Suicide and Alzheimer's Disease

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Suicide Facts & Figures

- 10th leading cause of death in US
  - 12.6 per 100,000 = 113 suicides /day or 1 every 13 minutes
  - Males nearly four times more likely than females
    - Represent 77.9% of all suicides
  - 800,000 people globally every year = 1 every 40 seconds


Suicide Across the Lifespan

Risk Factors for Suicide In AD

- White race
- Male sex
- High education
- Mild disease
- Preserved Insight
- Hx depression
- Hx psychiatric hospitalization
- Previous attempt
- Firearm access


Physician Assisted Suicide in AD

- AD is no less terminal than cancer, ALS, etc
- The loss of personhood is unbearable pain for some
- The ability to perform act is fundamentally altered in patients, requiring assistance
- Cheaper than long-term care, remove rationale for palliative care
- Remove imperative to conduct research to improve end of life care
- Slippery slope toward euthanize, including non-voluntary euthanasia (sedicide)

Pot, JAGS 2005

Ethical Arguments in Planned Suicide in AD

- For: Respect the autonomy of an individual who is competent and sets forth a plan to end life once dementia takes hold
  - Autonomy - distaste for a life of dependence
  - Non-maleficence - a wish to avoid burdening others
  - Beneficence - preservation of assets to pass on to others
- Against: Respect the autonomy of a person living with dementia, who may enjoy life in unexpected ways, must be respected, even if that person had earlier communicated a desire to end life
  - Autonomy - Person 2 may be a different person
  - Non-maleficence - Burden on caregivers and medical professional
  - Beneficence - Person 2 may be “pleasantly senile”

Physician Aid-in-Dying

Fay Blix
Attorney at Law

Governor Brown signed the Bill on October 5, 2015

“What I do not know what I would do if I were dying in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by the bill. And I wouldn’t deny the right to others.”

What is the End of Life Option Act?

• New California law effective June 9, 2016, sunsets 2026 (Health & Safety Code Section 443, et seq)
• Permits prescription of an aid-in-dying drug in specific circumstances
• Very detailed process, documentation
• NOT suicide, assisted suicide, active euthanasia or mercy killing
• Provider immunity (permissive statute for both patients and physicians)
Who Can Access this law?

- 18 years or older
- California resident
- Terminal illness-Incurable or irreversible illness, and prognosis of six months or less
- Request must be voluntary
- Capacity for medical decisions
- Ability, physically and mentally, to take the drug at the time he/she wants to take it
- ONLY the individual herself/himself can make the request

Overview of Process

- Requests and discussion with attending physician (2 oral and 1 written request)
- Second opinion from a consulting physician
- If needed, assessment by mental health specialist
- Prescription-direct or via pharmacy
- Patient decides when to self-administer and can change mind regardless of capacity
- Medical record documentation required throughout process

Attending Physician Must Determine

- Terminal disease and six-month prognosis
- That the patient request is voluntary
- That no coercion is involved (must meet separately with the patient)
- That the patient has capacity to make this medical decision (Referral to mental health specialist if needed)
- That the patient has made an informed decision
- That the patient has met all the criteria
- Refer to a consulting physician for second opinion

Capacity to Make Medical Decisions

- Ability to understand the nature and consequences of a health care decision
- Ability to understand its significant benefits, risks, and alternatives
- Ability to make and communicate an informed decision to health care providers

What is an Informed Decision?

- Diagnosis, prognosis
- Potential risks and results of taking drug, the fact that death might not come immediately
- Possibility that patient may choose not to obtain the drug or may obtain the drug but decide not to use it
- Alternatives or additional end-of-life treatment or palliative options such as comfort care, hospice, pain control, etc.

The Attending Physician Must Counsel the Patient

- To have another person present when the drug is taken
- The drug cannot be taken in a public place (Required)
- To notify next of kin
- To participate in hospice
- To keep the drug in a safe and secure place until use (Required)
The Attending Physician Must Counsel the Patient

• That the patient may withdraw or rescind at any time (even if the patient lacks capacity)
• Verify before writing the prescription that the patient still wants the drug
• Complete a mandated checklist
• Refer to a mental health specialist if concerns of a mental disorder

Consulting Physician Responsibilities

• Examine the patient and relevant medical records
• Provide opinion as to diagnosis/prognosis
• Provide opinion as to mental capacity and voluntariness of decision
• Refer to mental health specialist if determined necessary
• Complete all documentation required by law

Mental Health Specialist

• Psychiatrist or licensed psychologist
• Not a relative or person who will inherit from patient
• Consult is optional—at the discretion of the attending and/or consulting physician
• Examines patient and all relevant medical records (one or more visits)
• Determine that patient has mental capacity and decision is voluntary and informed
• Determine that patient’s judgment is not impaired due to a mental disorder
• Document these findings

Prescription

• Cannot be written until attending physician confirms all legal requirements have been met
• The law is not specific about which aid-in-dying drug can be prescribed
• Attending physician can directly dispense the drug, if authorized
• Pharmacist can dispense directly to patient, attending physician or other person designated by the patient or by mail or messenger service (signature required on delivery)
• The physician may not hand a written prescription directly to the patient or their representative
• Attending physician must report to the California Department of Public Health within 30 days of issuing the prescription

Patient Self-Administration

• Can change mind at any time, regardless of capacity
• Must be able to self-administer, others can prepare, but patient must take, ingest and swallow
• Cannot take in a public place
• Others, including providers, may attend

Final Actions

• Attending physician must report to the Department of Public Health within 30 days of patient’s death
• Cause of death on the death certificate CANNOT be suicide
• Patient death also cannot be considered suicide, assisted suicide, homicide or elder abuse for liability or insurance purposes
Attending Physician Refusal to Participate?

- Any provider can decline to participate for reasons of “conscience, morality or ethics”
- “Participate” includes providing information about rights under the act
- BUT, Right to Know End of Life Options Act mandates that providers “shall” give information about care options

Public Reporting

- California Department of Public Health is required to compile the information submitted by attending physicians and create public reports each year on or before July 1.

Applicability of the Act to Those With Alzheimer’s Disease

- Must have mental capacity And have terminal illness with six month prognosis to access the Act
- Usually capacity to make this kind of choice lost long before patients reach terminal phase
- Many frustrated to learn the Act will not apply to them

Vulnerability at Diagnosis

- Agony associated with prospect of loss of autonomy and independence
- Shame of stigma of loss of cognition
- Shattered dreams, loss of relationships, financial stress
- Discovering they do not qualify for the Act may tempt patients to take matters into their own hands realizing that it will be impossible to choose an end game if headed toward dementia and they wait too long to make the choice

Act Provides Opportunity

- Provides a gateway to talking about dying
- Gives an opportunity to partner to tailor care plans
- Affords a time to offer respect, affirmation and empathy—understand the complexity of the request
- Presents an opening for honest discussion, trust building and reassurance of commitment to quality care to the very end

Societal Role

- Need to change the care paradigm, reframe events, eg. “car mitzvahs”
- Watch our vocabulary—“empty shells,” “already gone”
- Do we inadvertently convey a “duty to die?”
- Would better social supports, financial flexibility and community education help?
- What if Orange County was dementia friendly?
“Last days need not be lost days”

Cicely Saunders