Treatment-Resistant Major Depressive Disorder and Assisted Dying

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Conflict of interest declaration

- We have no conflict of interest to declare.

Abstract

- Competent patients suffering from treatment-resistant depressive disorder should be treated no different in the context of assisted dying to other patients suffering from chronic conditions that can render their lives permanently not worth living to them. Jurisdictions that consider to, or that have, decriminalized assisted dying discriminate unfairly against patients suffering from treatment-resistant depression if they exclude such patients from the group of citizens entitled to receive assistance in dying. Suicide prevention efforts should be directed at people likely to regret their suicide attempt.

Support for Decriminalization of AD

- Is strong, provided you suffer from a ‘terminal illness’…
  - Around 75-80% *in favour* in Canada today
- Is very weak if you suffer from treatment resistant major depressive disorder
  - Around 75% *against* in a small-scale survey undertaken in Edmonton
- 28% of the Dutch agreed with VE in case of middle-aged female suffering from recurrent TRD
- 52% disagreed
- 20% uncertain

- Devastating suffering caused by TRD not given the same weight as comparable suffering caused by other illnesses.

Differences between TRD and Terminal Illnesses

- Time horizon
- Risk of misdiagnosis

What is treatment-resistant major depressive disorder?

- Treatment-resistant depression (TRD) is generally defined as failure to achieve remissions despite adequate treatment.
- Patients have little hope of recovering from their debilitating disease.
- About 20%-35% of all clinically depressed patients.

What is treatment-resistant major depressive disorder?

- ‘Despite the pervasive belief regarding the effectiveness of antidepressants and cognitive therapy among physicians and society at large (the largest antidepressant trial ever conducted showed that)… antidepressants and cognitive therapy fail to result in sustained positive effects for the majority of people who receive them.’

What it feels like – a patient

- *"You don't feel hopeful or happy about anything in your life. You're crying a lot for no apparent reason, either at nothing, or something that normally would be insignificant. You feel like you're moving (and thinking) in slow motion. Getting up in the morning requires a lot of effort. Carrying on a normal conversation is a struggle. You can't seem to express yourself. You're having trouble making simple decisions. Your friends and family really irritate you. You're not sure if you still love your spouse/significant other. Smiling feels stiff and awkward. It's like your smiling muscles are frozen. It seems like there's a glass wall between you and the rest of the world. You're forgetful, and it's very difficult to concentrate on anything. You're anxious and worried a lot. Everything seems hopeless. You feel like you can't do anything right. You have recurring thoughts of death and/or suicidal impulses. Suicide seems like a welcome relief. Even on sunny days, it seems cloudy and gray. You feel as though you're drowning or suffocating. Your senses seem dulled; food tastes bland and uninteresting, music doesn't seem to affect you, you don't bother smelling flowers anymore."*

What it feels like – a psychiatrist

- *"Suicidal depression involves a kind of pain and hopelessness that is impossible to describe — and I have tried. I teach in psychiatry and have written about my bipolar illness, but words struggle to do justice to it. How can you say what it feels like to go from being someone who loves life to wishing only to die?*
- *Suicidal depression is a state of cold, agitated horror and relentless despair. The things that you most love in life leach away. Everything is an effort, all day and throughout the night. There is no hope, no point, no nothing.*
- *The burden you know yourself to be to others is intolerable. So, too, is the agitation from the mania that may simmer within a depression. There is no way out and an endless road ahead. When someone is in this state, suicide can seem a bad choice but the only one."*

Dutch ‘due care’ criteria

- The patients’ requests are explicit, voluntary and well-considered;
- The patients are aware of their condition and prospects;
- their suffering is unbearable;
- there is no prospect of improvement based on the state of the medical science at the time when the decision is made;
- there are no reasonable alternatives to alleviate the suffering;
- an independent physician has given her opinion on these issues; and
- a doctor has provided assisted dying in a professional manner.

Slippery Slope in the Netherlands?

- 2012 12 cases of euthanasia for psychiatric patients
- 2013 42 cases
- 2014 41 cases
- 2015 52 cases
  - Increase partly due to the start of the 'end-of-life' clinic, an organization that aims to grant euthanasia to all who fulfill the due care criteria in the Netherlands, but who have been unable to obtain assisted dying from their treating physician.
  - Most of psychiatric patients requests are denied, because their death wish did not meet the due care criteria.
  - Legally competence is understood as '*being able to review and decide about the case at hand*'.
  - Exception: psychotic depression

Quality of life and end of life choices

- The public's support for assisted dying targets primarily, if not exclusively, cases of terminal illness. This does not map well on the actual reasons people provide for.
- Depressed people are not per se incompetent.
- Many depressed patients who survive a suicide attempt will make further suicide attempts, particularly in the period shortly following psychiatric hospitalization or during future major depressive episodes.

Reasonable objections

- Successful treatments might be developed
- We should invest in the provision of better care rather than in making AD available.
- Offering AD to people with TRD reinforces loss of hope

Recommendations

- We recommend that jurisdictions considering the decriminalization of assisted dying do not limit access to such services to patients suffering from a however defined terminal illness.
  - Relevant eligibility criteria should include competence and a patient's illness-caused inability to live a life he or she considers worth living.
- Suicide prevention programs should reconsider aggressive suicide prevention efforts targeting competent treatment-resistant patients suffering from major depressive disorder in the absence of demonstrably successful treatment programs for the underlying clinical condition. A proper target for suicide prevention programs are suicidal people likely to regret their suicide attempts, not people likely to regret their continuing existence.

Debate

- This paper was published in 2015 in the *Journal of medical ethics*.
- It has since been downloaded several thousand times… unusual for a humanities paper.
- A number of critical responses were since published, with rejoinders by the authors. Check em out ☺.