DEPRESSION AND ASSISTED Dying

Euthanasia and depression: no surprise

Nobody should be surprised at the prevalence of depression and anxiety in Oregon patients requesting physician assisted suicide.1 This was the pattern of euthanasia’s expansion in Holland—a movement for relief of unbearable suffering in terminal cases became a means of termination for those whose problems were often more existential, or psychological, than physical.

In Holland the critical case in law and ethics was the Chabot case, in which a divorced woman with clinical depression after the death of a son asked for, and received, euthanasia.2 In another case, a request for euthanasia by a young woman with anorexia later was granted.

A retrospective study of deaths attributed to Dr Jack Kevorkian found none with end stage disease and several in whom necropsy revealed no clear organic dysfunction.3 Again, what was publicly proclaimed as an end to suffering became a matter of termination of people whose physical or psychological suffering was not correctly palliated or treated.

Depression attends generally to cases of physical limit and chronic disease. The focus on euthanasia rather than on treatment, and state support for palliative and psychological treatment makes premature physician assisted death a default option.4 This ignores in the name of autonomy a wealth of evidence that argues that most of those with chronic limits and progressive conditions may, after an initial period of anxiety and depression, find a worthiness to life so long as physical and psychological treatment is provided.5 It similarly ignores the potential for fruitful life with both aggressive palliative care and psychological support.

Psychiatric review is mandatory in Australia

Ganzini and colleagues’ finding that 3 of the 18 Oregonians who received a prescription for a lethal drug met caseness criteria for depression raises concerns about the state’s Death with Dignity Act, which demands a psychiatric review only if “concern exists that the patient has a psychiatric disorder.”1

We know that depression is common in the terminally ill and that depression may be successfully treated in this population. We know that depression may impair a person’s capacity when requesting physician assisted suicide, and we know that non-psychiatristally trained physicians are poor at detecting depression. We also know that these four facts are true for delirium in patients who are terminally ill.

There is a strong argument for including mandatory psychiatric review in any legislation that enables physician assisted death, to detect and protect those who would not have requested assistance to die had they not been depressed or delirious.2 This safeguard was included in the Australian Northern Territory’s Rights of the Terminally Ill Act 1995 and has also been included in recent attempts at legislative reform in Victoria.

Psychiatric review is mandatory in Australia

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Depression in terminal illness

The article from Oregon raises questions about the relevance of depression in those who are dying.1 It is perhaps not surprising that anyone facing death might be depressed. One might almost say it is normal. But depression is not a psychotic disorder, and there is no reason to assume that a depressed person is not rational and therefore perfectly capable of making an informed decision about assisted suicide.

Those who are so anxious to identify depression will presumably also wish to treat it. This raises questions of patient autonomy since the patient has probably not complained of depression and may therefore not wish to be treated. In any case, treatment takes time, and may produce side effects if drugs are used. Is this really appropriate in a dying patient, who does not have much time?

And what exactly is the point of treatment? Is it to make sure that the patient is happy about his or her impending death? Is that a realistic or desirable therapeutic approach? Doesn’t it rather impose further medication and expectations on a patient who is already suffering greatly?

Why do people find it so difficult to accept that some people may wish to end their suffering, and may require assistance to do so, and that this is their inalienable right? Oregon has done excellent pioneering work which needs to be followed by similar legislation elsewhere. If the option of physician assisted suicide is available very few people will actually take it, and some will be so reassured by the fact that it is an option that they will never request it. To offer it is the only humane approach to intolerable suffering, if we really do claim to have a civilised society.

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OBESITY IN CHILDREN

Quality of guidelines on obesity in children is worrying

Kipping and colleagues argue that the differences between international guidelines on managing obesity reflect variations in the structure of health services, resources, culture, and behaviour between countries. However, a more worrying explanation is the poor quality of clinical practice guidelines.

We recently conducted a systematic review of 22 guidelines for preventing and treating obesity and overweight in childhood, assessing quality with the AGREE instrument. Their quality was generally low. Only two of the six domains included in the AGREE instrument (scope and purpose and clarity of presentation) had a mean score over 50%. Although half of the guidelines had a quick reference guide or summary to identify key recommendations, only four had specific guidance for patients.

Of most concern was the low score (just over 35%) obtained in the rigour of development domain, indicating that many of the recommendations were based on unsound grounds and far from an evidence based approach. Nearly half of the documents did not report the databases searched or a structured approach to evaluate the quality of the evidence or grade the strength of recommendations. We would recommend and apply only six of them.

When developing or updating guidelines on obesity in children, developers should adhere more closely to the AGREE instrument.

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ASSESSING COMPLEX INTERVENTIONS

Guidelines perpetuate inappropriate methods

The guidelines for research in complex systems confute complex with complicated.

Complex systems and interventions are most appropriately viewed as non-linear, which implies that they cannot be understood by reducing them to their component parts. Outcomes are never an end in themselves but simply a further reiteration of an ongoing process where a more appropriate focus is the interaction of system variables from which patterns emerge that are not always predictable.

A large systems literature ignored by the guidelines has addressed all these problems in a much greater depth, particularly in soft systems thinking. Realistic evaluation offers alternative methodological approaches, and complexity theory itself has much to offer.

Lakatos has suggested that research programmes in a discipline change with time but develop to form a protective belt of auxiliary theories that defend the fundamental and unassailable core. The centrality of the randomised controlled trial continues to be protected in this way. Therefore inappropriate methodologies are perpetuated and the development of more relevant approaches to research in complex systems are inhibited.

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RESEARCH METHODS AND REPORTING

EQUATOR Network collates resources for good research

The new BMJ section on how to do and write up research will help to promote more reliable health research literature. The EQUATOR Network, a new international initiative, also promotes clear, accurate, and transparent reporting of health research.

The EQUATOR website (www.equator-network.org) pulls together available reporting guidelines, making them easy to find and use, and also refers to other resources, training courses, and meetings concerned with reporting health research. It is a valuable source for anyone interested in improving the quality of scientific publications.

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1 Groves T. Enhancing the quality and transparency of health research. BMJ 2008;337:a718. (22 October.)

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Importance of behaviour in interventions

Many simple interventions are actually complex, so the guidance on developing and evaluating complex interventions is applicable more generally than might have been thought in the past.

The nature of behavioural instructions can influence the recipients’ intentions to adhere to and their success in adhering to their intended actions. The behavioural instruction in patient information leaflets is an integral part of a simple drug intervention. Recovery from surgery can be influenced by the information or instructions given. In unblinded trials, as in most trials of surgical interventions, the effects of behavioural instruction are likely to interact with the treatment being evaluated.

Behavioural instruction delivered through a patient information leaflet can be standardised (at the appropriate level) and tailored (to recipient and context).

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