



REVIEW ARTICLE



Choosing to Die with the Help or by the Hand of a Doctor (Medically-Assisted Death): Limitations and Safety Profiles



Authors' Contribution:

- A – Study design;
- B – Data collection;
- C – Statistical analysis;
- D – Data interpretation;
- E – Manuscript preparation;
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- G – Funds collection

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Background and Aim of Study:

Abstract

Depression severity can be profoundly impacting the life of individuals, while its persistence can provoke the conviction that recovery is unattainable. One of the extreme consequences is the request for euthanasia. However, during major depression cognition can be significantly impaired. In this study, we comment on the exemplar case of a Belgian lady, Mrs. Godelieva de Troyer, who made that request and obtained the desired outcome.

The aim of the study: to consider a specific case of a patient with major depressive disorder and the role of doctors in informing the decision about medically assisted death.

Material and Methods:

The history of the request made by Mrs. Godelieva is described. The procedure was followed by the reactive initiatives of the son of the lady, who made a formal complaint against the procedure that brought his mother to death and appealed the European Court of Justice.

Results:

A description of what happened is briefly reported, including considerations on the clinical treatments received by Mrs. Godelieva, the roles interpreted by the doctors she consulted and, finally, the appropriateness of the decision taken.

Conclusions:

In revisiting this case, the decision-making process during major depression episodes and the authenticity and robustness of end-of-life choices in similar cases are critically examined. Comments are made on the frequency of cognitive impairments during major depressive episodes and the need to provide depressed people the necessary support during their important choices.

Keywords:

Major depression, chronic persistent depression, euthanasia, medically assisted suicide, care for depressed people, psychological support, European Court of Justice

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Introduction

Depression and Bio-Legal Issues: General Framework
Depression is a clinical reality frequently encountered in psychogeriatric clinics; it is the leading cause of

disability globally, as confirmed by the Global Burden of Disease study (GBD) which calculated, for 2019, the disability adjusted life years (sum of years of life lost in



the world due to premature mortality and years of life lived in conditions of suboptimal health) estimated at 46.9 million years (GBD 2019 Diseases and Injuries Collaborators, 2020). Following the statistical indicators provided by the World Health Organization (WHO), there would be over 300 million depressed people in the world (World Health Organization, 2022) with a prevalence that can affect one in five people in the general population, increasing with age; 31.74% of old people (65+ years of age) would, in fact, be affected by a depressive disorder and its prevalence would be higher (40.8%) in developing countries (Zenebe et al., 2021), with peaks recorded in Africa – 43.1% (Bedaso et al., 2022) and in India – 34.4% (Pilania et al., 2019). In nursing homes, 18.9% of older adults reportedly suffer from major depressive disorder (MDD), as indicated by a recent meta-analysis of 32 observational studies (Fornaro et al., 2020).

Also in Italy, depression is the most widespread mental disorder: about 5-6% of the population is affected by it, while 10-15% of it would have experienced a depressive episode at least once in life even if these indicators vary according to the sources and diagnostic methodologies used. Recent studies indicate that MDD could affect over 7.5 million people (11.4% of the population), mainly women with low schooling and poor economic status (de Girolamo et al., 2005).

Not only because of its frequency, depression raises many (complex) practical questions, including juridical ones (as in the case of patient suicide) (Cupelli, 2013) and, more generally, bioethical ones, often faced with a feeble voice by psychiatrists “whose opinion is only rarely sought but, above all, even more rarely expressed” (Bersani et al., 2020, p. 57). It is therefore necessary to reflect on the impact of depression and the possible impact of cognitive impairment, especially in cases of severe (major) depression, when important decisions are to be taken by the individual affected by it. This is what we are meant to do in this short essay, in which we propose to address the quality and robustness of end-of-life choices given the relationship that exists, especially in old age, among depression, cognitive decline and risk of progression from mild cognitive impairment (MCI) to frank dementia (Rosenberg et al., 2013).

We would do so starting from a public matter that has recently come under examination by the European Court of Human Rights (Judgment n. 78017 of 4 October 2022, *Mortier vs. Belgique*), immediately acknowledging that the regulatory framework which Belgium has adopted for the non-punishability of euthanasia is very liberal (Cembrani et al., 2014; Dentamaro, 2019): it also allows minors capable of discernment and people affected by a mental pathology who find themselves “in a useless condition of physical or psychological suffering, unbearable and incurable” to access it if adults (Mehlum et al., 2020) provided they are capable of understanding and wanting, with limitations that have however proved to be completely insufficient in the face of the exponential growth of cases. In this regard, the latest Report from the Commission Fédérale de Contrôle et D'évaluation de L'euthanasie (2023) – documents the

progressive increase in cases of euthanasia (from 259 in 2003 to 2,790 in 2021) to which people mainly over 70 years old resorted (in 67.1% of cases), and those mostly affected by a neoplastic pathology (63.4% of cases), mainly through administration of barbiturates (99.6% of cases). Very small, but present, mental and behavioral disorders: this happened in 94 cases in 2021 (1.9% of the total); in 45 cases (equal to 0.9% of the total) this occurred due to a personality disorder, a depressive picture and schizophrenia; in 49 cases (1.0% of the total) due to the existence of a cognitive disorder produced by Alzheimer's disease, vascular dementia or Lewy bodies' dementia. In most patients, different types of suffering, both physical and psychic, were present simultaneously. The suffering has been described as constant, unbearable, and unrelievable. Among the most often mentioned physical sufferings are air hunger, digestive obstruction with vomiting, constant pain. Among the most frequent causes of psychological suffering, are dependence on others, loss of dignity, loneliness, social isolation and despair.

In this article we would like to try to give an answer to the many problematic questions that the principle of self-determination raises in the event that the holder of the right is a particularly fragile, vulnerable, influenced or otherwise suggestible person, and what is the support that these people must be guaranteed by whoever has the responsibility of care, especially in situations where the good put at risk is the protection of life protected by the European Convention on Human Rights (Council of Europe, 2002).

The aim of the study. To consider the exemplary case of a Belgian lady, Mrs. Godelieva de Troyer, with a major depressive disorder and the role of doctors in informing the decision about medically assisted death.

Materials and Methods

The Death through Euthanasia of Mrs. Godelieva de Troyer, which Came before the Examination of the European Court of Justice Following the Complaint Presented by Her Son

At the material time, Mrs. Godelieva de Troyer was a 64-year-old Belgian woman, suffering for over 40 years from a depressive disorder generally considered as “major” and unresponsive to the pharmacological treatments prescribed by the numerous psychiatrists near whom she was in therapy. She herself had decided to die by resorting to euthanasia, a practice permitted in that country due to the effects of the law of 28 May 2002, then modified by the law of 28 February 2014, which extended this option to minors with the consent of parents or legal representatives without setting any age limit, however, as instead requested by the Dutch legislation. Dr. G. T., her general practitioner, was informed of the decision, but declined the woman's invitation to start the procedure. He advised her to contact Prof. W. D., a Belgian oncologist well known in his country for being a strong supporter of euthanasia.

According to the reconstruction of the events made by the judges of Strasbourg, on 29 September 2011 Prof. W. D. spoke to Mrs. de Troyer, learning that she was at that time



being followed by a psychiatrist, that her depressive disorder had started very early (at the age of 19 years) and that the many pharmacological approaches had never resulted in full recovery, even if there was a break in 2006 when the woman, after the suicide of her husband, had embarked on a new relationship, then abruptly interrupted.

For the last two years, Mrs. Godelieva de Troyer had decided to sever ties with her children and her grandchildren, for reasons that were not explored at the time by Prof. W. D. This physician came anyway to the conclusion that the woman was suffering from a serious personality disorder, associated with a chronic mood disorder, and that she no longer believed in her functional recovery and in the success of any pharmacological option. He therefore agreed to become her attending physician in the path aimed at euthanasia, instructing her to consult a second psychiatrist (Dr. V.), as required by Belgian law.

The meeting between the woman and Dr. V. took place on 17 December 2011: on that occasion, the specialist confirmed the chronic depressive picture from which the patient was suffering, albeit with “ups and downs”, concluding that the request for euthanasia was premature, suggesting that she go to another psychiatrist to reset the drug treatment plan.

On December 23, 2011, Prof. W. D. met again the woman who expressed her deep concern of being abandoned and seeing not accepted her request to die with euthanasia while admitting that she was ready to see another psychiatrist (Dr. V. D.), as requested by Dr. V. On that occasion, Mrs. de Troyer spoke about the reasons that had motivated her to break off relations with her two children, in particular with her eldest son, described by the woman as a person she was afraid of due to his aggressiveness. In a subsequent meeting, which took place on January 12, 2012, Mrs. Godelieva de Troyer told Prof. W. D. she was feeling deeply exhausted, confirming her decision not to see her children anymore, specifying that she had yet to be visited by Dr. V. D. because not reachable. Prof. W. D. thus advised her to consult another psychiatrist, Dr. T.

The meeting with the latter took place on January 17, 2012, and during the meeting the woman specified that her daughter, with whom all contact had been interrupted for two years, knew of her request to die by euthanasia specifying that she no longer had anyone in her life, that she was alone, that she felt incurably ill, that she no longer had the stamina to do anything and that she wanted to die as soon as possible. Although she was never hospitalized in a psychiatric environment (this opportunity was never raised by any doctor), Mrs. de Troyer added that she had no faith in psychiatric science. On 20 January 2012, there was a new consultation with Prof. W. D., who agreed to accompany her personally to Dr. V. D. This psychiatrist suggested her to inform the children of her decision to die, so that they could accompany her and be present during the euthanasia procedure. Thus, on 31 January 2012, the woman sent an email to her two children to inform them of her decision, the endless severity of her suffering and her desire to die

with dignity. The son did not reply to her letter, while the daughter replied: although very saddened by the decision, she respected her mother’s will.

On February 7, 2012, Prof. W. D. contacted another psychiatrist, Dr. B., who stated that the woman’s health problem was chronic and no longer treatable on a therapeutic level. The same Dr. B., on the following 10 February, sent a letter to Dr. T. informing her that he had previously met the woman (in 1996) due to a very serious psychopathology probably related to a childhood traumatic experience, highlighting that the prognosis was extremely uncertain and obscure.

On February 14, the patient formalized her euthanasia request in writing, indicating in Prof. W. D. her attending physician. On the same day, Dr. T. signed a report acknowledging that the patient had consulted her several times to inform her of her decision to die in order to put an end to her unbearable and hopeless suffering. In that report, the woman was described as lucid and reasonable even after she had been provided with information on possible therapeutic options, and then concluded that the conditions established by the Belgian law permitted to help her die. The same conclusion was reached on the following February 17 by Dr. V. D., who confirmed the serious social isolation of the woman and her refusal to undergo any further drug therapy.

On February 27, 2012, the patient signed a handwritten declaration acknowledging her intention to donate her body to science; two days later, on February 29, 2012, she made a donation of 2,500 euros to Leif (Levensende Informathieforum), a non-profit association led by Prof. W. D., which also had among its members Drs. T. and V. D.

On 8 and 12 March 2012, Prof. W. D. spoke again with the woman concluding that there were no more prospects for continuing her life.

On March 20, 2012, Mrs. de Troyer met P. D., a person she trusted, confiding to her that she intended to write a farewell letter to her children.

On April 13, 2012, Prof. W. D. and P. D. met again Mrs. Godelieva de Troyer who accepted the idea of writing a letter addressed to her children with the assistance of P. D. At the end of the conversation, Prof. W. D. came to the conclusion that the only reasonable option was euthanasia and set the date for April 19, 2012.

On April 10, 2012, two telephone consultations took place between the woman and the same Prof. W. D. who reassured her regarding her will: the euthanasia act was practiced on the following April 19 by the same Prof. W. D. in the UZ Brussels University Hospital, in the presence of Mr. Samuel Vinck (an attorney) and some friends of the woman.

Information of her death was given to her children on the following 20 April, before the opinion expressed by the federal control commission provided for by Belgian law, co-chaired by the same Prof. W. D., who ascertained the regularity of the euthanasia procedure and the observance of all the criteria established by Belgian law verified by “deux médecins indépendants, qui confirmaient la capacité de la patiente, l’incurabilité de sa pathologie et



l'existence d'une souffrance psychique extrême, insupportable et unapaisable”.

The subsequent complaints expressed to the Judicial Authority by the patient's son T. M., a university professor, accusing of non-compliance with Belgian law and of not having been informed of what had been authorized by the two Belgian doctors, were not followed up; in May 2017 he was informed of the filing of his criminal complaint due to insufficient evidence. Hence, his decision to appeal to the European Court of Justice for the violation of articles 2 and 8 of the European Convention on Human Rights (ECHR).

Going into the merits of the matter, the Strasbourg judges, without declaring the existence of a conflict between art. 2 of the ECHR and the Belgian law (which, under certain conditions, decriminalized euthanasia), recognized that the strictness of the procedure envisaged by Belgian internal legislation had not been respected because the same Prof. W. D., having personally supervised the euthanasia procedure from the initial request of the woman, could not have expressed any judgment on the merits of his work, and would therefore have had to abstain for reasons of independence and competence.

Thus sanctioning Belgium, but without however addressing the compliance of Belgian law with art. 2 of the ECHR (Bucalo, 2023) and without discussing the robustness of the woman's decision as had been done, however, by the same judges in the Haas sentence against Switzerland (Butturini, 2011) whose protagonist had been a patient suffering from bipolar disorder who had resorted to the Court complaining about the inertia of the country to supply a drug lethal for his assisted suicide, which should have put an end to his unbearable suffering.

Results and Discussion

The Choice to Die with the Help or by the Hand of the Doctor (Medically Assisted Death): Limitations and Safety Profiles in Italy

Beyond the complexity of the case, as it has been reconstructed by the Judges of the European Court of Justice, the human story of Mrs. Godelieva de Troyer raises many questions. Two in particular, for what concerns us here, having to ask what it was:

(1) the robustness of her decision to die by euthanasia as scientific evidence demonstrates that cognitive deficits can represent an important component of MDD (Douglas & Porter, 2009) proving capable of compromising memory, attentional functions and learning (Kriesche et al., 2023) with a worsening of the deficits caused by repeated relapses (Semkovska et al., 2019) and aging (Dotson et al., 2020);

(2) the support (medical, psychological, pharmacological and human) that should have been guaranteed to the woman and with what possible precautions (or guarantee rules) could and should have brought to maturity the decision of the same to put an early end to her life.

The general impression that emerges from the analysis of this sad story is that the doctors consulted by Mrs. de Troyer were particularly attentive to the formal aspects required by Belgian law to finalize the euthanasia request

(existence of a serious pathology and incurable, producing constant and unbearable suffering) but little or nothing was done to offer her that support which could control or contain her suffering. In addition, it seems that her daughter's affection could probably be recovered, and that there was a network of friends and trust on which the woman could still count.

Without questioning the seriousness of the suffering caused by the psycho-pathological condition from which Mrs. Godelieva de Troyer was affected, her protracted state of suffering (albeit between the ups and downs that are normally recorded in these clinical situations), the incomplete control of the depressive symptomatology despite the prolonged pharmacological and psycho-behavioral therapies, the distrust gained towards psychiatric treatments, her social isolation and loss of hope, what appears indisputable is that the robustness of her decision was not subjected to any particular verification and that some of the doctors she interviewed politely declined the invitation or temporarily suspended it, believing that the decision to die at the hands of a doctor required a more complete maturation.

Trying to give a practical answer to these questions, we hypothesized to transfer the human story of Mrs. Godelieva de Troyer to the Italian context (where euthanasia is forbidden) asking ourselves what could have happened if she had asked Italian doctors to help her to die with assisted suicide, a practice permitted within limits and the guarantees provided by the Constitutional Judge in sentence no. 242/2019; sentence with which the art. 580 of the penal code (“Instigating and assisting in suicide”) makes the actor no longer punishable in the hypothesis in which the execution of the intention of suicide, autonomously and freely formed, of the adult person has been facilitated provided that the person is affected by an irreversible pathology, kept in life from life-sustaining treatments, the condition is a source of physical or psychological suffering that the person considers as intolerable, while remaining fully capable of making free and informed decisions.

These conditions and the methods of execution of assisted suicide must then be verified by a public structure of the national health service, subject to the opinion of the territorially competent ethics committee, thus identifying a whole series of constraints – not only procedural but above all substantial – which have set, and they continue to pose, problematic questions, not yet fully resolved.

For example, it is much debated which Ethics Committee is properly required to express its opinion in these cases. In response to the specific question posed by the Minister of Health, on 24 February 2023 the National Bioethics Committee considered that the responsibility should be attributed to the CETs (Territorial Ethics Committees), referred to in the Decree of 26 January 2023 (“Identification of forty territorial ethics committees”), uniformly present in the country.

Another important topic of debate concerns life support, on which there are frankly antithetical ideas, there being those who indicate it in those measures that require the use of artificial means and the support given by machines



and those who, on the contrary, extend it to the entire therapeutic weaponry available to doctors.

Different positions also exist on the validity of the treatment decision, there being those who subordinate it to the person's ability to understand and want, and those who, on the contrary, value the cognitive, affective and emotional aspects of decision making, believing that mental disability can never be neither a valid nor a reasonable reason to discriminate against people (Grahek et al., 2018), with all that it entails on a practical level for the rupture of the presumed ability/incapacity dichotomy, and of that still dominant paradigm which sees legal incapacity as the instrument to give support to those people.

The controversy that exists on the capacity, which is a broad and complex philosophical-political construct, whose polysemy – already verifiable in ordinary language – becomes even more evident in the juridical vocabulary due to the plurality and heterogeneity of the contexts, makes impossible to relate to each other by finding a common cross matrix.

Legal capacity (UN Convention on the Rights of Persons with Disabilities, art. 12), ability to act (law n. 219/2017, art. 1, paragraph 5), ability to understand and want (law n. 219/2017, art. 1, paragraph 1 and art. 5, paragraph 1), inability to look after one's own interests (art. 404 of the civil code), ability to make a will (art. 591 of the civil code), ability to consciously participate in the process (art. 70 criminal procedure code), procedural capacity (art. 75 civil procedure code) and ability to make a free and informed decision (Constitutional Court, ordinance n. 207/2018 and sentence n. 242/2019) are, thus, the so many known and formalized faces of the capacity present in the places of law that confirm its eclectic polysemy, probably exacerbated by the vague links and the overlapping of meanings that infer from the different expressions.

In this way, capacity has become a juridical abstraction that is not easy to classify, also due to the extraordinary resistance that it shows every time one tries to give it a unitary classification, fading – depending on the place – in juridical capacity, in imputability, in ability to act, in that of standing in court, in the ability to make a will and in the ability to understand and want, to quote some of its explanations of dubious significance.

However, it is on the ability to understand and want that refers the law n. 219 of 2017 (Cappelli, 2021). “Regulations on informed consent and advance treatment provisions”, whilst the Constitutional Court, in more appropriate terms, has repeatedly referred to the person's ability to make a free and informed decision, without however entering into the merits of how this should be explored.

This is an area on which discussion continues, as there are doubts as to whether the rationality of the scientific model is capable of exploring the quality, authenticity and robustness of decision making, with the rigor envisaged by the method of experimental science, as a reproducible and unquestionable final judgment because it is formulated on the basis of the criteria established by a universal scientific law.

Depressive Disorder, Authenticity and Robustness of End-of-Life Choices

Nonetheless, the Italian legislator, precisely regarding the end of life (law n. 219/2017), has subordinated the legitimacy of the choice of treatment to the integrity of the person's ability to understand and want without hint at what his judgment parameters are in order to reduce the evaluative suggestions often present, even among experts, in the courtrooms (Foucault, 2020).

The question is particularly complex, and some very useful indications have been proposed at an international level in this regard (American Psychiatric Association, 2012; Appelbaum, 2007) to correct trivializing professional styles without generalizing the complexity of situations.

In Italy, the Italian Psychogeriatric Association, AIP (Cembrani et al., 2019), and the Istituto Superiore di Sanità, ISS, did so in relatively recent times which, in an extensive document approved by the Conference of Regions and Autonomous Provinces (Istituto Superiore di Sanità, 2020), gave a definition of the decision-making capacity specifying that its evaluation falls within the sphere of responsibility entrusted to clinicians. These are required to fulfill it with the traditional tools of neuropsychological investigation combined with a careful functional evaluation of what the person can do in real life situations. The evaluation is therefore multidimensional: after the clinical-anamnestic interview, it focuses on the neurological/geriatric dimensions completed by the neuropsychological evaluation and by the diagnostic-instrumental tests aimed at excluding treatable secondary pathological forms.

The assessment involves the use of some international scales, which would allow for the selection of two cohorts of patients:

- a) those with scores on the Mini Mental State Examination (MMSE) between 20 and 30 (Clinical Dementia Rating – CDR 0.5-1.5) who would have very mild to mild cognitive limitations;
- b) those with MMSE scores below 20 (CDR equal to or greater than 2.0, i.e. moderate to severe cognitive impairments) who would not be able to give valid consent and who could be further evaluated by the administration of other neurocognitive tests, such as the Mac Arthur Competence Assessment Tool-Treatment (MacCAT-7), a 21-item scale (which takes 15-20 minutes to administer) or with simpler analytical methods such as the University of California San Diego Brief Assessment of Capacity to Consent (UBACC) (Jeste et al., 2007).

Naturally, one wonders, as AIP did, whether these tests are really able of selecting people capable of giving their consent from those unable to do so, who therefore should be initiated towards their legal incapacity, as recommended by the ISS. It should be considered that the MMSE is not a diagnostic tool created for this specific purpose and that the more sophisticated evaluation scales, such as the MacCAT-7, while exploring the domains of reasoning, planning, choice and control (complex cognitive processes), elude other important aspects (e.g., the social, relational, affective and



emotional ones) which certainly affect every choice of life.

In fact, rationality is an extraordinarily complex process, often fallible because it can be influenced by many choice alternatives, which are in turn influenced by not only cognitive but also emotional, social and environmental processes.

At this point, we should ask ourselves if the selection of those who are able to make a treatment decision from those who are not can be operated with these diagnostic tools and if the traditional scientific model, with its logical spectrum with a hypothetical-deductive matrix, is a tool suitable for achieving this specific purpose and whether or not it complies with the provisions of art. 12 of the UN Convention on the Rights of Persons with Disabilities (CRPD) (Cembrani et al., 2022) and the need not to discriminate against people in the exercise of their freedom rights.

However, the question remains open, even if what is beyond dispute is that the decision to die of Madame de Troyer was not targeted by any particular verification, whose robustness was taken for granted by the two doctors who finalized her euthanasia, without considering that major depressive disorder is capable of:

- interfering with the generative process of emotional responses (Joorman & Stanton, 2016) due to a frequent distortion of information caused by cognitive biases in interpretation and memory processes;

- to compromise – more or less severely – the domains of memory, attention and executive functions (Marazziti et al., 2010) with overall cognitive dysfunction emerging in demanding rather than automatic processes (Hartlage et al., 2018).

The result is impaired executive functions and a dysregulation of emotion control (Vazquez & Hernangómez, 2009).

The result is also a reduced cognitive control over the cognitive biases that make depressive symptoms chronic and dysregulation in the control of negative emotions (Grahek et al., 2018) the neurobiological cause of which could be identified in the reduced functioning of the anterior cingulate cortex, of the ventral prefrontal cortex (Beavers, 2005) and the dorsolateral one (Li et al., 2010). What really were the cognitive impairments of Mrs. Godelieva de Troyer is evident from the reconstruction of the facts carried out by the Judges of the European Court of Justice: the robustness of her decision-making capacity has been only partially investigated.

Only by Dr. T. the woman was described as lucid and reasonable, even if it is not known whether these general notes have been confirmed by a more in-depth test evaluation so as to investigate those cognitive and emotional domains (and, with them, suggestibility) that may be negatively affected by major depressive disorder. *On the Need to Also Give Depressed People the Necessary Support for the Maturation of Life Choices*

In addition to evaluating the robustness of Mrs. de Troyer's decision-making capacity, we still have to ask ourselves in what concrete ways her taking charge could and should have been strengthened with the aim of

coping with her loneliness, loss of hope and unbearable suffering.

Her contacts with the Belgian doctors, as confirmed by the procedural reconstruction of the affair, were repeated – this cannot be denied – but what seems to emerge is their ritual formality with the apparent renunciation of making any useful attempt to give the woman the support and comfort she needed.

This could have been achieved not only by setting up a new therapeutic plan which, probably, would not have had the desired effect (due to the patient's weak compliance, also testified by her most complete distrust in psychiatric care), but above all by providing her with the psychological support that the Italian law of 2017 confirmed to be indispensable in all cases of therapeutic refusal.

Support that could have strengthened relationships with friends and recovered the family affections that Mrs. de Troyer had interrupted for little-investigated reasons, even admitting that her inner feeling could be influenced by the aggressive behavior of her son, who later became the true and only protagonist of the judicial dispute initiated for the alleged violation of Belgian law, which was then examined by the Supreme Court of Justice.

Moreover, her relationship with her daughter was not completely severed by the latter, given her reply to her mother's email in which she declared that she accepted her decision to die, albeit with great pain. This confirms that an attempt should have been made in re-establishing family relations, if only for a better accompaniment of the woman in her last life project.

However, friends (who therefore existed) took part in it. Mr. P. D., met on 20 March 2012, and described as a trusted person, was the one the woman confided the inner need to write a farewell letter addressed to her children.

Conclusions

Formulating definitive conclusions from cases that have reached trial in the courtrooms is almost always a gamble, not only because the procedural reconstruction of events usually shows profiles of incompleteness but above all because the decision taken in sentence by the Judges is a confounding factor that may influence the final comment.

Nonetheless, news stories are an extraordinary training ground that motivates and trains reflection.

In the story here described, we wanted to try our hand without the ambition of arriving at an absolute truth.

The case of Mrs. de Troyer raises many questions concerning the robustness of the decision-making capacity of people suffering from major depressive disorder, which – in our opinion – must always be careful and in-depth, considering that their management cannot be limited to the pharmacological approach alone.

This assumes particular importance when the legal asset put at risk is the defence of life.

To all effects – even in the Italian legislation – this is the cornerstone of democratic life, which opens up to all the other rights and freedoms inscribed in the human person.



Ethical Approval

The case involved is a public case (European Court of Human Rights Judgment n. 78017 of 4 October 2022, *Mortier vs. Belgique*).

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