RANZCP Submission

Inquiry into the exposure draft of the Medical Services (Dying with Dignity) Bill 2014

August 2014

The Royal Australian & New Zealand College of Psychiatrists

Executive Summary of RANZCP response

The role of psychiatrists under section 12 of the Bill

The RANZCP believes that there is a crucial role for psychiatrists in the context of terminally ill patients seeking access to medical services in order to end their lives through the identification and treatment of mental illness as the capacity of terminally ill people can be affected by both mental and physical illness.

Therefore, the RANZCP supports and welcomes the Bill's requirements that:

- there must be a mandatory, independent psychiatric assessment of terminally ill people requesting access to medical services in order to end their lives;
- terminally ill people must be informed of any medical treatment options available to them, including psychiatric services;
- if terminally ill people request medical practitioners to provide dying with dignity medical services, practitioners can refuse to provide these services for any reason and at any time. The RANZCP believes that medical practitioners must have the right to choose whether or not they become involved in providing these services.

However – if the Bill were to become law in Australia - the RANZCP has concerns regarding the role of the psychiatrist as currently set out in section 12(e) of the Bill because:

- the Bill is unclear about the role of a psychiatrist in assessing the capacity of a terminally ill person who is seeking to access dying with dignity medical services. We believe that the appropriate role of a psychiatrist in this context is to assess whether a person's capacity to make decisions has been affected by a treatable psychiatric condition. A psychiatrist's role should also include, where relevant, a comprehensive clinical assessment of a terminally ill person and suggestions for that person's broader mental health management and care; and
- section 12(e) provides that a psychiatrist must confirm whether or not a terminally ill person is affected by a treatable clinical depression. Yet, there are other treatable psychiatric illnesses such as delirium, which can affect a terminally ill person's capacity to make decisions.

Therefore, if the Bill were to become law in Australia, the RANZCP recommends that Section 12(e) of the Bill should be amended to read as follows:

> (e) a further medical practitioner (*the third medical practitioner*) who is a qualified psychiatrist has examined the person and has confirmed that the person *is not suffering from a treatable clinic depression or another treatable psychiatric illness which is impairing the person's capacity to make decisions* (italics added).

The RANZCP also suggests that the references to "sound mind" in the Bill be removed because it has the potential to lead to confusion about what is involved in determining terminally ill people's capacity to make decisions about their medical treatment.

Older people, suicide and euthanasia

Given the Committee's focus is on appropriate safeguards for terminally ill people seeking to end their lives, the RANZCP believes that:

- if the Bill were to become law – that it must provide for suitable safeguards for older members of the Australian population, especially older people with dementia; and
- there is a crucial need to address, and raise community awareness of, common misconceptions about older people, euthanasia and suicide, for instance, that suicide in older people is largely driven by suffering associated with severe or terminal disease.

1. RANZCP's response to the Bill

The RANZCP has developed Position Statement 67 on Physician Assisted Suicide (the Position Statement). Physician Assisted Suicide (PAS) involves 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 choosing.

The Position Statement does not represent a RANZCP position for or against the legalisation of PAS. Instead, the Position Statement is intended to assist RANZCP members who wish to participate in the current PAS legalisation debate and, in the future, if PAS becomes legal in any Australian jurisdiction. The RANZCP's response to the Bill is based on this Position Statement.

The RANZCP wishes to particularly comment on:

- section 12 of the Bill, which provides that a qualified psychiatrist must confirm that a terminally ill person is not suffering from a treatable clinical depression in respect of that person's illness; and
- issues relevant to older people, suicide and dementia.

2. RANZCP's comments on Section 12 of the Bill

Section 12 of the Bill sets out a number of preconditions that terminally ill people must meet if they wish to request dying with dignity medical services from medical practitioners, including:

- satisfying a medical practitioner (the first medical practitioner) that they are suffering from a terminal illness and that any medical treatment reasonably available will only provide relief from their pain and suffering and enable them to die a comfortable death. First medical practitioners must also inform terminally ill people about the nature of their illness and the medical treatment options available to them, including palliative care, counselling and psychiatric services;
- being examined by a second medical practitioner who holds qualifications or experience in the treatment of the relevant terminal illness. The second medical practitioner must confirm the findings and prognosis of the first medical practitioner; and
- being examined by a third medical practitioner who is a qualified psychiatrist. The third medical practitioner must confirm that a terminally ill person is not suffering from a treatable clinical depression in respect of that person's illness.

The role of psychiatrists under section 12 of the Bill

The RANZCP notes that the Committee's inquiry focuses on "the rights of terminally ill people to seek assistance in ending their lives, and an appropriate framework and safeguards with which to do so."

Above all, the RANZCP considers that the primary role of medical practitioners, including psychiatrists in end of life care is to facilitate the provision of good quality patient-centred care so as to achieve the best quality of life in the final stages of a person's illness.

Importantly, under the Bill, if terminally ill people request medical practitioners to provide dying with dignity medical services, practitioners can refuse to provide these services for any reason and at any time. The RANZCP fully endorses this approach as it considers that all medical practitioners must have the right to choose whether or not they wish to participate in situations where terminally ill people are seeking medical assistance to end their lives.

In terms of appropriate safeguards for terminally ill people seeking assistance to end their lives, the RANZCP believes that there is a crucial role for psychiatrists in this context through the identification and treatment of mental illness in patients with terminal disease, including patients requesting to die. In particular, the capacity of a person with terminal illness may be affected by both mental and physical illness.

If legislation legalising PAS were to be introduced in Australia, the RANZCP considers that this must provide for a mandatory, independent psychiatric assessment of a terminally ill person requesting to die. Section 12(e) of the Bill provides that a qualified psychiatrist must confirm that a terminally ill person is not suffering from a treatable clinical depression in respect of that person's illness. The RANZCP supports this aspect of the Bill and also welcomes the Bill's requirement that the first medical practitioner must inform a terminally ill person of any medical treatment options available to that person, including psychiatric services.

However, the RANZCP considers that – if legislation legalising PAS were introduced into Australia – qualified psychiatrists should have a broader role under section 12(e) than the Bill currently provides for.

The RANZCP believes that the emphasis on the role of the psychiatrist in the Bill should be on whether or not psychiatrists believe that terminally ill people seeking to end their lives could respond to psychiatric treatment in a way that could later alter their decisions to seek PAS. To determine this, psychiatrists must make an independent assessment of terminally ill people's capacity to make decisions, including whether a treatable psychiatric illness was impacting on their decision to seek access to PAS services.

If a psychiatrist did find that a terminally person was rendered incapable of making decisions due to a treatable psychiatric illness, then that person could then be provided with, or referred to, appropriate treatment or care. The RANZCP notes that - if terminally ill people have been affected by a psychiatric illness and subsequently receive treatment for that illness – they could later change their mind about their decision in relation to PAS.

In other words, the RANZCP believes that the role of a psychiatrist in a PAS scenario should involve not only assessing whether terminally ill people's capacity to make decisions has been affected by a treatable psychiatric illness but also include, where relevant, a comprehensive clinical assessment and suggestions for their broader mental health management and care.

Further, while Section 12(e) of the Bill refers to "treatable clinical depression", other kinds of treatable psychiatric illnesses – which may or may not involve depressive symptoms – can impact on a person's ability to make decisions and arise in a PAS context. One example is delirium, which may not be readily identified by other physicians. RANZCP members are often called to hospital wards to assess whether a person with delirium who wishes to die is able to undertake advance care planning for their future medical care.

The RANZCP, therefore, considers that the focus of Section 12(e) should not just be on treatable clinical depression but on all treatable psychiatric illnesses, which have the potential to impact on a person's capacity to make decisions. This point is particularly important given the gravity of the issue under consideration. Consequently, the RANZCP suggests amending Section 12(e) to cover all treatable psychiatric illnesses and not just clinical depression.

On the basis of the comments above, the RANZCP recommends that – if the Bill were to become law - Section 12(e) of the Bill should be amended to read as follows:

> (e) a further medical practitioner (*the third medical practitioner*) who is a qualified psychiatrist has examined the person and has confirmed that the person *is not suffering from a treatable clinical depression or another treatable psychiatric illness which is impairing the person's capacity to make decisions* (italics added).

The use of "sound mind" in the Bill

A key factor in the Bill that determines terminally ill people's ability to access dying with dignity medical services is their competence or capacity to make decisions. Under section 12, terminally ill people seeking to access dying with dignity medical services must satisfy medical practitioners, including the first medical practitioner that they are of "sound mind". However, the process of how to determine whether someone is of "sound mind" and the exact role that the qualified psychiatrist, as third practitioner, has in this process is unclear. As mentioned, the RANZCP believes that, under the Bill, psychiatrists should play a critical role in determining the capacity of terminally ill people by assessing whether treatable psychiatric illnesses are affecting their capacity to make decisions about PAS.

The RANZCP notes that a person's legal capacity or competence to make decisions is defined by a common law test. This test has three requirements – patients must be able to comprehend and retain treatment information, weigh that information and reach a decision and then communicate the decision to other people.

However, we believe that the references to "sound mind" in the Bill may lead to confusion about what is involved in determining terminally ill people's capacity to make decisions about their medical treatment. This is because the capacity test is not diagnosis specific, meaning that the issue of whether or not terminally ill people may be suffering from a mental illness does not automatically pre-determine their competence to make decisions about their medical care. Instead, the test is context specific and focuses on a person's ability to make the decision at hand – in this case, seeking access to PAS services.[1]

The RANZCP, therefore, suggests that any references to "sound mind" be removed from the Bill to prevent any terminology confusion about the differences between "sound mind" and a terminally ill person's capacity to make decisions in regards to PAS services.

3. RANZCP's comments on older people, suicide and euthanasia

Given its focus on appropriate safeguards for terminally ill people seeking to end their lives, the RANZCP submits that it is important for the Committee's inquiry to examine relevant issues affecting older members of the Australian population.

One relevant issue is dementia, an age-related disorder. Due to the absence of effective prevention or treatment strategies, a significant consequence of Australia's increasing older population will be the disproportionate increase in the number of Australians with dementia. There is also growing evidence to suggest that people who 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, the question of competence to make decisions is of particular importance in this risk group. The RANZCP submits that effective strategies for this group will need to be informed by further research into, and evaluation of, attitudes towards PAS.

The RANZCP is also concerned about the use of advance care directives in circumstances where older people have dementia. Advance care directives enable people to plan for their future medical treatment and care at a time when they are not competent to make, or unable to communicate, these decisions for themselves. While people with dementia cannot give their consent to the provision of PAS services, they may have previously created an advance care directive requesting access to PAS services at a certain stage of their illness.

The RANZCP strongly opposes the provision of PAS services via advance care directives and takes this view regardless whether or not these directives provides proxy authorisation for a person's next of kin or primary carer to make decisions about PAS services. Proxy authorisation for PAS services is not acceptable in any circumstances due to the potential for abuse.

Another issue is the need to address misapprehensions about older people, euthanasia and suicide. While the community and media focus is often on youth suicide, Australian Bureau of Statistics figures show that Australia's oldest citizens, those aged 80 and above, are the most likely to die by suicide.[2] The RANZCP is especially concerned that the higher suicide rate of older people has led to a misconception by euthanasia and assisted suicide advocates that:

> *suicide in older people is largely driven by suffering associated with severe or terminal illness. It appears rare for a media report about suicide in older people not to be either framed as an argument for euthanasia, or responded to by advocates suggesting it was a 'logical act'. We live in a country that rightly celebrates free speech, and the euthanasia debate is a legitimate one, with strong arguments exchanged. However, to use our most vulnerable citizens in this debate is highly problematic, especially when the potential influence of media upon suicide is well known.*[3]

Therefore, it should not be assumed that older people are making a "reasonable decision" to seek PAS in response to severe or terminal illness. Older members of Australia's population have an equal right to psychiatric assessment and for the exclusion of treatable psychiatric illnesses or any other factors contributing to their request for PAS. The RANZCP also notes that elderly patients can and do respond as well as younger patients to appropriate psychiatric treatment.

The RANZCP strongly believes that it is unacceptable that older Australians – especially those with treatable mental illnesses - may feel that death is a preferable option due to their stage of life or because they may be facing changing life circumstances such as having to go into a nursing home. The RANZCP considers that the potential impact of the ongoing debate about euthanasia on older Australians is not widely known or acknowledged and it is something that requires much greater community attention - especially if the proposed Bill becomes law. We also refer the Committee to the RANZCP's media statement on this important issue.

REFERENCES

[1] Stewart, C, Peisah, C and Draper, B (2011) A test for mental capacity to request assisted suicide *Journal of Medical Ethics* 37: 34-39.
[2] Australian Bureau of Statistics (2012) 3303.0 - Causes of Death, Australia. Available at: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2012~Main%20Features~Age~10010 (accessed 7 August 2014).
[3] McKay, Dr Roderick (2014) Shrouds of silence Australian Ageing Agenda. Available at: http://www.australianageingagenda.com.au/2014/07/24/stigmas-shrouded-silence/ (accessed 7 August 2014).