Commentary on 'Treatment-resistant major depressive disorder and assisted dying'

Christopher Cowley

Schuklenk and van de Vathorst (henceforth "the authors") make the following starting assumption, which I will accept: that it is ethically permissible for doctors to assist suicide and it is permissible for those competent patients with terminal somatic diseases (such as inoperable stage IV cancer) or non-terminal but untreatable debilitating diseases (such as motor neuron disease, MND) to be assisted in their suicide.[1] Given these assumptions, there is a question about whether treatment-resistant major depressive disorder (henceforth 'clinical depression') is sufficiently similar to MND to qualify for assisted suicide: the authors think yes, I think no.

The first and most obvious problem concerns competence. With cancer and MND that do not affect the brain, the disease does not directly undermine competence. With depression, there is *always* an initial question about competence and about authenticity. Does the disease distort their judgement about the world, about the future and about themselves in that world? Are the depressed person's wishes authentic in expressing their long and deeply-held beliefs and desires about the world and about themselves? The authors claim that the data is ambiguous, and therefore, clinically depressed patients should be presumed competent and their suicidal request should be granted. I would draw exactly the opposite conclusion: because we are talking about an act that is so serious (death as the ultimate harm) and irreversible, then any ambiguity in the data must preclude granting their request. My conclusion is perfectly compatible with recognising the depressed patient's competence in many other contexts of their life, for example, in their financial affairs, where they can remain free to make and learn from mistakes.

This is not to deny that certain individual clinically depressed patients are competent, it is not to deny the reality of their suffering and it is not to deny that their suicidal ideation is intelligible. The quotes by patients should certainly prompt compassion. The problem is with medical doctors distinguishing the competent from the incompetent patients, the authentic from the inauthentic requests for assistance, the patients with an objective prospect of improvement from the ones without—with sufficient reliability. It is one thing to feel compassion for the depressed patient's report of their suffering and judgement that their life is not worth living; it is another to *endorse* such a report and judgement by granting the request, or even for a doctor to tell the patient that she is 'right to think that this will not change'. A rejected request may of course lead a depressed patient to attempt suicide on her own, despite the offers of assistance from social workers, psychiatrists, as well as friends and family. And as the authors say, a thwarted attempt may not lead to gratitude. But again, the likelihood of an independent suicide attempt is not *in itself* a reason to assist the suicide, and indeed comes uncomfortably close to blackmail.

The authors state that a 'significant number' of clinically depressed patients have 'little hope' of recovery. (By 'hope' he obviously does not mean the subjective attitude—the depressed patient lacks that almost by definition—but the objective prospect of cure or improvement.) If we accept the reliability of the diagnosis and the statistics here, by itself this does not allow sufficient confidence to identify *this* patient as one without objective prospect. There may be some grounds of confident prediction available to the experienced psychiatrist, but the relevant comparison has to be with MND and cancer, where the progression can be very accurately and confidently predicted on the basis of inductive generalisation of past samples of the same disease in the same type of organism. It is much harder to speak of the 'same' depression because it is often so wound up with the person's very unique life experience. This is not only an argument in favour of waiting for future medical progress that might cure depression; it is also a recognition that depression sometimes just disappears on its own, as in the famous case of the American novelist William Styron. Admittedly that might be of little reassurance to the depressed patient; but it is enough to deny that any depressed patient is sufficiently hopeless to legitimately expect assistance in suicide. Again, the authors and I disagree on which way to lean, given uncertainty. The authors believe that long-term depressed people should not have to live with the consequences of repeated therapeutic failure, and we should therefore incline to granting their competent request; I believe that we can never be sufficiently certain of the hopelessness, and we should therefore incline away from such a serious and irreversible decision as assisting suicide. But notice that the authors are surely mistaken or disingenuous when he declares that 'we have no right to require them to continue living'. In denying assistance with suicide, no doctor is thereby *requiring* a patient to do anything. It would be like saying that a bank teller who refuses to hand over the cash to an armed robber thereby 'requires' the robber to use their gun!

The authors cites with approval the cases of suicidal assistance offered to people in the Netherlands with non-somatic illnesses. I am not competent to speak about psychiatric illnesses such as anxiety or personality disorders: it may be that such illnesses are sufficiently unbearable, untreatable and without prospect of improvement to resemble MND in the relevant ways, and thereby to qualify for assistance. I have been speaking about patients with 'only' clinical depression, such as those in the famous Dutch cases of *Chabot* in 1991 (a woman in her mid-50s who was understandably depressed about the death of both her sons) and *Brongersma* in 1998 (a man in his 80s who claimed to be 'tired of life'). The authors do not mention these cases. Both these patients were ill, certainly, both patients had legitimate claims upon the state for continuing psychiatric treatment and other kinds of support, however ineffective. But they did not have a right, I would argue, to state assistance in committing suicide.

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