College of Psychiatrists of Ireland

Wisdom • Learning • Compassion

Physician Assisted Suicide and Euthanasia

Position Paper

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Contents

EXECUTIVE SUMMARY 3
INTRODUCTION 4
DEFINITIONS 4
IRISH CONTEXT 4
ETHICAL CONSIDERATIONS 5
- DIGNITY 5
- AUTONOMY 5
- COMPASSION 5
- PAS-E IN CHILDREN AND ADOLESCENTS 5

EXPANSION OF CRITERIA FOR PAS-E 6
ISSUES WITH CRITERIA FOR PAS-E 6
- UNBEARABLE SUFFERING 6
- TERMINAL ILLNESS 6
- DISABILITY 6

RELEVANCE OF PAS-E FOR PSYCHIATRY 7
- PSYCHIATRIC ASPECTS OF TERMINAL ILLNESS 7
- ASSESSMENT OF CAPACITY AND VOLUNTARINESS 7
- "CLEAR AND SETTLED INTENTION" 8
- EUTHANASIA AND SUICIDE 8
- PSYCHOLOGICAL SUFFERING AND PALLIATIVE CARE 9
- CONSCIENTIOUS OBJECTION 9
- EFFECTS ON THE THERAPEUTIC RELATIONSHIP 9

RECOMMENDATIONS 10
- DEVELOPING ADEQUATE END OF LIFE CARE 10
- PROTECTION OF THE VULNERABLE PATIENT AND EASING CARE-GIVER BURDEN 10
- ENHANCED PSYCHIATRIC CARE FOR THE TERMINALLY ILL 10

CONCLUSION 10
REFERENCES 11

Executive Summary

1. The College of Psychiatrists of Ireland believes that the introduction of physician-assisted suicide and euthanasia represents a radical change in a long-standing tradition of medical practice, as exemplified in the prohibition of deliberate killing in the Irish Medical Council ethics guidelines. We believe it will place vulnerable people at risk, and will lead to harmful consequences, such as an increase in the numbers requesting euthanasia or assisted suicide.

2. A dignified death is the goal of all end-of-life care. This is possible with good palliative care. Not only is euthanasia not necessary for a dignified death, but techniques used to bring about death can themselves result in considerable and protracted suffering.

3. Where physician-assisted suicide and euthanasia are available, many requests stem not from intractable pain, but from such causes as fear, depression, loneliness and the wish not to burden carers. Adequate resources including psychiatric care, psychological care, palliative medicine, pain services and social supports are needed for good end-of-life care.

4. Even when safeguards are introduced to ensure that the choice for induced death is made with clear knowledge and full consent, intentions regarding induced death can often fluctuate over short periods.

5. Perceived pressures in favour of induced death can be subtle. These cannot be excluded by tests of mental capacity, such as those used in psychiatric practice.

6. Once permitted, experience has shown that more and more people die from physician-assisted suicide. This is usually the result of progressively broadening criteria through legal challenges, because if a right to physician-assisted suicide is conceded, there is no logical reason to restrict this to those with a “terminal illness”.

7. Doctors should not be coerced to act against their values in the provision of euthanasia or assisted suicide.

8. Physician-assisted suicide and euthanasia are contrary to the efforts of psychiatrists, other mental health staff and the public to prevent deaths by suicide.

9. Some states permitting physician-assisted suicide or euthanasia recommend psychiatric assessments. This can create a conflict for a treating psychiatrist and an interference in the therapeutic relationship.

10. The use of law to address complex ethical issues is problematic and can have unintended consequences.

11. The College of Psychiatrists believes that with adequate resources, including early and equitable access to palliative medicine, social supports, pain services, psychiatric care and psychological care that good end-of-life care is possible without having to introduce physician-assisted suicide and euthanasia. We believe that Irish society can demonstrate leadership in this as a liberal and compassionate society in working together to achieve this.

Introduction

In Ireland, as in many other countries, the question has arisen as to whether doctors may become involved in ending patients' lives, either directly (euthanasia) or indirectly (physician-assisted suicide). A related question is whether the law should ever compel them to do so. There are medical, psychological and social implications to the direct and indirect ending of the lives of seriously ill and vulnerable people. Allowing doctors to assist in the suicide of their patients represents a fundamental and irreversible shift in medicine’s philosophy and practice. Acknowledging the psychological distress often associated with the end of life, and because of the unintended consequences of permitting physician-assisted suicide and euthanasia, the College of Psychiatrists of Ireland (CPsychI), as the representative professional body of psychiatrists in Ireland, has produced this position paper.

The CPsychI believes that the practice of physician-assisted suicide and euthanasia (PAS-E) is not good medical care and therefore the CPsychI is opposed to the provision of PAS-E.

Definitions

The terminology used in this position statement is based on psychiatric and medical literature.

Suicide is defined as death resulting from an intentional, self-inflicted act[1].
Euthanasia is the act of deliberately ending a life to relieve suffering[2].
Physician-Assisted Suicide is the act of helping a patient to die by suicide by giving them the means to do so[3].

Some speak of an equivalence between euthanasia and withdrawing treatment (“active” and “passive” euthanasia), but whereas there is general acceptance of an obligation to refrain from killing a patient, there is not a similar obligation to try (or to continue to try) to prevent every patient from dying[4].

Irish context

Euthanasia is illegal in Ireland, and the Irish Medical Council forbids participation in the deliberate killing of a patient[5]. Other jurisdictions have moved to permit euthanasia in one form or other, with some more restricted and others very broad. Euthanasia has increasingly become the subject of debate in Ireland, both within the medical profession and in the wider community. This has culminated in an Oireachtas Report in 2018[6], followed by a Private Member’s bill in 2020[7] which did not proceed.

Ethical Considerations

Dignity

The CPsychI recognises that each human being enjoys an equal and in-eliminable dignity, a dignity that is intrinsic, not contingent or attributed, and is not lost or diminished by illness or disability. As this dignity is inviolable, it is never lost, even if one finds oneself in undignified circumstances. It is precisely because of our intrinsic dignity that it is wrong for others to leave us in undignified circumstances. No circumstance can deprive patients of their inherent dignity or worth, a dignity all human beings share equally whether healthy or sick, able-bodied or disabled, competent or incompetent. The inviolability of human life, however, does not entail the preservation of life at all costs; it rather means that human life should not intentionally be shortened. In so far as our society makes strenuous efforts to prevent suicide, acceptance of PAS-E implies acceptance of the notion that some lives are not worth living; this is implicitly discriminatory.

In view of the frequency with which human dignity is cited as a justification for PAS-E, it is important to point out that medical euthanasia is frequently not a peaceful process; there are reports of prolongation of death (up to 7 days), and re-awakening from coma (up to 4%). This raises a concern that some deaths may be inhumane[8].

Autonomy

Although euthanasia is advocated on the principle of autonomy, the principle of autonomy is not a self-evident, absolute, stand-alone truth; our behaviour influences others and can harm the more vulnerable. Whereas a person with capacity can decline an intervention, one cannot demand an intervention that is not appropriate or would interfere with the rights of others (social justice).

Compassion

Compassion is a core value of the College of Psychiatrists of Ireland and has always been a characteristic of good medical care. It entails the recognition of suffering, an attitude of benevolence, a feeling of being personally addressed, and an inclination to relieve suffering[9]. Consistent with their dignity, a compassionate doctor tries to meet the needs and concerns of patients who may be approaching the end of their life. In the matter of PAS-E, however, a simplistic reliance on compassion is doubly problematic: first, if compassion is the yardstick then no restriction (such as terminal illness or competence) makes sense; second, sympathetic feeling may lead one person to respond in one way to a request for PAS-E, and another person to respond equally sympathetically in an opposite way. In this sense, compassion is something of a blind guide.

PAS-E in children and adolescents

In Belgium, the 2002 law, which originally allowed for euthanasia in the case of "competent minors", was amended to allow it in the case of all children with "constant and unbearable suffering"[14]. In the Netherlands in 2005, doctors published guidelines for providing euthanasia to severely disabled newborns[15]. As a result of a court decision, euthanasia of children is now permitted in Colombia[16].

Expansion of Criteria for PAS-E

Even with an intention to introduce euthanasia under very restricted safeguards, there are serious grounds for fearing that the practice would inevitably become more widespread. Two issues are at stake here. On the one hand, there is the "slippery slope" argument, according to which, even if a line can in principle be drawn between PAS-E for terminal and non-terminal illness, an expansion of criteria will occur in practice because the safeguards to prevent it cannot be made effective. There is good international evidence by now that euthanasia safeguards and controls are regularly flouted[17]. Where euthanasia or assisted suicide have been legalised in a country, the number of people dying in this way has increased by approximately 500%[18–23]**.** Secondly, there is a logical inconsistency between allowing PAS-E for suffering in one setting and denying it for such suffering in others, an inconsistency which could (and probably should) be unmasked as discriminatory on constitutional appeal. Indeed, once the killing by one person at the request of another is legalised, there are no logical grounds for "medicalising" the process at all[24]. Thus, the grounds for euthanasia in the Netherlands are shifting from relief of suffering to autonomous patient choice[25].

Issues with Criteria for PAS-E

Unbearable Suffering

The notion of "unbearable suffering", in illnesses of any kind, presents difficulties as a criterion for ending life. Often unbearable suffering is very long-lasting, sometimes extending back to an early age, and is associated with a gradual worsening of the experience. It can be accompanied by the perception that there is no prospect of improvement, and that the experience exceeds the patient's capacity to cope[26]. These features are either tautological (an experience exceeding the patient's capacity to cope) or shared with bearable suffering. The extent to which suffering is unbearable can only be determined from the perspective of the patient themselves and may depend on their physical and mental strength and personality, about which considerable disagreement may arise. It may also depend on availability and one's ability to access local services.

Terminal illness

Efforts to permit euthanasia only within certain highly restricted conditions often stipulate that the patient must be suffering from a "terminal illness". This is commonly understood as an incurable and progressive disease which cannot be reversed by treatment, such that the person is likely to die as a result of that illness or complications. Some jurisdictions specify the timeframe in which death is expected to occur. In reality, this could include a vast range of long-term conditions including diabetes, heart failure, depression, dementia and schizophrenia. Even in the case of terminal cancer, clinical estimations of survival times are not exact[10]. Such chronic illnesses, though not curable, can often be managed to make for a good quality of life.

Disability

Sometimes advocacy of a "right to die" is accompanied with a wish that any law permitting euthanasia or assisted suicide should have "strict safeguards" to prevent "abuse of the law". These supposed safeguards in effect prescribe who is to be considered "right to want to die", thus qualifying for euthanasia. People with disabling or degenerative conditions, or with terminal illnesses fall into this category. Others, who may be equally suicidal but have no obvious illness or disability, are considered

"wrong to want to die" and are helped to live. As part of our national mental health strategy "Connecting for Life" and our National Clinical Care Programme for Self-Harm in the emergency department, the Irish health service provides suicide prevention strategies and teams to help those who are suicidal to survive. The phrase "death with dignity" is very often used to mean the deliberately procured death of an ill or disabled person, and strongly implies that vulnerable people are "dignified" only in death[27].

Relevance of PAS-E for psychiatry

Attempts to restrict euthanasia to those suffering from "physical" illnesses would seem to exclude those with "psychological" suffering who are not suffering from a life-limiting condition, but this distinction is problematic. In several countries where PAS-E is legal, mental disorders are included in the criteria for access[11]. PAS-E was legalised in Canada in 2016. Thereafter, as a result of an amendment introduced in 2021, in order that those with psychiatric illness not suffer discrimination vis-á-vis other medical patients, those with mental illness will be eligible for PAS-E in 2023[12,13]. Psychiatric illness in the absence of medical illness may itself present with the conviction that life is not worth living, a death wish or suicidal ideation. Certain jurisdictions permit PAS-E for personality disorders and other psychiatric conditions[11].

Even in jurisdictions in which mental health disorders are specifically excluded as grounds for euthanasia, there are many implications for psychiatrists and their patients. Indeed, many jurisdictions permitting euthanasia recommend or require the involvement of a psychiatrist[28].

Psychiatric aspects of terminal illness

The most basic challenge at the end of life, which causes distress to both patients and their families, is fear: fear of loss, fear of pain and fear of the unknown. This can vary according to the nature of the illness, the person's prior state of mind, and the ability of the family and others to provide care and support. Psychiatric problems and issues commonly seen at the end of life include anxiety, depressive symptoms and depressive disorders, delirium, suicidal ideation, coping mechanisms for extreme stress, questions of capacity to make informed decisions, grief and bereavement, and general and health-related quality of life.

Psychiatric morbidity in the setting of terminal illness is exceptionally high[30]. The prevalence of depression among terminally ill patients with a desire for death is eight times higher than in those without a significant desire for death, and depression is the strongest determinant of suicidal ideation and desire for death in those with serious or terminal illness. We believe that high quality care for the psychiatric complications of terminal illness is and should be an integral component of excellent, comprehensive end-of-life care[8].

Assessment of capacity and voluntariness

The need to ensure that people are not put to death against their will through euthanasia inevitably raises questions regarding the assessment of mental capacity and freedom from coercion. Although all medical interventions to some degree involve an assessment of the ability of a patient to consent freely to treatment, most jurisdictions permitting euthanasia require or recommend formal assessments of capacity, but frequently fail to specify who shall assess capacity or what expertise they will have in doing so. In a general hospital setting, the assessment of capacity is usually performed by

the patient's primary physician, and a second opinion is often sought from a consultant geriatrician or a consultant psychiatrist. Mental disorders can impinge on capacity, yet this possibility and how to deal with it are rarely considered. In recent decades psychiatrists have tended to use a "four abilities" model[31] - namely the ability to express a choice about treatment, the ability to understand information relevant to the treatment decision, the ability to appreciate the significance of that treatment information for one's own situation and the ability to reason with relevant information so as to engage in a logical process of weighing treatment options. This values-free, cognitive approach is reliable in many treatment settings[32]; however, decision-making capacity can vary greatly according to personal context[33], and such a cognitive-capacity approach misses the complexity of the decision process in real life (values, emotions and other biographic and context specific aspects)[34]. It is therefore suggested that it misses the complexity of the decision process in real life. Few, if any, jurisdictions permitting euthanasia have a mechanism for managing disagreement regarding mental capacity, i.e. if one doctor thinks the person has capacity and another does not, it is not clear if a third doctor is required, or even a fourth. Nor is it clear who will be the ultimate arbiter. A person who, because of mental or physical illness, lacks understanding of their request for euthanasia could attend doctor after doctor until they eventually find one willing to endorse their application. This absence of safeguards in the assessment of capacity prior to euthanasia is often in stark contrast to the constraints in providing involuntary treatment under mental health legislation[35], which specifies who can carry out assessments, how long opinions are valid for, and review mechanisms and intervals.

"Clear and settled intention"

Efforts to prevent ill-considered or capricious requests for euthanasia often stipulate that the person has a "clear and settled intention". Yet this is impossible to define as people can change their minds on an issue at any point. For example, people who are suicidal can often express a "clear and settled" intention regarding their death, yet this can be a symptom of a treatable psychiatric illness. The process of adjustment in the face of serious illness requires a gradual transition through a range of emotions as part of the necessary adaptation to the challenges. Such emotions may range from shock and denial to anger and despair, intermingled with hope, acceptance, courage and serenity, often changing rapidly. The desire to hasten death for patients with terminal illness is strongly influenced by psychosocial and existential issues, and more clearly linked to depression, loss of hope and the fear of being a burden than it is to severity of physical discomfort[36]***.*** Even in the absence of mental illness, it has been shown that many patients with life-limiting conditions who choose euthanasia change their minds within even a few months[37].

Euthanasia and suicide

When there was less experience of euthanasia, it was claimed that its legalisation would lead to lower suicide rates[38]. The "social contagion" effect of suicide is well recognised in suicidology, and there is every reason to believe that legalising PAS-E normalises suicide and hence leads to higher overall suicide rates[39]. The practice of euthanasia undermines the suicide prevention ethos and policies of developed nations, including that of the Irish Government through its National Office for Suicide Prevention[40]. Suicide prevention initiatives play an important public safety role in providing and indicating the importance of appropriate social and legal protections to those who are psychologically vulnerable from pressures to kill themselves both within and without. Through both these means it is an expression of the Irish State's obligation under Article 2 of the European Convention on Human Rights (the 'right to life') to take positive steps to safeguard human life[41]. At a time where there is public concern regarding mental health and suicide to a greater degree than ever before, the

introduction of PAS-E undermines the valuable work done in addressing the causes of suicidality. In the face of claims that physician-assisted suicide and euthanasia are not "suicide", there is evidence in the academic literature that such induced deaths have a specific contagion effect, following the introduction of medically-induced death of whatever sort[18].

The emphasis on personal autonomy creates a climate where concerned others feel they should take a step back, and that they are interfering in another person's "right to die". Suicide is very often an act of despair or a symptom of a treatable mental illness, and intervention to relieve such suffering is standard practice, the understanding being that suicide is never a solution. It is unclear why this should be different in people with terminal illness. Indeed, it might be interpreted as discriminating against this group, in its suggestion that we are not obliged to prevent their death by suicide by treating any illness and alleviating their distress.

Psychological suffering and palliative care

Psychiatric complications at the end of life are treatable, but often go unrecognized and untreated. There are many reasons for this: difficulty in diagnosing and treating psychiatric disorders (e.g., anxiety, delirium, depression) in the setting of significant physical illness, owing to the overlap in the symptoms caused by the psychiatric disorder and the co-morbid physical problems; beliefs held by many patients, family members, physicians and hospice and palliative care providers whereby psychiatric symptoms, especially depression, are viewed as normal parts of the dying process; and the fact that many patients and physicians do not understand that patients who suffer from mental disorders at the end of life can respond to treatment. This therapeutic nihilism inhibits the search for treatable mental disorders at the end of life.

Conscientious objection

There is a moral equivalence in performing an action (be it for benefit or for harm) and having someone else perform it. Requiring doctors to refer patients to other practitioners for the purpose of assisted suicide would likely be felt by someone with strong views on the ethics of this process as collusion, as morally equivalent to performing the action themselves, and as ethically unacceptable. Some regard the refusal of doctors to cooperate in euthanasia as an outmoded medical paternalism, and see PAS-E as an extension of patient-centred care and a humane response to suffering[42,43]. Nobody can be compelled to act against their ethical values, and there is a universal recognition of the need to prevent deaths by suicide.

Effects on the therapeutic relationship

For psychiatrists, the possibility of a request for assisted death can complicate the therapeutic relationship and make psychiatric treatment problematic. Psychiatrists' primary role will always be to identify and treat mental illness and to try to reduce suffering, but the therapeutic relationship can be jeopardised if the doctor is seen as not complying with a request for euthanasia or assisted suicide. It is not surprising, therefore, that in countries where PAS-E is legal, while the number of people with psychiatric disorders who request euthanasia has increased, psychiatrists have become less happy with the practice[47].

Recommendations

The College of Psychiatrists of Ireland believes that PAS-E is not good medical practice and represents a detrimental and radical change in the practice of medicine and recommends that it not be introduced.

Developing adequate end of life care

Palliative care services in Ireland are well-developed according to a 2015 international comparison survey[48]. However, coverage can still be uneven and there is need for further investment in hospice buildings and palliative care staff and resources.

Protection of the vulnerable patient and easing care-giver burden

Feeling that one is a burden on families and other informal carers is also a reason given by patients for choosing euthanasia, and it may be that greater attention to the contribution made by those with serious illness, and patients' supportive roles in family, is required to counterbalance the already strong focus on family caregiver burden[49]. Evidence shows improvements in caregiver burden–associated symptoms (e.g., mood, coping, self-efficacy), even when caregiver burden itself was minimally improved[50].

Enhanced psychiatric care for the terminally ill

Enthusiasm for legalised PAS-E may at least partly reflect public concern that suffering (including suffering due to psychiatric causes) and distress at the end of life may elude or exceed our best current treatment efforts, making death seem preferable. Appropriate treatment for psychiatric complications of terminal illness is the best way to address this fear and should reduce requests for PAS-E. Integrated end-of-life care depends on a well-developed mental health service, and there is considerable need for more psychiatrists and more mental health teams. In a well-developed health service psychiatrists and psychologists would provide consultation and liaison services to palliative care units, hospices and teams[51]. In keeping with national and international experts in palliative care we believe that euthanasia is not necessary for a dignified death and on the contrary may diminish personal dignity

Conclusion

We believe that the introduction of PAS-E represents a fundamental and harmful reversal in medical care. It runs counter to the efforts of society in general, and psychiatrists in particular, to prevent deaths through suicide. In keeping with national and international experts in palliative medicine we are convinced that euthanasia is not necessary for a dignified death, and that, on the contrary, it diminishes personal dignity. The introduction of PAS-E is associated with a broadening of criteria and an increased number of deaths by suicide. Perhaps because regulations are difficult to enforce and because legalisation results in a cultural shift, the numbers dying from PAS-E inevitably increase within a few years of its introduction. Euthanasia creates the risk that many people will die from treatable psychological distress and mental illness.

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