

Depression and the Wish for Death in the Terminally Ill

A paper by South Australian psychiatrist, Frank Weston

In recent medical literature several authors have expressed the views that many terminally ill patients are depressed or suicidal. Depressed patients may be irrational. Doctors can miss the presence of depression and so not realise that these patients need special management. Such views have serious implications which need to be looked at carefully especially since some of these patients ask their doctors to hasten their death. If voluntary euthanasia were to become legal the matter would become increasingly important. There is considerable confusion about these matters which needs to be clarified.

The diagnosis of depression

Winton and Pollard, in a letter to the editor of the Medical Journal of Australia, express the view that there is a "close association between suicide and mental disorder"(1). They refer to a study by Brown et al. in which "every terminally ill patient who desired death was found to be suffering from clinically depressive illness"(2). Yale Kamisar is concerned about the same matter and writes, "There is considerable authority for the view that suicide rarely occurs in the absence of a major psychiatric disorder"(3). Breitbart considers most cancer patients who are suicidal have a psychiatric disorder and "approximately 25% of all cancer patients experience severe depressive symptoms," with about "6% fulfilling DSM III criteria for the diagnosis of major depression"(4). Bukberg et al. found that 42 per cent of the cancer patients they studied had "major depression" and another 14 per cent had depressive symptoms (5).

To understand what is being described we would need to know what these authors mean by 'depression'.

Several diagnostic schedules for 'depression' are available but perhaps the best way to ascertain what is meant by the word is to refer to the widely accepted diagnostic text, the DSM III R(6). This text gives only two categories for depression which are relevant to a situation involving terminally ill patients who do not have significant intellectual deterioration.

One of these is the 'Major Depressive Episode' or 'Major Depression'. The DSM sets out groups of symptoms necessary for patients to qualify for this diagnosis. To qualify patients would, 'during the same two-week period', need only to have the five following symptoms 'nearly every day': 'depressed mood'; loss of 'interest or pleasure' in 'almost all' 'activities'; 'decrease' in 'appetite'; 'insomnia or hypersomnia'; and 'fatigue or loss of energy'. Other symptoms could also be present, such as 'feelings of worthlessness', but they would not be necessary to qualify for the diagnosis - the ones stated would be sufficient.

If 'recurrent suicidal ideation', another symptom the DSM uses to qualify for the diagnosis, is also present, as it inevitably will be in a patient who is asking a doctor for help to die, one can see that a high proportion of terminally ill patients who want to die may well be diagnosed as having a 'Major Depression'. It is easy to see how Brown et al. could consider that 25 per cent of the 44 terminally ill patients in their study had severe depression and note three other studies showing 23 to 58 per cent of cancer patients as having depression.

The DSM III R indicates, however, that symptoms clearly due to a physical condition should not be included for the diagnosis of a 'Major Depressive Episode'. If such symptoms were excluded, possibly very few of the patients under consideration would qualify for the diagnosis. Even patients with; 'depressed mood'; 'feelings of worthlessness or excessive or inappropriate guilt'; 'diminished ability to think or concentrate'; and 'recurrent suicidal ideation', would not qualify under the DSM unless they had other symptoms as well, and these might have to be excluded as due only to physical illness.

The second possible DSM III R diagnosis of 'depression', 'Adjustment Disorder with Depressed Mood', can be applied 'when the predominant manifestation is symptoms such as depressed mood,

tearfulness, and feelings of hopelessness' are present, and if the condition is part of a maladaptive reaction to a 'psychosocial stressor' indicated by 'symptoms that are in excess of a normal and expectable reaction'. Derogatis et al. state that 12 per cent of the 215 cancer patients they studied fell into this diagnosis (7). Breitbart indicates that more than half the "suicidal cancer patients" he reviewed "had an adjustment disorder, usually with depressed or anxious and depressed mood".

Patients may be incurably ill, suffer from unrelieved distress due to the many possible stresses which can be present, and wish to die; but whether they fall within the diagnosis 'Adjustment Disorder with Depressed Mood' depends on what the doctor making the diagnosis considers to be a normal or expectable reaction. Doctors who consider a wish to die as abnormal or an excessive reaction to any psychosocial stress will be able to make this diagnosis almost every time.

It can be seen that making the diagnosis of depression in terminally ill patients according to DSM III R can be uncertain. Diagnosis will depend considerably on how the doctor interprets the situation and assesses individual factors. These ambiguities are enough to account for the wide range, 6 to 58 percent or more, reported for the presence of 'depression' in terminally ill patients. Generalisation and statistics have their uses but it is the state of mind of each individual patient which is of prime importance in a clinical situation.

Are depressed patients of unsound mind?

A diagnosis of depression would not be so serious were it not for the assumption that it implies the presence of unsoundness of mind. Conwell and Caine write "determination of a suicidal patient's rationality can be no more than a speculation".

Some terminally ill patients, in emotional distress, suffering loss of dignity or independence, or whose physical symptoms or pain cannot be relieved are very likely to be 'depressed' - as most people lay or medical understand and regularly use the term. Some of these patients will also be wishing to die - mostly not because they are depressed but because their situation is desperate in the presence of intolerable distress.

Many of them could be described as having a 'Major Depression' or an 'Adjustment Reaction with Depressed Mood' but this does not mean that they do not have a rational basis for wanting to die or that they are of unsound mind. Only if the wish for death is not congruent with the life situation, or if there is evidence of psychosis such as delusions, distortions of reality or hallucinations, or if thought is disconnected, should patients be considered as being of unsound mind. Bukberg et al., despite finding that 42 per cent of the patients they studied had major depressions, indicate that not one of them had "psychotic depressive symptoms". Two of their patients with histories of major depressions "spontaneously remarked" that their current depressions were unlike those previously experienced.

Most ordinary citizens can detect if a person's thought is so irrational or inappropriate that the person can be considered as being of unsound mind. If voluntary euthanasia were legal it would be unlikely that doctors would fail to notice that their patients were of unsound mind. The consequences of the doctors' decisions would be profound and subject to legal scrutiny which would focus their attention on the area. Most patients of unsound mind would be readily enough detected. In a few doubtful cases psychiatric consultation could be required.

Many doctors currently prescribe opiates to relieve pain even when they know that death may be hastened due to the large dosage sometimes required. These doctors believe they can tell when patients are of sound mind and truthful in their complaints of continuing pain, although a patient could be seeking more opiates as the only way to achieve death. If voluntary euthanasia were legal doctors should be able to recognise genuine and rational requests.

Do doctors miss depression in their patients?

Conwell and Caine also consider that "doctors on the front lines....are ill equipped to assess the presence and effect of depressive illness in older patients"(3). Kamisar also states that there is a

"failure of primary physicians to detect major depressions in their patients." Doctors may miss depression in their patients but in the euthanasia situation they would be alerted to the possible presence of depression because the patient expresses the wish to die. If voluntary euthanasia were legal a doctor wishing to provide euthanasia, and at the same time comply with the law, would have to explore the patient's mental and physical situation in detail. The request for aid would have to be repeated over a period of time and be documented. Discussions with attending nurses and the patient's family would be likely, and the opinion of another doctor required. In any uncertainty regarding a depression the doctor could be expected to seek specialist advice. It is unlikely that a doctor would miss depression in such circumstances.

Do doctors manage depression adequately?

Treatment for depression in the terminally ill may consist of providing counselling, support, appropriate medical and nursing management and alerting relatives to the patient's needs - standard palliative care procedures. In some, probably very few, cases it would be appropriate, with the patient's consent, to administer antidepressant medication. It is known that doctors who make the diagnosis of a significant depression for which medication could be appropriate may prescribe an inadequate dosage. In a legal euthanasia setting, however, doctors are likely to give recommended dosage up to the maximum tolerated. A doctor seriously considering euthanasia and uncertain about treatment for a depression, or any other medical condition present, is likely to seek specialist advice, if only as a medico-legal safeguard.

Conclusion

The current situation is a risky one for both patients and doctors since doctors who decide it is in their patient's best interests to meet requests for euthanasia must at present act illegally. Since there are no legal requirements to be met, acts of euthanasia are almost invariably hidden and the doctor cannot assess many considerations important for the patient.

Legal voluntary euthanasia would be less risky for patients and doctors, since a doctor who helped a patient to die would have to notify an overseeing authority, such as a medical or government board, and state what medical conditions were present and what treatments undertaken. Any significant depression present would have to be documented. Any doctor acting within the required guidelines would be protected by the law and the needs of the patient would be adequately assessed.

The presence of depression or a request for death in a terminally ill patient does not imply that a patient is of unsound mind or that medical mismanagement is likely to occur. If a patient is of sound mind the presence of depression should not preclude the provision of voluntary euthanasia.

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