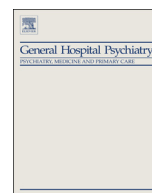




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Psychiatric evaluations for individuals requesting assisted death in Washington and Oregon should not be mandatory

The mental health evaluation of the patient requesting physician-assisted death (PAD) has two goals, often written into laws that permit PAD. One goal is to ensure that the patient does not have a potentially treatable mental disorder influencing the decision to hasten death. Most discussions of relevant mental disorders point to the roles of anxiety and depression, particularly major depressive disorder, in which possibly treatable and reversible hopelessness, sadness and anhedonia may impact views about suicide. The second goal is to guarantee that the patient is competent to decide to choose PAD. The most important component of the competency evaluation is to confirm that the patient understands alternatives to PAD including hospice, palliative and comfort care and the option of hastening death by stopping other life-sustaining treatments. Outside of these legal requirements, the evaluation offers the opportunity to explore and treat other sources of anguish. I wish to put forward the limited proposition that, in the case of legalized PAD in Washington and Oregon, requiring a psychiatric consultation in every case is burdensome, unnecessary and possibly unworkable. Table 1 outlines the virtually identical safeguards in these two state laws. The legislature of the state of Vermont legalized PAD in May of 2013 with a similar set of requirements as Washington and Oregon. The state of Montana has no prohibitions against PAD but, apparently, no safeguards [1].

Information from Oregon's 15-year experience with legalized PAD comes from information submitted by prescribing physicians to the Oregon Public Health Division [2], as required by law, and from surveys and interviews of health care professionals, requesting patients and their families. Washington legalized PAD in 2009, and investigators there have also begun to add to the literature. About two in every 1000 deaths in Oregon is through PAD. Only 2% of those who die by PAD lacked medical insurance, and 90% had been enrolled in hospice. Ninety-eight percent who die by PAD were White, and compared to other Oregonians, they were more highly educated (Oregon Department of Human services, Oregon Public Health Division). Important reasons for requesting PAD include wanting to maintain control, independence, self-sufficiency and avoid symptoms in the future such as pain, though symptoms, at the time of the request, are rated as relatively unimportant [3,4].

Arguments around PAD intend to be logical but, in fact, almost always have underpinnings of belief, emotion and inextricable connections to the deviser's moral views. My coauthors and I have demonstrated these associations in a series of studies of health care professionals. For example, in a survey of US forensic psychiatrists, respondents who believed that assisted suicide was never morally acceptable advocated higher standards for psychiatric evaluation and

more extensive mental health examination including more than one independent psychiatric examiner, followed by judicial administrative review. Those with moral opposition also supported a higher stringency in the standard for competency and were less likely to believe that patients with a mood disorder could ever be competent to choose PAD [5]. In a survey of Oregon psychiatrists and psychologists, many of those opposed to PAD indicated that even if they found the patient competent and not depressed, they would use their position to try to prevent the suicide, thus exploiting their role in ways that framers of PAD laws would not agree [6]. Determination of competence is not scientifically determined but a social construct that puts autonomy and societal concerns regarding patient welfare – beneficence and nonmaleficence – in tension. The degree to which the ethics of PAD are argued as distinct from the ethics of withholding and withdrawal of life-sustaining treatment is not entirely logical but imbued with moral tones and personal meanings. Ultimately, psychiatric consultation may, in fact, become an ethics consultation [7].

So, I strive to weave my beliefs into my arguments in a transparent manner. I do not believe that individuals with clinical or major depression should be given lethal prescriptions, even in the context of a terminal illness. I can acknowledge arguments that depressed persons should be allowed this access. First, depression causes extraordinary suffering, at times in ways that dwarf the physical torment of the most dreadful medical illnesses. If there are forceful arguments that PAD should be allowed for physical pain at the end of life, then those arguments might apply even more to emotional pain complicating terminal illness. Second, opponents of PAD argue that instead of offering hastened death, we should offer treatment for depression. Yet, treatments for major depression are less effective at the end of life, with patients often not living long enough for the most common antidepressant medications to be effective. Finally, persons may have depression yet maintain autonomy. In fact, I have evaluated patients who had a lifelong preference for control through PAD, and it seems unlikely that the pursuit of it was simply because they were also not enjoying the end of life. I am not alone in this opinion: In a study of 418 Oregon psychiatrists, only 3% endorsed that a request for physician assisted suicide was *prima facie* evidence of a mental disorder [6]. Only 6% of these psychiatrists were very confident that, in the context of a single assessment, they could determine if the patient had depression impairing judgement regarding PAD (as required by the Oregon Death with Dignity Law) [6]. But ultimately, despite these arguments, I do not believe that individuals with clinical or major depression should be given lethal prescriptions, even in the context of a terminal illness. What it comes down to is that if I concede this

Table 1
Legal requirements of the death with dignity acts in Oregon and Washington

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| The attending physician who is responsible for care of the patient's terminal illness must ensure that: |
| The patient is aged 18 years or older |
| The patient is a resident of the state of Oregon or Washington |
| The patient has made one written and two oral requests separated by 15 days |
| The patient understands the options of hospice and comfort care |
| The patient is assessed by a consulting physician |
| Information about the patient is reported to the State Department of Human Services |
| The attending and consulting physicians must ensure that: |
| The patient is capable of making and communicating healthcare decisions |
| The decision is voluntary |
| The patient has a terminal illness that would, within reasonable medical judgement, cause death within 6 months |
| The patient is referred to a psychologist or psychiatrist if concern exists that the patient has a psychiatric disorder including depression that may impair judgement |

position, I personally cannot continue my work as a geriatric psychiatrist and fight to convince my depressed patients to defer suicide, take their antidepressants and participate in therapy.

I have been relieved, therefore, to find that depression is less common than originally projected among patients requested PAD in Oregon. Although major depression is diagnosed in up to 59% of terminally ill patients who endorse a desire for hastened death, we found that 26% of 58 persons actively pursuing PAD in Oregon had major depression [8,9]. During the initial years of legalization, I evaluated all patients who requested PAD for one large health care organization; only two had clinically significant depression and a third lacked capacity (she had requested PAD but then was hospitalized for a gastrointestinal bleed and had mild delirium when I evaluated her; he was later found competent). This somewhat lower-than-expected rate of depression may be because the effort required to get through the Oregon and Washington laws winnows those with less energy, focus and fortitude. Ironically, the structure of PAD laws in Oregon and Washington may bias not only against the depressed but also the sick. However, in our study of Oregonians pursuing PAD, we did find that among the 18 who received lethal prescriptions, three did have major depression disorder, and none appeared to have been evaluated by a mental health professional [9]. Importantly, all would have identified as requiring further evaluation on a screening measure such as the Patient Health Questionnaire-9 (PHQ9) [10].

There are systemic problems with consultation by psychiatrists in this role in the Pacific Northwest. First, although psychiatrists may bring many important skills to this evaluation, only a handful have expertise in the types of concerns experienced by patients at the end of life. For example, in a survey of 321 Oregon psychiatrists about PAD, only two reported that they had worked in a hospice setting, 15 in a nursing home setting, and 64% had no terminally ill patients in their practice [6]. In contrast, in 2012, 97% of patients in Oregon who died by PAD were enrolled in hospice, of whom 95% died at home [11]. All hospice enrollees have at least one visit by a hospice clinical social worker, who over the course of employment builds enormous expertise about the psychosocial concerns of dying patients. I have advocated that hospice or health care system social workers might be in a better position to systematically screen for depression because they do not perform one time consultations but develop advocacy-based, positive, nonadversarial, longitudinal relationships with clients and their families from which to better assess depression and other mental health and psychosocial issues. After legalization of PAD in neighboring Washington, the Seattle Cancer Care Alliance did just that. Their specialized program assigned a licensed social worker who served as an advocate to assist the patient, family and pharmacist through the multistep death with dignity process while tracking

compliance with the law. The advocate screened the patient for depression using standardized assessments. Patients were referred to a psychiatrist or psychologist if there was either positive screening or a history of mental health disorder or impaired decision making. No patient with depression or who lacked capacity persisted in requesting PAD [12].

Currently, federal law prohibits the use of Medicare or Medicaid funds for death with dignity mental health evaluation (about one-third of death with dignity deaths) and hospice per diem rates are so scant that most cannot afford psychologists and psychiatrists on their staffs. I could rail about the situation except the greater tragedy is that Medicare reimbursement rates for psychiatrists in the fee-for-service sector in the Pacific Northwest are so low that there are currently no practicing fee-for-service outpatient geriatric psychiatrists in the large metropolitan area of Portland, OR (over 1 million people). The fact that thousands of elderly, mentally ill patients who want specialized mental health care cannot access it in my part of the world evokes my outrage; little passion is left for advocating that a small group of individuals who do not want psychiatric evaluation and, in general, do not need it are mandated to have it.

In summary, some Oregonians with depression access legal lethal prescriptions. This could be avoided through careful systematic screening for depression along with longitudinal evaluation by health care system and hospice social workers for psychosocial concerns and referral to psychiatrists or psychologists with expertise in care of patients at the end of life of those at higher likelihood for depression. In this model, not all individuals pursuing PAD would require difficult to access, unneeded, unaffordable and unspecialized psychiatric evaluations; yet, virtually no patient with clinical depression or who lacked decision-making capacity would access a lethal prescription.

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