

Lange Peter (Orcid ID: 0000-0002-0162-1664)
White Ben (Orcid ID: 0000-0003-3365-939X)
Philip Jennifer (Orcid ID: 0000-0002-3312-0645)
Komesaroff Paul (Orcid ID: 0000-0002-1360-3375)
Holmes Alex (Orcid ID: 0000-0003-3879-9471)

Can depressed patients make a decision to request voluntary assisted dying?

Associate Professor Alex Holmes

Department of Psychiatry, University of Melbourne, Melbourne, Victoria, Australia.

E-mail: acnh@unimelb.edu.au

Associate Professor Peter Lange

Geriatrician, Royal Melbourne Hospital, Melbourne, Victoria, Australia.

Professor Cameron Stewart

Director of the Centre for Health Governance, Law and Ethics, Sydney Law School,
University of Sydney, Sydney, NSW, Australia;

Professor Ben White

Australian Centre for Health Law Research, Faculty of Law, Queensland University of
Technology, Brisbane, Queensland, Australia.

Professor Lindy Willmott

Australian Centre for Health Law Research, Faculty of Law, Queensland University of
Technology, Brisbane, Queensland, Australia

Professor Michael Dooley

Director of Pharmacy, Alfred Health, Monash University, Melbourne, Victoria, Australia

Professor Jennifer Philip

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Chair of Palliative Medicine, St Vincent's Hospital, University of Melbourne, Melbourne, Victoria, Australia

Camille La Brooy

Faculty of Medicine, Nursing and Health Sciences, Monash University, Melbourne, Victoria, Australia

Professor Paul Komesaroff

Faculty of Medicine, Nursing and Health Sciences, Monash University, Melbourne, Victoria, Australia

Alex Holmes, Peter Lange, Cameron Stewart, Ben White, Lindy Willmott, Michael Dooley, Jennifer Philip, Camille La Brooy, Paul A. Komesaroff

Depression in a patient with terminal illness does not always mean an absence of capacity to make the decision to request Voluntary Assisted Dying (VAD). Under the Victorian *Voluntary Assisted Dying Act 2017* (the Act) (1), when there is uncertainty about capacity, referral to a health professional with 'appropriate skills and training, such as a psychiatrist in the case of mental illness' is required. This paper uses a case of a patient with depressive symptoms requesting VAD to highlight the complexity of making a determination of capacity and looks to identify factors which may influence differing opinions.

Box 1: Test for capacity under the *Voluntary Assisted Dying Act 2017* (Vic), Section 4.

A person has decision-making capacity in relation to voluntary assisted dying if the person is able to

- (a) Understand the information relevant to the decision relating to access to voluntary assisted dying and the effect of the decision;
- (b) Retain that information to the extent necessary to make the decision;
- (c) Use or weigh that information as part of the process of making the decision; and
- (d) Communicate the decision and the person's views and needs as to the decision in some way, including by speech, gestures or other means.

The Act permits adult residents to seek an assisted death if they have an incurable condition expected to end life within 6 months (or 12 months for neurodegenerative conditions) and if they are suffering in a way that cannot be relieved in a manner that the person considers tolerable. The capacity to request VAD which is legally defined by reference to set criteria (Box 1) has been adopted from that used to consent to medical treatment (2), including refusal of life affirming treatment (3).

Depressive symptoms, including those as part of a major depressive disorder, are common at the end of life (4), as is altered cognition and lack of capacity. A recent metanalysis suggested that 34% of patients in medical settings lack the capacity to consent to treatment (5). Many psychiatrists consider that a diagnosis of major depression precludes the capacity to make a decision to request VAD (8), although this is not a unanimous view. For example, in a study of 18 patients who received lethal medication under the Oregon legislation, 3 had been diagnosed with a major depressive disorder, though were judged to have capacity (6).

Despite an increasing awareness of the complex interactions between mood, agency, autonomy and control at the end of life, conclusions regarding capacity to request VAD in the presence of psychological distress, and in particular, symptoms of depression, are not always uniform. We present a case study of a patient with depressive symptoms for which two psychiatric opinions were received highlighting differing interpretations of the relationship between depression and the capacity to make a decision to request VAD. It is acknowledged that when providing such opinions the psychiatrists have a full range of clinical care responsibilities, but for the purpose of this discussion, the focus is upon their assessment of capacity.

Case Study*

Mrs A was a widowed woman in her 70s with a diagnosis of interstitial pulmonary fibrosis. Treatment had been ineffective. She became aware of the Act through the popular media and asked her sons to investigate. She was referred to a geriatrician who agreed to become her co-ordinating practitioner, a role designated within the Act.

The initial assessment by the co-ordinating practitioner occurred in an aged care facility. Mrs A explained that she was requesting VAD because she found the shortness of breath and fatigue distressing and was concerned about her progressive loss of independence, dignity, bodily control and inability to participate in social activities. She felt helpless and did not think her physical symptoms would improve. She said she had less interest in socialising, reading and watching television than previously. Her appetite was reduced, and her sleep was impaired. She said she did not feel depressed and that she experienced pleasure when her grandchildren visited. She did not express any guilt or thoughts of being a burden on others. Mrs A had been commenced on escitalopram 10mg 2 weeks previously, but otherwise had no previous history of mental disorder. On examination she was short of breath at rest and required oxygen. Mental state examination revealed a restricted range of affect and a lack of enthusiasm and enjoyment. She scored 28 out of 30 on the mini-mental state examination, not being aware of the recent date and dropping one item on recall.

The co-ordinating practitioner was troubled by her sense of apathy and her lack of enjoyment and arranged a review by a psychiatrist. During this assessment Mrs A said that she was "sad" because she could not die peacefully. She re-iterated a lack of interest and enjoyment in life, apart from when her family visited. On mental state examination on this occasion she presented as tired and she struggled to maintain the effort required to complete the consult. The psychiatrist determined that her mood was low and her range of affect was restricted. His opinion was that Mrs A had a moderate depression and VAD should not proceed until the

depression was treated. He recommended commencing mirtazepine at 15 mg, with a subsequent increase in dose to 60mg.

Over the ensuing three weeks no change was noted in Mrs A's mental state as observed by the co-ordinating practitioner and her family. She continued to request VAD and was supported in this by family. Consistent with his initial opinion, the psychiatrist assessed Mrs A as lacking capacity and declined to support the VAD process.

Mrs A was then referred to another psychiatrist for a second opinion. The history obtained was consistent with earlier assessments. Mrs A said she did not feel depressed. She said she would prefer to die rather than experience increasing shortness of breath and affirmed that she wished to choose the manner of her death which appeared to the psychiatrist to be an appropriate response to her current circumstances. She was keen to communicate that she did not want to suicide. She stated that she viewed VAD as different from suicide because it involved the help and consent of others. On mental state, Mrs A was oriented and attentive. She sat quietly with nasal prongs in place and exhaled through pursed lips. She did not impress as being tormented or having psychomotor retardation. She communicated fatigue and mild frustration. Over time she was able to demonstrate a range of emotions, smiling with pride when describing her enthusiasm for life when a young adult.

The conclusion of the second psychiatrist was that Mrs A indeed fulfilled the criteria stipulated in the Act. Specifically, she was able to understand, retain, weigh up the information put to her and to communicate a clear decision of her own. She understood that requesting VAD would end her life. Her wish to die appeared motivated by a desire not to suffer and, in the opinion of the psychiatrist, could not be predominantly attributed to the presence of a depressive disorder. Both a subjective depressed mood and decreased self worth were absent. A diagnosis of depression was therefore not made. The psychiatrist also formed the opinion that treatment for purported depression was unlikely to change her mental state in the foreseeable future.

A permit for the prescription of life ending medication was issued which Mrs A took, ending her life.

Discussion

Two different opinions were formed regarding Mrs A's capacity to make the decision to request VAD. This occurred in the absence of significant changes in her mental state or physical wellbeing over time (Box 2). The difference in views can be related to whether major depression was diagnosed and an association made between a diagnosis of major depression and capacity to request VAD.

Box 2: Assessments of capacity

Opinion 1

- Diagnosis of depression
- Depression determined to be affecting judgement
- Determined not to have capacity to consent to VAD

Opinion 2

- Depressive symptoms, not reaching threshold for diagnosis of depressive disorder
- Able to understand, communicate and retain information, describe consequences of pursuing and not pursuing VAD, and weigh the options
- Determined to have capacity to consent to VAD

The view that a diagnosis of major depression precludes the capacity to make a decision to request VAD is based on an interpretation of the impact that low mood has on judgement. Persistent low of mood, characteristic of major depression, drives a negative appraisal of the world, including what it will be like in the future. If depression is affecting the weighing up of options regarding the future, then the patient may be considered not to have a full, “pre-depression” level of judgement and therefore to have impaired capacity. This approach is supported by the principle that, when assessing capacity, the degree of rigour required of the assessment should increase with the consequences of the decision (7).

A counter argument relates to the legal requirement in relation to the criteria. Mindful that all patients are assumed to have capacity, a finding of an absence of capacity requires evidence that one or more criteria are not met. The inability to weigh up options, for example, needs to be demonstrated, rather than assumed. From this perspective, because it was never contested that Mrs A was able to present a detailed, rational and cohesive argument regarding her request, it should be concluded that she fulfilled the criteria for capacity specified in the Act.

There are clear circumstances in which the presence of a depressive disorder does lead to an absence of capacity to make a decision to request VAD. These are when the depression itself is the predominant factor driving the wish to die. It is assumed here that, in the absence of depression, the patient would no longer wish to die through VAD. In addition to low mood, a central element of depression is self-hatred and an attack on the self. These phenomena manifest themselves through low self-worth, guilt, thoughts of being a burden and a belief that the world is better off without them, features all absent in Mrs A's case. Depression may also be considered predominant when the wish to die appears ‘out of character’, or contrary to long expressed views and principles.

The differing opinions regarding the diagnosis of depression in Mrs A highlight the complexity in making this diagnosis in patients with medical illness. Symptoms of physical illness (appetite loss, weight loss, lethargy, sleep disturbance) overlap with those of depression (8). In some patients, demoralisation or existential distress may better describe their distress (9). Even if depression is not considered the predominant factor driving the wish to die, it may still play a part in the formulation, determination of agency and treatment recommendations. To deal with this, a range of approaches has been put forward which either include, exclude or substitute symptoms within the diagnostic criteria. Each method entails a different balance of sensitivity, specificity and validity (8) and may lead to differing diagnostic opinions, including those which occurred with Mrs A.

Just as depression does not inevitably imply lack of capacity, nor is suicide invariably linked to depression. Accordingly, the absence of depression does not preclude a suicidal process in a patient requesting VAD, even when capacity can be demonstrated. Suicidal motives, which may be inferred from themes of self-hate, isolation and an absence of meaning, may have particular relevance for the designated practitioner. Intense doctor patient relationships with features of overidentification, transference and counter transference have been identified as areas of concern in VAD (10) and through these processes the unwitting enactment of self destruction through VAD may leave a physician carrying a significant burden of guilt. In one study of oncologists it was reported that 25% of those who participated in euthanasia regretted having done so (11). Notwithstanding that the Act clearly emphasises the voluntary nature of a practitioner's participation in VAD, it may be associated with ongoing adverse personal consequences.

Mrs A's case revealed a tension that arises between the time frame usually required to treat depression and life expectancy in those looking to request VAD. If further anti-depressant treatment had been pursued with Mrs A, she may well have died before the course of treatment was completed. If a patient has depressive symptoms, recommending a trial of anti-depressants 'to see if the patient responds' is consistent with usual practice. Anti-depressants can be effective in terminally ill patients (12) and may increase the desire for life-sustaining medical therapies in some (13). Evidence exists, however, of decreased efficacy for anti-depressants in cancer patients (14). The possibility that treating depression may preclude VAD (given the limited time to death) without any amelioration of suffering needs to be acknowledged, and where a patient has capacity even in the presence of depression, a decision about VAD should not be made conditional upon a trial of treatment.

The emergence of VAD legislation raises a unique dilemma for psychiatry. A view that the wish to die is always pathological is not uncommon, including in the wider community (2). In one attempt to reconcile this impasse, the American Association of Suicidality has proposed differentiating 'traditional suicide' and physician aid in dying (15). The authors argue that VAD patients do not necessarily want to die, but choose to do so in the face of ongoing suffering, observing enhanced engagement with loved ones, a deepened sense of meaning and the absence of self-hate in VAD patients.

The alternative to mental disorder as a means to determination of capacity to request VAD is to use a psychiatric formulation (16). A formulation identifies the multiple factors in play at the end of life, including the patient's values, cultural context, religious beliefs and personal relationships. It requires detailed conversations and dialogue with relevant affected parties, including, where appropriate, other health professionals. The formulation acknowledges concurrent, contradictory pressures, including low mood and the wish to live were circumstances different, in order to address the question why the patient wishes to die at this time. A formulation in support of the decision to request VAD is one where the patient is motivated by a wish not to suffer. One where VAD would be considered inappropriate would be when themes of self-hate or negativity were predominant. It may well be that this differentiation already occurs in the psychiatric assessment or as a consequence of the assumption of incapacity in those diagnoses with major depression, albeit informally and imperfectly translated into a determination of capacity. In looking to better formalise how a formulation may better determine whether to accede to a request for VAD, the problem of reducing a complex clinical skill to a set of criteria becomes apparent.

Summary

VAD legislation has produced a paradigm shift in the way communities allow people with terminal illness to die. In granting access to VAD, the tasks carried out by medical practitioners differ from their usual clinical experience and practice. The assessment of depression and the capacity to decide to request VAD are related, but should not to be considered as synonymous. A wider formulation with attention to themes of suffering and self-hate may further inform advice to the patient and participating practitioners.

* The patient has been de-identified and non-essential details have been altered. Consent was received from her family to describe her experience.

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