

Velcro on the slippery slope: the role of psychiatry in active voluntary euthanasia

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Objective: The aim of the paper is to determine the role that psychiatrists should play in legislation that establishes a right to active voluntary euthanasia (AVE).

Method: One version of the slippery slope argument, usually invoked against the legalisation of AVE, is recast as an argument for the introduction of strong safeguards in any future AVE legislation. The literature surrounding the prevalence of psychiatric illnesses in the terminally ill, physicians' ability to identify such illnesses and the aetiology of suicide in the terminally ill is examined.

Results: The strength of the slippery slope argument combined with the poor ability of general physicians to diagnose psychiatric illness in the terminally ill, demands that any legislation allowing AVE should require a mandatory psychiatric review of the patient requesting euthanasia.

Conclusions: Any legislation adopted that establishes a right to active voluntary euthanasia should include a mandatory psychiatric review of the person requesting euthanasia and a cooling off period before the request is acceded to. In addition the discovery of a serious mental illness ought to disqualify the affected person from the right to AVE until that illness resolves.

Australian and New Zealand Journal of Psychiatry 1995; 29:580-585

Active voluntary euthanasia (AVE) refers to the practice of hastening a person's death, through means such as lethal injection, to allow that person to die at a time of their own choosing. It is generally assumed that the person involved suffers from a terminal illness and has a limited life expectancy. The person is assumed to have calmly and rationally weighed up the pros and cons of continuing to live in their current circumstances and come to the reasoned decision that she would be better off dying at a time of her own choosing than she would be lingering on and dying later in pain or without dignity.

On the 25th of May 1995, the Legislative Assembly of the Northern Territory became the first parliament in the world to pass an act legalising active voluntary euthanasia [1]. Since this time several other State, Territory and Federal politicians have expressed a willingness to examine similar legislation. Included among the provisions of the Northern Territory Act are the stipulations that the patient requesting euthanasia first be reviewed by a psychiatrist, that there be a nine day cooling off period between the request for euthanasia and the request being acceded to, and that the person is "of sound mind" and "not suffering from a treatable clinical depression".

This paper critically examines the role psychiatrists should play in legislation allowing AVE. It argues that any person requesting AVE should undergo mandatory psychiatric review, that there be a set cooling off period and that the right to euthanasia should be subject to the person's mental state. It argues that Northern Territory Legislative Assembly got it right and if other legislatures are to introduce

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AVE legislation, they should include these provisions.

The issue of whether or not a society should legislate to allow people to take up the option of AVE in the first place is not addressed in this paper. This is a complex question based on many ethical and social arguments. The place of psychiatry in that debate is limited.

The slippery slope argument

The ethical issues surrounding active voluntary euthanasia have been the source of much debate in recent years. Arguments supporting the practice have rested mainly upon either the suffering that a terminally ill person wishing to end her life may needlessly endure by continuing to live, or upon rights to self determination or autonomy [2-5]. Arguments against have been of two types. The first type claims that voluntary euthanasia contravenes one or more special inviolable moral principle - such as the sanctity of life or the duty of doctors not to kill [6-8]. The second type is the so called slippery slope or thin end of the wedge arguments [7,9-13].

The slippery slope arguments do not set out to show that there is anything intrinsically wrong with AVE, but rather maintain that the legalisation of AVE and its moral acceptance would inevitably lead to a deterioration of moral standards resulting in clearly unacceptable consequences. This deterioration is envisaged to take place in one of two ways. First, it may be that no logical distinction can be drawn between the allowable acts and the unacceptable consequences. Second, even if a logical distinction can be found, the proponents of the slippery slope worry that society will not heed that distinction. Psychological and social factors will, once unleashed, trample on the niceties of logical distinctions and the feared consequences will unfold.

In its fiercest form the slippery slope argument sees the legalisation of AVE as the beginning of a malignant and fulminating social decay. Some authors see the move as the first step on the road to a society similar to that of Nazi Germany, where murder is cloaked in the guise of legitimate medicine [12]. This armageddon approach depends on the notion that any erosion of the sanctity of human life or the notion that doctors should not kill will inevitably result in these terrifying consequences. Though frightening, this extreme form of the slippery slope argument owes more to rhetoric than real ethical power.

The claim that there is no logical distinction between AVE and the envisaged consequences is

easy to counter. The very fact that we find the feared consequences morally repugnant suggests that there are important differences between them and AVE. Active voluntary euthanasia is by definition voluntary, clearly an aspect not envisaged in the horrifying scenarios put forward by the slippery slope argument, so here is one clear dividing line.

The concerns raised about a psychological or social slippery slope are more substantial, but are still flawed. Any policy can be abused, but this does not mean that it will be. Arguments which claim that the legalisation of AVE risks a return of the horrors of Nazi Germany may also be mounted against legalising voluntary tubal ligation or any form of experimentation involving humans [14]. However we allow these practices because we feel they are important enough to take the risk and because we feel the risk is very small. We believe, with justification, that people will be able to see a difference between properly conducted clinical trials and the atrocities of the concentration camps. Nazi Germany arose through a series of complex sociopolitical forces, not through a single piece of well intended legislation. Moreover AVE has been practiced without prosecution in the Netherlands for over a decade and there is no evidence of any moral decay in Dutch society [4].

Other, stronger versions of the argument foresee several less dramatic consequences flowing from the legalisation of AVE. Some authors express concern that acceptance of AVE or of a right to rational suicide may lessen society's determination to provide resources for suicide intervention. Not only could this further diminish the provisions for the mentally ill but it may, perhaps via some weakening of the detention powers of mental health laws, also increase the number of suicides generally [9]. Concerns have also been expressed that the move could lead to a form of ageism where the elderly might feel under some moral duty to do the "rational" thing and relieve society of the burden placed on it by their continued existence [15]. Similar concerns about the possibility of a right to euthanasia becoming an obligation have also been expressed with respect to the terminally ill [16,17] and mentally retarded [18]. Supporters of AVE answer these concerns using a number of strategies, but their success or otherwise is not the concern of this paper [19,20].

This paper deals with a version of the slippery slope argument that is less often raised but is of particular concern to psychiatrists [21,22]. It raises the possibility that legalised AVE might become an alternative to standard suicide for the terminally ill. AVE legislation is designed for terminally ill people

who have come to a considered reasoned decision to end their lives on the basis of the suffering they endure. This version of the slippery slope argument highlights the possibility that AVE might become, for some of the terminally ill, an efficient alternative to suicide motivated not by their suffering but by either a mental illness or a temporary crisis.

The strength of this version of the slippery slope argument must be acknowledged. It is certainly possible that poorly conceived AVE legislation could be misused in this way. Even if one were to grant that terminally ill people should be able to end their lives at a time of their own choosing, no one would want this right to become a vehicle for the mentally ill to commit assisted suicide or for people to kill themselves because of a brief and easily reversible crisis.

Although the slippery slope arguments are usually cast as arguments against the introduction of AVE, it is possible to re-cast them as strong arguments for the introduction of careful safeguards with any future AVE legislation. We are not obliged to outlaw things because, even though they are permissible, they may lead to things that are not. We are, however, obliged to identify and outlaw those non-permissible things. The situation surrounding medical research provides a good example. The revelation that medical research has led in the past to gross abuses [23] does not lead us to the conclusion that all medical research should be banned, but rather that it should be more tightly controlled and monitored.

The mandatory psychiatric review and cooling off period are offered as safeguards against this version of the slippery slope. Without these safeguards two groups of people may fall victim to inappropriate voluntary euthanasia: those with a serious mental illness and those who decide to undertake AVE in a crisis. The legitimacy of the argument for each group is examined in more detail below.

Serious mental illness in the terminally ill

Even the strongest supporters of AVE recognise the need to protect those who may wish to end their lives because of the effects of mental illness [24]. Mental illnesses such as major depression or delirium will interfere with the person's ability to make a reasoned decision about undergoing AVE.

People suffering from major depression often believe their situation far worse than they would if they were free of illness. They experience a sense of despair and hopelessness that is part of the syndrome. Suicidal ideation may also be a manifestation. People suffering delirium are by definition confused and

unable to think clearly. It is widely agreed that people suffering such illnesses should be excluded from the right to make decisions about voluntary euthanasia until they are no longer so afflicted [4,20].

Major depression and delirium, are common in the terminally ill. Studies have reported prevalences of major depression in oncology patients of between 6 and 40 percent [25-27]. Patients with AIDS are reported to have a six month prevalence of major depression of between 3 and 17 percent [28,29] and patients with end stage renal failure have a prevalence of between 5 and 10 percent [30,31]. While a number of methodological problems in some studies mean that the true figure is probably towards the lower side of these estimates, the literature nevertheless supports the contention that major depression is common in terminally ill patients.

It is likely that major depression plays a key role in the desire for euthanasia in the terminally ill population. One study by Brown and co-workers found that among forty-four terminally ill patients, the only patients who had experienced a desire for an early death were those who were suffering from a clinical depressive illness [32].

Delirium may come about as the result of any serious physical or chemical insult to the brain. Terminally ill patients are likely to suffer a delirium not only secondary to their illnesses, but secondary to the treatments of their illness as well. Patients with cancer may suffer organ failures causing delirium via hypoxia or a build up of toxic metabolites. They may be susceptible to infection and fever, or the cancer may invade the brain directly. They may be prescribed an array of medications which can cause delirium as a side effect. Pain relieving drugs are particularly likely to contribute. Patients with AIDS may also suffer all these insults, and the presence of the HIV virus in the neuronal cells only increases the likelihood of delirium [29]. It is likely that as many as 10% of hospitalised patients are delirious at any one time [33].

If psychiatric illnesses, such as major depression and delirium, are common in the terminally ill population, and if the presence of such illnesses should be a contraindication to AVE, then it will be important for any future AVE legislation to incorporate a sensitive mechanism that will allow the detection of these illnesses in the terminally ill population and to prohibit them from undertaking AVE until their illness has resolved.

Terminally ill people wanting AVE because of a crisis

The temporary desire to end one's life is common in the general population [34]. Only very rarely though is this desire the result of a carefully considered, reasoned decision that one would be better off dead. Usually suicidal ideation is a result, either of a major psychiatric illness as discussed above, or a psychological reaction to a crisis. Crises may engender feelings of abandonment, feelings of loss of control, undirected anger and the desire for revenge. Often a decision to die in these circumstances is made precipitously and frequently under the influence of drugs or alcohol. The young man who, having just broken up with his girlfriend, gets drunk and decides to end it all, does not make a carefully considered and reasoned decision.

It is likely that the terminally ill population may also experience the desire for self-destruction for similar reasons, however very little empirical work has been done on the aetiology of self-destructive thought in the terminally ill [16]. Work that has been done supports the notion that suicidal ideation in this population is frequently not the product of a carefully considered and reasoned decision. If a desire for death in the terminally ill were usually the result of reasoned decision making, then one would expect that both completed suicide and interest in euthanasia would occur most often in the latter stages of illness. This would be the time when pain and suffering is at its worst and when there is little to look forward to. In fact however, completed suicide is most common in the first year after diagnosis in the terminally ill [35]. Moreover an Australian study by Owen et al. found that among patients with cancer the strongest interest in euthanasia was among those patients being offered potentially curative treatment. Patients with poorer prognoses, who were only being offered palliative care, tended to reject the idea of euthanasia as a future option ($p < 0.05$) [36].

The question of how one defines a rational reason for wanting euthanasia seems destined to remain an entirely subjective one. After all a situation which appears hopeless to one person, may not seem nearly so bleak to another. The important point however, is that the person doing the deciding must have come to that decision as a result of his own careful consideration. Decisions made over a very short time or under the influence of substances cannot be considered to have involved careful consideration.

If well considered and rational decisions to end one's life are the exception in the terminally ill, or even if they are less than common, any piece of AVE legislation will require a safeguard to prevent the use of the law when requests are ill-considered or clearly irrational.

Safeguards

In the Netherlands patients wishing to proceed with AVE must be reviewed by two independent doctors [37]. This safeguard is aimed at ensuring that the patient does in fact have a terminal illness and that all treatment options have been exhausted. Though not overtly stated it would also try to ensure that the patient is free from mental illness.

Several studies suggest that review by non-psychiatrically trained doctors alone will not be sensitive enough to positively exclude psychiatric illness in the terminally ill population. Doctors who do not have specialist psychiatric training are very poor at diagnosing major depression or delirium in the physically ill population [38-42]. Major depression, particularly, is under-diagnosed, with physicians tending to assume the symptoms are part of understandable reaction to the patient's situation. It is not surprising that this should be the case, as a certain degree of depression is to be expected as part of the normal reaction to a terminal illness and as many of the symptoms of major depression - sleep disturbance, loss of appetite etc. - may also occur as a result of physical illness.

In Australia and New Zealand psychiatric training includes a six month term in consultation-liaison psychiatry where specialist skills in the diagnosis of mental illness in the presence of physical illness are acquired. Psychiatrists are likely to be much better than their physician colleagues at identifying major mental illness in the terminally ill population. The mandatory review of a person requesting AVE by a psychiatrist would therefore provide a more sensitive screen against mental illness and thus lessen the chance of that person receiving AVE when she was not competent to request it.

This notion of a psychiatrist as arbiter of a patient's competence to decide to kill themselves is not new. Mental health acts generally contain a similar provision concerning suicidal ideation in the general community. In New South Wales, for example, suicidal patients may not be detained against their will longer than three working days unless, in the opinion of a psychiatrist, they are suffering from a mental illness [43]. Here "mental illness" is defined as the presence of one or more of hallucinations, delusions, thought disorder or a serious disturbance of mood, and is clearly designed to encompass schizophrenia, bipolar disorder, major depression and organic mental disorders including delirium. It is not difficult to imagine a similar definition being employed in future AVE legislation. Patients who as

a result of psychiatric review were thought to suffer such mental illnesses would then be ineligible to undergo euthanasia until that mental illness resolved.

The other group of concern - those that make ill-considered and hasty decisions to end their lives - are more easily protected. An enforced cooling off period of perhaps seven days between the request for euthanasia and the enacting of the request ought to be sufficient to sort out those who have come to the decision precipitously from those who have come to a considered determination. In these cases the psychiatrist should have no power of veto, but even in these cases a psychiatric review may have much to offer. Often it is difficult and time consuming to tease out the complex motives behind the desire to end one's life. Psychiatrists are experienced not only in excavating these motives, but at instituting management plans that might result in the desire for death evaporating [44]. Again therefore, even without a legislated power of veto, a mandatory psychiatric review may prevent inappropriate AVE.

Conclusion

Any legislation that establishes a right to voluntary active euthanasia without the mandatory involvement of a psychiatrist and an enforced cooling off period, will not provide adequate safeguards against the inappropriate use of AVE for patients with mental illness, or psychological reactions precipitated by a temporary crisis. Future legislation allowing AVE must include this review, the cooling off period and the provision for the right to AVE to be suspended while the person is thought to be suffering from a serious mental illness.

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