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Depression as a Terminal Illness – is there a place for palliative care?

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Abstract

In 2020, there were 5,224 suicide deaths registered in England and Wales [1]. The Mental Health Foundation reports that ~70% are in patients with depression [2]. The number of attempted suicides is much higher– South West London and St George's Mental Health Trust estimates that at least 140,000 people attempt suicide in England and Wales every year [3]. In suicidal depression, the psychological pain is often unbearable and feels overwhelmingly incompatible with life. One is no longer living; they are merely surviving and eventually, the exhaustion will lead to decompensation. This is marked by suicide. The goal is to end the suffering permanently and this is achieved through death.

Keywords: depression; illness, palliative care

Introduction

Depression, like all other physical and mental illnesses, runs a course. This is highly variable between individuals and can be the case even between separate relapse episodes in the same patient. Like many diagnoses, depression is known to lead to death in a significant number of people. Many suicidally depressed patients feel that death will be an inevitable result of the illness.

Suicide is often viewed as a symptom of severe depression, but what if we considered death as part of the disease process itself? Consequently, would it be justifiable to consider depression in these patients as a form of terminal illness? Since without treatment, the condition would lead to death? Accordingly, could there be a place for palliative care in a small minority of suicidally depressed patients? This would mean that instead of placing the focus on the prevention of deaths and prolonging of lifespan, the focus would be on making the patient comfortable as the disease progresses, maintaining their dignity, and promoting autonomy.

Suicidal depression and Rights

Patients with psychiatric conditions are generally not given the same rights to make decisions regarding their mental health and treatment, particularly if they wish to decline treatment. The rationale for this is that psychiatric patients do not have capacity to make such decisions in the acute setting, due to the direct effects of the unwell mind on their decision-making processes and cognitive faculties. Whilst this may be true in some cases, there is limited evidence that this applies to all suicidally depressed patients in all cases. Another argument against allowing suicidally depressed patients to decline treatment is the notion that the episode of depression can be successfully treated and the patient can return to their normal level of functioning. However, in individuals with a previous history of severe depression, it is possible that they will relapse again at some point. In the same way, a cancer can be treated and the patient could return to their baseline level of functioning, only for the cancer to then return later in life. In both cases, these relapses are emotionally and physically exhausting and painful to get through. The difference is that a cancer patient can decline further treatment and opt for no treatment or for palliative treatment, knowing that the disease will shorten their life expectancy. For suicidal depression, this is not an option. Such patients may be sectioned, admitted, and treated against their will. Suicide, which could be considered a natural end point of the depressive illness, is unacceptable.

Is it fair to confiscate one's right to decline treatment, solely because they suffer from a mental illness, as opposed to a physical one? Numerous studies have demonstrated clear structural, neurological, and neurochemical changes in suicidal depression. This is evidence that such a condition encompasses a clear physical property. Other conditions, such as dementia

and chronic pain have previously been accepted for euthanasia in certain countries. Pain is a subjective experience of nociceptive and neurochemical signaling. In the same way, depression is a subjective experience involving aberrant neurochemical signaling. The difference is that physical pain can often be localized. However, patients with suicidal depression often experience very severe and tangible pain that can be difficult to articulate and for others to understand if they have never experienced it themselves. Like distinct forms of physical pain, suicidal depression creates a different form of pain, but it is pain nonetheless. Is it therefore fair for suicidally depressed patients to be given lesser rights than those suffering from physical illnesses in determining their fate?

Suicidal Depression and Capacity

A patient is assumed to have capacity unless proven otherwise. This is often the reverse when managing psychiatric patients. However, if one is able to fulfil all criteria required for demonstrating capacity (understanding the information, retaining, weighing up, and communicating the decision), surely, they have demonstrated capacity to make their decision, whether that is to receive or to refuse treatment?

For physical illnesses, adults with capacity are permitted to make decision that their treating teams may not agree with, but this disagreement alone is generally insufficient to override their decision. These patients, unlike in suicidal depression, have the right to refuse life-saving or life-prolonging treatment.

An argument for this is that in terminal physical illnesses, the death is a passive process and neither the patient nor the physician is actively causing it. However, in many palliative settings, patients can be given medications and treatment for symptomatic relief, even if these may hasten their death. The principle that makes this permissible is that the primary aim is to improve the symptoms and ensure comfort. The unintended effect includes side-effects and hastened death. Similarly, in suicidal depression, one could argue that the patient should be permitted medications that may hasten or lead to their death, so long as the primary aim is to improve the symptoms of the unbearable mental pain and suffering.

Let us consider an alternative scenario. What if a previously suicidal patient is currently in remission from depression and makes an advanced directive? In their current healthy state, they assert that if in the future they were to relapse and, they would not want any form of treatment. Instead, they wish for the disease to run its course, which may end in death through suicide. In this case, the circumstances in which the statement was made would be entirely valid– the patient at that moment has capacity, is not under coercion, is able to articulate logical thought processes, and their reasoning would not be affected by a concurrent psychiatric pathology. Furthermore, they are able to demonstrate that suicide is not an impulsive decision and have considered the consequences of suicide on themselves and others. If the patient is able to demonstrate all of the above, what would the ethical grounds be for refusing this advanced directive?

Four Pillars of Medical Ethics

Non-maleficence

To determine whether an action is in line with non-maleficence, one must ask whether the proposed treatment will improve or resolve one's condition. In the case of severe suicidal depression, the treatment may help them in the short term, but what happens if or when they relapse? The treatment will likely prolong one's life, but also inadvertently prolong their suffering. What if the patient does not wish to go through this again? The treatment regime can be profoundly taxing for the patient, their loved ones, and sometimes even for the treating team. Are we doing more harm by forcing these patients to stay alive against their will?

Beneficence

Beneficence is the moral duty to promote the action that is in the patient's best interest. But who should determine what the patient's best interests are if the patient and their doctor disagree? Usually, this decision is made by the treating doctor, taking into account the patient's past and present wishes, beliefs and values and capacity assessment. Supposing that the law was not a restriction, could one's psychiatrist ever agree on psychiatric grounds alone that it is indeed in their patient's best interests to die?

Doctors play a central role in the duty of care. But care does not always mean active treatment. Caring encompasses physical, psychological and spiritual welfare and includes taking into account the individual's dignity, personal circumstances and wishes. In certain circumstances, keeping a patient with capacity alive against their wishes could be more harmful than caring.

Autonomy

Autonomy gives the patient ultimate decision-making responsibility for their own lives. It allows patients with capacity to decline treatment that is recommended by their physician and to make decisions regarding their own death. However, in suicidally depressed patients, this autonomy is confiscated. Severely unwell patients, at high risk of committing suicide, are not permitted the autonomy to make the decision regarding their treatment, suicide and death.

Justice

A justice-orientated and utilitarian view questions whether spending resources on these patients wastes time, resources and expertise, and should instead be spent on patients who actually want treatment.

The NHS holds an outstanding debt of £13.4 billion.[4] The financial cost of treating mental illness in 2020/2021 was £14.31 billion.[5] The NHS estimates that wider costs to national economy, including welfare benefits, housing support, social workers, community support, lost productivity at work etc. amounts to ~£77 billion annually.[6] Many severely depressed patients are so unwell that their ability to contribute to society, financially, socially and otherwise, is minimal. If a patient with capacity genuinely wants to die and society would benefit from a reduction in the pressures on health and social care services, would it not be in both their best interests to allow them to die? This way, resources could be redirected to service users who would appreciate and benefit from them the most.

A consequentialist view focuses on whether the action will benefit the patient overall; the action itself is not so relevant. According to this view, keeping a suicidally depressed patient alive against their wishes would be ethical if the patient lacks capacity. Keeping them safe and treating them until they are better would overall be in the patient's best interests. However, if the patient does have capacity and wishes to die, forcing them to stay alive and undergo treatment against their wishes would merely prolong their suffering and thus could be considered unethical.

When Enough is Enough

In suicidal treatment-resistant depression, where the patient has tried multiple treatments over time and carefully considered alternatives, when is it time to stop trying? For physical illness, the patient can refuse treatment provided they can demonstrate capacity. In depression, one can only refuse treatment if they can demonstrate that they are not at serious risk to themselves or others. Most societies consider suicide as a serious risk to self and therefore unacceptable. However, if we considered suicide as a natural endpoint of the disease process, should the patient have the right to refuse treatment and allow the disease to progress to death?

The treatment regime for suicidal depression is often profoundly taxing for the patient, their loved ones, and sometimes even for the treating team. It can be a lengthy process and the repeated failures to improve can be physically and mentally exhausting and further compound the hopelessness. Treatments often have side-effects, which further erode the patient's physical and mental wellbeing. Is there a time when giving up and withdrawing active treatment is in the patient's best interests, especially if that is what they want?

Terminal diseases are ones that are incurable and likely to hasten one's death. Severe suicidal treatment-resistant depression conforms to both conditions– it is unresponsive to treatment and has a high likelihood of precipitating premature death through suicide. Most terminal illnesses can be managed with palliative treatment. In the context of severe suicidal depression, euthanasia, and assisted suicide could be considered as means of palliative care.

Palliative care involves managing the patient's symptomatology, dignity, and comfort. Euthanasia and assisted-suicide help to address all of these. Like palliative care, euthanasia and assisted-suicide aim to improve one's symptoms of the depression by alleviating their pain and suffering, even if they may hasten their death.

Euthanasia and Assisted-Suicide in Severe Depression

Euthanasia and assisted suicide are legal in seven countries. Two countries (Belgium and the Netherlands) permit euthanasia for psychiatric illnesses. Passive euthanasia is practiced in most countries, e.g., withholding artificial life support. In suicidal depression, it could be considered that this withholding of treatment may directly lead to death by suicide.

In active euthanasia and assisted suicide, the patient is given a chemical that will directly lead to their death. Euthanasia and assisted suicide allow individuals to die with dignity in a controlled and organized manner. It ends the patient's suffering and

allows them to finally find peace. The difficulties that led them to seek euthanasia/assisted suicide indicate a loss of control of the pain and suffering in life, and euthanasia allows them to regain this control and autonomy through death. It allows these individuals to properly say goodbye to their loved ones, and a chance to share their thoughts and feelings.

In contrast, suicide is often covert, clandestine, planned in secret and frequently requires one to be dishonest with their closest loved ones. The suicide often comes as a shock to the loved ones and profound grief, questions, anger, pain, sorrow, and guilt follow. These are due to questions that have been left unanswered, thoughts that were never shared, regret that they had not done more to help, and aguish knowing that their loved one died alone, in unbearable mental agony, and unable to speak to anyone about this final hurdle.

Euthanasia and assisted suicide provide a path to overcome all of these issues. They encourage open conversations between the patient, their loved ones, and the treating team. They promote transparency, mutual support, and help prepare the loved ones for the death. In this way, euthanasia and assisted suicide can benefit both the patient and their loved ones.

A significant proportion of severely suicidally depressed patients will eventually go on to commit or attempt suicide. Thus, giving them the autonomy to choose euthanasia or assisted suicide could be considered a kind, fair, and compassionate course of action, as it respects their wishes, allows them to escape their suffering and to die with dignity.

Conclusion

Depression has historically never been considered a terminal illness, but there is undeniable evidence that a significant number of deaths every year are directly caused by depression. Should we therefore shift the focus from life-saving and life-prolonging treatment to ensuring comfort and maintaining dignity by exploring palliative options for extremely suicidally depressed patients with capacity, who are adamant on ending their lives?

Euthanasia and assisted suicide for depression pose a profound paradox when viewed through a deontological lens. According to this, the correct course of action directly corresponds to what the most 'moral' action would be. The moral stance would be to help those who are suffering. But what exactly constitutes 'help'? Are euthanasia and assisted suicide helping or harming? Likewise, is keeping a patient with capacity alive against their wishes helping or harming? Many believe that euthanasia, assisted suicide, and suicide itself are intrinsically and morally wrong. But this poses another clear impasse. Who should be the ones to decide whether an action is moral or not? Should it be the individual? The treating physician? Or society?

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