Physician-assisted dying legislation seems inevitable. We all need to try to make it as safe as possible.

The Australian Senate is currently reviewing a piece of proposed legislation that would, if passed, make it possible for a doctor to administer drugs to end the life of a terminally ill patient at a time of their choosing.* Numerous surveys have demonstrated that around 85% of Australians are in favour of legalising physician-assisted dying, and for this reason similar legislation has gone before the parliaments of most Australian states.

Although no Bill has yet been passed, some have only failed by two or three votes. Back in 1995 the Northern Territory briefly introduced a law that allowed physician-assisted dying, but because the Northern Territory is not a state, the Commonwealth Government had the power to overturn its legislation and it did after a few months.

Overseas doctors are now allowed to assist patients to die in many places including The Netherlands, Belgium, Switzerland, four states in the USA and the Canadian province of Quebec. In England, a law to allow assisted dying is being debated in the House of Lords.

It now seems inevitable that at some point an Australian parliament will again legalise physician-assisted dying. While people still focus a great deal of effort on whether or not physician-assisted dying should be legalised, in my view a much more interesting question is about how it should be legalised. What safeguards should be put in place to protect people who might be wrongly killed? Even if you are implacably opposed to physician-assisted dying, perhaps on religious grounds, you should still be interested in this question.

Here I am going to argue that people should not be offered physician-assisted dying without first seeing a psychiatrist. I am going to suggest that this is a safeguard that will protect people who appear to be asking for an early death but who are only doing so because they are depressed or confused.
The issue is very much alive because not all the pieces of legislation I listed above mandate a psychiatric review. The Northern Territory legislation did, and so does the Bill currently before the Senate, but the Bill before the House of Lords does not.

All physician-assisted dying legislation already demands that two doctors must see a terminally ill person who wants to access an early death. If the person also had to see a psychiatrist, that would make three medical consultations.

In rural areas psychiatrists might not be readily available, and requiring a psychiatric review might slow the process down by a day or two. Even in areas where psychiatrists are easily accessed, a third review is another impost on a person who is already suffering so much that they apparently want to end their life.

Why then, do I think this is a good idea? Surely, if I am in favour of physician-assisted dying legislation – and I am – then people should be allowed to access assistance to die with as little impost as possible?

It turns out that knowing when people are making a valid choice is often not as easy as one would imagine. Certain psychiatric illnesses, particularly severe depression and delirium, interfere with a person’s ability to make choices, and these illnesses are very common in people with terminal illnesses.

Delirium is a condition where, because of a person’s physical illness, his or her brain begins to malfunction. You often see this depicted in movies where a character has pneumonia, say, and he is pictured lying writhing in bed, hallucinating and mumbling to himself. In these cases the infection in the lung is disrupting the neuronal connections in the brain and that is what is causing the confusion.

In the movies, of course, the person’s delirium is obvious; but in real life delirium can be quite difficult to detect. Any severe medical condition can cause relatively minor disruptions to brain function and people can become quite subtly confused. We know that doctors who lack psychiatric training frequently overlook these subtle cases of delirium because superficially the person seems to be able to think and talk normally. Psychiatrists, though, are specially trained to detect even mild cases of delirium, and sometimes even these mild cases will prevent a person from being able to understand all the information being put to them. We don’t want people to opt for an early death because they didn’t properly understand all the options they were given, so it is vital that a psychiatric review makes certain that this is not happening.

There is a similar risk with severe depression. Most people with a terminal illness will be understandably sad or upset at various times as a result of their illness. That is a normal part of being human, and psychiatrists can do no more than provide support to those people in the same way that anyone would.
However, some people with a terminal illness will develop a severe medical depression. This is not normal understandable sadness, but a medical illness affecting those parts of the brain that control our emotions. People who are afflicted with medical depression often lose the ability to weigh up their options. Because of the depression, everything looks bleak and they are literally unable to see any hope at all for the future. Just as we don’t want people to be asking for assistance to die when they don’t understand their options, we don’t want them asking for it because they can’t weigh up those options, and severe medical depressions can have that effect.

It is not always easy to tell the difference between a terminally ill person who is understandably upset by their dire circumstances and one who is suffering a medical depression. Again, though, psychiatrists are experts in this and better placed to do it than ordinary doctors. They can also offer treatments that will make the medical depression better, even though when recovered from the depression the person might still be upset because of their terminal illness.

Delirium and medical depression are both common in people with terminal illness. Both can be effectively treated, but both can be hard to detect and are frequently missed by non-psychiatrically trained doctors. Importantly, when we are trying to protect people who might appear to be requesting physician-assisted dying, both delirium and depression may interfere with a person’s ability to make a valid choice, either by preventing a person from understanding the information they are given, or by interfering with their ability to weigh up that information to make a choice.

Making a terminally ill person see a third doctor – a psychiatrist – in order to access a desired peaceful death is an impost, but if we are serious about protecting people it is a burden worth imposing.

Currently, of course, some terminally ill people are already assisted to die by their doctors, but these deaths occur in secret and without any safeguards at all. Rogue doctors like Philip Nitschke make headlines when they facilitate access to lethal drugs, but no one checks if those seeking death are actually making those choices or if they only appear to be.

While people opposed to physician-assisted dying legislation worry that it will lead to more people dying, evidence from overseas suggests that when physician-assisted dying is legalised very few people actually make use of it. If, though, that legislation is properly constructed, including a mandatory psychiatric review, we can be fairly confident that it is only going to be used by people making a genuine choice to die.

* The Medical Services (Dying with Dignity) Bill 2014 (Cwth) – Exposure Draft is available at http://richard-dinatale.greensmps.org.au/sites/default/files/dying_with...