

**Evaluating Depression in Patients  
Who Request to Hasten Dying/  
Not to Prolong Dying**

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October 9, 2010**

# Topics:

1. How to tell if a patient is suffering from depression in addition to symptoms of a terminal illness: a clinical case and a differential diagnosis that can help professionals direct treatment options and form an opinion.
2. Why the **Depression Checklist** is unique, how it worked with a recent patient, and how its built-in “**Plan Now; Die Later**” **ironclad strategy** may help prevent premature dying.

Two important questions: **A)** Is hastened dying appropriate?, and **B)** Is **NOW** the right time?

3. How the **Depression Worksheet** can help professionals create and express diligent, comprehensive opinions.

# Is it depression? effects of the severe illness? or medication side-effects?

**Table 1** Differentiating between symptoms of depression, symptoms of terminal illness, and side effects of medication

Symptoms suggestive of depression	Symptoms common with terminal illness	Medication side effects
-changes in appetite and/or weight -sleep disturbance, difficulty falling asleep or staying asleep -fatigue, loss of energy -psychomotor agitation or retardation	-decreased appetite -weight loss -insomnia -fatigue -loss of energy -lack of concentration -sadness, feeling of hopelessness -pain	-changes in appetite and/or weight -change in taste perception, dry mouth -sleep disturbances -fatigue, decreased energy

Created for *Geriatrics* by Braun UK, Pham C, Kunik ME.

**“Treating depression in terminally ill patients can optimize their physical comfort at the end of life and provide them the opportunity to confront and prepare for death.” (Braun UK, Pham C, Kunik ME. Recognizing and managing depression at end of life. *Geriatrics*. 2008;63(6):25-27.)**

**→ Danger: “reasonable” (minimal) expectations could be a self-fulfilling prophecy.**

# Is it depression? Or, the effects of severe illness? Or, medication side-effects? OR???

1. Is the patient's pain and suffering increasing despite optimal Palliative Care? Is death expected soon? (If "Yes" to either, accede to the patient's request.)
2. If the answer to both questions is NO, ask: Is the patient depressed?
3. Not all patients who request *to hasten dying/to not prolong dying* are depressed, but depression is under-diagnosed. (Irwin SA et al. (2008). J Palliat Med 11: 158)
4. If depression is present: Is it affecting judgment and thereby contributing substantially to motivate the patient's request to die *NOW*?
5. Can the depression be treated effectively? If an Adjustment Reaction: by addressing its source? If a Major Depressive Disorder: by treating it directly. The goal is to balance sanctity of life with respect for patient autonomy.
6. A brief therapeutic trial can have TWO goals:
  - A) To reduce the patient's suffering if possible—always a goal of medicine; and
  - B) To provide the patient the opportunity to voluntarily postpone *WHEN* s/he wants *to hasten dying/not to prolong dying* based on receiving effective treatment—which is consistent with this goal of medicine: to preserve life.
7. If depression cannot be treated, this emotional source of suffering makes more compelling, the case *to hasten dying/not to prolong dying NOW*.

## Clinical case:

A 64 year-old woman had a hospice diagnosis of respiratory failure and chronic obstructive pulmonary disease. Oxygen dependent. Prognosis: weeks to months.

Symptoms: low mood, low energy, hypersomnia, decreased appetite with unintentional weight loss, hopelessness, and excessive feelings of guilt, feeling she is a burden on her roommate, preoccupied with thoughts of wanting to die, but stated, "I'm too chicken to die."

Stopped reading books and socializing with friends.

Complained of severe anxiety symptoms; one to three panic attacks per day; feeling irritable. Would shout and appear extremely irritated when the phone rang or the dog barked.

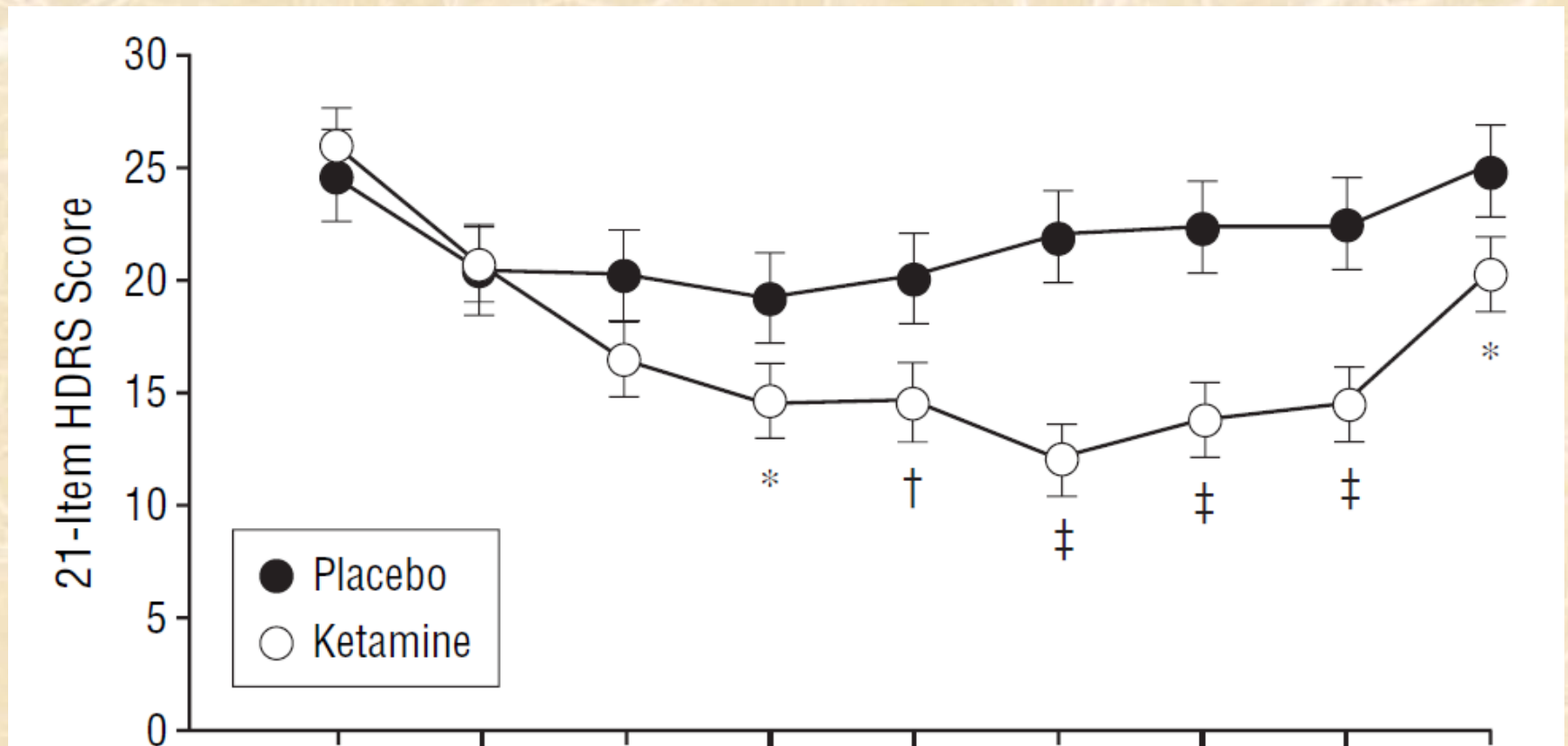
Somatic focus: perception of pain and shortness of breath.

No cognitive impairment.

Treatment possibilities for depression in the terminally ill, where rapid response is critically important.

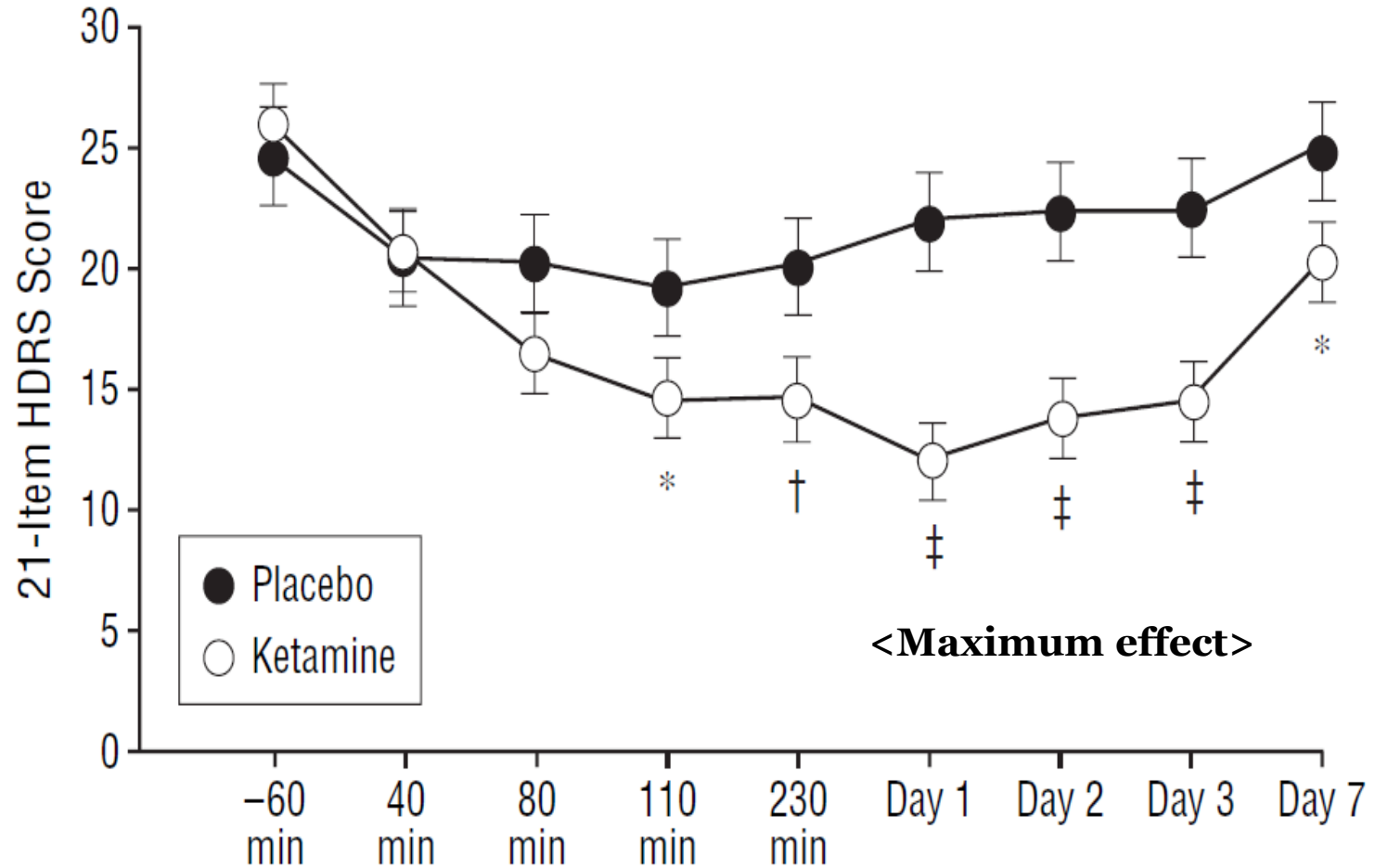
- **Traditional antidepressant medications?**
- **Methylphenidate (MPH; Ritalin, Concerta, Metadate or Methylin) (psychostimulant).**
- **Modafinil (Provigil, Alertec, Modavigil, Modalert, Modiodal, Modafinilo, Carim) (psychostimulant).**
- **Ketamine (Ketanest, Ketaset, Ketalar), a *N*-methyl-D-aspartate (MNDA)-Antagonist (typically an anesthetic or analgesic)!!**

# Effect of Ketamine as measured by the Hamilton Rating Scale for Depression



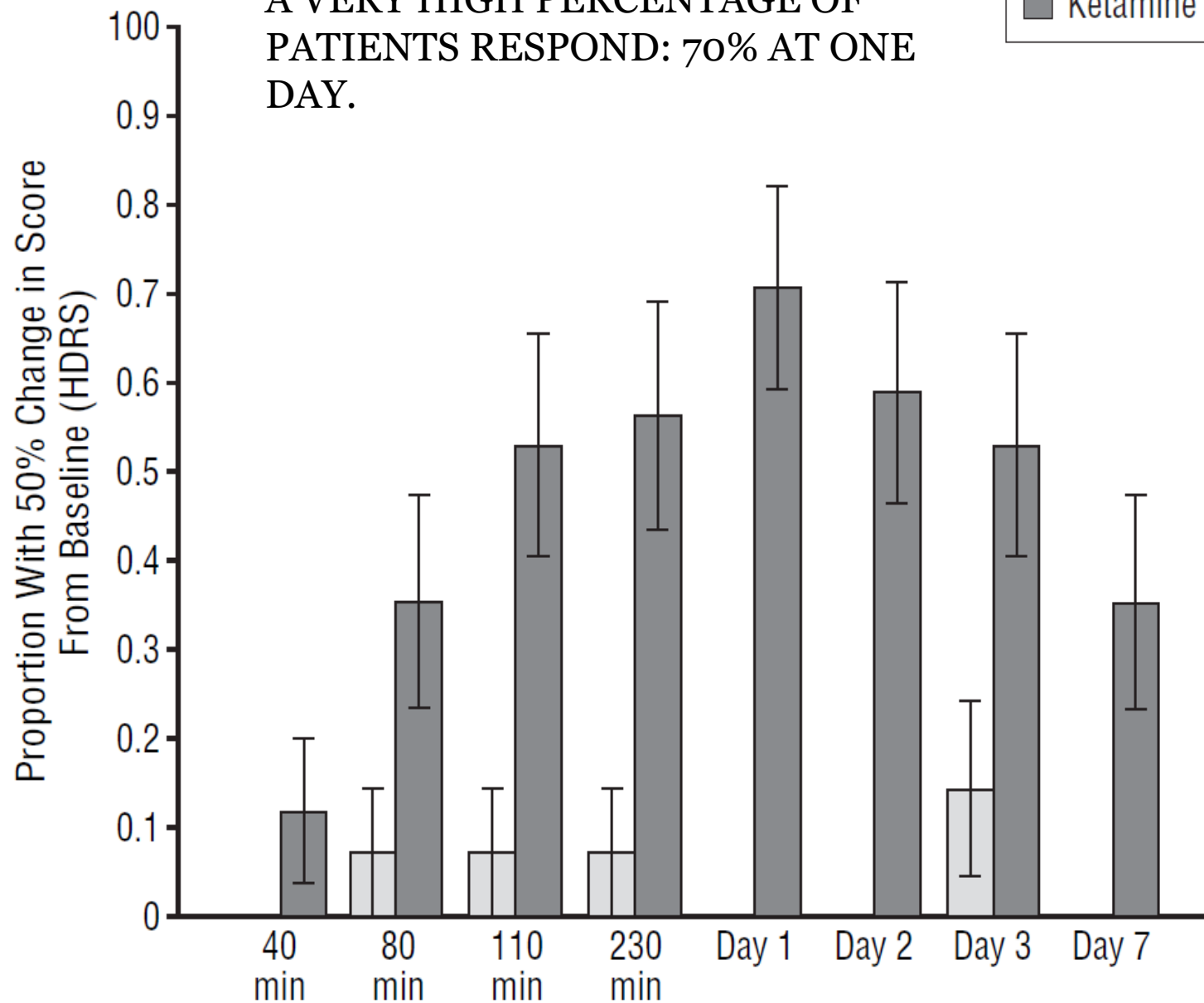
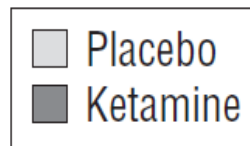
**HDRS = Hamilton Rating Scale for Depression**

# The rapidity of response is astounding



A

**A VERY HIGH PERCENTAGE OF PATIENTS RESPOND: 70% AT ONE DAY.**



# A Randomized Trial of an *N*-methyl-D-aspartate Antagonist in Treatment-Resistant Major Depression

Carlos A. Zarate, Jr, MD; Jaskaran B. Singh, MD; Paul J. Carlson, MD;  
Nancy E. Brutsche, MSN; Rezvan Ameli, PhD; David A. Luckenbaugh, MA;  
Dennis S. Charney, MD; Husseini K. Manji, MD, FRCPC

**Conclusions:** Robust and rapid antidepressant effects resulted from a single intravenous dose of an *N*-methyl-D-aspartate antagonist; onset occurred within 2 hours postinfusion and continued to remain significant for 1 week.

**Trial Registration:** [clinicaltrials.gov](http://clinicaltrials.gov) Identifier: NCT00088699.

*Arch Gen Psychiatry.* 2006;63:856-864

Following a 2-week drug-free period, 18 subjects with major depressive disorder (*DSM-IV* criteria) received intravenous infusions of saline solution and 0.5 mg/kg of ketamine hydrochloride (Abbott Laboratories, North Chicago, Ill), 1 week apart, using a randomized, double-blind crossover design. Patients were randomly assigned to the order in which they received the 2 infusions via a random-numbers chart. Study solutions were supplied in identical 50-mL syringes, containing either 0.9% saline or ketamine with the additional volume of saline

# **Oral Ketamine for the Rapid Treatment of Depression and Anxiety in Patients Receiving Hospice Care**

Scott A. Irwin, M.D., Ph.D., and Alana Iglewicz, M.D.

JOURNAL OF PALLIATIVE MEDICINE

Volume 13, Number 7, 2010: 903-908

In two patients, “a single oral dose of ketamine provided rapid and moderately sustained symptom relief for both depression and anxiety.

In addition, no adverse effects were noted.”

**Important:** This is the first report of successful treatment with **ORAL Ketamine in HOSPICE patients.** (Institute for Palliative Medicine at San Diego Hospice.)

# A good response to treatment.

After the 64-year old woman was given a **single oral dose** of 27.5 mg of Ketamine:

By 60 minutes her HRSD had dropped 45%;

By 120 minutes, she no longer had suicidal thoughts, expressed hope for the future, no longer felt irritable;

By day 15, she had a 66% (HRSD) improvement, had become more engaging, felt “relaxed,” was finishing chores, felt less preoccupied with feelings that she was a burden to her roommate, and was calling friends and initiating planning social gatherings.

Her caregiver/friend said to the physician, “Thank you for giving me my friend back.”

# A non-response to treatment.

After another month, however, significant depressive symptoms returned. Although they were not as severe as in the initial presentation, this time, delirium and pain complicated the clinical picture.

She did NOT respond to a repeat dose of Ketamine.

# Dr. Scott Irwin's current protocol

To avoid the “wearing off” effect—often as early as one week, psychiatrist Scott Irwin, PhD, MD, of The Institute for Palliative Medicine at San Diego Hospice, gives doses of Ketamine to patients every day or every three days. He estimates that nearly 9 out of 10 patients respond.

Question: If a positive response is possible in 1 to 2 hours, should a trial of Ketamine be part of the protocol to evaluate patients who request to hasten dying/to not prolong dying?

# Defining terms

Although assigning a diagnosis is NOT a high priority for administering this semi-structured interview, it is heuristic to consider two kinds of “depressions” in patients who suffer from a “**severe**” illness:

- **Adjustment Disorder of Adult Life with Depressed (and possibly Anxious) Mood** secondary to a *severe medical illness*; and,
- **Major Depressive Disorder**—a separate, distinct co-morbid disorder from which the patient is suffering—in addition to his/her severe physical illness.

“**Severe**” medical illness is an “**irreversible**” condition caused by an “**incurable**” and “**progressive**” disease.

Why not use the term, “**terminal illness**”? Because...

**A)** Physicians are not always correct when they try to predict how long a person is likely to live; **B)** Longer suffering (e.g., from a chronic illness) means greater suffering—if **irreversible** and **incurable**; and **C)** Many people, including professionals, do not (yet) appreciate that Advanced Dementia *is* really a terminal illness.

# Defining terms, continued

Why require the disease to be *irreversible*?

Because otherwise, requests *to hasten dying/to not prolong dying* may be *premature*.

Why require the disease to be *progressive*?

Because stable conditions due to injuries such as quadriplegia must be evaluated over a longer period of time; some patients adjust well to their disability and choose to live a long time.

Important note: the Checklist/Worksheet was NOT designed to evaluate patients with stable conditions.

The Checklist/Worksheet was designed to evaluate patients who can be considered as being in the process of dying.

# Adjustment Disorder with Depressed Mood

This diagnosis should NOT be used as a barrier to prevent patients from exercising their right to hasten dying/to not prolong dying.

Yet treatment collaboration is critical if there is a possibility of further improvement—by providing palliative care that leads to improvement in symptoms, or by a successful social/psychological *or* spiritual/pastoral intervention. Try any intervention that could lead the patient to postpone *WHEN* to hasten dying/not prolong dying.

Adjustment Disorders are classically treated by removing or lessening the stressful agents. While there is no way to change a “terminal” prognosis, there may still be critical misunderstandings. Example: Patients may believe they are a huge burden to others and a single session of family therapy may dispel that belief so they can appreciate how much their loved ones are learning and receiving from the experience of being their caregiver/carer.

# Major Depressive Disorder

This diagnosis is usually treated by pharmacologic agents, with or without psychotherapy.

Aside from the Ketamine trials, very few reports showed that antidepressant treatment is effective (Eychmueller S. (2009). Management of depression in the last month of life. *Curr Opin Support Palliat Care.* 3:186-9).

At best (perhaps): “The available evidence suggests possible effectiveness of methylphenidate for depressive symptoms, fatigue, and apathy in various medically ill populations.” From: Hardy SE. 2009. Methylphenidate for the treatment of depressive symptoms, including fatigue and apathy, in medically ill older adults and terminally ill adults. *Am J Geriatr Pharmacother.* 7:34-59).

# 3 Ways the Checklist/Worksheet is Unique

A) The “**cut-off score**” of the **Checklist** is **one**. If the relief of **any** physical, psychological, or social symptom could possibly postpone the patient’s wish to die, then a brief therapeutic trial is warranted. Two exceptions should be kept in mind: if physical suffering is escalating despite treatment, and if death is imminent.

B) The **Worksheet** asks evaluating clinicians to consider procedures that they might not otherwise. For example, “**Respite Sedation**” provides deep continuous sedation. Patients who are exhausted from pain and suffering, including existential suffering, can get a total rest. After a predetermined number of days, sedation is reduced to see if they have regained enough strength, and will, to resume conscious life. (This is the opposite of “*Terminal Sedation*.”)

C) Certain items were included to help clinicians avoid legal problems. For example: “Have you ever been treated for psychiatric illness? Hospitalized? Made a suicide attempt?” And, “Are you keeping your wish to die now, a **secret** from your family and close friends?”

# How can we “discuss” the Checklist?

To ASK all the questions on this semi-structured interview usually takes between 30 and 45 minutes.

To DISCUSS every question would take longer.

I can only present the highlights of a recent patient.

Refer to the handout.

➔ If you wish to offer a comment about ANY question, let me know—either now or later.

I can send you blank forms and additional information.

The Caring Advocates web site posts this PowerPoint Presentation. From any page, click the left navigation bar:

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Our clinical, legal, and pastoral professionals are dedicated to making sure others will honor your end-of-life decisions.

The Caring Advocates' team can help in three ways:

- >> Explore all legal end-of-life options so you can make informed decisions.
- >> Create effective documents to express your preferences and to empower your proxies
- >> Help implement your choices when "that time" comes.

Click this image for more information.



The Caring Advocates **DNR-Registry Medallion:**

- Informs 9-1-1 responders about your choices regarding medical treatment
- Helps ensure others will honor your wishes as your life ends
- Provides immediate download and FAX of your Advance Care Planning forms
- Notifies up to 10 people when you are admitted to a hospital



# The Depression Checklist (1-6)

- 1. When was the last time you were able to enjoy life? (Please tell me about it.)**
- 2. If your pain and suffering were controlled well, could you enjoy being around people you like?**
- 3. Have you dropped activities or interests for any reason other than your being so ill?**
- 4. If you had a “good night” and awoke feeling physically well, would you be glad to see another day?**
- 5. If you could be confident that you would feel physically well for an evening, could you enjoy your favorite restaurant, a good movie, or similar activity?**
- 6. Are you basically satisfied with how your life turned out? (Do you see yourself as a failure?)**

# The Depression Checklist (7-12)

- 7. Has guilt about events that happened long ago recently started to bother you again?**
- 8. Are you “fed up” with your existence? Why? (Must you spend almost all your time enduring medical treatments? Must others help you with all your basic care? Other reasons?)**
- 9. Are you bored with people since their concerns seem irrelevant to your challenges?**
- 10. For your loved ones and others you will leave behind, are you hopeful about their future?**
- 11. Have you ever been treated for psychiatric illness? Hospitalized? Made a suicide attempt?**
- 12. Is there a person for whom you have much anger?**

# The Depression Checklist (13-18)

- 13. Is there an issue about which you have much anger?**
- 14. Do you have a short fuse? (Are you easily annoyed or irritated? Do you snap at people?)**
- 15. Are you bothered by almost constantly intruding thoughts that your life will soon end?**
- 16. Do you feel you are a huge burden on others, even though they assure you that you're not?**
- 17. Has all the pain and suffering you have had to endure made you feel exhausted?**
- 18. Is there anything in life you would still like to do, if it were possible?**

# The Depression Checklist (19-24)

- 19. Does your anxiety or fear of dying prevent you from enjoying any moments of your life?**
- 20. Are you worried that problems with your memory will get much worse?**
- 21. Are you worried that your physical abilities will decline much further?**
- 22. If you felt physically well for a while, would you feel glad that you were still alive?**
- 23. Have you experienced any losses recently, such as the death of a pet or a sibling?**
- 24. Do you feel sad, unhappy, downhearted, blue, or cry a lot—which you cannot shake?**

# The Depression Checklist (25-30)

- 25. Do you feel you have nothing to contribute to anyone or to society? (Do you feel worthless?)**
- 26. Is there anything on your agenda of “unfinished business”? If so, what is it?**
- 27. Are you keeping your wish to die now, a secret from your family and close friends?**
- 28. Do you feel you no longer deserve to live? (Do you feel you have a duty to die?)**
- 29. If a cure was just announced for your illness, and treatment could easily restore you to a reasonable degree of health, would you take the treatment so you could continue to live?**
- 30. Do you feel your loved ones would be better off, if you were gone?**

# The Depression Checklist (31-34)

**31. Are you angry at God?**

**32. How long have you wanted to hasten your dying? If this is a recent desire, what changed?**

**33. Do you fear you might become trapped in a condition that you consider “worse than death” due to pain and suffering for which there will be no relief?**

**34. Do you fear you might become trapped in a condition that you consider “worse than death” due to your becoming totally dependent on others and/or losing your dignity as you define it?**

# The Depression Checklist (35-36)—a

**This audio excerpt is from my interview in mid-September 2010, with Attorney John West, author of The Last Goodnights: Assisting My Parents with their Suicides (Counterpoint, Berkeley, 2009). [Transcription is on the next slide.]**

**This part of the interview came after we completed much of the Depression Checklist/Worksheet. I asked John West to respond based on his knowledge of his mother, to answer as she would have responded. Mrs. Kathryn West, PhD, had much to be depressed about: She had recently lost her husband, had lost the ability to continue working as a teaching psychologist, and had lost some executive functioning and some ability to communicate due to a difficult to diagnose but certainly progressive dementia—which she considered “torture.”**



ST: Switch gears now, and say that it is definitely appropriate as a reasonable decision for your mother to ask for her dying to be hastened or for her dying not to be prolonged, which is perhaps a better way of putting it.

Now the question is, what is the best time for that? Some people feel that they need to do this **earlier** because they want to be **sure they still can**. In your mother's case, in fact, you had a nightmare about this and lots of fear that she wouldn't be able to swallow her pills. She might get tired or something would go wrong because of her physical or mental inabilities and it would be a botched attempt which could be worse than anything else that could possibly happen. **So earlier it's more likely that she would be successful** in completing the act of hastening her dying. Was that a major consideration in timing for her, for you, for the two of you?

JW: It was. And we talked about it a lot. I mention it in the book a few times... always gauging when to do this. She in fact was the proponent of sooner. And I was more a proponent of "but not too soon." I mean, "let's keep an eye on it, I see where you are and I'm not going to let it get to the point where you don't know what's going on because that would be way too far, nothing would be able to be achieved then." But I did have concerns even from the beginning of our discussion about her physical ability to take sufficient pills, would I even have the right pills, etc., etc. So it was really more tension between her saying, "I'm ready," and me saying, "Well, let's talk about it."

ST: So there was a bit of tension there?



JW: Yes, a little bit of tension there, but it was partly me helping her gut-check herself and making sure that it wasn't just a transitory depressive episode.

# The Depression Checklist (35-36)—b

**Another audio excerpt from my interview in mid-September 2010, with Attorney John West, author of The Last Goodnights: Assisting My Parents with their Suicides (Counterpoint, Berkeley, 2009):**

**This excerpt shows how John West determined that it was time for his mother to die—without professional help, since it had to be done, in secret.**



JW: When she really was ready and, and . . . I could tell. It's like so many things when you work in a particular milieu. You know when you've crossed a certain line. It's like painters who know the difference between red and crimson. They just know. They don't have to look at it for more than a second. They just know.

When I was driving with her that one time, she said in a very special voice that she was ready. And I pulled over and stopped. And we talked about it. From the timbre of her voice, the tone, the pace, her body language, the way--, the clarity of her expression, the ease of her ability to speak--.

I knew she was in another one of these “pools of clarity” and at a place of true resolution and readiness. And then I knew it was really real, and the time had come. And we planned accordingly.



→ *Question for audience: How many people consider John West's decision, that he made with his mother, as timely?*

# The Depression Checklist (35-36)—c

**Final audio excerpt:**

**John West stated he did not want to help his mother die if she was suffering from what he called, a “transitory depressive episode.” Then he further postulated that someday there would be a new subspecialty of psychiatry to help with the difficult issue of deciding when it is time to die.**

**The full 55-minute interview is available at [www.CaringAdvocates.org/audio.php#Podcasts](http://www.CaringAdvocates.org/audio.php#Podcasts) (Just click Podcasts on the Left Navigation Bar.)**



JW: Yes, a little bit of tension there, but it was partly me helping her gut-check herself and making sure that it wasn't just a transitory depressive episode.

That's why I think this area is so important to study and why ultimately I think there will be a sub-specialty in psychiatry— let's call it "Thanatology"—for people who are trained in psychiatry and understand depression and also understand the time table of these things and who can take the time to assess over time. Of course, this implicates the amount of time a physician can spend with a patient in our modern system, but that's a whole other kettle of fish.

→ So in hindsight, John West says *not just a physician or a psychiatrist*, but a psychiatrist who has a *sub-specialty interest* in depression and dying should *determine when*. John did the best he could: he based his timing decision on many previous discussions and knowing his mother well, and her present "very special voice" including its "timbre," "tone," "pace, and "her body language," "clarity of her expression," and "ease in her ability to speak," to conclude she was in "a pool of clarity," so that the time had come. Without a "ironclad strategy": fear of being trapped.

# Depression Checklist (Intro for 35-36)—d

For the next two questions, assume your condition will get worse. Thus if you wait too long, you will **lose control** over when and how you die. *Now* you can understand and appreciate the consequences of your actions. *Now* your judgment is NOT affected by your mood. If physician-assisted dying is legal where you live, *now* you CAN ingest a lethal dose of medication by yourself: you can take the pills out of a bottle, put them in your mouth, and swallow them. Or you can mix them in the liquid that enters your body via a feeding tube. If physician-assisted dying is NOT legal, you may have another way to die *now*. But you know you must act **without direct assistance** since anyone who helps you might be charged with **murder**.

➔ To avoid being trapped in a condition you consider “worse than death”—if you lose your mental or your physical ability **to hasten dying/not to prolong dying**—you could die **NOW**. But you still want to enjoy life as long as you can. Life is **precious (sacred)** and you do NOT want *premature dying*.

# Depression Checklist (Intro for 35-36)—e

Consider a strategy called “**PLAN NOW; DIE LATER.**” It is similar to a plan everyone knows: “Buy now; pay later.” That plan lets buyers enjoy TVs, cars, and homes *now*—even if they cannot finish paying until *later*. Sellers must *trust* buyers; buyers must sign a loan document or similar *agreement*.

➔ The “**PLAN NOW; DIE LATER ironclad strategy**” requires you to **trust** your healthcare proxy after you sign a **Natural Dying Agreement** that gives your **proxy** (or “agent” or “durable power of attorney”) extra **power** to make sure everyone will honor your previous end-of-life wishes—even your “future demented self.” Confidence in this strategy may eliminate fears about becoming trapped in a condition you feel is “worse than death.” If you can trust others to make sure you will NOT become trapped, you might consider postponing **WHEN** you will ***hasten your dying/not prolong your dying***. Consider these two legal/clinical possibilities:

**35.** Suppose *active* physician-assisted dying IS legal: local laws allows physicians (under very specific circumstances) to administer a lethal dose of medication into your mouth, feeding tube, or vein—in order to bring about a quick “good death.” Your “Plan now; die later” strategy clearly and specifically states *WHEN* you want this physician assistance. **If you can trust this strategy, would you decide to remain alive for a few more weeks or months?**

**36.** Suppose *active* physician-assisted dying is NOT legal, but **Natural Dying** IS legal everywhere. **Natural Dying** means you will receive no life-sustaining treatment; no assistance with feeding or drinking; but excellent comfort care, especially to your mouth. **Natural Dying** usually leads to a peaceful dying within two weeks. Your “Plan now; die later” strategy clearly and specifically states *WHEN* you want others to permit Natural Dying. **If you can trust this strategy, would you decide to remain alive for a few more weeks or months?**

## ***Clinician's Worksheet:***

I considered the possibility of several interventions to make the patient's present quality of life more "livable." I do NOT feel there are any options that would make a significant difference in the patient's decision *to hasten dying/to not prolong dying* at this time. I specifically considered the following:

- 1. Treatment (additional, if already tried) with stimulants or Ketamine is NOT likely to help;**
- 2. Focused brief individual psychotherapy is NOT likely to help;**
- 3. Relationship psychotherapy with significant others (such as to discuss the issue of how much burden others really feel the patient has become) is NOT likely to help;**
- 4. Respite Sedation (temporary deep sedation for unbearable pain and suffering to provide a few days of total rest before letting the patient wakeup) is NOT likely to help;**
- 5. Other interventions in palliative care are NOT likely to help;**
- 6. Meeting with religious or spiritual counselors is NOT likely to help;**
- 7. A "Plan Now; Die Later Ironclad Strategy" to empower Proxies to make sure dying is NOT prolonged—in the event the patient loses current mental competence and physical abilities—either has already been done, OR is NOT likely to help. (Indicate which and state why.)**

# Ethical tension between autonomy, and both the sanctity of life and the law.

Some professionals would argue that patients do not always appreciate what is best for them—especially if they are not informed about certain facts. Yet others worry about giving professionals license to exercise their biased **paternalism**, which they may inappropriately use to override patients' **autonomy**.

The probability of being in compliance with the law is maximized if professionals show respect for the **sanctity of life**. Professionals should be able to provide proof that the patient's decision was made after **being informed of other options**, with decisional capacity (especially good reasoning), by judgment NOT affected by mood, and with consistency over time.

**Professionals should strive to show that they made reasonable attempts to contact all legitimately concerned.**

## **Clinician's Statement of Opinion:**

**I evaluated the patient on \_\_\_ / \_\_\_ / \_\_\_\_\_, and on \_\_\_ / \_\_\_ / \_\_\_\_\_ .**

**I considered the option to have another clinician interview/evaluate the patient. This did/did not occur on \_\_\_ / \_\_\_ / \_\_\_\_\_ with**

\_\_\_\_\_, whose opinion is/is not attached, and briefly summarized below:

**I have considered the need to discuss the patient's plan to hasten dying/to not prolong dying with others—including family members, close friends, primary care physician, spiritual or religious or psychological counselor, attorney, and others: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_. (I have attached notes from those meetings.)**

**This is my opinion: The patient, in reaching the decision to hasten dying/not to prolong dying, demonstrated all of the following: diligence, solemnity, decisional capacity, judgment NOT affected by mood, and good reasoning—given the *patient's* feelings about his/her present condition and prognosis. In my opinion, the patient's decision would NOT be changed by offering further treatment.**

**In my opinion, the patient's decision has been consistent over time.**

*[Note: Cross out this last opinion if you have not performed a second interview, or not consulted others who have known the patient's wishes over time.]*

**Clinician's signed name and date:**

# Further resources

Main website is [www.CaringAdvocates.org](http://www.CaringAdvocates.org).

The “ironclad strategy”: [www.PlanNowDieLater.org](http://www.PlanNowDieLater.org).

Also of interest: [www.MyWayCards.org](http://www.MyWayCards.org).

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# Literacy and Comprehension of Beck Depression Inventory Response Alternatives.

Tetine L. Sentell, Brenda Ratcliff-Baird. (2003).

Community Mental Health J. 39(4): 323-331.

**TABLE 1**

## **BDI Response Alternatives by Percent of People Who Correctly Paraphrased Them**

	<i>Correctly Paraphrased</i>
<i>Elderly N = 14</i>	
I have no appetite at all anymore.**	62% (8)
I am purposely trying to lose weight by eating less.**	54% (7)
I am worried about physical problems such as aches and pains; upset stomach; or constipation.**	54% (7)
I feel there are permanent changes in my appearance that make me look unattractive.	29% (4)
I used to be able to cry, but now I can't even though I want to.*	21% (3)
I am dissatisfied or bored with everything.	21% (3)
I am less interested in people than I used to be.	21% (3)
I am critical of myself for my weaknesses or mistakes.	21% (3)
I feel I have failed more than the average person.	14% (2)
I am not particularly discouraged about the future.	7% (1)
I am no more irritated now than I ever am.	0% (0)

Natural Dying can prevent patients and spouses from becoming victims. Quote: a mental health worker who guides Advance Care Planning for dementia

“We have a lady in her sixties at the present moment with advanced multi-system atrophy. She has been bed-bound for **6 months**, is **fed through a syringe into her mouth**, is paralyzed, doubly incontinent, and unable to communicate. Despite the best efforts, she now has a **large pressure sore and is on a morphine pump for continuous pain relief**. She has had a couple of bad chest infections, which one doctor chose to treat with antibiotics after another doctor had obtained the husband’s agreement to not treat with antibiotics. The husband is on the verge of a nervous breakdown from being asked by doctors to make a decision about not treating. He is so deep in the woods with grief that in my opinion, he is no longer able to make a decision and tends to agree with which ever doctor is talking to him at the time. I suspect that he is desperate for her to die and is so tormented by guilt for this emotion that he does not want to participate in any decision making that could hasten death. Natural dying (the withdrawal of food and drink) would obviously hasten a dreadfully prolonged dying process, so also would the refusal of antibiotics when she has an infection. The great shame in this story is that they did not discuss what her preferences would be when it was still possible to do so.”

# Recent article on Ketamine

**A Randomized Add-on Trial of an *N*-methyl-D-aspartate Antagonist in Treatment-Resistant Bipolar Depression** Nancy Diazgranados, MD, MS; Lobna Ibrahim, MD; Nancy E. Brutsche, MSN; Andrew Newberg, MD; Phillip Kronstein, MD; Sami Khalife, MD; William A. Kammerer, MD; Zenaide Quezado, MD; David A. Luckenbaugh, MA; Giacomo Salvatore, MD; Rodrigo Machado-Vieira, MD, PhD; Hussein K. Manji, MD, FRCPC; Carlos A. Zarate Jr, MD

*Arch Gen Psychiatry*. 2010;67(8):793-802.  
doi:10.1001/archgenpsychiatry.2010.90

## **Table 2. Patient Health Questionnaire-9 (PHQ-9)\* Depression Screening Scales**

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Over the past 2 weeks, how often have you been bothered by any of the following problems?

- (1) Little interest or pleasure in doing things.
  - (2) Feeling down, depressed, or hopeless.
  - (3) Trouble falling asleep, staying asleep, or sleeping too much.
  - (4) Feeling tired or having little energy.
  - (5) Poor appetite or overeating.
  - (6) Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down.
  - (7) Trouble concentrating on things such as reading the newspaper or watching television.
  - (8) Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual.
  - (9) Thinking that you would be better off dead or that you want to hurt yourself in some way.
- 

\*Questions are scored: not at all=0; several days=1; more than half the days=2; and nearly every day=3. Add together the item scores to get a total score for depression severity.

### Appendix: Patient Health Questionnaire (PHQ-9)<sup>66</sup>

Courtesy of MacArthur Foundation Initiative on Depression and Primary Care. PRIME-MD® Patient Health Questionnaire - Copyright © 1999 Pfizer Inc. MacArthur Toolkit - Copyright April 2006 3CM, LLC. Used with permission. Also available at <http://www.depression-primarycare.org/>.

**NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?  
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns:  +  +

TOTAL:

10. If you checked off *any* problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all \_\_\_\_\_

Somewhat difficult \_\_\_\_\_

Very difficult \_\_\_\_\_

Extremely difficult \_\_\_\_\_