



REVISTA COLOMBIANA DE PSIQUIATRÍA

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Editorial

The right to die with dignity through euthanasia, six years on



Del derecho a morir con dignidad a través de eutanasia, seis años después

Colombia is one of the seven countries with specific regulations¹ regarding euthanasia as a way of exercising the right to die with dignity and a means for medically-assisted death. In Colombia, this regulation has depended on the jurisprudential² evolution arising from the decriminalisation of mercy killing, a consequence of ruling C-239 of 1997, unlike the other six countries, which have legislation that regulates the practice based on legislative initiatives that have been passed by their congresses and assemblies, the Netherlands (2002), Belgium (2002), Luxembourg (2009), Canada (2015), Spain (2020) and New Zealand (2020).¹⁻⁶ A striking feature of the Colombian regulation is that it requires evaluation⁷ of a person's capacity and mental competence to make decisions in the face of his or her own death, particularly in the face of the request for early death through euthanasia, by a psychiatrist or clinical psychologist.

Compared to the other regulations around the world, in the evaluation of the capacity and competence with respect to the decision, it is important to note that, although the presence of capacities is recognised as necessary to give direct consent for the procedure and to raise the application in the first instance, this does not require an evaluation by Psychiatry to give free rein to the application process or to carry out the euthanasia procedure. The aforementioned, with the minor exception of including the request for such an evaluation as a third eval-

uator of the case if the professionals responsible for handling it consider it necessary, has been included in New Zealand law.

The participation of the psychiatrist in the euthanasia application process in Colombia is based on the statement of ruling C-239 of 1997: "[...] consent implies that the person has serious and reliable information about his or her disease and treatment options and prognosis, and has sufficient intellectual capacity to make the decision,⁸ which is reiterated in the establishment of guidelines for the attention of the application in the context of the health system, given by ruling T-970 of 2014, in which it is referred to that "to exclude the criminal nature of the conduct [...], consent implies that the patient has serious, reliable and accurate information, but also has sufficient intellectual capacity to make the decision.⁹ Consequently, the evaluation of mental capacity was brought to the specific regulation, in Resolution 1216 of 2015⁷ and its contemporary, the document on recommendations for handling the euthanasia request, the "Protocol for the application of the euthanasia procedure in Colombia, 2015". In the latter, it is pointed out that, in addition to establishing the capacity to make decisions, the evaluation must determine whether the decision was well considered, whether there is involvement of mental illnesses or a decrease in decision-making capacity, indicating that this is a priority evaluation.¹⁰

Over the years and as clinical exercise derived from the comprehensive accompaniment of people who request euthanasia has progressed, four spaces have been identified where psychiatrists actively relate to the process: a) information on rights: patients often access information about their rights at the end of life from the conversation with the psychiatrist, who openly, neutrally and objectively investigates their personal preferences, beliefs and end-of-life desires; b) evaluation of capacity: a medical exercise that aims to identify how the patient understands the information about their current

¹ Resoluciones relacionadas con el Derecho a Morir con Dignidad a través de la eutanasia vigentes en Colombia, Resolución 1216 de 2015, Resolución 4006 de 2016, Resolución 2665 de 2018, Resolución 825 de 2018 y Resolución 229 de 2020.

² Sentencias que revisan la materia del derecho fundamental a morir con dignidad: SC-239 de 1997; ST-970 de 2014; ST-423 de 2017; ST-322 de 2017, ST-132 de 2017; ST 544 de 2017; ST 721 de 2017; ST 060 de 2020.

situation from a condition of terminality, reasons about the available treatment alternatives, while there are no curative and only palliative alternatives, discusses how these available treatment alternatives align or not with the concepts of quality of life, quality of death, dignified life, dignified death and suffering, among others, and accordingly communicates this decision to the parties involved; c) exploration of the concept of suffering: this is perhaps the evaluation that requires the psychiatrist to be at his or her most sensitive, respectful, and empathetic and able not to reduce the experience of suffering to a disease condition and to the elements related to physical symptoms, but to regard it as a dimension of the finite, fragile and fallible beings that we are; it is in this evaluation that doctors, psychiatrists and non-psychiatrists, caregivers, family and others involved dare to universalise their own concept of suffering and extend it to the capacity that the patient “should” have and pursue, and d) participation in the Scientific-Interdisciplinary Committee for the Right to Die with Dignity. As part of being the second evaluator, in this instance, the psychiatrist must have a deep understanding of the related regulations in force, communicate with multiple medical specialties that act alongside the patient's treating physician, lead the process of evaluation and verification of the requirements and, ultimately, promote a deliberation that does not lose sight of the role of the Committee as guarantor of the right to dignified death through euthanasia, ensuring all the time the prevalence of autonomy, impartiality, speed and confidentiality that the process demands.

Six years ago an editorial in this journal called attention to the faculties of Medicine as “those in charge of educating their residents in these issues, training them in the current regulations so that a practice of quality so necessary in this evaluation starts from us.”¹¹ Today as psychiatrists, as teachers and as educational institutions, it is worth questioning to what extent we have fulfilled this task or whether we remain in debt. And to the invitation that was made to us six years ago, we must add our duty to participate actively in the creation of regulations in this regard, the education of non-psychiatrists for the accompaniment of these patients and the training of civil society on the exercise of rights at the end of life, among others. Beyond the merely technical fact of preventing, diagnosing and treating mental illnesses, to practise psychiatry is to have the chance to witness and travel through the deepest and most intense dimensions of the human condition.

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<https://doi.org/10.1016/j.rcpeng.2023.03.003>