Physician assisted suicide (PAS) continues to be widely debated in Australia and New Zealand. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has developed this position statement to inform psychiatrists, other medical professionals and the wider community in the context of the current Australian and New Zealand legal environments. This document may also serve to assist doctors whose patients wish to discuss PAS with them.

The RANZCP considers that the primary role of medical practitioners in end of life care is to facilitate the provision of good quality patient-centred care. Nothing in this position statement should be taken as explicit or implied support of the legalisation of PAS by the RANZCP.

Background

The RANZCP notes that there is considerable debate about the use of terminology in the euthanasia context. The terminology used by the RANZCP in this position statement is based on the psychiatric and medical literature.

The focus of this position statement is physician assisted suicide (PAS), which is sometimes also called ‘physician assisted dying’, ‘physician assisted death’ or ‘physician aided dying’. PAS refers to situations where doctors prescribe, but do not administer, lethal substances to informed patients who have a terminal illness or a grievous and irremediable medical condition and have the legal capacity to decide that they may end their own lives at a time of their own choosing. By contrast, ‘euthanasia’ refers to the act of deliberately ending another person’s life at his or her request. If a doctor prescribes or supplies the drug at the patient’s request, this constitutes ‘PAS’ whereas if a doctor administers a drug to bring about a patient’s death at the patient’s explicit request, this constitutes ‘euthanasia’ (Naudts et al., 2006).

The issue of capacity is a critical consideration on the debate on PAS. Generally, in Australia and New Zealand, all adults are presumed to have decision making capacity but that can be rebutted if it can be shown, for instance, that the person is either unable to understand and retain the information relevant to the decision or to understand the consequences of the decision. The capacity test is not diagnosis-specific but rather focuses on a person’s ability to make the decision at hand in the situation (Stewart et al., 2011).

RANZCP members should note that legalising any activity does not make it ethically correct. The Australian Medical Association, New Zealand Medical Association and World Medical Association consider that doctors’ involvement in euthanasia to be inappropriate and unethical (AMA 2014; NZMA 2009; WMA 2013). This position statement is not intended to bring any resolution to the ethical debate.

Although PAS is currently illegal in Australia and New Zealand, the RANZCP notes that some patients may request PAS of their doctors. There are also anecdotal reports of patients requesting assessment of their capacity by psychiatrists in Australia and New Zealand in order to facilitate PAS in another country.

Public opinion is divided over PAS and euthanasia in Australia and New Zealand. Recent surveys suggest that around 85% of Australians and 70% of New Zealanders support the legalisation of some kind of medically assisted dying (Gendall, 2010; Robotham, 2011).
PAS legislation

PAS (and euthanasia) was legalised in Australia’s Northern Territory in 1995 by the Rights of the Terminally Ill Act. In 1997, the Northern Territory legislation was quashed by the Federal Parliament, using its power to overturn Territorial (as opposed to State) laws.

Currently, the provision of PAS is a criminal offence in all Australian jurisdictions and New Zealand. A 2015 New Zealand case – Seales v Attorney-General [2015] NZHC 1239 – confirmed that only Parliament could change the law to legalise PAS.

In recent years, both Australia and New Zealand have debated the issue of PAS. Recent examples of legislation that have been introduced into parliament include Medical Services (Dying with Dignity) Bill 2014 (Australia) and the End of Life Choice Bill 2015 (New Zealand).

The RANZCP notes that PAS or, in some cases, euthanasia has been legalised in some overseas jurisdictions. These include some European countries and some states of the United States of America.

PAS and role of psychiatrists

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. Palliative care should strive to achieve the best quality of life during the final stages of patients’ illnesses and allow patients to die with dignity. This should be adequately resourced and widely available.

Psychiatrists have specific skills and expertise to identify psychiatric illnesses and to assess suicidal ideation in patients, including the terminally ill. A person’s capacity to make decisions may be affected by both mental and physical illness, including a treatable psychiatric condition.

Psychiatrists may have a role with patients who are considering or wish to discuss PAS through the identification and treatment of mental illness and, when appropriate, making recommendations for patients’ mental health treatment and care.

To help inform the PAS debate, the RANZCP believes that the following issues should be considered in the Australian and New Zealand context:

- **The rights of people with mental illness** – The RANZCP does not believe that psychiatric illness should ever be the basis for PAS. The RANZCP also considers that unreliable psychiatric suffering is rare and that ensuring that a person with mental illness has capacity in the PAS context may pose significant challenges.

- **The rights of older people, including people with dementia** – There is growing evidence to suggest that people who develop dementia under the age of 70 are at increased risk of suicide, especially if there are symptoms of depression and anxiety, meaning that they might, in some circumstances, consider PAS. The RANZCP strongly supports good quality assessment, care and support mechanisms for people with dementia.

- **Misconceptions about older people, PAS and suicide** – Figures show that Australia’s oldest citizens, those aged 80 and above, are the age group most likely to die by suicide (ABS, 2012). This has led to a misconception that suicide in older people is largely driven by suffering associated with chronic, debilitating or terminal illness (McKay, 2014) whereas the aetiology factors of suicide are complex and multifactorial. The RANZCP is concerned about the potential impact of the debate about euthanasia on older persons (Hooper et al., 1997) and considers that suicide prevention programs must be extended to, and target, older persons.

- **The right of medical practitioners to choose whether or not they wish to be involved in a PAS situation and the extent of their involvement, if any** – While psychiatrists see the psychiatric assessment and treatment of patients who are considering suicide as a core part of their role, psychiatrists may not wish to take on a ‘gatekeeper role’ in a potential PAS scenario.
Research shows that while some 64% of British psychiatrists agree that psychiatric assessments are important in the PAS context, only 35% would be willing to carry out such assessments (Shah et al., 1998).

**Recommendations**

- The RANZCP considers that the primary role of medical practitioners in end of life care is to facilitate the provision of good quality, comprehensive and accessible patient-centred care.
- The need for psychiatric assessment and treatment should be considered for patients who request PAS of their doctors.
- RANZCP members should note that currently PAS is illegal in Australia and New Zealand.
- The RANZCP recommends that psychiatrists in Australia and New Zealand carefully consider their position if asked to undertake a capacity assessment of patients who are seeking to obtain PAS in another country.
- By virtue of their expertise about physical and mental illness, psychiatrists can play a crucial role in informing the debate about PAS.

**References**


**Disclaimer**

This information is intended to provide general guide to practitioners, and should not be relied on as a substitute for proper assessment with respect to the merits of each case and the needs of the patient. The RANZCP endeavours to ensure that information is accurate and current at the time of preparation, but takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.

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