



A member of The Selwyn Foundation Group

Euthanasia , older people and mental health



**DR. CHRIS PERKINS
SELWYN CENTRE FOR AGEING AND
SPIRITUALITY**

SELWYN FOUNDATION

CHRISP@SELWYNCARE.ORG.NZ

WWW.SELWYNCARE.ORG.NZ

Definitions



- Euthanasia: “The intentional termination of a persons’ life at his / her explicit request.” (Dutch law definition, Hertogh, C. 2009 p. 100)
- Physician assisted suicide (PAS): “a person killing him- or herself by using medications or a device provided by a physician for that explicit purpose” (Lyness 2004 .p.468)

Ways of dealing with issue of euthanasia



- Reject as forbidden by principle of respect for life and give good palliative care
- Respond with compassion making medical judgement about suffering- respect for life principle may be overridden
- Respect for patient autonomy- includes advance decision (van Delden, 2004)

Issues to be considered



- Depression
- Dementia
- Capacity
- Vulnerability

Depression



- Symptoms may include wish for death:

“Depression is associated with poorer will to live and greater desire for a hastened death” (Lyness 2007)

- Feelings of worthlessness, uselessness, guilt and the belief that one is a “burden” are common
- Agitation, brooding, preoccupation with thoughts of death or suicide
- Difficulty thinking and concentrating.
- May affect capacity to make decisions and lower resistance to outside pressure

Depression in older people



- Common
- Often missed
- Undertreated

Common



In the community:

People > 60 years

15-30% have depressive symptoms

In residential care:

30-75% have depressive symptoms

In people with dementia

23% have depression

Depression is commonly associated with physical illness or disability

Under-recognised



- Symptoms put down to physical illness or disability
- Seen as natural response to bereavement or “old age”
- OP resistant to acknowledging and reporting symptoms
- Atypical presentation- often physical symptoms predominate
- Lack of available GP time (Lapid et al 2003)

Under-treated



- 2/3 better in 1 year with treatment
- Easier to use newer antidepressants (may contribute to recent decrease in suicide in OP)

Older people receive

- Fewer referrals for psychology input
- Social interventions important e.g. reduction of social isolation

compared with other adults

Depression and euthanasia /PAS



- In cancer patients with < 3 months of life expectancy, depression was associated with requests for euthanasia (van der Lee et al 2005)
- Swiss (EXIT) study- 27% of those requesting PAS had depressive illness (Booshard et al 2008) and 25% in Oregon (Ganzini & Dobscha 2008)
- Treatment of depression does not necessarily reverse preference for euthanasia (Hooper et al 1997)
- Having a depressive illness does not necessarily make the person incompetent (Stewart et al 2011)

Summary- depression



- Depression is common in older people especially those with physical illness and disability
- Depression is commonly associated with the wish to die
- Request for euthanasia / PAS should trigger psychiatric review for depression and capacity to decide
- Successful treatment of depression is likely to (but not always) reduce wish for death

Dementia



- “Hyper-cognitive society” → emotional, physical, spiritual, social aspects of less value than our thinking abilities.
- Dementia one of the most feared conditions in our society (Perkins,2004)
- Fear relates to loss of autonomy and dependence on others → “degrading suffering” (Hertogh , 2009)

Suffering in dementia?



“The literature on the perspective of the patient gives no solid support to the widespread assumption that dementia is necessarily a state of dreadful suffering.”

(de Boer et al 2007 p.1034)

Living with dementia



“Although the impact of dementia and the experiences of loss resulting in multiple “negative” emotions cannot be denied, our findings also indicate that people do not undergo the disease passively and use both emotion-oriented and problem-oriented coping strategies to deal with its challenges.

The experiences of living through dementia as told by the sufferers appear to yield a more subtle picture than the assumptions made by the general public.”

(de Boer et al 2007 p.1034)

“dementia as a transitional process...”



- “ ...one that starts with the sensation something is wrong and progresses into the integration of the disorder into one’s life.” (de Boer et al 2007 p. 1034)
- Insidious onset allows adaptation and development of coping strategies
- Lack of awareness → less suffering (Hertogh 2009)
- In Alzheimer’s disease wish to die is usually associated with depressive symptoms (Draper et al 1998)

“Patients with ‘locked-in syndrome’ can still be happy, study shows.” Dominion Post 25/2/11



- 47/65 patients happy and 18/65 unhappy
- Only a handful often had suicidal thoughts

“We cannot and should not presume to know what it must be like to be in one of these conditions. Many patients find happiness in ways that we simply cannot imagine” Adrian Owen, University of Western Ontario

Advance directives for euthanasia in dementia (AEDs)



- When writing AED, person does not know what the future will bring; people adapt to situations previously thought unbearable
- People with dementia still have values, wishes, opinions. Which should have priority- current preferences or AED ?
- It is difficult to know what terms of AED mean e.g. failure to recognise family
- How do we know the situation / conditions in which the person wrote the AED?
- Practical issues – euthanasia in an incompetent person?

(van Delden 2004)

Euthanasia in dementia



- Active termination of life in PWD is very rare
- Possibility of shared understanding of patient's desires is reduced. Cannot have sustained autonomous request or a bilateral assessment of suffering
- Issues in dementia care such as failure of palliative care, inadequate symptom control and malignant social environment are not viable motives for euthanasia

(Hertogh 2009)



“He was drugged up and put in front of TV for his last 6 months... that killed him. He could have been treated better. He had no trousers on under the blanket-we could see this when blanket slipped- to make him easier to change when incontinent. He would be dressed in only a T-shirt in winter and be very cold. That’s why I believe in euthanasia.”

Dementia carer Northland, March 2011

Competence to request assisted suicide (Stewart et al 2011)



1. Comprehend and retain information regarding their decision- nature of illness and prognosis, available treatments / palliation, nature and effects of methods of suicide, risk of adverse events-including effect on family and friends
2. Able to weigh the information and reach a decision.
3. Decision should be consistent over time with past expressed wishes and beliefs
4. Able to communicate choices
5. Free from undue influence patient strength of will vs pressures placed by others

Summary- dementia



- Having dementia might not be as bad as we imagine
- The distress of families or inadequacy of care are not grounds for euthanasia
- Advance directives for euthanasia are very difficult to activate
- Competence to request euthanasia or PAS must be assessed very carefully if patient has cognitive impairment

Vulnerability of older people with mental illness



- Old: “grey tsunami” “burden” “fair innings”
- Women: alone, economic disadvantage, dementia, female self-sacrifice, less genuine autonomy
(George 2007)
- Mentally ill / cognitively impaired: seen as non-people

Old, female and ill



- **An orderly at a retirement home in Spain has confessed to killing 11 residents by poisoning them with bleach, an overdose of insulin or a cocktail of drugs.**
- Joan Vila, 45, who worked at La Caritat home in the north-eastern town of Olot, said he killed some of them to "end their suffering and give them peace".
- Most of the patients had terminal illnesses, including Alzheimer's, and had fevers or were disoriented.

2 December 2010 (Radio NZ website)

Summary



“ Clinicians, including thoughtful proponents of PAS, recognize that proper evaluation of requests for PAS may lead to a range of appropriate responses, including the use of reassuring assertions of the tenet of *physician non-abandonment*, or by *identification and treatment of remediable suffering* from pain, depression, or other symptoms” (Lyness 2004 p.468)

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