Assisted suicide and mental health

The proposition currently being considered by the Andrews Labor Government is to legalise assisted suicide for persons whose are "*suffering from a serious and incurable condition which is causing enduring and unbearable suffering that cannot be relieved in a manner the patient deems tolerable*."

Will the Bill be able to keep people with mental health issues such as depression safe?

The proposed model would apparently exclude assisted suicide solely on the basis of a mental health condition but would not exclude people who otherwise qualify even if they have severe mental health issues. Instead there would be an optional referral to a psychiatrist or other relevant professional only if one of the two assessing medical practitioners think it is necessary.

The evidence from other jurisdictions is that optional referrals for psychiatric assessment by gatekeeping medical practitioners are seldom carried out and that this results in persons with treatable clinical depression being wrongfully assisted to commit suicide.

OREGON

Oregon's *Death With Dignity Act*, which has been operative since 1998, 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*". [1]

Depression is supposed to be screened for under the Act. However, in 2016 less than one in twenty five (3.75%) who died under the Oregon law were referred by the prescribing doctor for a psychiatric evaluation before writing a script for a lethal substance.[2]

Another paper by Ganzini et al. found that "*in a study of 321 psychiatrists in Oregon only 6% were very confident that in a single evaluation they could adequately determine whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide*".[3]

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*."[4]

WASHINGTON (STATE)

Washington State's *Death With Dignity Act*, based on Oregon's, came into operation on 9 March 2009.

Only 4% of those given a lethal prescription were referred to a psychiatrist or psychological for evaluation. In some cases the prescribing doctor knew the patient for less than a week before writing the prescription, and in just over half the cases (51%) the doctor knew the patient for less than 25 weeks.[5]

NEW YORK

The New York Task Force on Life and the Law in a 1997 supplement[6] to its 1994 report, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*,[7] summarised its views on the primary risks associated with the legalisation of assisted suicide or euthanasia as follows:

Undiagnosed or untreated mental illness.

Many individuals who contemplate suicide — including those who are terminally ill — suffer from treatable mental disorders, most commonly clinical depression.

Yet, physicians routinely fail to diagnose and treat these disorders, particularly among patients at the end of life. As such, if assisted suicide is legalised, many requests based on mental illness are likely to be granted, even though they do not reflect a competent, settled decision to die.

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.

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*."

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*".

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*".[9] 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.[10]

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 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.[11]

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".

---

[1] Linda Ganzini et al., "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey", *BMJ* 2008;337:a1682, http://www.bmj.com/highwire/filestream/384131/field_highwire_article_pdf/0.pdf

[2] Oregon Public Health Division, *Oregon Death With Dignity Act: Data Summary 2016, Table 1. Characteristics and end-of-life care of 1,127 DWDA patients who have died from ingesting a lethal dose of medication as of January 23, 2016 [sic = 2017], by year, Oregon, 1998-2016,* p.9, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf

[3] Linda Ganzini et al., "Attitudes of Oregon psychiatrists toward physician-assisted suicide", American Journal of Psychiatry 1996; 153:1469-75, http://ajp.psychiatryonline.org/doi/abs/10.1176/ajp.153.11.1469

[4] Charles Bentz, "Oregon's assisted suicide law isn't working", *The Province,* December 5 2011, http://blogs.theprovince.com/2011/12/05/province-letters-icbc-egypt-assisted-suicide-oregon-christmas-pre-marital-sex/

[5] Washington State Department of Health *2015 Death with Dignity Act Report*, p. 4, http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2015.pdf., Table 3 on p.8

[6] www.health.state.ny.us/nysdoh/taskfce/sought.pdf , pp 4-5.

[7] www.health.state.ny.us/nysdoh/provider/death.htm

[8] Kissane, D W, Street, A, Nitschke, P, "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia", *The Lancet*, Vol 352, 3 October 1998, p 1097-1102.

[9] Ibid. p 1100.

[10] Nitschke, P., *Hansard,* Senate Standing Committee on Legal and Constitutional Affairs, Reference: *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008,* Monday, 14 April 2008, Darwin, p 42; http://www.aph.gov.au/hansard/senate/commttee/S10740.pdf

[11] Kissane DW., "Deadly days in Darwin" in *The Case Against Assisted Suicide*, K. Foley & H. Hendin (ed), Johns Hopkins University Press, 2002, p.192-209 Available at: http://www.aph.gov.au/senate/committee/legcon_ctte/terminally_ill/submissions/sub589.pdf

For more FACT SHEETS on Assisted Suicide go to the HOPE website