The Moral Status of Medical Assistance in Dying (MAID): Should Cases of Treatment Resistant Depression Qualify?

Author: Daniel Rodrigues
Edited by: Marcus MacKenzie

Introduction

In Part I of this essay I argue that the practice of medical assistance in dying (MAID) is of no greater moral concern than allowing patients the right to refuse life-sustaining treatment. By "MAID" I refer to the practices of voluntary active euthanasia and physician assisted suicide. Denying MAID to competent patients with an irremediable illness prolongs unnecessary suffering and violates the bioethical principles of non-maleficence and respect for autonomy.

In Part II I argue that extending MAID to patients whose request is motivated by treatment-resistant clinical depression (TRD) alone should not be permitted. It is currently unclear under what criterion clinical depression can be accurately judged to be irremediable. Due to missing data and publication bias we cannot currently tell how effective the primary treatment methods for depression are, which casts doubt on whether or not even the most severe cases of TRD are truly irremediable. These issues might mislead doctors and patients to believe a particular case of depression is irremediable when it is not. For this reason, TRD patients might be put in a vulnerable position for premature death if MAID is permitted for them.

Part I

Dan Brock highlights the wide consensus among academics and patients that the right to refuse life-sustaining treatment is morally permissible and supported by the principles of respect for patient autonomy and beneficence (Brock 1992, 297). However, controversy remains around whether or not MAID is morally permissible. I argue that MAID is morally permissible when the request is made by a fully informed, competent patient and the request is due to an irremediable medical condition.

Brock (1992, 297-308) argues there is no relevant moral difference between allowing the right to refuse life-sustaining treatment and allowing the right to MAID. When a patient refuses life-sustaining treatment they have decided that the net well-being made available to them by their treatment is worse than death. They would rather die than to continue their suffering, and find this choice to be the greatest exercise of their autonomy. The same judgement also underlies the request for MAID and is backed by the same bioethical principles, namely beneficence and respect for autonomy (Brock 1992, 299). If one's refusal and/or withdrawal from treatment will result in her death, then she finds death to be the best available choice. If death is decidedly the greatest exercise of one's autonomy, the best choice for one's well-being, and the only way to effectively relieve suffering then there is no good reason to deny MAID while allowing her to refuse life-sustaining treatment. MAID enables the patient to control the timing of her death and eliminates the suffering she would otherwise be forced to endure in the time between withdrawal from treatment and death. For competent patients with irremediable illness, MAID is an even greater act of beneficence as it might prevent more suffering and give patients more meaningful deaths.

A common reply goes like this: killing is wrong, and doctors should not (and do not) kill. Letting someone die is not wrong when it alleviates suffering and provides the patient with the greatest capacity to exercise their autonomy. MAID amounts to the physician killing the patient, whereas respecting the refusal to life-sustaining treatment amounts to letting the patient die, which is an unintended side-effect of alleviating suffering and enabling the patient to exercise their autonomy in the greatest available way. So, the argument goes, MAID is wrong, and doctors should not perform it even if we allow the right to refuse life-sustaining treatment.

This argument is flawed, however, because it rests on the mistaken assumption that when physicians discontinue life-sustaining treatment they are merely letting the patient die (Brock 1992, 299-301). To support this claim, Brock uses the example of a respirator-dependent ALS patient who requests (with competence) to be taken of her respirator because she finds her condition intolerable (Brock 1992, 300). The patient cannot do this herself as she is completely

paralyzed. In this case the physician, if she abides by the patient's request, intends and plays a necessary causal role in the patient's death. Now, imagine a greedy son of the ALS patient who removes his mother from her respirator to hasten his inheritance, and then claims to have done nothing wrong because he merely let her die. The physical actions are the same, but the physician has good intentions and has obtained informed consent. The son has ill intent and has not obtained consent at all. Both play necessary causal roles, but only the son does so wrongly. It would be cruel to force the ALS patient to remain in her condition against her wishes, so letting her die her by taking her off her respirator (with informed consent) is morally permissible. If we say the physician in this scenario did nothing wrong *merely* because she let the patient die, we would be forced to say that the son did nothing wrong too. The physician did nothing wrong because she enabled the patient to exercise her autonomy in the greatest way available, whereas the son denied her this capacity. That is the crux, not the physical actions themselves.

MAID is supported by the principles of respect for autonomy and beneficence. If we can be sure that the requesting patient's medical condition is irremediable and that unbearable suffering will continue, we can be sure that MAID is an act of beneficence if extra measures are taken to ensure the requesting patient is sufficiently competent to make this serious decision.

Part II

Bill C-14 currently disqualifies Canadian patients from receiving MAID for psychiatric illness alone because in order to qualify the natural death of the patient must be "reasonably foreseeable" (Kim 2016b, 1). Some argue, however, that patients with psychiatric illnesses such as severe treatment-resistant depression (TRD)[1] should be eligible for MAID and that the reasonable foreseeability of death criterion should be removed (Dembo et al. 2018). I agree that this criterion is vague and potentially problematic

[1] TRD has been defined in one study as depression which has been unresponsive to 2-6 treatment regimes, though it has been defined slightly differently in others (Rooney, Schuklenk, and Vathorst 2017).

in cases where an illness is truly irremediable but death is not reasonably foreseeable. Suffering is suffering. If death is the only way to relieve it, MAID should not be denied to patients just because it is unclear how long they would otherwise have to suffer before death. However, I argue that we should not extend the right to MAID to include patients whose request is motivated by TRD alone because it is unclear under what criteria TRD, even in severe cases, can be accurately judged to be irremediable. As things stand, allowing MAID for TRD alone would put patients in a vulnerable position by exposing them to risk of false positives and an unjustly premature death. From here-on, I will focus on arguing against extending the right to MAID for TRD alone, not psychiatric illness in general.

S.Y.H Kim (2016b) argues that the criteria for judging irremediability is inherently vague. In another paper, Kim et.al. (2016a) examined all published cases of MAID for psychiatric illness in the Netherlands from years 2011-2014. Kim (2016a) found that if a patient's depression persisted for twenty years despite several treatment attempts (including antidepressants), their depression would likely meet the irremediability criterion. But Kim cites evidence suggesting that even patients in this situation can achieve remission through "high-quality treatment" (Kim 2016b, 1) , which raises the worry as to whether or not some TRD patients in the Netherlands have undergone premature deaths, thereby depriving them of a real chance of recovery. I would like to raise a similar worry.

In *Bad Pharma* Ben Goldacre (2013) argues that the available evidence on the effectiveness of antidepressants is inherently flawed due to missing data and publication bias in pharmaceutical research. Goldacre (2013, 19-20) cites research which examined all seventy-four trials reported to the FDA for every antidepressant on the U.S. market between 1987 and 2004. The researchers found that thirty-eight of the trials showed positive results and thirty-six showed negative results. All thirty-eight positive trials were published, but only three of the negative trials were published without distortion (Goldacre 2013, 20). Twenty-two of the negative trials were never published, and the remaining eleven were distorted to appear positive (Goldacre 2013, 20). When we look at the data of all 74 trials the evidence suggests that these antidepressants are no better than a

placebo. Furthermore, Goldacre (2013, 5-6) mentions an antidepressant that had been approved for use in the UK and explains that only one of seven trials for this drug were ever published. This one trial showed positive results, but the remaining unpublished trials showed this antidepressant to be no better than a placebo (Goldacre 2013, 6). This is a paradigm example of publication bias which has misled doctors and patients into using the drug, falsely believing it to be effective. The upshot of these findings is that we cannot at this time be sure that the common antidepressants work. There is strong evidence that they do not, and in some cases they might even be more harmful than helpful (Goldacre 2013, 5-6). If this is true, the fact that a case of depression shows treatment-resistance to several different antidepressants cannot justify the claim that the depression is irremediable.

Antidepressants are not the only available treatment method for depression, but it is the most common in Canada (Flett and Kocovski 2017, 221). Goldacre (2013, 12) also argues that missing data and publication bias has affected all areas of science. This suggests that these issues are likely to be infecting the evidence pertaining to the effectiveness of non-pharmaceutical alternative treatment methods as well. Furthermore, the effectiveness of alternative treatment methods are often measured in comparison to that of pharmaceutical treatments, as pharmaceutical treatments are commonly considered to be some of the best treatments available. Since we do not have accurate knowledge of the effectiveness of these pharmaceutical treatments due to the reasons stated above, this strategy cannot lead to an accurate measurement of the effectiveness of alternative treatment methods. Rooney, Schuklenk and Vathorst cite skepticism about the effectiveness of cognitive therapy as well (2018, 3).

Now, consider the fact that treatment resistance is a central factor in how physicians in the Netherlands judged the irremediability of depression for those who received MAID (Kim 2016a). Did treatment resistance occur in these cases because the treatments were ineffective, or because the illnesses were truly irremediable? This question bears heavily on the moral status of extending the right to receive MAID for TRD at this time. Since we lack the required

evidence to answer this question in good faith we cannot yet be sure that providing MAID for depression is morally permissible in any case. Due to the serious doubt concerning the effectiveness of the current primary treatment methods for clinical depression, resistance to these treatments is not a valid criterion for irremediability. Without valid criteria, we cannot be sure if *any* given case of depression is truly irremediable. Thus, we cannot be sure that granting MAID to patients for their TRD would not result in their premature deaths and thereby deprive them of the chance to alleviate their suffering by less costly means and experience a more valuable life than the ones they live currently. To deprive them of this chance would be to violate at least two bioethical principles: non-maleficence and justice (Fisher et. al. 2018, 17).

Rooney, Schuklenk, and Vathorst (2018), however, argue that concerns about irremediability do not justify an outright ban on MAID for TRD. They too point to skepticism of the effectiveness of available treatment methods, but argue that this instead provides reason to understand some cases of TRD as irremediable. Rooney, Schuklenk, and Vathorst (2017, 5) propose an understanding of irremediability based on a cost-benefit analysis between "statistically likely outcomes" and the burden of treatment. They admit this understanding can lead to false positives, but argue that these cases will be relatively few compared to the "majority of individuals who would have pursued MAID" (Rooney, Schuklenk, and Vathorst 2018, 5) who will be harmed by being forced to endure their, perhaps irremediable, suffering.

However, to base an understanding of irremediability on current "statistically likely outcomes" (Rooney, Schuklenk, and Vathorst 2018, 5) is to ignore the issues I raised above. These outcomes are precisely what are difficult to accurately determine as a result of our uncertainty regarding the effectiveness of our most common treatment methods. Rooney et. al. (2018) cite studies of TRD which show patient prospects to diminish after each unsuccessful treatment and note that this is a "central component" (4) of evidence-based assessment of TRD and determining its irremediability. But if the majority of common treatments have not reliably been shown to be effective then it is no wonder why prospects should not improve after

several treatment attempts. Also, if we cannot accurately conclude that the common antidepressants are effective from the available evidence, this evidence cannot justifiably be used to determine patient prospects.

Rooney et. al. (2018) also cite evidence suggesting that even in long-term high-quality care facilities forty percent of patients did not achieve remission, and they deny the claim that a better resourced mental health system would make a "significant difference" (3). But this is to ignore the fact that many requesting patients might not have access to such long-term care and also that long-term care often involves the use of antidepressants and cognitive therapies as primary treatments as well (see Logan 2013). Perhaps better access to such long term care, combined with an improved treatment approach, would result in a significant decrease in the amount of TRD cases deemed to be irremediable.

Thus, Rooney, Schuklenk, and Vathorst (2018) have failed to show how irremediable cases of TRD can be accurately distinguished from remediable cases. Without a reliable distinction we cannot be sure that any case is not a false positive. Rooney, Schuklenk, and Vathorst (2018) claim that the number of false positives will be relatively few compared to those patients who will be forced to endure their illness for the rest of their lives, but this is unfounded and a rather risky claim to make without reliable criteria to distinguish irremediable cases of TRD from remediable ones. Furthermore, it seems plausible that seriously addressing the issues of missing data, publication bias, and the ineffectiveness of current treatment methods might yield research findings that affect current clinical practices such that better treatments are developed and a greater chance of recovery is made available for patients with TRD. These concerns should be considered before permitting MAID for TRD alone considering the potential for a great number of lives to be saved and improved.

Conclusion

I maintain that MAID is morally permissible for competent patients with irremediable illnesses causing grievous suffering. However, my position provisionally excludes patients who request MAID solely for TRD because the medical field currently lacks

adequate criteria to judge the irremediability of any case of depression. Providing MAID to patients with a real chance of recovery would violate the bioethical principles of non-maleficence and justice, and we lack the necessary tools to determine which patients have this chance and which do not.

Note that my main supporting claim, namely that we cannot yet accurately determine irremediable cases of TRD, is empirical in nature. Its status may change with further advancements in research as it rests on the current available evidence (or lack-thereof) of the effectiveness of available treatment methods. If we can determine adequate criteria for judging the irremediability of TRD, I will be happy to reconsider my position in the absence of other issues.

Bibliography

Brock, Dan W. "Voluntary Active Euthanasia." In *Biomedical Ethics: A Canadian Focus*, edited by Alister Browne, Johnna Fischer, J.S. Russel, and Leslie Burkholder, 297-308. Don Mills: Oxford University Press, 2018.

Dembo, Justine, and Schuklenk, Udo, and Reggler, Johnathan. "For Their Own Good": A Response to Popular Arguments Against Permitting Medical Assistance in Dying (MAID) where Mental Illness Is the Sole Underlying Condition. The Canadian Journal of Psychiatry. In *The Canadian Journal of Psychiatry* 63, no. 7 (2018): 451-456. https://doi.org/10.1177/0706743718766055.

Fisher, Johnna, and Russel, J.S., and Browne, Alister, and Burkholder, Leslie. "Morality and Moral Decision Making: A Brief Introduction" in *Biomedical Ethics: A Canadian Focus*, edited by Johnna Fisher, J.S. Russel, Alister Browne, and

Leslie Burkholder, 1-22. Don Mills: Oxford University Press, 2018.

Flett, Gordon L., and Kocovski, Nancy. *Abnormal Psychology*, 6th Canadian ed. John Wiley and Sons, 2017.

Goldacre, Ben. *Bad Pharma: How Drug Companies Mislead Doctors and Harm Patients*. USA: McClelland and Stewart, 2013.

Kim, Scott Y.H., and Peteet, John R, and De Vries, Raymond G. Euthanasia and Assisted Suicide of Patients with Psychiatric Disorders 2011-2014. In *JAMA Psychiatry* 73, no.4 (2016): 362-368. doi:10.1001/jamapsychiatry.2015.2887.

Kim, Scott Y.H., and Lemmens, Trudo. Should Assisted Dying for Psychiatric Disorders Be Legalized in Canada? In *CMAJ* 188, no. 14 (2016): 337-339. https://doi.org/10.1503/cmaj.160365.

Logan, Linda. "The Problem With How We Treat Bipolar Disorder." *New York Times Magazine,* April 26, 2013.

Rooney, William, and Schuklenk, Udo, and van de Vathorst, Suzzane. "Are Concerns About Irremediableness, Vulnerability, or Competence Sufficient to Exclude All Psychiatric Patients from Medical Aid in Dying?" *Health Care Anal.* 26, no. 4 (December 2018): 326-343. DOI 10.1007/s10728-017-0344-8.