

WRONGFUL DEATHS BY ASSISTED SUICIDE OR EUTHANASIA

MENTALLY ILL AT RISK

- People with a mental illness are at risk of wrongful death under any law authorising assisted suicide or euthanasia.
- In the Netherlands and Belgium mental illness is seen as a condition for which euthanasia or assisted suicide is increasingly considered to be an appropriate response.
- In Oregon and Washington State where the laws provide for *optional referral* for psychiatric assessment the evidence shows that the gatekeeping medical practitioners very seldom refer and that this results in persons with *treatable clinical depression* being wrongfully assisted to commit suicide.
- In the Northern Territory, where euthanasia was legal from July 1996-March 1997, and compulsory screening by a psychiatrist was required, there was a failure to adequately identify depression, demoralization or other psychiatric issues which may have been treatable in all four cases of persons killed under that regime.

Belgium

Belgium offers assisted suicide or euthanasia for persons suffering with depression or other mental illnesses.

[A total of 201 people with psychiatric disorders were killed by euthanasia in Belgium between 2014 and 2017](#) including for mood disorders such as depression, bipolar disorder (73 cases); organic mental disorders, including dementia and Alzheimer's (60 cases); personality and behavioural disorders (23 cases); neurotic disorders, and disorders related to stressors including posttraumatic stress disorder (16 cases); schizophrenia and psychotic disorders (11 cases); organic mental disorders, including autism (10 cases) and complex cases involving a combination of several categories (8 cases).

Of these 201 cases there were 25 cases of people under 40 being killed by euthanasia. In relation to these troubled young people the Commission observes:

In the group of patients under 40, it is mainly personality and behavioral disorders. All these patients have been treated for many years, both outpatient and residential. There has always been talk of intractable suffering. For this type of disorder, serious psychological trauma at a very young age has been

mentioned several times, such as domestic violence, psychological neglect or sexual abuse.¹

Belgium is treating the victims of child abuse by domestic violence, neglect and sexual abuse by killing them.

US psychiatrist Dr Mark Komrad [explains](#) how profoundly the law on euthanasia has affected the practice of psychiatry in Belgium:

The criteria for euthanasia— a condition that is “insufferable and untreatable”— has called into existence a new category for the mentally ill who have those characteristics. As in the US, the notion of [a] truly “untreatable” condition in psychiatry really didn’t exist in the Benelux countries, until their legislatures conjured that category into legal existence, thinking of the terminal somatic conditions with which physician administered euthanasia originally began. Once this category opened to “psychological suffering” it became a beckoning space which influenced how psychiatrists and their patients began to see some cases.²

Netherlands

Euthanasia is legally permitted in the Netherlands for dementia patients and for persons with depression or other mental health issues in the complete absence of any physical illness or suffering.

In [2017 there were 83 notifications of euthanasia or assisted suicide involving patients with psychiatric disorders](#). There were 166 notifications involving dementia. All these cases were in the absence of any other condition justifying euthanasia. Three of the dementia cases of euthanasia were performed on the basis of an advanced directive rather than a contemporary request by the person who was euthanased.³

[Psychiatric conditions for which euthanasia was performed in 2015](#) included personality disorder with posttraumatic stress disorder and self-mutilation; and obsessive compulsive disorder.⁴

¹ https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/8_rapport-euthanasie_2016-2017-fr.pdf

² <http://www.psychiatrictimes.com/couch-crisis/psychiatrist-visits-belgium-epicenter-psychiatric-euthanasia>

³ <https://www.euthanasiecommissie.nl/actueel/nieuws/2018/maart/7/vijftien-jaar-euthanasiewet-belangrijkste-cijfers-2017>

⁴ https://www.nvve.nl/files/8414/6166/0719/RTE_jaarverslag2015DEF.pdf

Oregon

Oregon's *Death With Dignity Act*, which has been operative since 1997, provides for medical practitioners to provide prescriptions for lethal medications to be taken later by the person for whom the lethal dose is prescribed.

[Research by Linda Ganzini](#) et al. found that "*Among terminally ill Oregonians who participated in our study and received a prescription for a lethal drug, one in six had clinical depression*".⁵

Depression is supposed to be screened for under the Act. However, [of the 1275 people who have died by ingesting lethal dose prescribed under the Act only 62 \(4.9%\) were first referred for psychiatric evaluation](#).⁶

This means **as many as 150 people with depression may have been helped to commit suicide** without any such referral.

In 2011 Dr. Charles J. Bentz of the Division of General Medicine and Geriatrics at Oregon Health & Sciences University explained that Oregon's physician-assisted suicide law is not working well. He cited the example of a 76-year-old patient he referred to a cancer specialist for evaluation and therapy. The patient was a keen hiker and as he underwent therapy, he became depressed partly because he was less able to engage in hiking.

He expressed a wish for assisted suicide to the cancer specialist, who rather than making any effort to deal with the patient's depression, proceeded to act on this request by asking Dr Bentz to be the second concurring physician to the patient's request.

When Dr Bentz declined and proposed that instead the patient's depression should be addressed the cancer specialist simply found a more compliant doctor for a second opinion.

Two weeks later the patient was dead from a lethal overdose prescribed under the Act.

[Dr Bentz concludes:](#)

"In most jurisdictions, suicidal ideation is interpreted as a cry for help. In Oregon, the only help my patient got was a lethal prescription intended to kill him." He urges other jurisdictions "*Don't make Oregon's mistake.*"⁷

⁵ http://www.bmj.com/highwire/filestream/384131/field_highwire_article_pdf/0.pdf

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<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf>

Northern Territory

The *Rights of the Terminally Ill Act 1995* (the ROTI Act) was in operation in the Northern Territory from 1 July 1996 until it was suppressed by the Commonwealth's *Euthanasia Laws Act 1997* on 27 March 1997.

During the nine month period in which the ROTI Act was in effect and under its provisions, four people were assisted to terminate their lives by Dr Philip Nitschke.

[Case studies on these four deaths have been published.](#)⁸ The principal author of this paper is Professor David Kissane, who is a consultant psychiatrist and professor of palliative medicine. Philip Nitschke is a co-author of the paper.

The case studies examine how the conditions required by the ROTI Act were met. Cases numbered 3, 4, 5 and 6 in this paper refer to those cases which ended with the person's life being terminated with the assistance of Dr Philip Nitschke.

From the case histories, it is apparent that cases 3 and 4 each had depressive symptoms.

In case 3, the patient had received "*counselling and anti-depressant medication for several years*". He spoke of feeling sometimes so suicidal that "*if he had a gun he would have used it*". He had outbursts in which he would "*yell and scream, as intolerant as hell*" and he "*wept frequently*".

Neither the patient's adult sons nor the members of the community palliative care team who were caring for him were told he was being assessed for euthanasia. "*A psychiatrist from another state certified that no treatable clinical depression was present.*"

In case 4, "*the psychiatrist noted that the patient showed reduced reactivity to her surroundings, lowered mood, hopelessness, resignation about her future, and a desire to die. He judged her depression consistent with her medical condition, adding that side-effects of her antidepressant medication, dozepin, may limit further increase in dose.*"

Kissane comments that "*case 4 was receiving treatment for depression, but no consideration was given to the efficacy of dose, change of medication, or psychotherapeutic management.*" While Dr Nitschke "*judged this patient as unlikely to respond to further treatment*", Kissane, comments that "*nonetheless, continued psychiatric care seemed warranted – a psychiatrist can have an active therapeutic role in ameliorating suffering rather than being used only as a gatekeeper to euthanasia*".

⁷ <http://blogs.theprovince.com/2011/12/05/province-letters-icbc-egypt-assisted-suicide-oregon-christmas-pre-marital-sex/>

⁸

http://www.healthprofessionalssayno.info/uploads/1/0/9/2/109258189/seven_deaths_in_darwin_case_studies_unde.pdf

In case 6 a key factor seemed to be the patient's distress at *"having witnessed" the death of her sister who also had breast cancer, "particularly the indignity of double incontinence". She "feared she would die in a similar manner". She "was also concerned about being a burden to her children, although her daughters were trained nurses"*.

Kissane noted that *"fatigue, frailty, depression and other symptoms" – not pain – were the prominent concerns of those who received euthanasia. He observed that "palliative care facilities were underdeveloped in the Northern Territory, and patients in our study needed palliative care... There is a need to respond creatively to social isolation, and to treat actively all symptoms with early and skilled palliative care."*

Further concerns are raised by the report on case 5. Dr Nitschke reported that *"on this occasion the psychiatrist phoned within 20 min, saying that this case was straightforward"*. This assessment took place on the day on which euthanasia was planned. This case involved an elderly, unmarried man who had migrated from England and had no relatives in Australia. Dr Nitschke recalled *"his sadness over the man's loneliness and isolation as he administered euthanasia"*. [Dr Nitschke has since revealed in testimony to a Senate committee](#), that he personally paid for this psychiatric consultation and that it in fact took less than 20 minutes.⁹

[Dr David Kissane, comments on the issue of demoralisation:](#)

Review of these patients' stories highlighted for me the importance of demoralization as a significant mental state influencing the choices these patients made. They described the pointlessness of their lives, a loss of any worthwhile hope and meaning.

Their thoughts followed a typical pattern of thinking that appeared to be based on pessimism, sometimes exaggeration of their circumstances, all-or-nothing thinking in which only extremes could be thought about, negative self-labelling and they perceived themselves to be trapped in this predicament. Often socially isolated, their hopelessness led to a desire to die, sometimes as a harbinger of depression, but not always with development of a clinical depressive disorder. It is likely that the mental state of demoralization influenced their judgement, narrowing their perspective of available options and choices. Furthermore, demoralized patients may not make a truly informed decision in giving medical consent.

Demoralization syndrome ... is an important diagnosis to be made and actively treated during advanced cancer. It is recognised by the core phenomenology of hopelessness or meaninglessness about life. The prognostic language within oncology that designates 'there is no cure' is one potential cause of demoralization in these patients, a cause that can be avoided by more sensitive medical communication with the seriously ill. While truth telling is needed, hope must also be sustained so that life may be lived out as fully as possible. Patients with advanced cancer can be guided to focus on 'being' rather than 'doing', savouring the experiential moment of the present, so that purpose and meaning are preserved through inherent regard for the dignity of the person. Active treatment of

⁹ https://www.aph.gov.au/~media/wopapub/senate/senate/commttee/S10740_pdf.ashx

*a demoralized state by hospice services would involve counselling and a range of complementary therapies, use of community volunteers and family supports, all designed to counter isolation and restore meaning.*¹⁰

Conclusion

There is no model from any jurisdiction that has legalised assisted suicide and/or euthanasia for adequately ensuring that no person who is assisted to commit suicide or killed directly by euthanasia is suffering from treatable clinical depression or other forms of mental illness that may affect the capacity to form a competent, settled, determination to die by assisted suicide or euthanasia.

Jurisdictions, like Oregon, that provide for optional referral for psychiatric assessment manifestly fail to identify all cases of clinical depression.

The only jurisdiction which has required a psychiatric assessment for each case of euthanasia was the Northern Territory. However, this system signally failed to adequately identify depression, demoralization or other psychiatric issues which may have been treatable in all four cases of persons killed by former doctor Philip Nitschke under the Rights of the Terminally Ill Act 1995 (NT).

Compulsory referral to a psychiatrist, who may have never seen the person before, for a single brief assessment of whether the person's decision making capacity about assisted suicide or euthanasia is affected by depression or other psychiatric factors is clearly an inadequate safeguard and will not make assisted suicide "safe".