

Letters to the Editor

To the Editor:

Mendz and Kissane argue in their recent work on medical aid in dying (MAID) that assessing the decisional capacity of individuals with psychological conditions such as depression fails to adequately assess their ability to make life or death decisions.¹ The authors therefore call for a “significant revision of the criteria and ways of assessing the agency of persons”² who request MAID. They do not, however, provide clarity on how this is best done.

The authors also misrepresent the Oregon Death with Dignity (DWD) Act’s counseling referral requirements, stating that a patient shall be referred for counseling if she is suspected to be suffering from a psychiatric, psychological disorder, or depression.³ The Oregon statute specifically states that referral is required if “a patient may be suffering from a psychiatric or psychological disorder or depression *causing impaired judgment*.”⁴ Therefore, in addition to confirming decisional capacity, the law requires physicians to assess a requestor’s judgment and ensure that symptoms of psychological distress are not exercising undue influence on her decision.

Are even stricter frameworks required to “prove positively the person’s ability to act with unaffected and undamaged agency?”⁵ What exactly would they be and what are the potential burdens for patients? First, because the authors “do not agree with euthanasia or assisted suicide as a solution for the problems faced by patients at the end of life”⁶ they push for higher standards to determine competence to consent to MAID. A survey of forensic psychiatrists found that physicians with moral objections to MAID advocated for higher standards of evaluation, which included a mental health examination by more than one expert followed by a judicial review using a “clear and convincing” evidence standard, “even if this higher standard might disallow some competent persons the option”⁷ of MAID. Thus, if more extensive clinical or legal review were required, one would also have to ensure that evaluators with strong personal biases against MAID would be excluded. Requiring this level of evaluation could be a great burden on terminally ill patients, for whom it may be difficult to physically endure.⁸

The authors point out that only one patient out of the 188 who received a lethal prescription in Oregon

was referred for mental health evaluation,⁹ perhaps to suggest that higher standards are needed to identify and refer patients with psychological conditions, such as depression. While diagnosing depression in terminally ill patients can be difficult, a survey of physicians in Oregon¹⁰ revealed that they recognized symptoms of depression in patients requesting MAID at a rate similar to psychologists.¹¹ Many of the physicians also reported that they prescribed trials of antidepressants and made mental health referrals for such patients.¹² Notably, the annual Oregon data summary does not capture information regarding patients who are referred to counseling, but who did not ultimately ingest the lethal medication.

A broad consensus on how, or even if, one can determine whether a person with a mood disorder can validly consent to MAID may never be reached. However, contemporary research is seeking to move this discussion forward. SWOG Cancer Research Network is designing a multi-center prospective analysis to determine the prevalence of depression in patients making a first oral request for MAID. A future clinical study will evaluate whether interventions in patients with depression affect their desire for DWD.¹³ This research builds off of work by Ganzini and colleagues, who have shown that the majority of those who receive MAID prescriptions do not have depression, and that patients, health care professionals, and family members in Oregon believe that depression is *rarely* a factor that influences requests for MAID.¹⁴

The results of the SWOG study could have important ethical and policy implications. If depression in patients requesting MAID is treatable, and a desire to hasten death is shown to be reversible, the Oregon DWD Act’s counseling referral requirements should be amended. Absent such data, however, we believe the current clinical and legal standards for assessing agency in patients with psychological disorders are sufficient and on par with accepted standards for other high-stakes medical decisions.¹⁵ Raising additional obstacles for an already stigmatized population with mental illness, may deny eligible patients equal access to this infrequently used but important option for patients nearing the end of life.

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References

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Dear Editor:

In their recent paper, Mendz and Kissane¹ highlight an important and often neglected issue in the ongoing debate regarding the role of assisted suicide and euthanasia in medical practice. They highlight the impact of suffering on autonomous choice and decision-making, particularly the elements of despair, demoralisation and existential distress experienced in the face of the threat of death. Furthermore, their important contribution emphasises the limits confronted when applying familiar principles of autonomy and decisional capacity in this context.²

Beauchamp's commentary³ refers to the assumption of autonomous choice and capacity to make autonomous decisions as a key principle underlying biomedical ethics. The underlying debate and tension regarding application of such principles, as they apply to euthanasia and assisted suicide, is indicative of the complexity of any effort to navigate the clinical context of end-of-life care for patients, families and their doctors. Assisted suicide, as legislated in many jurisdictions, embeds suicide as an intervention to be provided by clinicians when certain conditions are met. The debate and previous evidence highlight the challenge of achieving these conditions. What is a standard of capacity for such a decision? The issue remains unresolved for many clinicians.⁴

Moreover, what does autonomy mean in circumstances that, like many instances throughout life, can compromise individual agency and serve to emphasise an individual's interdependence on others and the interpersonal nature of our life choices? The evidence from studies of patients requesting assisted suicide or a wish to hasten death have highlighted the interpersonal underpinnings of such decisions — fear of burden on others and as highlighted by Mendz and Kissane, family relationships and cohesion.⁵ Furthermore, concern about loss of dignity features prominently in such studies, itself an attribute so often bestowed by the reactions of others to the dying person.⁶ Others have also highlighted the cultural bias in this focus on autonomy alone, a specific feature of so-called western or industrialised societies that is at odds with the dominant values of interdependence and communitarianism in other cultures.⁷

The involvement of the medical practitioner in the act of assisted suicide is itself a critically important dimension — the nature of medical practice, and its important boundaries and moral frameworks have historically enabled doctors to navigate the emotionally tumultuous terrain of end-of-life care with a clear understanding of what is and what is not permissible, with a responsibility to work to understand and address, where possible, sources of suffering and distress.⁸ As Pellegrino⁹ and others¹⁰ have argued, such