

Psychology's Ethics and the End of Life Option Act

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Psychologists are specifically identified in the End of Life Option Act (ELOA; 2015), along with psychiatrists, as the only “mental health specialists” who are given an *evaluative* role in determining a patient’s competence to make a decision to hasten death. Not mentioned in the law is the clinical role that psychologists may fulfill as patients with life-threatening illnesses begin to consider the ELOA as one possibility at the end of life. The APA Ethics Code (EPPCC; APA, 2010) provides some guidance for psychologists who are considering these two different professional roles.

Applying the general ethical principles of beneficence and nonmaleficence, which form the EPPCC Principle A, has concerned health care providers throughout the considerations of legalizing aid in dying. Each provider must decide ethically whether more harm is done to a patient who seeks aid in dying, or to a patient whose death is not hastened and faces possible complications and negative outcomes before dying.

An important difference in terminology is that between *aid in dying* and *suicide*. By law, the decision to hasten one’s death at the end of life is not deemed suicide. “It is important to remember that the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide” (Farberman, 1997). The consideration of hastened death in and of itself does not indicate psychopathology.

The conflict of a single psychologist providing clinical services and forensic evaluations for the same patient is viewed as a multiple relationship (EPPCC Standard 3.05; Greenberg & Shuman, 2007). Psychologists decline to perform an assessment where a multiple relationship would exist. Because a multiple relationship may not always be unavoidable, such as in rural or underserved settings, psychologists must carefully document their thoughtful attention to objectivity, competence, and effectiveness should a multiple relationship be deemed necessary.

Competency (EPPCC Standard 2.01) in providing evaluation or clinical services for patients and families requires unique training. Without specialized training in the medical, psychological, social, and suicide issues in the specific disease, in facilitating conversations that consider options to address end-of-life concerns, including aid in dying, and in conducting capacity evaluations at the end of life, psychologists run the risk of practicing outside their area of competence.

For psychologists providing evaluations of competence, the



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use of standard tests and assessments is questionable (EPPCC Standard 9.02). While a variety of tests and assessments may be used “to differentiate between a diagnosable mental or cognitive disorder, such as clinical depression or dementia, and the effects of illness or treatment” (WSPA, n.d., p. 3), their lack of validity and reliability in use with patients at the end of life may make their best use one of hypothesis generating.

Providers have the legal right to decline to participate in ELOA activities. This does not give psychologists the ethical right to abandon the patient considering this option (EPPCC Standard 10.10). Clinicians declining to participate in the ELOA process may opt to refer patients to other providers. Others may maintain treatment responsibilities for clinical concerns while referring to colleagues for conversations about the ELOA. It is incumbent upon the psychologist to provide appropriate referrals as needed.

It is ethically wise for all psychologists, whether providing clinical or evaluation services, to consult with knowledgeable colleagues when working with the patients, families, and health care personnel who are involved in this intimate decision at the beginning of the end of life (EPPCC Standards 3.07, 3.09, 4.06, 10.04). ■

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