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**Ethical Issues When Working with Terminally-Ill People who Desire to Hasten the
Ends of Their Lives: A Western Perspective**

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Abstract

Terminally-ill people might want to discuss the options they have of hastening their deaths with their psychologists who should therefore know the law that regulates euthanasia in the jurisdictions where they practice. The legal, and therefore ethical, situation that influences psychologists' position and terminally-ill people's options, however, differs notably across jurisdictions. Our aim is to provide a brief moral-legal historical context that explains how the law reform processes in different jurisdictions created these different legal contexts and options that in turn influence psychologists' ethical position. We conclude by considering eight specific ethical issues at a conceptual level that might confront psychologists irrespective of where they practise.

Keywords: assisted-dying; ethics; euthanasia; palliative care; terminal-illness

**Ethical Issues When Working with Terminally-Ill People who Desire to Hasten the
Ends of Their Lives: A Western Perspective**

Psychologists as a collective should serve the needs of all people who reasonably require their services and they should be competent to work with people throughout their life cycle (e.g., American Psychological Association [APA], 2014; Australian Psychology Accreditation Council, 2018). Psychologists should therefore provide services to terminally-ill people (i.e., who have advanced, irreversible incurable diseases) and/or their carers and family members (supporters) who individually and collectively face many difficult emotional, physical and practical challenges during the often slow dying process (Carpenter, 2014). Terminally-ill people, for instance, frequently experience psychological distress that could influence their compliance with treatment and even lead to their earlier death (Christensen & Ehlers, 2002). They frequently suffer pain and losses due to disability as their illness progress (Carpenter, 2014). They could also suffer mental disorders and/or impairments that could be longstanding, or related to their physical illness, or their cause might be difficult to establish (Carpenter, 2014). Cognitive impairment might, for instance, be part of pathological decline and/or the side-effects of medication. Terminally-ill people's interpersonal relationships can also cause them psychological distress. Their physical and mental frailty and relative immobility often make them reliant on support from their wider (e.g., religious) and narrower treatment, carer and family systems (Schroepfer, 2008). Family members' lack of knowledge (APA, 2014) and own emotional suffering (e.g., Sherman, 1998), however, can make it difficult for them to help terminally-ill people and to cope with their own psychological distress. Qualitative researchers further found that terminally-ill people rarely mention their mental health problems to supporters (Courage, Godbey, Ingram, Schramm, & Hale, 1993). Terminally-ill people's boundaries with some supporters can also be permeable and they often have concerns about the practical and emotional difficulties their

approaching deaths create for their supporters (e.g., Schroepfer, 2008). Quantitative researchers have therefore consistently found that some terminally-ill people feel a burden to others (e.g., Chochinov et al., 2007; Wilson, Curran, & McPherson, 2005). Supporters further often ignore terminally-ill people' autonomy by imposing their values and wishes on them and terminally-ill people might often be incapable of asserting themselves (APA, 2014).

They might in extreme cases even be vulnerable to exploitation and undue influence.

Psychologists can help terminally-ill people address these issues, thereby improving their functioning and their supporters' current functioning and adjustment after the terminally-ill person's death (Farberman, 1997).

Psychologists working with terminally-ill people should anticipate that their clients might want to talk to them about hastening their deaths. Qualitative researchers found that terminally-ill people frequently think about death, dying and suicide (Courage et al., 1993) and quantitative researchers found that 25% of terminally-ill people desire to hasten their deaths (see Brown, Henteleff, Barakat, & Rowe, 1986; Wilson, 2018). Courage et al. (1993) found that they rarely mention their thoughts about hastening deaths to their supporters (also see Palliative Care Australia, 2018). Terminally-ill people are also reluctant to talk to their medical practitioners (practitioners) about entering palliative care or hastening their deaths (Courage et al., 1993) and if they do some oppose their wishes and there might even be different opinions within their treatment teams (R. Smith et al., 2018). These differences between health practitioners also manifest in the lively (Borry, Schotsmans, & Dierickx, 2006), complex (Hughes, 2006), and intense (Harris, 2001) ethical debate regarding what their role is when their clients consider hastening their deaths.

Psychologists recognise the ethical issues they face when providing services to terminally-ill people who desire to end their lives (e.g., Farrenkopf & Bryan, 1999). Some practitioners (e.g., Edleman, 2017) and scholars (e.g., Burt, 2000; Hadjistavropoulos, 1996), however, say

that their ethical codes and the professional literature (e.g., Peruzzi, Canapary, & Bongar, 1996; Werth, 1999) often do not help them resolve the issues they face. We identified eight ethical situations that could confront psychologists providing services to terminally-ill clients and we will consider them at a conceptual level. Professional ethical decision-making, however, takes place within a public legal-moral context and this can differ notably across jurisdictions. We therefore start this article with a brief historical overview of the public moral-legal evolution regarding life-ending options across Western jurisdictions during the last three decades to help psychologists understand why and how psychologists' professional legal-ethical obligations and their terminally-ill clients' options differ among jurisdictions.

A Brief Historical Overview of the Moral-Legal Evolution in Respect of Euthanasia and Suicide

Euthanasia is “a deliberate intervention undertaken with the express intention of ending a life to relieve intractable suffering” (Select Committee, 1994, p. 1364) and can be active (i.e., the hastening of death) or passive (i.e., allowing death to occur by omission; Harris, 2001; though see Rodway, 1994 who complains that the term is imprecise). The word euthanasia is derived from a combination of the early 17th century Greek words eu (well) and thanatos (death) and describes easy or good death (Oxford Dictionary Online, ud.). It covers situations where practitioners provide lethal drugs to people, or administer it to them, to hasten their deaths. The deliberate causing of one's own death and the intentional allowing or causing of the death of other people are, however, highly emotional and morally sensitive issues (Cholbi, 2017; Rodríguez-Prat & van Leeuwen, 2018). The public policy in Western countries is therefore to protect the sanctity of life and this together with the policy to protect vulnerable people from potential abuse, is an obstacle for those who advocate for euthanasia (Pretty v United Kingdom, 2002; Rodriguez v. British Columbia [Attorney General], 1993).

The opposition to suicide and euthanasia, however, does not go back far because ancient, and even more recent, hunter-gatherers (e.g., Appel, 2017; Mwaria, 1996-1997; Pounder, Prokopec, & Pretty, 1983; Van der Post, 1963) and people in the Bible (see Ben-Noun, 2015) practised suicide and euthanasia to ease their own or other people's suffering. The Ancient Greeks and Romans held complex views about euthanasia and suicide, but accepted them as means to stop unbearable physical or mental suffering (Dickinson & Leming, 2010; Emanuel, 1994; Minois, 2000; Szasz, 1999). Euthanasia and suicide were, however, not universally accepted (see, e.g., Hippocrates, circa 380BC) and the growth of Christianity across Europe furthermore made them both taboo topics that authors did not write about except when commenting on suicide's legal consequences (e.g., Barry, 1965). Discussion of these constructs, primarily suicide, re-emerged after the Renaissance as part of the broader philosophical debate about the relationship between science and religion (Emanuel, 1994) by authors such as John Donne (1572-1631) and David Hume (1777). The secularisation of society and philosophers' emphasis on people's right of self-determination (Kant, 1785/2001; Mill, 1859/1974), which still influences health ethics, softened opinions about suicide even though it remained stigmatised, discouraged and criminalised (Sareen & Trivedi, 2009).

The current euthanasia debate ignited in the 19th century when morphine was isolated and used with ether as anaesthetic that could also be used to relieve dying people's pain (Anonymous, 1873; Dowbiggin, 2003). This debate led to unsuccessful attempts to legalise euthanasia in the United States (US) in 1906 and the United Kingdom (UK) in the 1930s. Uruguay, however, introduced a Penal Code (1933) that made active euthanasia possible (Julesz, 2016) and Switzerland's Criminal Code (1937) made assisted suicide possible (De Castro et al., 2016).

The public's response to two unrelated, but highly emotional events that continue to crop up in debates about assisted suicide and euthanasia, however, dampened support for euthanasia

in the 1940s. The first was the reaction against the movement that advocated for the “eugenical sterilization of ... potential parents carrying degenerate hereditary qualities” (Gejman & Weilbaecher, 2002, p. 227) that “... included the feeble-minded, insane ..., criminalistics ..., epileptic ... and dependent (including orphans, ne'er-do-wells, the homeless, tramps and paupers)” (p. 227). The second was the response to revelations about Nazi (Rummel, 1992) and Soviet (Naimark, 2011) killing of people with intellectual disabilities, Jews and minority groups during the Second World War (Emanuel, 1994). Three developments during the 1960s nevertheless reignited the debate about medical end-of-life options.

First, several Western jurisdictions decriminalized suicide but “a person who aids, abets, counsels or procures the suicide of another, or attempt by another to commit suicide” (section [s](2)(1) of England and Wales Suicide Act, 1961) remained guilty of an offence. Practitioners outside Switzerland could therefore be charged if they assisted patients’ suicide.

Second, medical technological and practice developments allowed practitioners to provide treatment that was previously not possible (Emanuel, 1994), but they could also withhold or stop such treatment. Practitioners, could, for instance, treat or refrain from treating pneumonia or resuscitating patients well knowing that there was a high probability that untreated terminally-ill patients would die (Den Hartogh, 2016). They could provide or withhold life-sustaining treatment (e.g., by dialysis, respiration or intravenous provision of nutrition and fluids [hydration]) to prolong the life of people who would previously have died (Den Hartogh, 2016). Practitioners could therefore sustain hopelessly unconscious patients’ cardiac, metabolic and respiratory functions almost indefinitely, but they then had to decide when to stop such treatment (Ad hoc committee, 1968). Practitioners in some jurisdiction started using the neurological criteria to determine whether people were dead (i.e., brain dead; Gardiner, Shemie, Manara, & Opdam, 2012; M. Smith, 2012) so they could

discontinue treatment and, sometimes, transplant their organs (Hoffenberg, 2001). Some argue that there is philosophically no difference between allowing people to die by omission and acts (i.e., giving a lethal drug; e.g., Fenton, 2018).

Practitioners could also administer drugs to relieve patients' symptoms and make dying easier but simultaneously hasten their death (i.e., the so-called double effect of medication; Hills, 2007; Quill, Cassel, & Meier, 1992; Silveira, DiPiero, Gerrity, & Feudtner, 2000) and some argue this practice is difficult to distinguish from euthanasia (e.g., Den Hartogh, 2016; Raus, Sterckx, & Mortier, 2011).

Third, people through the patients' rights movement insisted that both mental (e.g., Weiner & Wettstein, 1993) and non-mental health (Emanuel, 1994) patients have a right to refuse medical care provided their decisions do not harm society. The main motivation for the movement was patients' insistence that their autonomy should be recognised, but for some it was also their fear of being kept alive by technology against their will (Gupta, Bhatnagar, & Mishra, 2005). The medical-ethical position is therefore that life-sustaining treatment is elective and require patients' or their legal representatives' consent (American Medical Association [AMA] Council on Ethics and Judicial Affairs, 2008). Law also accepts that competent patients (i.e., they have the ability to make legal decisions) can retract consent for life-sustaining treatment even if this is likely to result in their deaths (e.g., Re B, 2002). By the 1970s the only practical difference between homicide and assisted and passive euthanasia in most jurisdictions was therefore practitioners' intentions. Matters came to a point when practitioners in countries such as the Netherlands (Rb. Leeuwarden [Postma-case], 1973) and South Africa (S v Hartmann, 1975) were convicted of murder after administering lethal drugs to patients. The sentences in these cases were symbolic but nevertheless impacted on the practitioner's registration and therefore their ability to practise (Anonymous, 2014; Griffiths, 1995a). Practitioners and the public in several jurisdictions in reaction insisted on legal

reform that would bring greater clarity and certainty (e.g., South African Law Commission 1998).

The intense public and legal debate that followed led to a variety of outcomes in the different jurisdictions (see De Castro et al., 2016 for a discussion). Voters, for example, directly adopted legislation that gives terminally-ill people legal options to end their lives through ballot in the US State Oregon (Death with Dignity Act, 1994). In other jurisdictions voters did this indirectly through parliament as in the Australian State Victoria (Voluntary Assisted Dying Act, 2017). Courts in other jurisdictions handed down decisions (e.g., *Baxter v. Montana*, 2009) that allowed practitioners to assist terminally-ill people following informal professional guidelines (see Orentlicher, Mason Pope, & Rich, 2016; Quill et al., 1992) or that led to legislation that regulates the situation (e.g., the Dutch Termination of life on request and assisted suicide [Review procedures] Act, 2002). Individual and group attempts to bring about constitutional change led to mixed outcomes. The US Supreme Court's position (see Canick, 1997) remains that people do not have a constitutional right to die (*Vacco v Quill*, 1997) and/or to assisted suicide (*Washington v Glucksberg*, 1997). The UK Supreme Court has similarly refused to rule that terminally-ill people have a constitutional right to die on several occasions (e.g., *R [Nicklinson and Lamb] v Ministry of Justice*, 2014). The Colombian Constitutional Court (C-239, 1997; T-970, 2014) and the Canadian Supreme Court (*Carter v. Canada [Attorney General]*, 2015) in contrast made constitutional findings compelling their governments to provide terminally-ill people legal options to end their lives.

Legal Position of Psychologists across Jurisdictions

Many psychologists who work in Australia, Europe and South and North America (see Gureasko, 2018 for a list of US States) will therefore practice in jurisdictions whose law gives terminally-ill people the option of hastening their deaths after they have considered all other reasonable treatment options. Many other psychologists, however, practice in jurisdictions where this is not possible, and the law in the jurisdictions where it is possible also differs. The legal context within which psychologists provide services to terminally-ill people can therefore vary considerably across jurisdictions and this will influence what information they provide to their clients. Psychologists should consequently determine what the legal position is in the jurisdictions where they practise. Psychologists might, however, find it difficult to access the relevant law that could be part of case law, specific legislation (e.g., Victoria) or in criminal legislation that provide an indemnity to practitioners who assist patients to die (e.g., Canada). Most of the legislation we reviewed furthermore do not specifically mention psychologists, or mention them together with other health professionals (e.g., s241[5.1] of the Canadian Criminal Code, 1986).

We can therefore not provide a succinct summary of all Western psychologists' legal situation but our review of the law revealed some common features. The legislation consistently allows practitioners who have conscientious objections to refuse to provide services to people who want to hasten their deaths even though the specific wording of the relevant provisions differ. Most jurisdictions only give people older than 18 (see Watson, 2014 for exceptions) who are suffering of physical disorders (see Olié & Courtet, 2016 for exceptions) and who are competent to give consent (see Luxembourg's Act on Palliative Care, 2009 for an exception) the opportunity to hasten their deaths. The law also generally requires patients to self-administer the lethal drugs (see Termination of life Act, 2002 for an exception).

Psychologists should therefore ascertain what the specific law is in the jurisdictions where they practise. The Victorian legislator for instance specifies that psychologists can undertake decision-making capacity assessments (Voluntary Assisted Dying Act, 2017) but requires these assessors and their assessments to meet specific criteria. Some psychologists who currently undertake decision-making assessments might therefore not be able to do them under this legislation, or might have to change their assessment procedures. Psychologists should also specifically enquire whether the law they practise under requires them to inform patients about life-ending options, or forbid them to raise the option (e.g., Voluntary Assisted Dying Act, 2017).

Options of Terminally-Ill People

Terminally-ill patients' options differ depending on the legal jurisdiction they reside in, but most terminally-ill patients in Western countries have access to effective palliative and hospice care in metropolitan and well-populated areas. Palliative care is the option most terminally-ill people choose, especially those whose religious and personal values prevent them from considering other options (Joint Select Committee, 2018). People from some cultural, religious and minority groups, however, either do not know of palliative services or underuse them (Noh & Schroepfer, 2015). Palliative care might further not be equally effective for all conditions (e.g., some forms of motor neuro disease; Joint Select Committee, 2018) and some practitioners appear resistant to referring patients to palliative care. Mukherjee (2011) speculates that it is because they see such referrals as admissions that they have failed.

Competent recipients of life-sustaining therapy can instruct their practitioners to cease all treatment other than managing their pain even if they do not have terminal or irreversible

illnesses. Their instructions can include the cessation of nutrition and hydration (American Medical Association [AMA], 2008) and is lawful even when likely to result in patients' deaths (Re B, 2002).

About 10% of Australians who end their own lives by suicide have a terminal or debilitating illness (Joint Select Committee, 2018). People can only use this option whilst they are independent because those assisting them could be charged of assisting their suicide in some jurisdictions (e.g., the UK, *Pretty v United Kingdom*, 2002). The UK Director of Public Prosecutions (DPP) did after a later case (*R [Purdy] v DPP*, 2009) publish a policy setting out the criteria prosecutors will use when deciding whether to prosecute people under the Suicide Act (1961) for aiding and abetting others. This policy does not, however, stop the police from investigating and arresting people suspected of planning to assist terminally-ill people (Salkeld, 2013). They must further find the appropriate method to kill themselves and some use traditional methods such as carbon monoxide poisoning, hanging, poisoning, and self-inflicted gunshot wounds, or driving their mobility scooters off quays or train platforms. Patients often avoid these violent methods because their situation could be worse if they are unsuccessful (Griffiths, 1995b) or because they want to prevent trauma to those who discover their bodies. Some use non-violent methods (e.g., starving themselves) and those who can afford it and are still healthy enough can travel to a jurisdiction (e.g., Switzerland) where practitioners can legally assist them (Cohen, 2017) if there are no other obstacles, such as residency restrictions (e.g., in Oregon). Suicide also has negative civil law consequences (e.g., life insurance policies might not cover death by suicide, Barry, 1965) in some jurisdictions.

Patients could finally approach practitioners who are willing to assist them in ending their lives despite the potential risk of prosecution and disciplinary proceedings because they see the relief of pain as a professional obligation (Orentlicher et al., 2016; Quill et al., 1992). The

clandestine nature of these activities makes it difficult to fully describe them or to establish how many patients make such requests and how frequently practitioners assist them (Magnusson, 2002; Parliament of Victoria, 2016). An anonymous survey of Australian practitioners nevertheless found that 35% of them have provided assistance to patients at their request to hasten their deaths (Joint Select Committee, 2018). These practitioners generally adhere to existing unofficial clinical criteria (Orentlicher et al., 2016).

Common Ethical Issues When Providing Services to Terminally-Ill People

Psychologists might occasionally accept terminally-ill people who say they are considering hastening their deaths as clients and those who specialise in the area might receive referrals to assess the decision-making ability of terminally-ill people (Farrenkopf & Bryan, 1999). Terminally-ill clients can, however, raise the hastening of their deaths with psychologists whom they consult for other reasons, such as requiring assistance with mental health issues (specifically depression or anxiety) or interpersonal problems with their supporters and/or practitioners (Carpenter, 2014; Miles & Maletta, 1996). We will therefore briefly examine eight ethical issues that all psychologists who provide services to terminally-ill clients might encounter irrespective of the setting they work in.

Contracting

Psychologists who receive referrals to provide services to terminally-ill people must determine whether they are acting on their own volition (Werth, 1999) to avoid further eroding their self-worth, sense of control, autonomy (i.e., ability to make choices and execute them) and/or privacy (i.e., right to be left alone and to confidentiality). They should inform potential clients about any limitations in the services they offer before establishing

professional relationships with them as these people have few options of consulting other psychologists later. Psychologists whose organisational rules, lack of ability or competence, or values limit the services they can or are willing to provide must advise potential clients of such restrictions in their information documents.

Psychologists who hold such strong values about the sanctity of life that they are not prepared to discuss life-ending options with clients can refuse to provide services requiring them to do this because as autonomous people they can make decisions and behave in accordance with their values provided they remain within the law and their organisation rules, if any, and their professions' ethics. They should, however, provide the information when contracting because if they disclose their values after clients have disclosed their desire to die such clients might feel judged or rejected.

Clinicians who take these precautions could nevertheless find that existing clients who were diagnosed after establishing a professional relationship with them want to discuss hastening their deaths with them. Psychologists may refer such clients to competent colleagues who are prepared to provide the services and aid the transfer process. Some psychologists might argue that even this compromise their values, but discontinuing the service would constitute abandonment of their clients and psychologists who ignore their wishes do not act in their clients' best interest. Psychologists who do not want to find themselves in this situation carry the burden of preventing it from happening.

Responsibility to raise life-ending options

Psychologists' obligation to respect their clients' legal rights raises the question whether they should spontaneously tell clients about all the lawful life-ending option available in jurisdictions where they practise. Clients in jurisdictions like Vermont in the US have a right

“to be informed of all available options related to terminal care” (§ 5282, Act relating to patient choice, 2014), whilst Victorian practitioners may not “initiate discussion” about voluntary assisted dying or suggest it (s8, Voluntary Assisted Dying Act, 2017).

Psychologists in jurisdictions where the legal situation is unclear must make an ethical decision and there are two broad arguments.

Some argue that people can only exercise their legal rights if they are fully informed and point out that a significant proportion of people do not understand their end-of-life care options (Silveira et al., 2000), are not assertive enough to ask about them (Nissim, Gagliese, & Rodin, 2009) or do not use available opportunities (Orentlicher et al., 2016; Quill, Back, & Block, 2016; Stokes, 2017). This is especially true for people from minority (Kwak & Haley, 2005) and lower socio-economic (e.g., Noh & Schroepfer, 2015) groups. Others argue that clients have a right not to be informed (Weiner & Wettstein, 1993) and that terminally-ill people’s needs are so complex that psychologists cannot assume that they want to know about life-ending options when they approach them (Buchbinder, 2017). Psychologists could unwittingly put pressure on those clients who interpret their unsolicited information about end-of-life options as an indication that psychologists think their prognosis is poor; the medical team has lost hope and/or that psychologists are communicating implicit value judgments or endorsements for hasten dying (Buchbinder, 2017).

The potential risk of causing harm to clients in this situation appears to out-weight their right to information. Psychologists should rather adopt a neutral stance allowing clients to determine the parameters of services congruent with their needs and values. Many terminally-ill people want to talk to people they trust about their desire to die (Courage et al., 1993) but psychologists might need several sessions to demonstrate to them that they are non-judgmental and fair-minded. Psychologists should therefore be sensitive and able to respond

appropriately to their clients' implicit or explicit disclosures of their desire to die (Buchbinder, 2017).

Clients who desire to die

Psychologists complain that their professional guidelines and scholars' advice about the management of terminally-ill clients' desire to die are confusing (e.g., Edleman, 2017). The only reference to terminally-ill people in the Australian Psychological Society's Guidelines Relating to Suicidal Clients (2009) is that they "have an elevated risk of suicide" (clause 3.4) and that whilst clause 3.1 provides that psychologists "must at all times respect their clients' autonomy" the rest of the document is about prevention of self-harm.

The purpose of these guidelines is to advise psychologists on managing clients with suicide ideation and therefore the drafters' decision to emphasise psychologists' obligation to prevent harm rather than respect their clients' autonomy is understandable. This reflects the public policy that emphasises the sanctity of life and the protection of vulnerable people (Rodriguez v. British Columbia, 1993). Psychologists' clients who contemplate suicide are often vulnerable and ambivalent people whose decision-making abilities might be temporarily or permanently impaired (Johnson, Cramer, Conroy, & Gardner, 2014).

The general ethical rule is, however, that psychologists should respect their autonomous clients' wishes to die (see Allan et al., 2006 for an exception to this general rule). Some psychologists argue that people with suicide ideation are never autonomous agents (see Werth, 1996; 1999 for a discussion), but ethics and law (e.g., s4 of the Voluntary Assisted Dying Act, 2017) require them to assume that their clients are autonomous agents unless there is evidence to the contrary (see Abeles & Barlev, 1999; Szasz, 1986, for a discussion). Such evidence could be that clients' decision-making abilities are at the time impaired by

substances (including prescribed medication) or their mental conditions. A desire to die is not indicative of a mental disorder (Werth, 1996), nor is the presence of pathology or treatment proof that clients cannot make lawful decisions (Werth, Lewis, & Richmond, 2009). There must be evidence that clients' abilities to understand the risks and benefits of their decisions; reason logically (i.e., the conclusion follows from the prepositions) and sustain decisions are compromised (Appelbaum & Grisso, 1995).

Psychologists should therefore cautiously explore their terminally-ill clients' desire to die (Gupta et al., 2005) taking into account the theories of suicide and how to interpret such ideation (see Wilson, 2018). Most terminally-ill people do not desire to die (Wilson, 2018), but some without mental health diagnoses have genuine and consistent desires to die because they are ready to die (Nissim et al., 2009) or for a variety of other reasons (Muskin, 1998). These include wanting to control how they die and to ensure it is dignified (Rehmann-Sutter, Gudat, & Ohnsorge, 2015; Rodríguez-Prat & van Leeuwen, 2018). Others' ideation could be part of their adjustment to the dying process (Johnson, Cramer, Gardner, & Nobles, 2015) and psychologists should not confuse these clients' prospective grief and fear of dying, the unknown, and pain with anxiety and depression (Farberman, 1997).

Some terminally-ill clients' wishes to die might, however, be related to their treatable mental disorders that could influence their decision-making abilities (Johnson et al., 2015).

Psychologists should further consider the possibility that malevolent people might be putting pressure on clients to hasten their deaths (e.g., Parliament of Victoria, 2016). Werth (1999) therefore suggests that psychologists maintain the right to disclose information without consent if clients' ideation "appears to be impulsive or influenced by a mental disorder, coercion, or impaired judgment" (p.175).

Managing boundaries

Psychologists sometimes exchange information or take instructions from supporters without terminally-ill people's consent and the beneficence principle might justify this practice, but it undermines clients' self-worth, autonomy and privacy. There are also practical objections to this practice. Research indicates that supporters often over-estimate their knowledge of what clients want and that their values, needs and opinions might differ from those of clients (see Haley, Allen, Reynolds, Chen, & et al., 2002 for a discussion). Malevolent people could also exploit psychologists' willingness to collaborate with them secretly.

Psychologists should confirm who the clients are and what they want (Werth, 1999). They should specifically determine when they can take instructions from terminally-ill clients' supporters; who can act as clients' agents; and when and with whom they can share information (Johnson et al., 2014). Psychologists should ensure that all involved understand these ground rules; consistently maintain strict boundaries; and avoid dual relationships by, for instance, refraining from providing services to clients' family, carers or members of their treatment team or by facilitating group of family sessions.

Decision making assessments

Psychologists would generally assess terminally-ill peoples' decision-making abilities when they observe, or receive reports that suggest, that their clients' physical and/or mental deterioration or the medication they use are impairing their legal decision-making abilities. Others might also refer terminally-ill patients to them to assess whether they have the ability to make legal decisions, such as to hasten their deaths.

Psychologists' conclusions about people's decision-making abilities impact on their autonomy and legal rights and interests and psychologists should therefore ensure their

decisions are fair and defensible. They should consider working under close supervision because the evidence is that psychologists' values influence the outcomes of their assessments of people's abilities to make decisions to hasten their deaths (DiPasquale & Gluck, 2001; Fenn & Ganzini, 1999) and that people find it difficult to overcome the influence of their values (e.g., Babcock & Loewenstein, 1997; Babcock, Loewenstein, & Issacharoff, 1997). They should further avoid other potential influences (e.g., multiple relationships) by not assessing their own clients; people who are related to clients they provide, or recently provided, psychological services to, or of people whom they work with, for instance in a group practice. Psychologists must be competent assessors of decision-making ability who are capable of undertaking the systematic and thorough assessments required, but that clients might find difficult to tolerate (Galbraith & Dobson, 2000). Assessors must be good diagnosticians (Werth et al., 2009) because terminally-ill clients can present with symptoms (e.g., of depression) associated with their medication or physical disorders (e.g., end-stage renal disease; Christensen & Ehlers, 2002). Psychologists should follow relevant legal criteria (e.g., Voluntary Assisted Dying Act, 2017) or in their absence frameworks generally accepted in the profession. Most experts suggest using a framework that takes into account assessee's affective, behavioural (e.g., communication) and cognitive (ability to understand risk and benefits; reason logically and sustain decisions) functioning (Appelbaum & Grisso, 1995; Grisso & Appelbaum, 1998). Assessors should further preferably use generally acceptable assessment tools such as the MacArthur Competence Assessment Tool-Treatment (MacCat-T; Grisso & Appelbaum, 1995). Assessors should further assess people when their functioning is optimal, generally early during the day, and exclude possible undue influence by exploring whether their clients current desire to die is consistent with what they had said in the past and the reasons they give for the current requests (Werth, 1999).

Referral networks

All psychologists should have a network of professionals whom they can refer clients to if their abilities, competence and values (e.g., the value of life, autonomy and dignity; Rodríguez-Prat & van Leeuwen, 2018) would make it unethical to work with these clients. They might also not be competent to work with people whose culture (Kwak & Haley, 2005), ethnicity (Noh & Schroepfer, 2015), religion and socio-economic status (Noh & Schroepfer, 2015) differ from their own. Clients' needs might also be beyond psychologists' field of expertise such where they practice in rural areas where clients' options are limited.

Risk management

Psychologists should take special care of their own functioning to allow them to act in the best interests of their clients. Working with terminally-ill clients is always emotionally taxing (Katz, 2006) and the emotional burden increases when clients desire to die (Stevens, 2006), partly because what psychologists do might be subject to legal scrutiny. Psychologists should take active steps to manage their emotional stress and anticipate legal scrutiny by working under close supervision; consulting when they confront difficult issues and keeping risk-management orientated notes.

Deciding whether to work with terminally-ill clients

Psychologists who consider working with terminally-ill clients should through self-reflection, supervision, and consultation with experienced colleagues explore whether they have the abilities, skills and knowledge to ethically provide services to terminally-ill people. They should specifically explore their values regarding hastened dying because these values

influence both antagonists and proponents' professional decisions and behaviour (DiPasquale & Gluck, 2001).

They must also explore how their personal characteristics (Fenn & Ganzini, 1999), life-experiences (Johnson et al., 2015) and personal fears (Yalom, 2008) about aging, loss of control, faith, illness and mortality could influence their ability to discuss issues of death and dying with clients, and what impact doing it could have on them personally (Yalom, 2008). They should do this continuously because experiences such as bereavements or deaths of clients through self-harm might temporarily or permanently impair their ability to provide services to terminally-ill people (Katz, 2006).

Clinicians should consider whether they have the skills and knowledge to work with all terminally-ill clients. They should for example be able to start conversations about dying (Bailey, 2018); provide the evidence-based interventions terminally-ill clients require (Carpenter, 2014); and work with the systems surrounding them, such as facilitating group, team and/or family meetings. They should have a sound knowledge of the relevant law in their jurisdictions to ensure that their interactions with clients comply with the law (e.g., the prohibition in s8[1] of the Voluntary Assisted Dying Act, 2017 against initiation of discussions with clients that are "in substance about voluntary assisted dying"). They should specifically know what legal life-ending options exist in the jurisdictions where they practise to facilitate discussions and manage their clients' unrealistic expectations regarding their options. Psychologists should also have at least a general knowledge of the practical implications of all the different options, including palliative care at a hospice or elsewhere, and the availability and cost of those services at the place where clients live (Buchbinder, 2017). Psychologists can do harm if they discuss unattainable options with clients and they should therefore know the legal and medical criteria and the administrative steps required to gain access to assisted dying, the time it takes, the costs and the side-effects of the methods

used. Some clients might, for example, be unable of self-administering or ingesting the lethal substance as required in their jurisdictions (Buchbinder, 2017).

Conclusion

Psychologists across the world have an important role to play in providing services to terminally-ill people and their family members, including those who want to hasten their deaths (Abeles & Barlev, 1999; Farberman, 1997). Euthanasia, however, has strong cultural and spiritual undertones and this leads to moral and legal debates both in the profession and society. The social debate has generated law reform in several jurisdictions during the last three decades that have created a situation where psychologists' legal-ethical situation and their clients' options can differ notably depending on the jurisdiction they practice in. An examination of psychologists and their clients' legal situations across jurisdictions is beyond the ambit of this paper, but psychologists should establish what the legal situation in their jurisdictions is to avoid doing something unlawful or exploring unlawful options with their clients. Psychologists' own values might also influence their interaction with terminally-ill people who want to hasten their deaths and we recognise that this article reflects a strong Western bias. Psychologists' ethical position should, however, at a conceptual level be the same and therefore the eight issues we discussed will, subject to modifications required by law and organisational rules, be the same for psychologists across the world.

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