. There were no grounds at all for forcing treatment upon her.

Was her decision for a premature death, in MacLeod's terms, 'rational, humane and "healthy"'? I am really not sure. Perhaps fortunately, though, psychiatrists are not required to judge.

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