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2002

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# GERIATRIC DEPRESSION: DO OLDER PERSONS HAVE A RIGHT TO BE UNHAPPY?

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*Elder Law Review Vol 1 (2002)*

Mrs. C is an eighty-five year old widow in the United States. Due largely to her lifelong pushy, manipulative, extremely demanding personality, her relationship with her two grown children is not a close one psychologically, even though the children are dutiful and both see and speak with her by telephone frequently. Mrs. C has resided for over a year in an assisted living facility, but worries that the rapid depletion of her personal funds coupled with her declining health will force her to enter a nursing home within the near future.<sup>1</sup> She had lived her earlier adult life as a wealthy physician's wife, but unwise retirement planning and investments<sup>2</sup> by her late husband, Dr. C, have placed her now in precarious financial circumstances to which she is not accustomed.

Mrs. C suffers (and not silently) from a panoply of physical ailments. A series of cerebrovascular accidents (strokes) have occurred over the past several years, and she now is virtually confined to bed and a wheelchair, requires constant artificial oxygen, is incontinent of bowel and bladder much of the time, has poor digestion that discourages her from ingesting adequate nutrition, and her sight and hearing are severely impaired and worsening over time. Her physicians prescribe a litany of medications to address these problems; her compliance with these prescriptions is uneven. Mrs. C exhibits no observable symptoms of dementia,<sup>3</sup> but she has been diagnosed as being clinically depressed. Her physicians have recommended to Mrs. C that she take medications to treat her depression, but she refuses to follow this recommendation.

## **BACKGROUND**

While some have argued that clinical depression among older individuals like Mrs. C is simply a normative and expected part of the process of growing old,<sup>4</sup> there is a strong current professional consensus that it is instead a noteworthy public health problem.<sup>5</sup> Although it is considered to be highly treatable through medication, psychotherapy, and electroconvulsive therapy,<sup>6</sup> physicians and other health care professionals often are criticized for doing an inadequate job of recognizing, and then treating, depression generally<sup>7</sup> and in this patient population particularly. They are routinely exhorted to improve their performance by being more aggressive in recognizing and intervening with this clinical condition.<sup>8</sup>

Yet, the mandate to provide aggressive treatment of depression in patients like Mrs. C is not always uncontroversial. Rather, medical intervention for such patients may raise a number of challenging legal, as

well as ethical, questions. There are widespread anecdotal indications that these issues are raised explicitly in conversations, as well as frequently being dwelled on privately, by gerontological professionals in the context of many cases. Surprisingly, however, there is very scant analysis in the published literature thus far linking the issue of clinical depression in older persons to the legal and ethical aspects of imposing involuntary treatment on 'at risk' elders. This article briefly outlines some of the more salient of the legal issues, not with the intent of comprehensively resolving or even adequately defining any of them, but rather to serve as an initial springboard for more in depth, continuing discussion and analysis by advocates and caregivers for older persons with depression.

## **THE RIGHT TO BE AND ACT DEPRESSED, AND ITS EXCEPTIONS**

As a general proposition, a health care or human services professional seeking to introduce any sort of therapeutic intervention aimed at curing or alleviating Mrs. C's depression, or at managing various other aspects of her life while she has depression, would require Mrs. C's prior informed consent or permission to do so. Put differently, we begin with the presumption that Mrs. C has a legally protected personal right to refuse to permit any medical or social intervention, even if health care or human services professionals strongly recommend the intervention as, in their professional judgment, likely to serve Mrs. C's best interest.<sup>9</sup> The legal right to bodily integrity or self-determination is predicated on the ethical principle of personal autonomy,<sup>10</sup> which is the preeminent ethical value in contemporary bioethical discourse in the U.S.<sup>11</sup> at the beginning of the new millennium.

Neither the principle of autonomy nor its legal manifestation, the doctrine of informed consent, are automatically abrogated or trumped in the case of Mrs. C solely because she has been categorized by health care professionals with the diagnostic label of clinical depression. At the same time, however, the individual's right to informed choice regarding medical treatment, while fundamental in stature, is not absolute and unlimited. Although it is difficult to find, especially in print, advocacy for the unqualified position that properly aggressive treatment of depression necessarily entails forced treatment of patients like Mrs. C who are resisting, there is a prevalent attitude among gerontological practitioners that severe depression robs individuals of the insight that they have a problem requiring help. When, then, is unwanted external intervention, medical and/or social, for an older depressed person justified?

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### **Danger to Others**

First, certain interventions might be justified or even compelled if Mrs. C were believed to pose a threat to the lives or well-being of other persons, i.e., if she were a danger to others. Under their inherent police power to protect and promote the general health, safety, and welfare of the general community,<sup>12</sup> states through legislation and/or judicial decisions impose on certain categories of professionals a legal obligation to warn third parties, either directly or by notifying law enforcement agencies, who are imminently and seriously endangered by someone (for example a patient or client) with whom the professional has a relationship.<sup>13</sup> The precise extent of the duty to warn, the degree of foreseeability expected, and the acceptable methods of fulfilling the responsibility vary considerably among jurisdictions within the U.S.,<sup>14</sup> and in many states there has been an expansion of responsibility from just a duty to *warn* imperiled third parties to one of actually taking steps to *protect* them from the harm threatened by the professional's patient or client.<sup>15</sup>

Let us suppose that Mrs. C is so depressed that the professionals who have been involved in her diagnosis and care reasonably suspect that there is a substantial risk that she may forget to turn off her stove one day soon and start a fire, placing not just herself but her neighbors in the assisted living facility in danger of serious injury. Under the existing law in most states, those professionals would be mandated to report this suspicion to law enforcement authorities, who probably in turn would request the involvement of the local adult protective services (APS) agency.<sup>16</sup> In considering particular options for intervention to prevent or substantially reduce the likelihood of the danger to others posed by Mrs. C from actually materializing, any law enforcement or social service agency would be legally guided by the least restrictive/least intrusive alternative principle. This principle, embodied both in statutes<sup>17</sup> and constitutional interpretation,<sup>18</sup> provides that when the state is contemplating intervening in someone's life in a manner that restricts that individual's freedom, the state may intervene only to the minimal degree (i.e., only in the least restrictive or intrusive way) actually necessary to accomplish the legitimate purpose(s) of the intervention.

Thus, in the scenario described here, it is likely that APS and/or the administrators of the assisted living facility would first explore with Mrs. C (and her children, if she will permit their participation and they are willing to participate) the possibility of her voluntarily accepting some environmental modifications in her housing unit (e.g., extra smoke detectors) that might eliminate or reduce the risk of the danger foreseen by Mrs. C's caregivers. If that strategy fails, APS may consider pursuing forced treatment for Mrs. C's depression and/or forced relocation of Mrs. C to a nursing home. If Mrs. C is unwilling to voluntarily receive treatment or move,<sup>19</sup> those interventions could be carried out legally

only if either (a) she were declared to be incompetent<sup>20</sup> to make those decisions by a court in a formal guardianship proceeding—a process that is far from automatic when the petition is actively contested<sup>21</sup>—and a guardian<sup>22</sup> were appointed by the court to make these decisions on her behalf<sup>23</sup> or (b) Mrs. C had, while still capable of making her own autonomous choices, executed a durable power of attorney for health care or other advance written proxy directive instrument appointing another person to act as her decision making agent when she became unable to speak for herself.<sup>24</sup> As a practical matter, if Mrs. C's professional caregivers concluded, based on the exercise of their clinical judgment, that she lacked adequate decision making capacity but there was no available surrogate who had been formally appointed to act by the court or advance proxy directive, the caregivers would likely act *as though* her children were the proper surrogates and rely on their decisions. Even in the absence of formal legal authority, the adult children (if they are willing to take on this role) probably would be treated as the assumed surrogates as a matter of longstanding custom.<sup>25</sup>

If, but only if, less restrictive or intrusive alternatives have been explored and found unsatisfactory or infeasible, proceedings may be initiated to civilly (involuntary) commit Mrs. C to a public mental institution. Before a court would involuntarily commit Mrs. C, it would need to be convinced by at least clear and convincing evidence<sup>26</sup> that she presented a specific, serious, imminent danger to other persons, and that this danger arises from the fact that she suffers from a mental illness.<sup>27</sup> Moreover, despite a recommendation by the American Psychiatric Association to the contrary,<sup>28</sup> involuntary commitment would not automatically assure that Mrs. C would receive medical or psychological treatment for her depression without her consent to such treatment. In almost all the states, Mrs. C's right to refuse treatment for her depression would not summarily be extinguished by the involuntary commitment order; whether or not she retains the prerogative to choose would depend on a separate and distinct inquiry regarding her present capacity to make particular treatment decisions despite her depression and dangerousness.<sup>29</sup>

### **Danger to Self**

The more probable scenario to unfold in the case of Mrs. C would involve a judgment by her professional caregivers that, because of her depression, she is engaging in conduct that creates unacceptable risks of harm to herself. Types of conduct, among others, that might lead a physician to consider a depressed patient to be unable to protect his or her own well-being sufficiently could include the person's refusal of treatment for depression (exemplified by Mrs. C's conduct), express refusal of<sup>30</sup> or surreptitious noncompliance with<sup>31</sup> medical treatment for other (especially life-threatening) conditions, requests for assisted suicide or another form of assisted death,<sup>32</sup>

or an actual suicide attempt.<sup>33</sup>

In the overwhelming majority of states, statutes have been enacted that mandate (under threat of criminal penalty for noncompliance) enumerated categories of health and social service professionals to report to designated public health or social welfare authorities cases in which there is a reasonable suspicion of past or current abuse or neglect, including self-neglect, of an adult.<sup>34</sup> Although refusal of treatment for depression, by itself, likely would not qualify as self-neglect, usually such refusal directly brings about other conduct (e.g., refusal of medical treatment for serious physical conditions, refusal to eat) or situations (e.g., enhanced mortality risk)<sup>35</sup> that more clearly presents a danger to self and therefore would so qualify. In the remainder of the states, reporting of suspected abuse or neglect is voluntary, but the good faith reporter is provided with immunity against any civil or criminal repercussions based on the report.<sup>36</sup> Mandatory and voluntary reporting laws dealing with danger to the patient/client, rather than to a third party, are predicated on the state's inherent *parens patriae* authority to protect persons who are unable to fend for themselves.<sup>37</sup>

Any interventions that APS or another agency would consider imposing on Mrs. C to protect her against self-neglect would either require her competent, voluntary, informed consent or need to be authorized under the state's *parens patriae* power. The state's authority to force services or other interventions on an unwilling Mrs. C is constrained by the least restrictive/least intrusive alternative principle.<sup>38</sup>

One form of intervention that might be considered would be forced medical treatment of Mrs. C specifically aimed at ameliorating her depression. Mrs. C's legal right to veto unwanted intervention of this type depends on her present mental capacity and, as noted earlier, a diagnosis of depression by itself does not automatically determine the issue of decision making capacity. If Mrs. C's functional capacity is severely impaired, the argument for overriding her asserted refusal of treatment for depression is strengthened if treatment is aimed primarily at restoring or improving her capacity to make other important life decisions in the future, rather than just because health care or social service professionals believe she will be happier after treatment. Such an argument might be more difficult to make convincingly for Mrs. C than for a younger, otherwise more healthy, individual. Even when there is a valid long range autonomy-enhancing motivation, however, absent Mrs. C's prior appointment of a health care proxy, forced treatment would normally require a judicial finding of Mrs. C's incompetence and appointment of a surrogate decision maker (e.g., a guardian of the person) with explicit authority to consent to treatment on Mrs. C's behalf.

The same set of factors would be pertinent if the involuntary interventions contemplated consisted of forced treatments for Mrs. C's medical problems other than depression. Regardless of the particular type of treatment being considered, both the health care professionals and surrogate decision maker should be guided by the principle of substituted judgment, that is, an attempt to carry out the known or reasonably inferred wishes of Mrs. C as developed and expressed while she still retained decision making capacity.<sup>39</sup> Put differently, they ought to make decisions about specific treatment alternatives (including the alternative of no treatment at all) by trying to stand in Mrs. C's shoes, with her values, preferences, and idiosyncracies—by 'donning her mental mantle.'<sup>40</sup> Only if Mrs. C did not, while previously competent, create a clear evidentiary record of her desires regarding medical treatment that could be applied to her current circumstances without tortured, essentially fictitious intellectual speculation may the health care professionals and appointed or assumed surrogate(s) impose interventions over her objection because they believe those interventions would serve Mrs. C's objective best interests.<sup>41</sup>

Involuntary commitment of Mrs. C to a public mental institution for forced treatment of her depression or other medical problems justified on a *parens patriae* rationale (i.e., 'for her own good') seems rather far fetched. Not only would such a commitment be subject to the same substantive and procedural prerequisites as discussed earlier in the context of police power commitments,<sup>42</sup> without any guaranty that treatment would take place without a separate adjudication of Mrs. C's decisional incapacity, but justifying such involuntary confinement as the least intrusive or restrictive intervention available would appear to be difficult. Forced relocation to a nursing home or assisted living facility, in the form of a 'voluntary' admission consented to by a formal or informal surrogate for Mrs. C, is more likely, although medical treatment in those settings still could not occur without explicit permission from the surrogate.

## CASE OUTCOME

Mrs. C is a real person. Her professional caregivers have repeatedly but unsuccessfully tried to negotiate directly with Mrs. C a voluntary treatment plan for her depression. They also have contemplated and discussed among themselves and with Mrs. C's children the various forms of involuntary intervention discussed in this article. However, the strong consensus has been that neither guardianship nor involuntary commitment are realistic or desirable strategies as applied to this individual. Neither the involved professionals nor family members believe that a sufficient showing of decisional incapacity could be established to justify a court's imposition of a surrogate decision maker for Mrs. C without her concurrence. Since Mrs. C has grown so progressively

weak that she no longer even attempts to cook for herself, she is not endangering fellow assisted living residents with her stove and therefore could not be involuntarily committed based on a police power rationale. Involuntary commitment predicated on the danger that her refusal of treatment for depression poses for Mrs. C herself has been rejected because it is too drastic an alternative and would not assure treatment for her depression anyway.

Thus, the current status of Mrs. C is similar to that of many other older individuals with similar psychiatric profiles. Despite the continuing attention and entreaties of the health care team and her children, she remains—paradoxically—miserable and glad to be so. The professionals and family remain frustrated, angry at both Mrs. C and the legal restrictions that prevent them from forcing treatment on her.

## CONCLUSION

Older individuals with depression of varying degrees of severity and other chronic<sup>43</sup> as well as acute medical problems are becoming more prevalent as the population ages dramatically. As the case of Mrs. C prominently illustrates, the care of these individuals raises a plethora of legal and ethical issues, as professional caregivers, advocates, and society endeavor to balance compassion and benevolence for suffering persons, on one hand, with respect for the autonomous right to control vital facets of one's own life, on the other. We must continue to grapple, from legal, ethical, and practical perspectives, with complex questions about when, how, and with whom we ought to be using the tools in our modern scientific armamentarium to intervene against the wishes of older persons like Mrs. C who purport to choose to be miserable and to act accordingly.

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3. Regarding dementia in older persons, see generally Steven H. Zarit and Judy M. Zarit, *Mental Disorders in Older Adults: Fundamentals of Assessment and Treatment* (1998), 31-61.
4. Stanley Jacobson, 'Overselling Depression to the Old Folks' (1995 April) *Atlantic Monthly* 46-51.
5. See, e.g., Marc E. Agronin, 'Selling Depression to the Oversold' (1999) 39 *Gerontologist* 489-492; Patricia A. Arean, Heather Uncapher, and Derek Satre, 'Depression' in Michel Hersen and Vincent B. Van Hassert (eds), *Handbook of Clinical Geropsychology* (1998) 195-216; Rachel Wolfe, Jannay Morrow, & Barbara L. Fredrickson, 'Mood Disorders in Older Adults' in Laura L. Carstensen, Barry A. Edelstein, & Laurie Dornbrand (eds), *The Practical Handbook of Clinical Gerontology* (1996), 274-303.
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7. See, e.g., U.S. Agency for Health Care Policy and Research, *Depression in Primary Care: Vol. 2. Treatment of Major Depression*. Clinical Practice Guideline Number 5 (1993), 1.
8. Dan G. Blazer, 'Depression' in George L. Maddox (ed), *The Encyclopedia of Aging* (3<sup>rd</sup> ed, 2001) vol. 1, 287-289; Barry D. Lebowitz et al., 'Diagnosis and Treatment of Depression in Late Life: Consensus Statement Update' (1997) 278 *Journal of the American Medical Association* 1186.
9. See, e.g., Fay A. Rozovsky, *Consent to Treatment: A Practical Guide* (3<sup>rd</sup> ed, 2000); Ruth R. Faden and Tom L. Beauchamp, *A History and Theory of Informed Consent*, (1986).
10. See, e.g., Benjamin H. Levi, *Respecting Patient Autonomy* (1999); Carl E. Schneider, *The Practice of Autonomy: Patients, Doctors, and Medical Decisions*, (1998).
11. There are other cultures that do not assign the principle of autonomy such a preeminent position in their priority of values. See, e.g., Mary Ip, Timothy Gilligan, Barbara Keonig, & Thomas A. Raffin, 'Ethical Decision-Making in Critical Care in Hong Kong' (1998) 26 *Critical Care Medicine* 447; Leslie J. Blackhall, Sheila T. Murphy, Gelya Frank, Vicki Michel, & Stanley Azen, 'Ethnicity and Attitudes Toward Patient Autonomy' (1995) 274 *Journal of the American Medical Association* 820.

12. Regarding the states' police power in the health arena, see generally Lawrence O. Gostin, *Public Health Law: Power, Duty, Restraint* (2000), 47-51.
13. *Tarasoff v. Regents of University of California*, 551 P.2d 334 (Cal. 1976).
14. Under Ohio Revised Code § 2305.51, for instance, a covered professional may discharge the duty by:
- (1) Initiating emergency hospitalization
  - (2) Otherwise obtain hospitalization voluntarily or involuntarily
  - (3) 'Establish[ing] and undertake[ing] a documented treatment plan that is reasonably calculated...to eliminate the possibility that the patient will carry out the threat...'
  - (4) Communicating to a law enforcement agency and each potential victim the nature of the threat, identity of the patient making the threat, and the identity of each potential victim.
15. See, e.g., Massachusetts General Laws Ch. 123 § 36B; *Lipari v. Sears, Roebuck & Company*, 497 F. Supp. 185 (D. Neb. 1980). See also Paul S. Appelbaum, *Almost a Revolution: Mental Health Law and the Limits of Change* (1994), 71-113.
16. Regarding the adult protective services (APS) system in the U.S., see generally Rosalie S. Wolf, 'Adult Protective Services' in George L. Maddox (ed), *The Encyclopedia of Aging* (2001), 26-28.
17. Ingo Keilitz, David Conn, & Andrea Giampetro, 'Least Restrictive Treatment of Involuntary Patients: Translating Concepts into Practice' (1985) 29 *St. Louis University Law Journal* 691.
18. *Shelton v. Tucker*, 364 U.S. 479 (1960).
19. But see Marshall B. Kapp, 'The 'Voluntary' Status of Nursing Facility Admissions: Legal, Practical and Public Policy Implications' (1998) 24 *New England Journal of Criminal and Civil Confinement* 1.
20. A thorough elucidation of the complex subject of decisional incapacity/incompetence is beyond the scope of this brief article, beyond reiterating that a clinical diagnosis of depression does not necessarily invalidate a person's factual, ethical, and legal ability to make personal choices. See, e.g., Ernie W.D. Young, James C. Corby, and Rodney Johnson, 'Does Depression Invalidate Competence? Consultants' Ethical, Psychiatric, and Legal Considerations' (1993) 2 *Cambridge Quarterly of Healthcare Ethics* 505. The literature on the legal implications of the decisional capacity/competence issue is voluminous. See, e.g., Paul R. Wolpe & Arthur Caplan, 'Ethical Issues in Research and Treatment of Patients With Mood Disorders' in Jay D. Amsterdam et al. (Eds), *Textbook on Refractory Depression* (2001), 504-516; Paul S. Appelbaum, Thomas Grisso, Ellen Frank, Sandra O'Donnell, & David J. Kupfer, 'Competence of Depressed Patients for Consent to Research' (1999) 156 *American Journal of Psychiatry* 1380; Jennifer Moye, 'Mr. Franks Refuses Surgery—Cognition and Values in Competency Determination in Complex Cases' (2000) 14 *Journal of Aging Studies* 385.
21. John W. Burruss, Mark E. Kunik, Victor Molinari, Claudia A. Orengo, & Pamela Rezacabek, 'Guardianship Applications for Elderly Patients: Why Do They Fail?' (2000) 51 *Psychiatric Services* 522.
22. The terminology for a surrogate appointed by the court and empowered to make personal, including medical, decisions on behalf of a mentally incompetent ward varies among different states. Compare, e.g., Ohio Revised Code § 2111 et. seq. (using the term 'guardian') with California Welfare & Institutions Code § 5350 et. seq. (using the term 'conservator' to refer to a person who is authorized to perform the exact same functions).
23. For background on guardianship in the U.S., see generally George H. Zimny and George T. Grossberg, *Guardianship and the Elderly: Psychiatric and Judicial Aspects* (1998).
24. Charles P. Sabatino, 'The Legal and Functional Status of the Medical Proxy: Suggestions for Statutory Reform' (1999) 27 *Journal of Law, Medicine & Ethics* 52.
25. John M. Luce, 'Ethical Principles in Critical Care' (1990) 263 *Journal of the American Medical Association* 696.
26. *Addington v. Texas*, 441 U.S. 418 (1978) (the 14<sup>th</sup> Amendment Due Process clause of the U.S. Constitution held to require a minimum standard of 'clear and convincing evidence'—more than the usual civil standard of preponderance of the evidence but less than the criminal standard of proof beyond a reasonable doubt—in involuntary commitment cases).
27. Regarding the substantive requirements for involuntary commitment, see Gary B. Melton, John Petrila, Norman G. Poythress, & Christopher Slobogin, *Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers* (2<sup>nd</sup> ed, 1997), 306-313.
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36. *E.g.*, Illinois Statutes ch. 320, para. 20/4.
37. Gostin, *supra* note 11, at 51-55.
38. This principle is discussed at notes 16 and 17, *supra*, and accompanying text.
39. Regarding the principle of substituted judgment, see Marshall B. Kapp, *Key Words in Ethics, Law, and Aging: A Guide to Contemporary Usage* (1995), 71-72.
40. *Eichner v. Dillon*, 426 N.Y.S.2d 517, 548 (App. Div. 1980), *rev'd*, 420 N.E.2d 64 (N.Y. 1981).
41. Regarding the best interests principle, see Marshall B. Kapp, *supra* note 37, at 11-12.
42. Notes 25-28, *supra*, and accompanying text.
43. See generally Ilene M. Lubkin, *Chronic Illness: Impact and Interventions* (4<sup>th</sup> ed. 1998).