

THE NEXUS BETWEEN ELDER ABUSE, SUICIDE, AND ASSISTED DYING: THE IMPORTANCE OF RELATIONAL AUTONOMY AND UNDUE INFLUENCE

ANNE P F WAND*, CARMELLE PEISAH**, BRIAN DRAPER*** AND HENRY BRODATY****

The term elder abuse encompasses a wide range of acts or lack of action (neglect) which cause harm or distress to an older person and occur within trusted relationships. Harm may occur when older people are unduly influenced to make decisions, including to end their lives. With the legalisation of assisted dying in Victoria, there is an urgent need to consider the relevant aspects of decision-making in this setting. Assessment of the social and relational context of older individuals is essential in evaluating whether decisions for assisted dying are autonomous or potentially an extreme form of elder abuse, or anywhere in between.

I INTRODUCTION

With the introduction of the *Voluntary Assisted Dying Act 2017* (Vic)¹ ('the Act') in Victoria, and active bills and parliamentary inquiries into assisted dying in New Zealand, New South Wales, the Australian Capital Territory and Western Australia, there is an urgent need to discuss the potential implications of such legislation for elder abuse. Notably, s 5(1)(i) of that Act specifically acknowledges 'there is a need to protect individuals who may be subject to abuse'.² Implicit to such 'protection', and arguably the safe and effective functioning of any assisted dying legislation, is the recognition and mitigation of risks of such abuse.

Older people, the age group with the highest rate of suicide internationally,³ may be particularly vulnerable to abuse under this legislation⁴ given their interpersonal contexts, especially the frequently dependent nature of their relationships and comparatively greater health burden, combined with other psychosocial factors such as perceived burdensomeness influencing decision making.

According to the World Health Organisation, elder abuse can be defined as

a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an *expectation of trust* which causes harm or distress to an older person.⁵

* B(Sc)Med(Hons); MBBS(Hons); FRANZCP; M(Psychiatry). Conjoint Senior Lecturer, University of New South Wales, Sydney, Australia.

** MBBS (Hons); FRANZCP; MD. Conjoint Professor, University of New South Wales, Sydney, Australia and Clinical Associate Professor, University of Sydney.

*** MBBS (Hons); MD; FRANZCP. Conjoint Professor, University of New South Wales, Sydney, Australia.

**** MBBS; MD; DSc; FRACP; FRANZCP; FAHMS. Scientia Professor, University of New South Wales, Sydney, Australia.

¹ *Voluntary Assisted Dying Act 2017* (Vic). Notably when using the term 'assisted dying' we use the definition from the Act, namely 'the administration of a voluntary assisted dying substance and includes steps reasonably related to such administration'. Euthanasia is not a legal term and does not have a universally accepted definition, so is not otherwise used in this paper unless specifically used by the reference source.

² *Voluntary Assisted Dying Act 2017* (Vic) Pt 1 s 5(1)(i).

³ Ajit Shah, Ravi Bhat, Sofia Zarate-Escuredo, Diego DeLeo and Annette Erlangsen, 'Suicide Rates in Five-Year Age-Bands after the Age of 60 Years: The International Landscape' (2016) 20 *Aging and Mental Health* 131, 138.

⁴ *Voluntary Assisted Dying Act 2017* (Vic).

⁵ World Health Organization, *A Global Response to Elder Abuse and Neglect: Building Primary Health Care Capacity to Deal with the Problem Worldwide* (2008), 1 <http://www.who.int/ageing/publications/ELDER_DocAugusto8.pdf>.

Elder abuse can take various forms such as physical, psychological or emotional, sexual and financial abuse.⁶ It can also be the result of *intentional or unintentional neglect*. This definition clearly includes harm and distress incurred within the context of a relationship where there is exploitation of trust and vulnerability, a key factor distinguishing abuse of older adults and that of younger adults.⁷ One means of incurring harm is to adversely influence decision making, otherwise conceptualised as undue influence,⁸ a prominent target of Articles 12 and 16 of the Convention on the Rights of Persons with Disability.⁹ Hitherto used in the context of will-making and the execution of contractual documents,¹⁰ but also in reference to treatment consent (see *Re T*),¹¹ undue influence has relevance to both suicide and assisted dying.

Decisions to suicide or to request assisted dying are never undertaken in a vacuum. Relational autonomy¹² suggests that autonomy emerges within and because of relationships,¹³ and the corollary of this is that decision-making occurs within and because of relationships. There is evidence of the impact of relationships on the decision to die by suicide,¹⁴ but little attention has been given to the impact of relationships on requests for assisted dying. Clarification of these issues is of utmost importance with the passage of the *Voluntary Assisted Dying Act 2017* (Vic).¹⁵

The aim of this paper is to explore the ways in which relationships can cause harm mediated by suicide or requests for assisted dying, which by definition constitute elder abuse. We firstly discuss how interpersonal (relationship) factors relate to abuse and suicide. Secondly we explore concepts of undue influence and relational autonomy in the context of suicide and assisted dying in older people; and thirdly, criminal prosecutions. Finally, the implications for policy and guidelines in regards to requests for assisted dying are discussed.

II UNDERSTANDING RELATIONSHIPS, ABUSE AND SUICIDE

People rarely exist in isolation, but function within various interacting social and family systems, which are inextricably linked with mental health. Most older adults with functional and/or cognitive impairment are in dependent relationships with family members and carers, rendering them vulnerable to abuse. Carers may feel stressed and burdened by their caregiving role and the shift in family roles,¹⁶ with anger and conflict culminating in abuse¹⁷ of a myriad of psychological, physical, neglect and financial varieties.¹⁸

⁶ Ibid.

⁷ Rae Kaspiew, Rachel Carson and Helen Rhoades, 'Elder Abuse: Understanding Issues, Frameworks and Responses' (Research Report No 35, Australian Institute of Family Studies, February 2016) 8.

⁸ Carmelle Peisah et al, 'The Wills of Older people: Risk Factors for Undue Influence' (2009) 21(1) *International Psychogeriatrics* 7, 15.

⁹ *United Nations Convention on the Rights of Persons with Disabilities*, opened for signature on 30 March 2007, A/RES/61/106 (entered into force on 3 May 2008).

¹⁰ Peisah et al, above n 8, 7.

¹¹ *Re T (An Adult): Refusal of Medical Treatment* [1992] All ER 649.

¹² Carolyn Ells, Matthew R Hunt and Jane Chambers-Evans, 'Relational Autonomy as an Essential Component of Patient-Centered Care' (2011) 4(2) *International Journal of Feminist Approaches to Bioethics* 79, 101.

¹³ Jennifer Nedelsky, 'Reconceiving Autonomy: Sources, Thoughts and Possibilities' (1989) 1(7) *Yale Journal of Law and Feminism* 7, 36.

¹⁴ Gustavo Turecki and David A Brent, 'Suicide and Suicidal Behaviour' (2016) 387 *The Lancet* 1227, 1239. This review paper describes the social, including relationship factors associated with suicide, such as living alone, interpersonal stressors, loss and bereavement.

¹⁵ *Voluntary Assisted Dying Act 2017* (Vic).

¹⁶ Carmelle Peisah, 'Practical Application of Family and Systems Theory in Old Age Psychiatry: Three Case Reports' (2006) 18(2) *International Psychogeriatrics* 345, 353.

¹⁷ Susan Kurrle, Paul Sadler and Ian Cameron, 'Patterns of Elder Abuse' (1992) 157(10) *Medical Journal of Australia* 673, 676.

¹⁸ Ibid. Kurrle and colleagues describe the frequency of various forms of elder abuse in a sample of community dwelling older people.

In a more indirect way, family relationships have an impact on suicide in older people. The interpersonal theory of suicide¹⁹ recognises the role of relationships in the decisions to end one's life. According to this theory, three factors of thwarted belongingness, perceived burdensomeness and capability for suicide must be present for the decision to suicide. There is empirical evidence to support this hypothesis in older people. Van Orden and colleagues found that greater perceived burdensomeness and painful and provocative experiences were associated with suicide case status.²⁰ The sense of being a burden to loved ones and/or society has also been identified in quantitative studies of risk factors for suicide,²¹ as well as in qualitative work on why older people have self-harmed.²² This includes our own empirical work that demonstrated the combined effects of feeling like a burden to others, and often compounded by the very helplessness of family and professional caregivers alike.²³ As such, carer stress may amplify the older person's internalised perceptions of burdensomeness.²⁴ When a carer's burden culminates in an older person's suicide in order to relieve the carer of that distress, it clearly does not constitute abuse. However, it shows the relational pathways of decision making in suicide, which at their extreme can constitute abuse, as will be discussed.

In depressed older adults, the psychiatric and physical health of their carers, and reported difficulties caring, increase the risk of suicidal behaviours in older adults.²⁵ How this is mediated is unclear, although it has been postulated that the older person may become demoralised by viewing their own depression as burdensome to the family carer and their relationship with them.²⁶ This demoralisation may lead them to conclude that their family member would be better off without them. On the other hand, it may be that when the family caregiver is not coping they are unable to provide social support to their depressed older relative, increasing the risk of a suicide attempt.²⁷ It is likely that both possibilities contribute to suicide risk, but passively so. In our own qualitative work on late-life self-harm we have empirically confirmed that the relational context is important, with perceptions of family and caregiver rejection acting as both a trigger for, and consequence of, self-harm.²⁸ The older person's self-harm may reflect a defensive response of projective identification (when a person projects, onto another, unacceptable feelings or impulses that the recipient adopts as their own), whereby the older person acts out their burdened caregiver's unexpressed wish for their death.²⁹

Another mechanism for family relationships culminating in suicide or influencing the decision of an older person to end their life is the untenable situation. In some cases, older people are

¹⁹ Thomas E Joiner, *Why People Die by Suicide* (Harvard University Press, Cambridge, Massachusetts, 2005).

²⁰ Kim Van Orden et al, 'A Case Controlled Examination of the Interpersonal Theory of Suicide in the Second Half of Life' (2016) 20(3) *Archives of Suicide Research* 323, 335.

²¹ Jerome Motto and Alan Bostrum, 'Empirical Indicators of Near-Term Suicide Risk' (1990) 11(1) *Crisis* 52, 59.

²² Van Orden et al, above n 20, 324; Anne Wand et al, 'Understanding Self-Harm in Older People: A Systematic Review of Qualitative Studies' (2018) 22(3) *Ageing and Mental Health* 289, 298; Joiner, above n 19.

²³ Anne Wand et al, 'Why Do the Very Old Self-Harm? A Qualitative Study' (2018) *American Journal of Geriatric Psychiatry* <<https://doi.org/10.1016/j.jagp.2018.03.005>>.

²⁴ Kimberley Van Orden et al, 'The Interpersonal Theory of Suicide' (2010) 117(2) *Psychological Review* 575, 600.

²⁵ Gregory A Hinrichsen and Nancy A Hernandez, 'Factors Associated with Recovery from and Relapse into Major Depressive Disorder in the Elderly' (1993) 150(12) *American Journal of Psychiatry* 1820, 1825; Richard A Zweig and Gregory A Hinrichsen, 'Factors Associated with Suicide Attempts by Depressed Older Adults: A Prospective Study' (1993) 150(11) *American Journal of Psychiatry* 1687, 1692.

²⁶ Zweig and Hinrichsen, above n 25, 1692.

²⁷ Ibid.

²⁸ Wand et al, above n 23.

²⁹ Projective identification is a defence mechanism or interpersonal communication whereby subtle interpersonal pressure from the carer is placed upon another [older] person to take on the feelings/thoughts of an aspect of the carer – in this context the wish their elder relative was dead. The older person who is the target of that projection then begins to think, feel and behave in the way the carer projected, ie 'I want to die'.

'bullied' into suicide. Family conflict, elder abuse, and complex interpersonal dynamics may lead to untenable situations, whereby suicide is perceived by the older person to be their only option. The following situation illustrates this outcome.

Mrs B was an 86 year old widow with dementia who had recently moved to a nursing home after a prolonged medical admission following a fall. She was referred to an aged care psychiatry service for assessment due to continued refusal to eat and take medications. She was largely mute upon review, but her daughter, a geriatrician and nursing home staff provided a history of massive weight loss (20kg in four months), low mood, reduced talkativeness, and poor engagement with staff. Her daughter had been her primary co-resident carer for the preceding two years. Mrs B's son had learned his sister, and not he, was appointed their mother's representative under Power of Attorney (POA). This was perceived as an unforgivable slight against his expected role as the male of the family in their cultural context. He was also angry his mother had chosen to live with his sister and not move to a nursing home, concerned this would diminish his inheritance. He became increasingly hostile, accusatory and abusive towards his mother for choosing his sister for the POA role. This involved him shouting at her, abruptly stopping and starting the car when driving with her, throwing her rosary beads, accusing his sister of taking advantage of her, and verbally threatening his mother. Her daughter explained: 'Sometimes she'd rush at me [after outings with her son] and just sob and I was powerless to do anything.' The abusive behaviours occurred when Mrs B was alone with her son on weekly scheduled outings. Mrs B's daughter offered her mother an excuse of being 'unwell' to protect against having to experience the weekly visits, but she declined saying 'he's my son and I love him'.

When Mrs B was admitted to hospital after a fall she developed a delirium (an acute confusional state) during which time she voiced paranoid ideas about her son electrocuting her and coming to 'throw me in the Nile'. She was increasingly withdrawn and started to refuse food, most fluids and medication. Her son's abusive behaviours continued in hospital and escalated to the point where he had to be escorted from the building by security staff. Mrs B refused to look at or speak to her son. Subsequently, he was allowed to visit his mother for short periods, and was reportedly quiet and non-confrontational towards her, with no further accusations made about her finances. Mrs B's delirium resolved, but her cognitive and functional impairment had progressed to the point where she needed nursing home care. Upon discharge to a nursing home her oral intake improved, but it was noted she would not eat after her son visited.

Mrs B's indirect self-harm (refusal to eat and take medications) emerged in the context of an untenable situation – elder abuse from her son whom she simultaneously loved and feared. Although she would withdraw during his visits and was visibly distressed afterwards, she was unable to voice this and would not agree to suggested measures to stop him visiting. This response derived from her role as a mother, and also culturally, as he was the eldest child and a man, and as such his position was the head of the family. The indirect self-harm inadvertently served to solve this problem as her son's accusations and overt hostility stopped when she stopped speaking, eating, and taking medications. Mrs B's daughter and others were aware of the abuse, but felt unable to protect her, understanding the complexity of the interpersonal dynamics of the situation for Mrs B. As her daughter summarised, 'She would put up with anything and just wanted to see him because she loves him. He's her son.' Her daughter, the nursing home staff, geriatrician and GP all felt torn between respecting Mrs B's apparent wish to maintain contact with her son and wanting to protect her from her son's abuse. Notably there was no requirement for the abuse to be reported or clear guidelines for how they should respond. Moreover, the reluctance of the older person to cease contact with or prosecute the perpetrator is a common phenomenon for several reasons.³⁰

³⁰ Australian Law Reform Commission, *Elder Abuse—A National Legal Response*, Report No 131 (2017) 209.

Other situations perceived as untenable which have been implicated in the suicide deaths of older adults analysed by psychological autopsy include loss of self-esteem following migration to a different culture, guilt, shame, rejection by spouse, financial disaster and inability to stop drinking alcohol.³¹

III UNDUE INFLUENCE AND RELATIONAL AUTONOMY IN RELATION TO ELDER ABUSE, ASSISTED DYING, AND SUICIDE

A *Undue Influence*

The legal construct of undue influence is usually applied to testamentary undue influence,³² but it has much broader application. O'Neill and Peisah argue that the concept should be extended to consideration of how relationships may influence decision making, particularly in people with cognitive impairment, who may be influenced by others to make a range of legal decisions in the other person's favour.³³ Undue influence is also relevant to discussions about euthanasia and suicide, particularly when the decision making of individuals is recognised as bound to their relationship context. Peisah and colleagues described several risk factors or 'red flags' for undue influence in will-making, which remain relevant to other areas of decision making.³⁴ The red flags relate to the social environment, the social circumstances, and vulnerability of the person (testator):³⁵

(i) The social environment includes consideration of the relationship with the 'influencer', such as a relationship between an older cognitively impaired person and a family member, helpful neighbour or friend, carer, distant relative, a 'suitor'/de facto partner or spouse (often younger and not cognitively impaired), and professionals (doctors, lawyers, clergy etc).

(ii) The social circumstances that may indicate risk include the presence of family conflict, loss of favour of previously trusted relatives or friends, psychological and/or physical dependency on a carer, and isolation and sequestration.

(iii) The personal factors that render a person vulnerable to undue influence include: physical illness, disability and/or sensory impairment; substance misuse; mental illness (eg depression, schizophrenia, paranoid ideas) and cognitive disorders (delirium, dementia, intellectual disability); psychological factors including mourning and grief, personality disorders; and impaired neuropsychological functions required for decision making capacity (eg problems with judgement and reasoning, apathy/passivity).

B *Relational Autonomy*

Many older people are burdened by these risk factors outlined in the previous section. An understanding of how these factors affect decision-making can be drawn from the concept of relational autonomy, which proposes that the autonomy of individuals is founded upon their social connections and context.³⁶ Our identity is shaped by social environments and our interactions with other people. Nedelsky suggested that autonomy emerges within and

³¹ John Snowdon and Pierre Baume, 'A Study of Suicides of Older People in Sydney' (2002) 17(3) *International Journal of Geriatric Psychiatry* 261, 269.

³² Peisah et al, above n 8, 6.

³³ Nick O'Neill and Carmelle Peisah, *Capacity and the Law* (Australasian Legal Information Institute (AustLII) Communities, 2nd ed, 2017).

³⁴ Peisah et al, above n 8, 10.

³⁵ *Ibid.*

³⁶ Ells, Hunt and Chambers-Evans, above n 12, 86.

because of relationships.³⁷ According to this concept, self-identity and decision making capacity are dynamic and change with the individual's network of relationships, and their cultural and social context.³⁸ For example, in Maori people (and some other indigenous peoples), decisions about an individual may be made as part of a family group in a cultural context: *taha whanau* (family health).³⁹ In relation to decision making specifically, a relational autonomy approach promotes understanding and incorporating a person's interpersonal context when assisting them to make choices in line with their sense of self and values.⁴⁰

A related concept in evaluating whether a decision is made autonomously is authenticity. Conditions for authenticity stipulate that the persons' decisions, beliefs, values and commitments are identified as their own, coherent with their sense of self and identity.⁴¹ Thus, even though most tests of decision making capacity focus upon procedural aspects (ie understanding, retaining and weighing up relevant information and then communicating a decision) and emphasise capacity being decision-specific, the context of the person should also be considered to ensure the decision is autonomous.⁴² This context includes authenticity, consistency and social dimensions – that decisions are made in line with the persons' values, commitments and beliefs and in continuing interactions with others.⁴³ As we are social beings, we are accountable for these decisions and must be able to explain the reasons for making decisions and take responsibility for them and their consequences. Understanding undue influence and relational autonomy may be the key to understanding why some older people decide (or not) to attempt suicide or, in the future, request assisted dying.

Long term abuse and family violence also affect autonomy and decision-making through the insidious undermining of self-esteem and identity. When a person has a mental disability, including vulnerability in terms of sense of self and identity, more time must be spent understanding their values and decisions and exploring aspects of authenticity, accountability and social context necessary for autonomy.⁴⁴ One example is the following case of Mrs H, as discussed by Mackenzie:

Mrs H is a woman with an aggressive bone cancer who has had a leg amputation as part of treatment. Her husband has just left her due to her disability, disfigurement and the anticipated burden she would pose on him. She is a woman who has a poor sense of self, with a practical identity determined by norms of traditional femininity, such that her husband's leaving her results in her feeling worthless and with no reason to live.⁴⁵

This self-concept informs her decision to decline further treatment and to tell the treating team that she wants to die.⁴⁶ It is not difficult to see how her position could extend to a request for assisted dying. The difficulty in assessing the autonomy of decision making here is that her sense of self or identity and the values she endorses seem to stem from an oppressive social relationship.⁴⁷ Mackenzie suggests that Mrs H's autonomy in the decision to stop treatment, and potentially to go on to request assisted dying, is therefore compromised. This is because her capacity to reflect has been impacted by distorting influences, and the appropriate response for the medical team would be to try and shift Mrs H's perception of her situation,

³⁷ Nedelsky, above n 13, 36.

³⁸ Ells, Hunt and Chambers-Evans, above n 12, 86.

³⁹ Tane Ora Alliance, *Taha Whanau – Family Health* <<https://www.maorimenshealth.co.nz/te-whare-tapa-wha-health-whare/taha-whanau-family-health/>>.

⁴⁰ Ells, above n 12, 87.

⁴¹ Catriona Mackenzie and Wendy Rogers, 'Autonomy, Vulnerability and Capacity: A Philosophical Appraisal of the Mental Capacity Act' (2013) 9(1) *International Journal of Law in Context* 37, 52.

⁴² *Ibid* 44.

⁴³ *Ibid* 45.

⁴⁴ *Ibid* 50.

⁴⁵ Catriona Mackenzie, 'Relational Autonomy, Normative Authority and Perfection' (2008) 39(4) *Journal of Social Philosophy* 512, 533.

⁴⁶ *Ibid* 526.

⁴⁷ *Ibid* 518.

for example, by helping her explore whether she could see her life as having value within a broader social network (other than just her husband) and identifying sources of self-esteem around which she could reconstruct her identity.⁴⁸ Thus patient autonomy can be supported by attention to the relational context.⁴⁹

The issue of autonomy and requests for assisted dying are complex. On the one hand, if ever there was a decision that had to be autonomous it should be the request to end one's life. On the other hand, we have previously encouraged discussion and family consultation about such decisions.⁵⁰ In reaching an informed decision to end one's life, we have suggested that the person requesting assisted dying should demonstrate that they have considered the potential adverse impact of their death on their loved ones.⁵¹ Distorted perceptions of relationships and how their death might affect family and friends are relevant here. Discussion with family also allows an opportunity to explore these perceptions, and potentially resolve issues underlying the decision to request assisted dying. Rabins has also pointed out that whether there is a 'good reason' to die by suicide, family and friends are often permanently and seriously damaged by such a death of their loved one.⁵² Whether this is also the case in assisted dying remains to be seen, although some families have reported feeling pressured to accept a relative's wish for assisted dying when repeatedly threatened with the alternative prospect of their suicide.⁵³

The reality is that notwithstanding burdened carers and a failing sense of self, a decision for assisted dying is never made in a vacuum, nor should it be. Principles of relational autonomy may be used to protect older people from this most serious potential form of abuse. Constraints on the competence condition for autonomy may come from influences which distort capacity for reflection and self-awareness. Cognitive impairment in older people is an obvious cause of such. Traditionally, this has been interpreted narrowly, in terms of impairments in the practical operation of capacity, through compromised functions such as understanding and appreciating information, weighing up the pros and cons of various options and applying these to one's situation and values, and then arriving at a decision.⁵⁴ However, cognitive impairment may also impede accurate appraisals of relationships and consequently guide decisions through mechanisms such as changes in personality or family alliances, persecutory ideas, and apathy/passivity.⁵⁵ Christman gives other examples of distorting influences such as overpowering emotions, depression or other mental illness, being subject to physical, emotional or verbal abuse, being under the influence of substances which distort perception, or being deprived of educational and social opportunities to develop skills in reasoning, criticism and reflection.⁵⁶ Lack of self-esteem or self-confidence, often the end result of longstanding abuse, impair one's capacity to understand his or herself and to respond in a flexible way to life changes. Autonomy is compromised by lack of self-esteem because it is hard to make a decision if one does not think his or her life and activities are worthwhile.⁵⁷ Given the array of potential factors described by Christman which may distort self-awareness in younger adults, the additional challenges faced by older adults are particularly sobering. These challenges include impaired cognition causing passivity, impaired reasoning and

⁴⁸ Ibid 526.

⁴⁹ Ells, Hunt and Chambers-Evans, above n 12, 95.

⁵⁰ Cameron Stewart, Carmelle Peisah and Brian Draper, 'A Test for Mental Capacity to Request Assisted Suicide' (2010) 37(1) *Journal of Medical Ethics* 34, 39.

⁵¹ Ibid 38.

⁵² Peter V Rabins, 'Can Suicide be a Rational and Ethical Act in Persons with Early or Pre-Dementia?' (2007) 7 *American Journal of Bioethics* 47, 49.

⁵³ Claudia Gamondi, Murielle Pott, Sheila Payne, 'Families' Experiences with Patients Who Died after Assisted Suicide: A Retrospective Interview Study in Southern Switzerland' (2013) 24(6) *Annals of Oncology* 1639, 1644.

⁵⁴ *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819.

⁵⁵ O'Neill and Peisah, above n 33; Carmelle Peisah et al, 'Family Conflict in Dementia: Prodigal Sons and Black Sheep' (2006) 21(5) *International Journal of Geriatric Psychiatry* 485, 492.

⁵⁶ John Christman, 'Relational Autonomy, Liberal Individualism and the Social Constitution of Selves' (2004) 117 *Philosophical Studies* 143, 164.

⁵⁷ Mackenzie, above n 45, 525.

reflection, and the disintegration of a sense of self, which is conferred not only by impaired cognition but also by disintegration of the body.

C Elder Abuse and Undue Influence

These concepts of undue influence and relational autonomy are highly pertinent to elder abuse in general, as well as to decisions for assisted dying and suicide in older people. Firstly, we deal with elder abuse. Older age often comes with more ill health, which impacts on a person's view of themselves, their needs within relationships, and how they respond to maltreatment in these relationships.⁵⁸ Dementia, for example, is more prevalent with increasing age and has been associated with greater risk of elder abuse compared to people without dementia. The risk of elder abuse increases incrementally with the degree of cognitive impairment.⁵⁹ Several reasons have been proposed for this increased risk of elder abuse in dementia, including greater ill health, frailty and dependency on family/carers for support, and less ability to defend oneself from physical and verbal abuse.⁶⁰ Neglect may occur due to the dependency upon others for activities of daily living and personal self-care (eg continence management). People from culturally and linguistically diverse communities may be at heightened risk of abuse due to language difficulties if their primary language is not English due to dependency on family members for support with instrumental activities of daily living (eg paying bills, seeking health care) and social contact, and potential conflict from different expectations of care between generations.⁶¹

Abuse in older people may also be long standing, such as 'domestic violence grown old'.⁶² For some families and couples, conflict and abuse may be well entrenched patterns of relating which simply persist into old age (thus called domestic violence grown old), rather than arising for the first time in late life. Cognitive or functional changes and ill health in older age may shift the balance of needs in a relationship, for example, with a long-term victim of abuse struggling to provide care for the perpetrator.⁶³ Additionally, perpetrators of domestic violence may not make good carers, as a poor premorbid relationship may lead to elder abuse.⁶⁴ Furthermore, long-term domestic violence is associated with depression and anxiety and the undermining of confidence and self-esteem, capability for independence, opportunities for success and personal development and resilience. Additionally, it may promote isolation.⁶⁵ Many of these consequences are also risk factors for undue influence. As discussed above, individuals make decisions in the context of their social environment, personal factors (physical, psychological and cognitive) and significant relationships. Decisions are also guided by how people conceptualise themselves, which may be distorted by abusive interpersonal relationships and social structures, thus impairing autonomy.⁶⁶ Therefore, as in the circumstance of making wills, these factors may interact to render an older person vulnerable to undue influence and abuse within their significant relationships.

⁵⁸ Lucy Knight and Marianne Hester, 'Domestic Violence and Mental Health in Older Adults' (2016) 28(5) *International Review of Psychiatry* 464, 474.

⁵⁹ Xinqi Dong et al, 'Decline in Cognitive Function and Elder Mistreatment: Findings from the Chicago Health and Aging Project' (2014) 22 *American Journal of Geriatric Psychiatry* 598, 605.

⁶⁰ Knight and Hester, above n 58, 466.

⁶¹ Dale Bagshaw, Sarah Wendt and Lana Zannettino, 'Preventing the Abuse of Older People by their Family Members' (Stakeholder Paper 7, Domestic Violence Clearing House, 2009) 16
<<http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.843.2682&rep=rep1&type=pdf>>.

⁶² Chanaka Wijeratne and Sharon Reutens, 'When an Elder is the Abuser' (2016) 205(6) *Medical Journal of Australia* 246, 247.

⁶³ Knight and Hester, above n 58, 466.

⁶⁴ Claudia Cooper, 'Abuse of People with Dementia by Family Carers: Representative Cross Sectional Survey' (2009) 338 *British Medical Journal*, 583, 586.

⁶⁵ Knight and Hester, above n 58, 469.

⁶⁶ Mackenzie, above n 45, 526.

D *Assisted Dying and Undue Influence*

Assisted dying is potentially a fertile ground for undue influence, and this has been recognised in the recent Victorian legislation.⁶⁷ Eligibility for assisted dying under the *Voluntary Assisted Dying Act 2017* (Vic) requires a person: to have lived in Victoria for a minimum of one year; to be over the age of 18; to have decision making capacity in relation to voluntary assisted dying; to have a condition which is incurable, advanced, progressive and will cause death; to have six months to live (or 12 months if suffering from particular neurodegenerative conditions such as motor neurone disease which they are expected to die from with 12 months); and experience suffering which cannot be relieved in a manner perceived as tolerable to the individual.⁶⁸ Apart from the formal three-step request process, which mandates two independent medical assessments and a written declaration from the person requesting assisted dying, the legislation includes safeguards to protect vulnerable people from coercion and abuse. Requests will be subject to review by a dedicated board.⁶⁹ Notably, the Act also requires that the two doctors involved in assessing the person are satisfied that they are ‘acting voluntarily and without coercion’.⁷⁰ It is also clearly stipulated that a person whose primary reason for requesting assisted dying is a mental illness (as defined under the *Mental Health Act 2014* (Vic)) or a disability (as defined by the *Disability Act 2006* (Vic)) alone is ineligible.⁷¹

Thus, in addition to assessing decision making capacity in relation to assisted dying, clinicians must assess or screen for undue influence. In a proposed legal test for competence to request assisted suicide, we previously emphasised both components of the assessment task. Specifically in relation to undue influence, we suggested that the decision must be made by the person him or herself and not one he/she feels compelled to make, or coerced by others involved in their care into making, in order to relieve them of burden.⁷² The possibility of making a voluntary and informed decision despite the likely presence of dependent relationships with carers was noted.⁷³ The person’s strength of will and the degree of pressure upon them to request assisted suicide should also be considered when assessing for undue influence. The same assessment could be usefully applied to the determination of their capacity to request assisted dying.

Terminal illness is of itself a risk factor for undue influence, and it is conceivable that people suffering from the associated physical and psychological symptoms would be more vulnerable to pressure, whether express or implied, from significant others. The definition of a terminal illness is in itself complex. There is a clear difference, for example, between someone with a condition that confers a very short life expectancy and someone with a diagnosis of early Alzheimer’s dementia. Whilst a person with early dementia has a statistically shorter life expectancy than someone without dementia of the same age, there is uncertainty about when or how they will die many years before their death. Knowledge of having, or even fear of developing, dementia may confer anxiety about the imagined experience of functional and cognitive decline, which is not often realised.⁷⁴ Notably, the *Voluntary Assisted Dying Act* specifies that, for a person to be eligible for access to voluntary assisted dying, they must have a disease that is expected to cause death within weeks or months, not exceeding six months,⁷⁵ which is perhaps a protective measure for those contemplating assisted dying in early dementia.

⁶⁷ *Voluntary Assisted Dying Act 2017* (Vic).

⁶⁸ *Ibid* s 9.

⁶⁹ *Ibid* pt 9.

⁷⁰ *Ibid* ss 20(1)(c), 29(1)(c).

⁷¹ *Ibid* ss 9(2)–(3).

⁷² Stewart, Peisah and Draper, above n 50, 38.

⁷³ *Ibid*.

⁷⁴ Brian Draper et al, ‘Early Dementia Diagnosis and the Risk of Suicide and Euthanasia’ (2010) 6 *Alzheimer’s and Dementia* 75, 82.

⁷⁵ *Voluntary Assisted Dying Act 2017* (Vic) ss 9(1)(d), (3).

Depression is not uncommonly comorbid with terminal illness and may influence decision making capacity. It may compound perceptions of hopelessness, isolation and burdensomeness,⁷⁶ especially when accompanied by a poor prognosis. For example, depression in patients with cancer with a poor prognosis of less than three months life expectancy was found to be associated with requests for euthanasia.⁷⁷ Further, the wish for euthanasia may be state-dependent, as preferences for euthanasia in depressed older people mostly resolved upon treatment for depression.⁷⁸ Depression can be screened for in the terminally ill, and there is evidence that treatment is effective and can improve quality of life.⁷⁹ It is worth noting, however, that the presence of depression does not automatically preclude decision making capacity, a point which has been raised elsewhere.⁸⁰

E Suicide and Undue Influence

Older people, especially those reliant on carers, may feel obliged to end their lives by suicide to reduce care giver burden, for similar reasons to those proposed to potentially underlie euthanasia requests. We have previously described two cases of older people who requested euthanasia, but as it was not legal in their jurisdiction, they attempted suicide instead. In one case, an 88-year-old woman who was the primary carer for her frail older husband took an overdose with suicidal intent in the context of acute chronic pain. She had previously expressed a wish to die by euthanasia should she ever lose her independence. The acute pain was a trigger to her suicide attempt as she could no longer perform her caregiving role for her husband and feared both placement in residential aged care facility and becoming a burden on her family. In the other case an 89-year-old man with cognitive impairment and alcohol misuse who lived alone made multiple attempts to end his life. He stated he would have opted for euthanasia were it legal, and concluded that the only solution was to take matters into his own hands. With some awareness of his declining cognition, death for him meant avoiding becoming a burden on his family, nursing home placement and dependency. Avoiding placement also meant that his children would receive the full amount of his estate.⁸¹

In both of these cases, although there was no apparent external undue influence, it was the interpersonal or relational factors that underpinned their requests for euthanasia and ultimately, as it was unavailable, their decisions to attempt suicide.

IV ASSISTED DYING AND CRIMINAL PROSECUTIONS

Manslaughter and homicide are extreme manifestations of elder abuse. However, the line between assisting a person to die if they ask for help to end their life and abuse or criminal behaviour is not always clear. According to Australian law,⁸² aiding and abetting a suicide is a crime. We have previously discussed *R v Justins*,⁸³ an Australian case of involuntary euthanasia due to incapacity.⁸⁴ Two women, Justins and Jennings, were found guilty of the manslaughter of Graeme Wylie, a man with severe dementia and depression who had

⁷⁶ Van Orden et al, above n 24, 600.

⁷⁷ Marije L van der Lee et al, 'Euthanasia and Depression: A Prospective Cohort Study among Terminally Ill Cancer Patients' (2005) 23 *Journal of Clinical Oncology* 6607, 6612.

⁷⁸ Stuart Hooper et al, 'Preferences for Voluntary Euthanasia during Major Depression and Following Improvement in an Elderly Population' (1997) 16(1) *Australasian Journal on Ageing* 3, 7.

⁷⁹ Lauren Rayner et al, 'Antidepressants for the Treatment of Depression in Palliative Care: Systematic Review and Meta-Analysis' (2011) 25(1) *Palliative Medicine* 36, 51.

⁸⁰ Stewart, Peisah and Draper, above n 50, 37.

⁸¹ Anne Wand et al, 'Rational Suicide, Euthanasia, and the Very Old: Two Case Reports' [2016] *Case Reports in Psychiatry* 1, 2-3.

⁸² *Crimes Act 1900* (NSW) s 31C.

⁸³ *R v Justins* [2008] NSWSC 1194 (12 December 2008).

⁸⁴ Stewart, Peisah and Draper, above n 50, 37.

requested euthanasia but lacked capacity to suicide. Justins was Wylie's long term de facto partner and Jennings was a friend of the couple and a member of the voluntary euthanasia organisation Exit International. Wylie had made suicide attempts and expressed to friends and family a wish to end his life rather than succumb to the inevitable stages of decline in dementia.⁸⁵ He did not prepare an advance directive outlining his wishes at the end of life in the event that he had lost capacity or give any indication as to who should make health care decisions for him. An application to visit the Dignitas clinic⁸⁶ for euthanasia was written by Jennings on behalf of Wylie in 2005. Dignitas rejected his application due to concerns about his capacity to consent to assisted suicide. Following this rejection, Wylie unsuccessfully attempted suicide again, whilst Justins – who was aware of the attempt – was out of the house at his request. Jennings then visited Mexico in order to procure Nembutal (pentobarbitone), after reading about the effectiveness of the drug for euthanasia, and gave it to Justins upon her return. In the same month Justins took Wylie to his solicitor to change his will which substantially increased her proportion of his estate. The couple had a medical certificate stating Wylie was competent to make his own decisions. Justins testified that she left the open bottle of Nembutal on the table in front of Wylie, which he then poured into a glass. She left the house. Wylie then drank from the glass. Justins returned and found him deceased. An autopsy revealed the Nembutal in his system and confirmed the presence of Alzheimer's disease. The prosecution rejected the women's offer to plead guilty to assisting suicide and a jury subsequently found both women guilty of manslaughter. Jennings killed herself before sentencing and Justins was sentenced to periodic detention. The verdict rested on two key issues: Wylie's capacity to decide to end his life by taking the Nembutal, and whether a reasonable person in Justins' position would have known he had the capacity or explored whether he had the capacity to end his life.⁸⁷

Justins subsequently successfully appealed her conviction in 2010 in the Court of Criminal Appeal (CCA),⁸⁸ with a key element in the determination being that a decision to commit suicide need not necessarily be informed in order to be competent.⁸⁹ Specifically, Johnson J (with Simpson J agreeing) held that:

[4] The concept of 'an informed decision' is not apt to an assessment of the capacity of a person to decide to commit suicide. Nor is it useful to speak of a rational decision for which a good reason may be ascribed or identified.

[5] A person possessing capacity may decide to commit suicide on a basis that is ill-informed or not supported by reason, but it may be the reasoned choice of the person, which the law accepts will render the act of suicide the act of the person and not another person who provides the means of death.⁹⁰

It is important to note that the CCA found that, in suggesting a sequential set of capabilities the deceased must have in order to have capacity, the trial judge fell into error because these transformed factual propositions into legal requirements.⁹¹ Notwithstanding these findings, which disconnected clinical criteria for capacity from the determination of whether the act of suicide was the act of the person or the other providing the means of death, the case highlighted the relational context of assisted suicide, notably the question of aiding and

⁸⁵ Thomas Faunce, 'Medical Law Reporter: *Justins v The Queen*: Assisted Suicide, Juries and the Decision to Prosecute' (2011) 18(4) *Journal of Law and Medicine* 706, 715.

⁸⁶ Dignitas is an association founded in Switzerland in 1988 with the objective of ensuring a life and death with dignity for its members. They offer services to people internationally, including the possibility of assisted suicide for people making a reasoned request in the context of medical proof and cases of terminal illness, pain or disability.

⁸⁷ Stewart, Peisah and Draper, above n 50, 37.

⁸⁸ *Justins v R* (2010) 79 NSWLR 544.

⁸⁹ Faunce, above n 85, 706.

⁹⁰ *Justins v R* (2010) 79 NSWLR 544 [4]–[5].

⁹¹ *Ibid* [2].

abetting a suicide or manslaughter,⁹² an important distinction in the discourse about assisted dying.⁹³

It is unclear what constitutes aiding and abetting in suicide in Australia as there have been no tested cases and, unlike the UK,⁹⁴ there are no guidelines for prosecution. The six public interest factors against prosecution that comprise the Policy for Prosecutors in Respect of Cases Encouraging or Assisting Suicide ('the Policy') for prosecuting assisted suicide cases in England emphasise the following: the importance of the victim reaching a determined, voluntary, settled and clear informed decision to end their life; the accused being motivated by compassion; the accused trying to dissuade the victim from ending their life; the minor and reluctant encouragement or assistance to the victim; and the reporting of the suicide to police and assisting in the investigation of the circumstances of the suicide.⁹⁵ The emphasis is on the motivation of the accused who assisted the suicide, not the victim. The Policy also suggests that it is not in the public interest to prosecute someone who has reluctantly and compassionately assisted in the suicide of a competent and determined adult.⁹⁶

Assisting suicide will include conduct where the defendant supplies an instrument or drug that a person then uses to kill herself or himself. It can also consist of advice on methods which help the suicidal person in his or her task. If the assistant takes a more active role and actually kills the person (for example, by injecting the patient with drugs), the charge of murder or attempted murder may apply. This was the question in Kate Gilderdale's case.⁹⁷ Gilderdale's daughter Lynn had myalgic encephalomyelitis that resulted in a form of chronic fatigue syndrome. She had consistently asked for help to end her life, had attempted suicide and made an advance directive indicating she refused life-sustaining treatment. After Lynn tried and failed to end her life by morphine overdose, Gilderdale administered morphine and injected air into her daughter's veins. She pleaded guilty to assisting a suicide but was found not guilty of attempted murder. The jury expressed much sympathy for Gilderdale's case, deeming her role in the suicide to be compassionate. She was sentenced to 12 months' conditional discharge.⁹⁸

The motivation of the person assisting the suicide is an important determinant for prosecution. In contrast to the Gilderdale case, that in the case of *McShane* is a clear case of (elder) abuse.⁹⁹ Mrs McShane was in serious financial difficulty and was convicted under the *Suicide Act 1961* for trying to persuade her mother to kill herself.¹⁰⁰ McShane was video recorded instructing her mother to take an overdose and cautioning her mother, before she took the overdose, not to tell anyone of her (McShane's) role in assisting the suicide in case she would lose her inheritance claim. Her mother did not want to end her life and did not make an attempt. *McShane* illustrates malevolent motivation leading to coercion and pressure on a potential victim, in direct contrast to someone who makes an informed and voluntary decision to end their life,¹⁰¹ having asked for the assistance of another.

⁹² *R v Justins* [2008] NSWSC 1194 (12 December 2008).

⁹³ Faunce, above n 85, 710.

⁹⁴ Director of Public Prosecutions, *Suicide: Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide* (October 2014) Crown Prosecution Service <http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html>.

⁹⁵ Ibid.

⁹⁶ Alexandra Mullock, 'Overlooking the Criminally Compassionate: What Are the Implications of Prosecutorial Policy on Encouraging or Assisting Suicide?' (2010) 18 *Medical Law Review* 442, 470.

⁹⁷ 'Mother Cleared of ME Daughter's Attempted Murder', *BBC News* (online), 25 January 2010 <http://news.bbc.co.uk/2/hi/uk_news/england/sussex/8479211.stm>.

⁹⁸ Afua Hirsch, 'Kay Gilderdale Case: A Clear Verdict on the Law's Confusion on Assisted Suicide', *The Guardian UK* (online), 26 Jan 2010 <<https://www.theguardian.com/uk/2010/jan/25/kay-gilderdale-case-expert-view>>.

⁹⁹ (1977) 66 Cr App Rep 97; R Huxtable, *Euthanasia, Ethics and the Law: From Conflict to Compromise* (Routledge-Cavendish, 2007) 60.

¹⁰⁰ *Suicide Act 1961* (UK).

¹⁰¹ *McShane* (1977) 66 Cr App Rep 97 [43(3)].

V IMPLICATIONS FOR POLICY AND GUIDELINES FOR ASSISTED DYING

We have previously recommended an approach to assessing mental capacity to request assisted suicide.¹⁰² The proposed criteria for assessment include evaluating the following: the person's understanding of their conditions and prognosis; their perceptions of quality of life; their ability to give informed consent (including comprehending and retaining relevant information on the potential risks and likely result of taking a drug for assisted suicide, and feasible alternatives); their reasons for requesting physician assisted suicide; and their process of reasoning (weighing up the information and arriving at a decision).¹⁰³ Consistency in decision-making should be present over time and in line with past expressed wishes and the person must be able to communicate their wish. Focus was also given to the patient's mental status, mood (and possible mood disorders), general and interpersonal functioning, the presence of internal or external coercion; and

[t]he decision must be free from undue influence. While patients will still be able to make competent decisions when they are highly dependent on others for care, their decisions must truly be ones that they have made, rather than decisions which they have been forced to make or feel they should make to relieve others of burden. Undue influence must be assessed by having regard to both the patient's strength of will and level of pressure being placed on the patient by others to commit suicide.¹⁰⁴

In addition, we have highlighted how concepts of relational autonomy are relevant to the assessment of requests for assisted dying. Whilst such a decision must be autonomous, the person must be considered in the context of their relationships, with the accompanying complexity. Where possible, people requesting assisted dying should be encouraged to discuss this decision with their friends and family, not only for support or to ensure they understand the broader effects of this decision on others, but to safeguard against abuse.

Noting the reference in the Act to the need to protect individuals who may be subject to abuse,¹⁰⁵ we propose that a robust set of guidelines be developed to support this and indeed all of the other principles of capacity assessment for the purposes of that Act. Such guidelines need to be promulgated amongst all health practitioners involved in assessments for the purposes of the legislation in line with the principles of training embodied within it.¹⁰⁶ It is the responsibility of all health practitioners involved in assessments for the purposes of the Act to understand the importance of determining capacity and undue influence and the potential for abuse in this context. It is important for the implementation of this legislation that health practitioners understand the legislation and their responsibilities under the legislation. Active policy regarding such specific education is essential given what is already known about the gaps amongst medical practitioners in understanding capacity in general¹⁰⁷ and other key provisions pertaining to end of life, such as withholding and withdrawing life-sustaining medical treatment.¹⁰⁸

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) published a Position Statement on Physician Assisted Suicide.¹⁰⁹ It was recognised that the practice was illegal at the time of publication and the emphasis was on the ethical issues inherent in physician-assisted suicide, particularly in relation to psychiatrists. Several key points were

¹⁰² Stewart, Peisah and Draper, above n 50, 38.

¹⁰³ Ibid.

¹⁰⁴ Ibid.

¹⁰⁵ *Voluntary Assisted Dying Act 2017* (Vic) ss 5(1)(i), 12.

¹⁰⁶ Ibid ss 4(b), 17, 18.

¹⁰⁷ Greg Young, Alison Douglass and Lorraine Davison, 'What Do Doctors Know about Assessing Decision-Making Capacity?' (2018) 131 *New Zealand Medical Journal* 58, 71.

¹⁰⁸ Ben White et al, 'Doctors' Knowledge of the Law on Withholding and Withdrawing Life-Sustaining Medical Treatment' (2014) 201(4) *Medical Journal of Australia* 1, 4.

¹⁰⁹ Royal Australian and New Zealand College of Psychiatrists, *Physician Assisted Suicide, Position Statement No 67* (2016) 1, 4.

raised: the rights of people with mental illness and that psychiatric illness should never be the justification for physician-assisted suicide; the rights of older people, especially those with dementia; misconceptions about older people and factors underpinning high suicide rates in older people; and the right of doctors to determine whether or not they will be involved in physician-assisted suicide.¹¹⁰ The RANZCP concluded that the main role of doctors in end of life care is to promote good quality, comprehensive, accessible patient-centric care; that psychiatric assessment and treatment should be provided for people requesting physician-assisted suicide; and that psychiatrists should add their expertise to the debate. Noting the reference to psychiatric expertise in the Victorian legislation,¹¹¹ we would add the requirement that psychiatrists be trained in capacity and undue influence assessment.

VI CONCLUSION

With assisted dying now legal in one state of Australia, there is an urgent need to consider how capacity to request assisted dying should be assessed, including the potential for undue influence and abuse. We are social beings and, as such, decision-making capacity, including for assisted dying, must be considered within a relational autonomy framework. Older people are at particular risk of undue influence in decision-making, and we know that relational factors drive decisions to self-harm and suicide in older people. Relationships would therefore be expected to influence requests for assisted dying.

¹¹⁰ Ibid 2.

¹¹¹ *Voluntary Assisted Dying Act 2017* (Vic) s 18(1).