

Commentary on “Decision-Making Capacity to Consent to Medical Assistance in Dying for Persons with Mental Disorders”

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Commentary in Response to: “Decision-Making Capacity to Consent to Medical Assistance in Dying for Persons with Mental Disorders” by Charland, Lemmens, & Wada

Charland, Lemmens, and Wada¹ make the interesting suggestion that bioethicists should be open about their ethical conflicts of interest when involved in the medical assistance in dying debate. There is something to be said for this given the vexed history of argument about suicide in philosophy (Hume famously defended the ethics of suicide; Kant considered suicide inherently unethical). Yet, in their essay on the current policy situation in Canada there is no self-application of the suggestion. This is a pity as my hunch is that thinking through how individual differences and interests relate to ethical positions on autonomy may help the debate on medical assistance in dying.

So with this in mind here is my conflict of ethical interest statement. I am a UK academic psychiatrist who has worked for some years on decision-making capacity (DMC) in mental health settings. Like many doctors I tend to the view that self-killing is not necessarily irrational or unethical but that we have not found reliable ways to legislate for the medical profession’s involvement². I cannot see a humane or honest way to simply exclude people with mental disorder from the question of medical assistance with dying because the prevalence of mental disorder at end of life (e.g. depression) is so high and there is often unclear demarcation between so called mental disorder and physical disorder (dementia being the classic example) and between physical and psychological suffering. But I also think that if mental disorder is not considered to pose unique challenges there is a danger of societies drifting into wishful thinking and neglect in the application of autonomy to healthcare. I believe it is a good idea that rights (including those relating to personal autonomy) are written down and binding upon states (in the UK we have the Human Rights Act 2005). But I also hold the view that democracies are entitled to assert the sovereignty of parliament. In the UK our supreme court has recently suggested that the UK’s commitments under the Human Rights Act are in conflict with its laws prohibiting assistance with suicide and that parliament should revisit the law³. Yet, despite this, the UK parliament, asserting its sovereignty, has rejected a physician

assisted suicide bill⁴. I think we have to accept this rejection not just as a political fact but also as a here and now social-ethical decision in the UK. I am content with that decision - for now - but the policy debate will not just go away and I believe the research base informing it needs to strengthen.

So with that statement made, let me make a few comments on Charland, Lemmens, and Wada’s interesting essay. I will not comment on the discussion of the Canadian political context as, being UK based, I do not have a good feel for it.

One comment concerns accuracy. The authors refer to the Mini Mental State Examination (MMSE) as an early global mental capacity test. That is not correct. The MMSE is a bedside clinical test aimed at screening for cognitive impairments secondary to neuropsychiatric disorders and providing a simple means to track them over time. Its norms were developed entirely separately from law and ethics and the ‘cognitive impairment’ it measures is not the ‘cognitive ability’ which the authors assert is at the heart of the legal test of mental capacity. They are different tests with different histories and aims – one clinical and one legal. Of course they can be correlated and doing this, particularly in medical settings, is informative. But the difference between clinical concepts of cognitive impairment and legal tests of mental capacity need to be held clearly in mind. Legal concepts of mental capacity do not reduce to clinical concepts of cognitive impairment and vice versa.

The authors draw attention to the topic of emotion, or affectivity, in assessments of DMC. I agree with the authors that this represents an important area of research in the still young interdisciplinary field of DMC. And the points the authors make about not placing practical weight on a concept not able to bear that weight are apposite. But in stressing the importance of emotion, I think the authors are getting a bit out of balance. Law does recognise the role of emotion on DMC with case law containing many examples (anorexia, depression, needle phobia, emotionally unstable personality disorder all contribute to the common law of DMC). So it is not true to say that law treats persons solely as ‘cognizers’ and not ‘emoters’ in relation to DMC. That said, the authors, in drawing attention to a ‘cognitive bias’ in DMC law, do highlight an important issue. The decision-making abilities law

recognises which may be compromised by disorders of emotion and evaluation (e.g. the appreciation ability, or, in the UK, the ‘use or weigh’ ability) are less elaborated and specified than the abilities compromised by disorders of cognition (e.g. the understanding ability). But work to specify them is being made. One research study models the effect depressed mood has on the abilities to project oneself into a future (abilities necessary to appreciate, or use, information relating to one’s future)⁵. In depth clinical data, used in the analysis, suggests that in mild depression these abilities remain but in severe depression, for some decisions at least, they can be absent. So as research into DMC develops, law may be able to place more practical weight upon the construct of DMC even in settings where emotion and evaluation are at issue.

Finally, in assessing requests for medical assistance for dying in people with emotional problems the issue of DMC needs to be put in perspective. Most of the legal and ethical work will fall in the area of vulnerability not DMC. Commonly, there are complex interplays of milder mood disorders, reactions to stress and pre-existing personality traits impacting upon decision making such that it does not achieve its full potential. Here the relevant ethical, legal, and clinical questions will be about how the decision making over dying can and should be *supported* rather than whether DMC is present or not. DMC may be present but suboptimal or absent only in so far as reasonable accommodation or ‘scaffolding’ has not been provided.

Supported decision making is at a very nascent stage of development in applied mental health law and ethics and in relation to requests for medical assistance in dying it raises complex problems. Does the doctor have a duty to support the patient to decide a happy or good death (happy or good death being, of course, the original meaning of ‘euthanasia’)? If so what is the doctor to do if the patient requests, what the doctor believes to be, a bad or unhappy death? Or does a doctor have a duty to help the patient make their own ‘true’ choice independent of a value perception of a happy or good death (the more modern ethics of autonomy)? If so how is that duty to be reasonably discharged? How much supported decision making is enough? In my view the questions concerning supported decision making need to be at the front of debate on consent to medical assistance in dying rather than the questions concerning DMC. Issues surrounding vulnerability and supported decision making will be much more prevalent than issues surrounding DMC in requests for medical assistance in dying. And in the area of supported decision making in mental health we have an even weaker research base. Policy makers need to bear this in mind.

References

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