Silent Suicide in the Elderly

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The suicide rate in the United States rises consistently with age. Silent suicide is defined as the intention, often masked, to kill oneself by nonviolent means through self-starvation or noncompliance with essential medical treatment. Silent suicide frequently goes unrecognized because of undiagnosed depression and the interjection of the personal belief systems of health-care providers and family members. Elderly individuals committing silent suicide are often thought to be making rational end of life decisions. However, the elderly committing silent suicide must be distinguished from terminally ill patients who refuse further treatment in order not to prolong the act of dying. The clinical/legal issues surrounding silent suicide will be discussed.

Suicide is a pernicious killer of the elderly. The suicide rate in the United States rises consistently and markedly with age (see Figs. 1 and 2). Current statistics place the suicide rate for the individual 65 and over at no less than 17.7 per 100,000 as compared to the national average of approximately 11.9 per 100,000.[1] This disparity in mortality rates is no overnight development. As one commentator observed in 1951, "[S]uicide in the *last 50 years* has increasingly been a disorder of the elderly people . . ." [emphasis added][2].

Suicide among older people has received little public attention and relatively little notice from clinicians or researchers. This neglect stems in part from the myth that little can be done to treat older people who are suicidal, an assumption that reflects a general neglect of the mental health of older people. Quite apart from the problem of obvious suicide is a dilemma that confounds even the most responsible and astute clinician, family member, or researcher—silent suicide.

Silent suicide is defined as the intention, often masked, to kill oneself by nonviolent means through self-starvation or noncompliance with essential medical treatment. It is the preferred method of self-destruction by the depressed, bedridden elderly. Psychological, physiological, social, ethical, cultural, economic, and situational factors may all play a part in the elderly person's decision to die. Unlike teenagers who might attempt suicide or harbor suicidal feelings as a manifestation of a current situational distress, the decision to die by the elderly is typically much more resolute and therefore more successful.[3]

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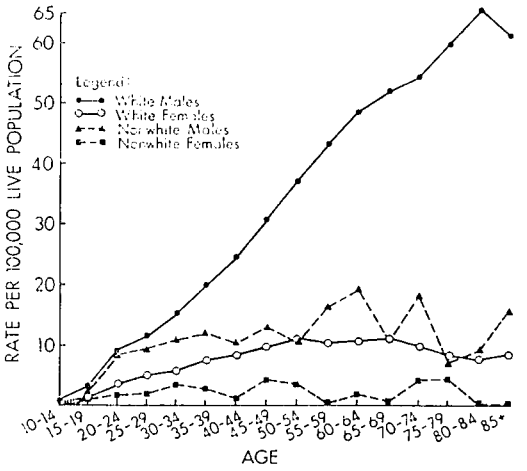

Figure 1. Suicide rates in the United States by age, sex, and race, 1950. (Calculated from Vital Statistics of the United States, 1950, pp 56–7, 118–9).

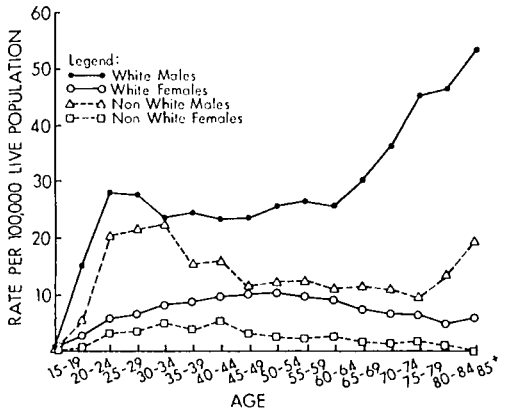

Figure 2. Suicide rates in the United States by age, sex, and race, 1980. (National Center for Health Statistics, Vital Statistics of the United States, 1980, Vol. II, Part A, DHHS Pub. No. (PHS) 85-1101. U.S. Government Printing Office, 1985.)

For example, the success rate for elderly persons who attempt suicide through violent means approaches 100% as compared to adolescents who succeed approximately 1% of the time.[4] Similarly, it is speculated that the attempt–success ratio of silent suicide by nonviolent means among the elderly also approaches 100% simply because the motivation or factors creating the desire to die are no different. Only the method is different. Compounding the problem of detection and diagnosis of silent suicide is the fact that persons refusing to eat or comply with medical treatment do so without warning or drawing attention to their true motives.

Silent suicide frequently goes unrecognized for several reasons: the absence of overt mental illness, the presence of real medical complaints, and recent personal losses may obscure suicidal indices by creating the false impression that the patient has "real" reasons for feeling depressed. Thus, the silently suicidal elderly may easily escape the health-care provider's suspicion of self-destructive intent, forcing clinicians to grope for other explanations for the patient's ominous decline. Too often, quasi-scientific conclusions such as "failure to thrive,"[5] the "giving up—given up complex,"[6] or "psychogenic mortality syndrome"[7] are proffered. Even family members may be unwitting collaborators in silent suicide by thwarting necessary therapeutic intervention out of a well intended but often misguided concern that the elderly patient be spared further suffering.

Case Illustrations

Case A A 90-year-old married woman with a 25-year history of recurrent depression was admitted to a nursing home from a general hospital. She had been hospitalized for one month for sepsis and dehydration. Previous depressions were successfully treated with antidepressants and electroconvulsive therapy. Depression and a hypothyroid condition were overlooked at the hospital but belatedly discovered after transfer

to the nursing home. One year prior to her nursing home admission, her favorite son had accidently died. The family said that she never recovered from this loss. One week after admission, the patient ceased eating and drinking. She also pulled out her Foley catheter. She spat out her thyroid medications. During her first week at the nursing home, the patient was fully oriented and cognitively intact. She responded to entreaties to either eat or drink by shouting, "Leave me alone!" Her husband refused permission for a gastrostomy. The patient pulled out her nasogastric tube. The nursing staff felt that she had "given up" and "at 90 was entitled to do so." Her physician thought she was depressed, but the family refused his recommendation that she be treated for depression. The physician decided not to push the issue, and the patient died of inanition three weeks later.

Case B An 85-year-old man had been living in a nursing home for about a month. He was fully oriented with no discernable cognitive deficits. Prior to his admission, he lived alone. He was familiar with all of the local bus schedules and was able to move about town without difficulty. After being fitted with a Holter monitor to check for heart block, he became depressed, negativistic, and stopped eating. He eventually lost ten pounds. Formerly outgoing and gregarious, he announced that it was time to die. He frequently complained of fatigue and lethargy, stating, "I have lived long enough." For the first time, mild confusion and disorientation became evident. Although visited by his family daily, he insisted that they came to see him only once a week. The family thought that the patient was depressed because of being forced to live in an institution. His physician diagnosed major depression. The patient and the family agreed to a trial of antidepressant medication therapy. Within two weeks, the patient ceased his talk about wanting to die and resumed eating and engaging in familiar social activities. Six months later, mild confusion remained but the depression was no longer evident.

Clinical Aspects

Diagnosis of Depression in the Elderly

Although few would dispute that suicide in old age can occur in the absence of any mental pathology, several studies have indicated a relatively high incidence of depression, chronic organic brain syndrome, and other diagnoses in cases of successful suicides (see Table 1).

Table 1
Incidence of Depression and Chronic Organic Brain Syndrome (OBS) in Suicides of Old Age

Author	No. of Suicides	Age	Depression	Chronic OBS
Batchelor and Napier (1953)*	40	60+	80%	10%
O'Neal *et al.* (1956)†	19	60+	47%	26%
Capstick (1960)‡	351	60+	48%	NK§

* Batchelor & Napier, Attempted suicide in old age, II Br Med J 1:1186, 1953
† O'Neal, Robins & Schmidt, A psychiatric study of attempted suicide in persons over 60 years of age, 75 Arch. Neurol. Psychiat. 275 (1956).
‡ Capstick, Recognition of emotional disturbance and the prevention of suicide, II Br Med J 1179 (1960).
§ NK, not known.

One commentator noted:

> Suicide rates for the affective psychoses and for neurotic or personality disorders were twice as high after age 65 than before that age. This age differential for the diagnosis of neurotic or personality disorders suggests the *depressive symptomatology is missed in the elderly.* This finding bears out the conclusions of other studies that depression among the aging is far more common than has generally been recognized and is a precursor to suicide.[8] [emphasis added]

One reason why "depressive symptomatology is missed in the elderly"[9] is that many silent suicide patients do not complain of dysphoria.[10] Nevertheless, elderly suicidal patients do encounter various factors that trigger depressive symptoms (see Table 1). Depression in the elderly is usually manifested by multiple physical complaints, pain, and noncompliant behaviors. The high incidence of physical illness typically associated with the elderly also makes obtaining an accurate diagnosis of depression even more difficult.[11] In addition, depression may simulate the symptoms of several medical illnesses, while certain organic disorders may produce symptoms identical to the vegetative signs of depression.[12]

Table 1

Factors Precipitating Depression in the Elderly

Physical illness
Loss of an important relationship
Institutional living
Loss of autonomy
Loss of financial resources
Loss of occupational identity
Coexisting psychiatric disorder
Drugs
Alcohol
Physical and emotional abuse
Genetic-biologic vulnerability to depression

In Case A, a firm diagnosis of depression was missed in part because of the presence of physical illness—sepsis, dehydration, and hypothyroidism. However, in Case B, confusion and memory deficits signaled a significant change in the patient's general demeanor which could not be explained by any apparent physical problems. Cooperation by an involved family assisted the treating physician to adequately treat the depression and circumvent a possible death by silent suicide. Clinicians, in evaluating the competency of patients who have apparently "given up" as in Case B, should not be misled by the finding of "cognitive competency." Patients who attempt silent suicide often display relatively intact cognitive decision-making capacity but are *affectively* incompetent because of depression. Reactive depression or ordinary human unhappiness usually do not render the individual functionally incompetent. However, major depressive disorders can impair decision-making capacity and morbidly distort the person's world view. Such depressions must be diagnosed accurately and promptly in order to be effectively treated.

Depression may mimic dementia. The depressive syndrome of pseudodementia is well known but often overlooked. When seen in elderly people, it is often misdiagnosed as organic in nature when in fact it is functional in etiology.[13] Demented patients, even if not depressed, may stop eating due to physical inability

to feed themselves.[14] In Case A, noncompliant behaviors included rejecting medication, food, and water. When a patient refuses medication and rejects food and water, covert depression should be suspected and ruled out.

Depression and Mental Competency Competence, in a general legal sense, refers to the capacity or fitness of a person to make certain decisions with regard to activities in daily living.[15] From a legal perspective, there are two types of competence: de jure and de facto.[16] "De jure" competence is competency established on the basis of one's status under the law, e.g., all adults, due to their age, are presumed competent. "De facto" competence is based upon a person's understanding of whatever act is being proposed, e.g., consenting to medical treatment, executing a will, or deciding to marry.

Competence is the key to any legal decision involving the elderly, whether it entails consent, hospital commitment, civil or criminal law. In order to assess competency involving the elderly, two factors must be addressed. First, in what context is the competency ("de facto") being determined? Different circumstances require different levels of understanding due to the varying nature of the subject matter. For example, the question of competence to marry, execute a will, enter into a legal contract, or make an informed decision about medical treatment all require different levels of understanding.[17] Accordingly, the mental capacity required to render a decision regarding continuing or terminating one's life is of a very high order. This decision-making process can be impaired by many factors, including severe pain, delirium, dementia, depression, and family coercion.[18]

The second factor regarding competency and the depressed elderly patient is the need to distinguish between cognitive and affective aspects of the patient's decision-making capacity. Even when a patient is severely depressed, cognition may remain intact. However, there often can be affective impairment. On a mental status examination, a depressed elderly person may present as fully oriented and be able to accurately perform on informational and abstract testing yet be quite depressed.[19] The depression can very easily impair rational decision-making capacity by making life appear totally unlivable, leading to the rejection of essential treatments. On the other hand, severely depressed patients may incompetently accept recommended treatments, particularly out of a sense of guilt or from a need for punishment. Incompetent acceptance of treatment recommendations tend not to be questioned carefully by health-care providers. Therefore the need to carefully evaluate the elderly patient for depression is critical (see Table 2). For example, in Case B, the patient, due to his depression, concluded it was time to die and began self-starvation. If he had not been properly diagnosed as depressed and had remained untreated, he would likely have died, as in Case A.

Treatment Considerations The elderly patient who is regarded as either depressed and/or suicidal is highly treatable if accurately and promptly diagnosed. Treatment usually can be provided in a general hospital setting or in

Table 2

Geriatric Depression Scale

Choose the best answer for how you felt over the past week:

1. Are you basically satisfied with your life? yes/no
2. Have you dropped many of your activities and interests? yes/no
3. Do you feel that your life is empty? yes/no
4. Do you often get bored? yes/no
5. Are you in good spirits most of the time? yes/no
6. Are you afraid that something bad is going to happen to you? yes/no
7. Do you feel happy most of the time? yes/no
8. Do you often feel helpless? yes/no
9. Do you prefer to stay at home, rather than going out and doing new things? yes/no
10. Do you feel you have more problems with memory than most? yes/no
11. Do you think it is wonderful to be alive now? yes/no
12. Do you feel pretty worthless the way you are now? yes/no
13. Do you feel full of energy? yes/no
14. Do you feel that your situation is hopeless? yes/no
15. Do you think that most people are better off than you? yes/no

Note: "No" answers on questions 1, 5, 7, 11, and 13, and "yes" answers on the others count for one point each. Geriatric Depression Scale Scores: Greater than 5 suggestive of depression; greater than 10 strongly suggestive of depression. (From An Overview of Legal Issues in Geriatric Psychiatry, Task Force Report #23, pp. 36, 38. Copyright (c) 1986, the American Psychiatric Association. Used with permission.)

Table 2 cont.

the nursing home. The objective of treatment should be to provide emergency lifesaving measures and to treat the underlying emotional disturbance.[20] Clinical intervention should be the goal while premature conclusions that the patient has made a "rational" decision to die must be avoided. Furthermore, psychiatrists must be careful not to interject their own value system about life and death into health care considerations and decisions. This is especially important when working with an elderly patient who is refusing food, water, or medical intervention. It is critically important to refrain from making initial moral judgments that might preclude diagnosing and treating the patient's depression and thus preventing suicide.

Several psychiatric interventions are available for the elderly depressed patient. Electroconvulsive therapy can be the treatment of choice, particularly for the elderly depressed patient with concomitant medical problems. Antidepressants are useful but must be used cautiously in the medically ill, depressed patient. The depressed elderly respond to various psychotherapeutic approaches that are focused on the suicide crisis and the underlying precipitants.

Legal Considerations: Sanctioning Suicide?

Suicide or the Right to Refuse Treatment Ethically, a patient's dignity and

right to privacy require that personal autonomy be respected whenever possible. This means that the patient retains the prerogative to make decisions regarding what is and what is not going to be done with his or her body. These ethical considerations are recognized by law and embodied in the doctrine of informed consent.[21] Health-care professionals serve a secondary role, albeit an essential one, of providing treatment and the requisite information the patient needs in order to make an informed decision.[22]

It is only on rare occasions that the courts have authorized treatment over the objections of a competent patient. Typically, this has occurred under extreme circumstances, for example, when there has been risk to the fetus, when the patient was responsible for the care of dependent children and life sustaining treatment such as a blood transfusion was required[23], and when otherwise competent and medically healthy persons have attempted suicide.[24]

Traditionally, a competent adult has the power to give or refrain from consent for medical treatment.[25] However, there are exceptions, as noted above, often determined by law, statutory policy, or legislative order. An elderly patient's decision to refuse treatment should prompt health-care providers to carefully assess cognitive and affective functioning as well as the patient's reasoning for his or her decision. Despite the input from psychiatric evaluations and other clinical information, judges generally decide these matters on very narrow grounds, typically giving much deference to the expressed or implied wishes of the patient. Where the patient is determined to be competent by the court, the patient's decision will usually be honored.

Inherent in the right to give informed consent to treatment is the right of informed refusal of medical care, even in instances in which the person is acting against medical advice. "The right to make certain decisions concerning one's body is also protected by the federal constitutional right to privacy."[26] Neither the common law nor constitutional bases for the right to decline needed medical treatment are absolute. However:

> on balance, the right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death. Most of the cases that have held otherwise . . . have concerned the patient's competency to make a rational and considered choice of treatment.[27]

When a person is incompetent or lacks the ability to comprehend the information conveyed, to assess the options, or to communicate a decision, a number of factors must be addressed. First, the determination of incompetency must be properly made. This procedure is governed by statute and varies from state to state, but generally at least two physicians should furnish evidence regarding the applicable competency standard to the court. The proof must be clear and convincing that the patient does not have the capability of making rational decisions. Courts recognize that the inability to govern and manage one's own affairs does not automatically render that individual legally incompetent.

With respect to incompetency and medical decision-making, courts are faced with the need to balance seemingly competing interests:

> [T]he goal of decision-making for incompetent patients should be to determine and effectuate, insofar as possible, the decision the patient would have made if competent. Ideally, both aspects of the patient's right to bodily integrity—the right to consent to medical intervention and the right to refuse it—should be respected.[28]

In order to make this "substitute determination,[29] courts refer to a number of sources such as a living will stating the patient's wishes, an oral directive to family members, friends, or health care providers, a durable power of attorney or proxy to a specific person to make the decision on the patient's behalf, opinions or reactions expressed by the patient to others regarding medical treatment during a lucid period, implied preferences deduced from a person's religion or moral beliefs, or any other appropriate information that would aid in making a decision about the patient's preference.[30] A common judicial procedure regarding substituted decision making on behalf of an incompetent is the appointment of a guardian. Depending upon the state and the circumstances, the substitution by a guardian may be complete, covering all legal decisions, including medical treatment, or it may be limited to one or more aspects of the patient's life.[31]

It should be noted that courts are often reluctant to wrest away a person's legal right to self-autonomy. Therefore, the mere presence of some degree of impairment, such as memory dysfunction, will not automatically foreclose a patient's right to choose or refuse medical treatment.[32] Moreover, a decision that appears irrational or not in the patient's best interest is not by itself an acceptable basis for a determination of incompetence.

Case Law Examples An 85-year-old college president residing in a nursing home stopped eating. He decided to hasten his death by fasting after becoming depressed over a series of debilitating illnesses. The nurses, unsure whether to respect the patient's refusal to eat or commence force feeding and treatment, sought guidance from the court. The court concluded, "despite being heavily burdened by these questions" and disapproving of the termination of life as contemplated, that the patient knowingly and willfully made [his] decision with the full understanding of the consequences, a hastened death and therefore it should be respected."[33]

Although this decision is consistent with the general case law precedent establishing a patient's right to privacy and personal autonomy, it aptly illustrates the lack of psychological sophistication inherent in these types of medical-legal decisions. The attending physician presented testimony to the court that he "believes this patient to be competent." Cognitive competency appeared to be the sole concern in the court's ruling. However, this incomplete perspective of competency overlooked the possibility of affective incompetence, a real consideration when dealing with a depressed elderly patient such as in this case. This omission by the professional staff and ultimately the court raises serious questions regarding the patient's true deci-

sion-making capacity. Since the affective component was overlooked, appropriate treatment may not have been provided. Is it possible that a silent suicide was committed in connection with a well-meaning but inappropriate protection of a patient's right to refuse treatment?

The second case law example involved the much publicized Elizabeth Bouvia. Ms. Bouvia has had cerebral palsy since birth. Although she graduated from college and married, her condition deteriorated to the point that her parents were no longer able to care for her. As a result, she was placed in a public hospital. She is presently a quadraplegic, completely bedridden, physically helpless, and wholly unable to care for herself. Nevertheless, she is intelligent and appears to be mentally competent. In 1983, while in the care of a general hospital, she sought to starve herself. A lower court denied her petition to have the hospital permit her to accomplish this objective.[34]

Partly because of a liquid diet and her continued desire to starve herself, Ms. Bouvia's weight dropped to 70 pounds, creating concern among the hospital staff that her weight loss might become life threatening. Against her objections and written instructions, a nasogastric feeding tube was inserted into her stomach. Subsequently, she sought a preliminary injunction to halt force feeding, but this was denied. As a result, Ms. Bouvia took the extraordinary step of filing a writ of mandamus with regard to the lower court's decision.

On appeal,[35] the California court began by rejecting the hospital's argument that this matter not be adjudicated expeditiously but proceed through the normal appellate channels. The court noted that although the petitioner was experiencing no great physical discomfort from the tube, this did not diminish her mental and emotional feelings regarding having her body violated by an artificial device against her will.

The appellate court then concluded, based on earlier state decisions,[36] that an adult of sound mind "has the right to refuse *any* medical treatment, even that which may save or prolong her life."[37] Further,

> The right to refuse medical treatment is basic and fundamental. It is recognized as a part of the right of privacy protected by both state and federal constitution .... Its exercise requires *no one's approval.* It is not merely one vote subject to being overridden by medical opinion.[38] [emphasis in original]

In upholding Ms. Bouvia's right to refuse treatment, the court reiterated rejections in earlier cases of the hospital's arguments that the state's interest in preserving life, preventing suicide, protecting innocent third parties, and maintaining ethical standards of the medical profession outweighed the particular circumstances in this case.[39] In essence, the court noted that the prevailing consideration in a case like this is not the amount of life the petitioner is still able to have, as erroneously noted by the lower court, but the "quality of life."[40] And in "Elizabeth Bouvia's view, the quality of her life has been diminished to the point of hopelessness, uselessness, unemployability and frustration ... [It] is a moral and philosophical decision that being a competent adult is hers alone."[41]

With respect to mortality, the question of honoring the patient's wish to withdraw life support equipment runs squarely into the question of whether the state is party to and, in effect, sanctioning suicide. Rejecting the lower court's feeling that it was aiding a suicide, the Court of Appeals noted that while Bouvia may have earlier expressed suicidal intent, the withdrawal of life support serves only to effectuate her expressed objective to live out the remainder of her life in dignity and peace, "not hasten death, though its earlier arrival may be an expected and understood likelihood."[42]

Despite a "well reasoned and superbly crafted opinion"[43] by the Court of Appeals, the question was never raised regarding the petitioner's affective state and what impact this might have had on the "informedness" of her decision. Two physicians who were appointed special masters by the court to evaluate Ms. Bouvia and upon whom the judge relied heavily in his opinion, never asked her about any suicidal intent. Interestingly, they found that her "predominant mood was neutral." However, they did opine about her pain management that "the most important lack has been attention to the psychological and social aspects of pain control." Judge John H. Hews in his 1983 ruling noted that Ms. Bouvia was "displaying certain effects of depression" but concluded that she was "free from any acute mental or physical disorder." No one appears to have addressed the related issues of masked depression and affective competence. Despite the sweeping rejection by the court that it possibly could be an accomplice in bringing about the petitioner's self-acknowledged death wish, is it possible that masked depressive feelings significantly impaired her ability to make a rational life and death decision? Could the upholding of Ms. Bouvia's right to refuse treatment be viewed as an unwitting endorsement of silent suicide?

The narrowing of competency to include only cognitive capacity has its origins in the law of transactions. The law wishes to preserve good faith contracts between individuals from psychological attack. As one court stated, "Any benefit to those who understand what they are doing, but are unable to exercise self-discipline, will be outweighed by frivolous claims which will burden our courts and undermine the security of contracts."[44] However, the rigid application of this principle to the decision-making capacity of individuals suffering from serious mood disorders undermines the authority and dignity of the law. Psychiatrists have an ethical and professional duty to inform the courts of the potentially debilitating effects of mood disorders upon decision-making capacity. Only by the concerted efforts of mental health professionals to inform the courts can the law governing competency encompass contemporary psychiatric knowledge.

Maintaining a Treatment Position

Patients who are depressed and competent may decide to commit silent suicide. Certainly every elderly patient who is depressed is not incompetent. Competent patients do have the right to refuse treatment. However, even when the depression appears realistic given the individual's circumstances, ethically and

professionally, physicians must still try to enlist the patient's cooperation in treating the depression by whatever reasonable means available. In Case B where the patient, family, and physician agreed on a course of treatment, the optimal care situation developed.

Major difficulties for the psychiatrist will arise when staff and family have decided against treatment of a nonterminally ill patient who is rendered incompetent by depression. The depression may be completely unrecognized or denied. The value judgments of caretakers and family may further cloud medical judgment. In Case A, the nursing staff felt that the patient had lived long enough and was entitled to "give-up." Rather than seeing the patient as psychiatrically ill and in need of treatment, personal biases may lead to the view that a rational decision is being made by the elderly patient to exercise his or her right to die. Moreover, clinicians may unwittingly withdraw from pursuing active treatment of an elderly patient who they suspect is depressed and in need of care, believing that they are legally compelled to respect the patient's wishes. The physician must not confuse the terminally ill patient's right to refuse treatment that prolongs dying with a nonterminal patient's refusal of essential nutrients and medical treatment. These are completely different situations. Physicians must be physicians first and should not abdicate their role as health care providers.

Physicians who are faced with this difficult situation do have options. As in Case A, some have decided to pursue the matter no further, allowing the patient to die of self-starvation and from refusal of essential treatments. However, many have found this alternative repugnant and have either discharged patients or have gone to court to seek a judicial order for treatment rather than stand by while patients kill themselves. Gutheil *et al.*[45] have pointed out that the more incompetent the suicidal patient, the greater the need for active, unilateral action by caretakers. Obtaining a court order to treat or discharging noncompliant patients are extreme measures. They have their place, but whenever possible the cooperation of the patient and his or her family should be obtained.

The thesis of this paper is that health-care providers should maintain their treatment position as much as possible vis-à-vis elderly depressed patients without violating their civil rights. Finally, physicians must remember that they are physicians first. Moral and ethical issues are extremely important, but they must be integrated into the physician's treatment strategy rather than paralyzing it. Not to make this distinction will cause serious role confusion and may possibly lead to overlooking patients who are bent on silent suicide. The patient who attempts silent suicide requires the full care and treatment provided for any other suicidal patient.

Conclusion

Elderly patients who are depressed and competent create a precarious clinical and legal situation for the health care professional. The depression may appear realistic on the surface, especially if the patient's condition or reality situation might seemingly explain it. How-

ever, this is precisely the kind of clinical situation where the treating professional must remain wary. Depression can render the elderly incompetent or at least adversely affect their decision-making capacity to a significant degree. In those circumstances it is not uncommon for both physician and family, though perhaps well-meaning, to avoid pursuing an aggressive treatment plan. Falling prey to the narrow assumption that "there is nothing that can be done" or that the patient "is better off left alone" may lead to the patient's underlying depression remaining undetected and untreated. This dilemma is further complicated by the seemingly competent patient who expresses what appears to be an informed decision to refuse further medical intervention, which may include the refusal of food and water. While the trend of the law appears to recognize the rights of competent patients, terminally[46] or nonterminally ill,[47] to refuse medical treatment if it is the result of informed decision making,[48] the law has failed to recognize that it might be unwittingly assisting silent suicides. This is largely due to the predominant emphasis placed on cognitive competence without considering the effects of the patient's depression upon decision-making capacity.

Physicians who treat the elderly must be knowledgeable in diagnosing and actively treating the protean manifestations of depression in this age group. Affective incompetence is frequently overlooked as a serious impediment to the informed decision making required to legally refuse treatment. When affective incompetence is determined, its consequences and implications must be explained to the appropriate parties, including family and guardians, as well as the courts.

Recent decisions have concluded that the refusal of life-prolonging treatment does not constitute "aiding and abetting" suicide.[49] Similarly, no criminal or civil liability is attached to the physician who honors a competent informed patient's refusal of medical services.[50] Notwithstanding these *legal* conclusions, physicians who fail to assess for affective competency are not only remiss in their medical responsibilities but are, in effect, accomplices to silent suicide.

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34. Bouvia v. City of Riverside, #159780 (Cal Super Ct December 16, 1983)
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38. *Id* at 301
39. *Id* at 304
40. *Id*
41. *Id*
42. *Id*, also see *Id* at 307 (Compton, J., concurring)
43. *Id* at 307 (Compton, J., concurring)
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