Dobrovoljna eutanazija i depresija: Etički aspekti

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VOLUNTARY EUTHANASIA AND DEPRESSION: ETHICAL ASPECTS

ZAVRŠNI RAD

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Summary

Although there is no consensus on this, some European countries approve voluntary euthanasia due to mental illness for almost two decades. In Belgium, you may demand euthanasia if you are suffering from depression or bipolar disorder. On the example of the "major depressive disorder" (MDD) and "treatment-resistant depression" (TRD) this paper questions whether the right to die by the means of voluntary euthanasia should be extended from physical to (some) mental illness(es). In the present thesis, the author considers a series of arguments and empirical data claiming that MDD and TRD do not meet the minimum requirements for justifying the practice of euthanasia. In discussing relevant cases, he gives special attention to the impairments of depressed patients' cognitive and rational decision-making competence.

Keywords: voluntary euthanasia, depression, treatment-resistance, rationality, ethics

1. Introduction

Demand for voluntary euthanasia due to mental illness is considered either a taboo or a taken-for-granted human right – the latter being the case especially in countries whose laws allow for voluntary euthanasia in general. A telling example is *The Belgian Act on Euthanasia of May 28th 2002* which defines euthanasia as "intentionally terminating life by someone other than the person concerned, at the latter's request." The Act, however, provides very few criteria that must be met to justify the practice. Euthanasia is considered justified, namely, if the patient desires to die and experiences constant physical or mental suffering through a prolonged period, regardless of whether the condition will certainly lead to death or not (2002, pp. 182–183).

On the other hand, Robert Young in his *Stanford Encyclopedia of Philosophy* entry about voluntary euthanasia specifies five[1] conditions under which voluntary euthanasia is deemed permissible by its advocates. For them, euthanasia is permissible if the person

> (i) is suffering from a terminal illness;
>
> (ii) is unlikely to benefit from the discovery of a cure for that illness;
>
> (iii) is suffering an intolerable pain or, as a result of the disease, is living an unacceptably burdensome life;
>
> (iv) has an enduring, voluntary and competent wish to die (Young, 2017).

The primary goal of the present thesis is to argue that some mental illnesses, although used as justification for granting euthanasia, actually have serious difficulties meeting the above criteria, even if each criterion listed (i–iv) is taken separately as sufficient for justifying euthanasia. In such cases, its practice could be considered morally questionable, if not unacceptable.[2] Throughout the paper, I will use major depressive disorder[3] (MDD) as an example of a mental illness which, according to some empirical data, has difficulties satisfying the above

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[1] This essay will not analyze the fifth criterion from *Stanford Encyclopedia of Philosophy* ("patient is unable without assistance to end their life") because wide variety of medical conditions fail to satisfy it.

[2] The essay will focus on patients affected solely by a mental disorder, i.e. who are otherwise physically healthy.

[3] I will use the term "depression" throughout the text as a synonym to MDD.

criteria, if satisfying them at all, but has nevertheless been used to grant the right to voluntary euthanasia (Mortier, 2013; Chan, 2015). Following the (i) introduction, the thesis is divided into the following sections: (ii) terminological and other definitions related to the topic discussed in this paper, (iii) debate on whether depressed patients should qualify for the right of voluntary euthanasia by examining the criteria listed above, (iv) brief outcome of the severity paradox in the case of euthanasia and depression with explanation of its implications on the matter, and (v) a conclusion.

2. Terminological and Definitional Issues

Before addressing the problem, it is necessary to clear some terminological and definitional issues regarding euthanasia and major depressive disorder as a mental disorder.

Firstly, the term ‘euthanasia’ can be used to refer to voluntary, involuntary and non-voluntary euthanasia. ‘Involuntary euthanasia’ refers to cases of euthanasia carried out on a person capable of making a competent request for ending their life, but does not do so, either because they were not asked or were asked but chose to keep on living. Rarely are the cases of voluntary euthanasia, and rarely are they considered justifiable. ‘Non-voluntary’ euthanasia refers to a type of euthanasia regarding patients who are not able to understand the difference between life and death (and accordingly are unable to make such a decision) at the moment euthanasia takes place. ‘Voluntary euthanasia’ refers to a type of euthanasia carried out at the request of the person who is being killed, who must be mentally competent for such a decision at the moment of making the request (Singer, 2011, pp. 157–158). Throughout this thesis, I use ‘euthanasia’ to mean ‘voluntary euthanasia’.

As mentioned above, I will use major depressive disorder (MDD) as an example of mental disorder linked to justifying the practice of euthanasia in some countries. Throughout the text I use ‘depression’ as a commonly known synonym for ‘MDD’. Furthermore, I chose depression because the aim of my thesis is to specifically address requests for euthanasia coming

from patients who are solely affected by a mental disorder and are otherwise physically healthy. It should be emphasized that my treatment of mental disorder is based on two premises: (1) that there is a significant difference between physical and mental disorders (or illnesses), and (2) that there is at least one mental disorder that does not entail some (sort of) physical ailment. However, for the purpose of the present thesis, and due to space limits, the two premises are taken for granted and are not discussed further.

Lastly, as it is stated in the introduction, my thesis does not discuss the fifth criterion listed in Young's entry about voluntary euthanasia ("patient is unable without assistance to end their life") because wide variety of conditions fail to satisfy it. For example, someone could argue that most requesters of voluntary euthanasia, except for the severely disabled, are indeed able to end their lives on their own. Since the aim of the thesis is to address the problems with justifying the practice of euthanasia on the mentally ill, I find that satisfying the fifth criterion is of little relevance to the point I am trying to prove, and it has been completely taken out.

3. Should Depressed Patients Qualify for the Right of Voluntary Euthanasia?

Depression is a psychological disorder characterized by persistent low mood present in almost all situations for at least two weeks. Some of its symptoms are irritability, pessimism, difficulties with remembering and making decisions, anxiety, sadness, sense of worthlessness, physical pain (headaches, back pain, joint pain), suicidal thoughts and more (National Institute of Mental Health, 2017). Apart from these symptoms, depressed patients tend to attempt suicides (Breitbart, 1990; Simon et al., 1998; Richards et al., 2014) and are at a greater risk for various infections (Andersson et al., 2016). In addition, there are some noticeable impairments in their cognitive and executive functioning abilities (Murphy et al., 2001; Cella et al., 2010).

3.1. Mortality and Curability in Depression

Depression is, undoubtedly, a severe mood disorder with aggravating symptoms that both mentally and physically affects a great sum of world population. But can it be treated as a sufficient reason for terminating life by means of voluntary euthanasia? If we look at the first criterion from our list above ("suffering from a terminal illness"), it is easy to argue that depression does not satisfy it because it is not a terminal illness. Yet, this is relative to how we define 'terminal illness'. If we wished to interpret 'being terminally ill' as charitably as possible, we would say that phrase stands for 'almost certainly leads to death'. Hence, depression, or at least one type of depression, can plausibly be treated as a disorder that almost certainly leads to death (like terminal illnesses do). After all, it is commonly accepted that patients diagnosed with depression – along with feeling empty, anxious and worthless – tend to commit suicides. Hypothetically, if letting them live (by denying them voluntary euthanasia) would eventually also lead to death by suicide, we could say that granting them right to euthanasia, or depriving them of that right, has the same consequences for them – death. The only difference is that suicide is, quite plausibly, treated as an act of violence. So, the proponents of euthanasia infer that if patients are granted euthanasia, they have the advantage to die peacefully, which is, ethically, considered to be a more acceptable solution.

As for the numbers, it is frequently argued that about 50 percent of suicide victims were clinically depressed (Breitbart, 1990, p. 399). This may look like a strong statistical support to the claim that depression is, charitably speaking, a "terminal" illness and, therefore, being a solid ground for granting euthanasia to depressed patients, but (as I will claim) it is not. Even if half of suicide victims are indeed people with depression, it does not follow that depression necessarily, always or even most frequently leads to death by suicide. Moreover, according to Richards et al. (2014, p. 254), only 2 to 7 percent of adults affected by depression die by suicide and, according to Simon et al. (1998, p. 155), no more than 15 percent of all affected. These numbers suggest that only the minority of depressed people end up dying by suicide. In addition, some authors argue that depression is an undertreated disorder, expecting that better recognition and "more widespread treatment of depression" might reduce the number of suicide victims (Rihmer, 2001,

p. 408). However, suicide should not be treated as the single and only cause of death regarding depressed patients.

Niklas Andersson et al. (2016) investigated the link between certain physical conditions, primarily infections, with depression. They conducted a study based on 976.398 Danish citizens, of whom 142.169 had a history of depressive episodes between 1995 and 2012, and highlighted three principal findings. Firstly, they concluded that patients with history of depression are associated with a higher risk of various infections when compared to patients who have no history of depression. Secondly, the increased risk of infections appears to be consistent in depressed patients, regardless of the stage of their disorder. Thirdly, they encountered some evidence of connection between the number of depressive episodes and the risk of infections, but the results did not show a very strong association. In other words, these three findings suggest that depressed patients are generally met with a higher risk of infections, including: gastrointestinal infection, hepatitis infection, sepsis infection, skin infection, urogenital infection and respiratory infection (pp. 133–137). Any of these infections, especially if severe, could lead to death. Therefore, a presumed number of individuals dying from one of these opportunistic infections linked with depression should be added to the suicide rate numbers. Although there are no complete statistical records on this issue, it is plausible to conclude that depression, at least in some cases, leads to death. Nevertheless, this does not support the conclusion that it almost certainly leads to death.

The second of the afore mentioned criteria refers to the curability of the condition. If the proponents of euthanasia could show that the depressed patients would not much profit from a curing treatment, i.e. that their disorder is irreversible or irremediable, the practice of euthanasia could be considered as unacceptable for such patients. Depression is one of the most common mood disorders and it is generally treatable, with some patients achieving spontaneous or therapy induced remission (Karasu et al., 2000). Psychiatric literature, however, recognizes a much more severe subtype of major depressive disorder called “treatment-resistant depression” (TRD).

3.2. Treatment-Resistant Depression

Some authors take this type of depression to be characterized by an inability to respond to numerous therapeutic interventions, including non-pharmacological ones (Olin et al., 2012). Other authors – including Souery et al. (2006; 2007), Wijeratne and Sachdev (2008) – define TRD as a type of depression that does not respond to a continuous therapy of at least two antidepressants. It is therefore crucial to emphasize that a "clear consensus regarding the criteria defining TRD is lacking in the psychiatric community" (Souery et al. 2006, p. 16):

> […] there is no operational, validated, and systematic definition for treatment-resistant depression. There is no consensus over what constitutes adequate treatment in terms of drug dosage and duration of therapy or on the number of failures of adequate treatment that a patient must experience before being considered treatment resistant. (Souery et al., 2006 cited in Steinbock, 2017, p. 33)

Moreover, Souery et al. argue that "many patients who are considered treatment resistant are actually misdiagnosed or inadequately treated" (2006, p. 16). TRD diagnosis often comes down to *pseudo-resistance* – a phenomenon of too early treatment discontinuation or inadequate treatment choice due to which patients are misdiagnosed as treatment-resistant (Souery et al., 2006, pp. 16–17).

According to a study conducted by Souery et al. a year later (2007), there is another disorder possibly associated with TRD: "comorbid anxiety disorder". However, authors themselves acknowledge that "the link between [these two disorders] is not clear and deserves further studies" (p. 1069), which suggests that a possible therapy change needs to be studied too. Nonetheless, there are successful therapy options available even for the most exclusive definitions of TRD. Mayberg et al. (2005) conducted a study on possible treatment solutions proving that deep brain electrical stimulation of the white matter "can effectively reverse symptoms in otherwise treatment-resistant depression" (p. 651). They showed that high-frequency deep brain stimulation causes significant behavioral changes in patients diagnosed with TRD. Although small sample size was one of the limitations of their study, 4 of 6 subjects achieved a lasting response, or even remission, by the end of a six-month period without changes in concurrent medication (pp. 656–657).

Another possible TRD therapy solution emerged a few years ago. Several clinical studies reviewed by Serafini and other authors (2014) have shown positive effects of intravenous ketamine therapy on TRD patients. Ketamine has been shown to cause a significant clinical improvement in patients' condition. Three studies even "reported the efficacy of ketamine on suicidality in TRD patients", reducing both suicidal attempts and ideation scores by up to 81 percent. Although poorly studied long-term efficacy is one of the limitations of ketamine therapy, ketamine may be considered a valid option for TRD because of its positive effects and due to the fact that 64 percent of TRD patients responded to treatment (pp. 452–456). The evidence presented so far suggests that depression, even TRD, is not an incurable disorder and that diagnosed patients could benefit from discoveries of new cures and treatment options. Still, there is an ongoing debate about the definition of TRD and the severeness of its symptoms, so any definitive conclusion as to its curability is rather loosely, if at all, based on infallible facts. When discussing TRD as a disorder potentially qualifying people for voluntary euthanasia, the proponents ought to provide clear statistical and qualitative evidence of severity, incurability and intolerability of the mentioned disorder. Considering the present state of research of this disorder, this criterion simply cannot be met.

3.3. Life Quality and Pain Tolerability

Our next criterion from the list cited at the outset is that the person demanding euthanasia must suffer from a disease that causes intolerable pain or lessens the quality of life to the point where it becomes unacceptably burdensome. Opponents of euthanasia, philosophers and scientists alike, generally consider physical pain as somewhat, though not entirely, subjective (Cowley, 2013 cited in Savić, 2014, p. 7). Even if someone would argue that severity and tolerability of pain are subjective in nature, there are arguments aiming to show the opposite – the possibility of their objective estimate. For example, different types of physical pain can be localized and thus compared to each other. Knowing relevant facts about the nervous system, one is able to predict the severity and tolerability of different types of physical pain.

As to the mental illnesses, it is hard to define what 'pain' and 'suffering' really mean. Certain depression symptoms themselves (e.g., anxiety, hopelessness, suicide thoughts) suggest

that depressed people are suffering because they experience symptoms which are both generally and by medical standards considered unfavorable. But what is the extent and nature of their suffering? One could argue that the mental suffering manifests itself in the form of physical pain that depressed patients feel (e.g., headaches, joints and back pain). As soon as we accept such an argument, we are faced with a plausible question: should a headache or chronic back pain qualify you for euthanasia? If yes, then there is no reason not to extend the right to voluntary euthanasia to patients suffering from migraine or osteoporosis. The alternative is to argue that the whole experience of physical pain, along with some mental projections of worthlessness, pessimism and anxiety, all add up to the concept of mental suffering. In that case, we are dealing with a subjective approach to a concept that is, at best, poorly defined. In addition, this view is destined to meet with a strong refute – if we are to grant euthanasia based on subjective experience, shouldn't we allow it to everyone, regardless of their condition and irrespective of any "objective" indicator?

Such discussions reveal a profound lack of clarity when it comes to concepts like 'mental suffering' or 'mental pain'. So, to avoid obvious objections, one should address the involved issues more seriously. In specific, if we are to support euthanasia of depressed patients, we must show that intolerability of their pain is equal to or worse than that of terminally ill patients, or their life as burdensome as that of patients with severe physical disabilities, i.e. quadriplegics. The burden of depressed patient's life does not appear to be anywhere near to what people with quadriplegia, multiple sclerosis or ALS experience, not being able to move or perform even the simplest motoric functions. Therefore, using the "argument from mental pain or suffering" in order to justify voluntary euthanasia can be done only if we assume that the severity and intolerability of pain in cases of depression are comparable to severity and intolerability of pain of terminally ill patients (or that lives of patients in these two cases are comparably burdensome). There is, however, no evidence suggesting that the assumption about pain or suffering comparability is correct. For that particular reason, advocates of granting voluntary euthanasia to depressed patients should consider building their case on more plausible assumptions.

Opposed to their view, some authors like Bonnie Steinbock (2017) suggest that the restriction of euthanasia to physical illnesses is a consequence of trivializing the suffering that depression brings, stating that "the suffering imposed by psychiatric conditions is often regarded as less severe than that caused by physical illness" (p. 32). In support to her view, Steinbock states that the suffering of people with depression is commonly considered similar to feeling a bit bad. However, it is hard to imagine that any critical attempt at arguing against the severity of mental suffering is, or will be, based on the assumption that depression is not a serious disorder. Moreover, since there almost exists a consensus among the scientific community regarding the seriousness of the depressive disorder and its symptoms, the debate is focused on the severity of suffering. Bearing this in mind, it is unclear who, if anyone, is the target of Steinbock's argument. It seems that she is, either intentionally or otherwise, misinterpreting counter-arguments and replacing them with ones much easier to refute. On first impression, her argument may seem convincing, but she is in fact attacking a *straw man* and thus avoiding the hard issue – i.e. whether the suffering and burdensome life of depressed patients is comparable to pain in physical illnesses or life quality of severely disabled patients.

3.4. Rational Decision-Making Impairment

The fourth criterion demands the person's voluntary wish to die or, more specifically, that the request for euthanasia come from the patients themselves. Moreover, the relevant desire needs to be enduring (persist through time) and competent. Since competence is one of the necessary conditions for voluntary decision-making, this obviously requires a decision-making ability on the part of the patient. However, this requirement does not apply to *all* decisions people make but only to the ones regarded as rational. For instance, patients who are able to speak and articulate their thoughts are typically able to make decisions – but not necessarily rational and considered ones.

Those who generally lack the ability to make rational decisions, as is typically the case with children or adults with severe cognitive impairments, depend on those who are able to make such decisions for them. Even the proponents of granting euthanasia to the severely depressed,

such as Steinbock (2017), agree on this point (p. 34). If we look at The Belgian Act of Euthanasia, we will see that this act explicitly requires that the requests for euthanasia come from patients themselves. However, in cases of patients lacking decision-making competence, there is no way a request for euthanasia can be lawfully made. It seems as if the creators of the Act were not concerned with this aspect at all. From my point of view, the Act does not adequately address the patient's ability for making such a decision (e.g., by prescribing standard testing procedures). The only requirement are the physicians' or psychiatrists' opinions of the patient's competence, which, no matter how professional, are still subjective. In other words, it is fully conceivable that a psychiatrist or a physician fail to identify – or choose to ignore – certain impairments to the patient's cognitive abilities. If so, granting such patients euthanasia actually boils down to 'demanding' a rational decision from a person who apparently lacks the required competence, and that would be a clear violation of the ethical principle "Ought implies can".

So, the critical question is: Can patients suffering from severe depression be considered as able to make the required decision – about terminating their life – by themselves? Intuitively, and most certainly, they cannot. This becomes clear already by looking at the main symptoms of depression – decision-making difficulties, thoughts of death and suicide, or suicide attempts, feelings of hopelessness or pessimism (National Institute for Mental Health, 2017). Although these symptoms per se cannot justify any conclusions concerning the patient's ability to make an end-of-life decision, and neither can our intuitions, it is plausible to say that the symptoms are likely to have some effect on such a person's attitude towards death and their ability to carry out a competent decision about dying. Precisely, if hopelessness and thoughts of death and suicide are confirmed symptoms of depression – and therefore treated as abnormal – how can a depressed person's wish to die easily and unequivocally be taken as a rational ground for a considered decision? It could merely be a manifestation of the symptoms. And even if it were not, it is far from clear whether the symptoms themselves could have amplified, and to what extent, the (potentially) existing and rationally founded end-of-life decision. Again, even the proponents of granting euthanasia to depressed patients admit that depression might affect patient's attitude toward death:

> In depression, things look bleak, and the prospect that things could change for the better seems remote or even impossible. Severely depressed individuals may not be able to appreciate the chances for recovery or remission. Anhedonia may make it impossible to imagine that life will offer any pleasures that will make it worth enduring the discomforts and indignities of medical treatment. Guilt and worthlessness may make individuals believe that suffering and death is deserved. (Steinbock, 2017, p. 35)

One of the patients who received euthanasia or assisted suicide for psychiatric reason told the researchers that "she had had a life without love and therefore had no right to exist" (Kim et. al., 2016 cited in Steinbock, 2017, p. 35). Consequently, Steinbock concludes that "such a statement is a red flag for distorted thinking, as opposed to a carefully considered, rational request to die" (2017, p. 35). The patient Steinbock refers to may not have been granted euthanasia, but there are similar cases involving statements that are comparably distorted, and people were still granted the right to euthanize themselves. A case in point is Laura (or Emily), a 24-year-old Belgian woman who was granted euthanasia few years ago. In an interview, when asked to explain her death wish, she makes the following telling statement: "Life, that's not for me" (Chan, 2015). This statement is telling because, instead of an elucidation as to the burden of her disorder or the pain she is feeling, we are offered an impulsive, emotionally aroused decision that Steinbock herself would most probably deem as distorted rather than rational.

In her article Steinbock (2017) also states that depression may not affect patient's understanding of the facts, but just their attitude towards life and death (p. 35). But if we agree that depression may affect patient's attitude towards life, making it seem worthless and hopeless, how do we simply dismiss the possibility of depression affecting the normal understanding of facts? I find this strange because people, among other sources and influences, base their values and attitudes on facts. Steinbock does not provide any additional evidence for her claim that cognitive and decision-making impairments selectively affect only patient's attitudes, but not their ability to understand the facts linked to their condition. Moreover, it could be argued that exactly the opposite is the case – if depressed patients were able to clearly understand the facts behind their condition, their attitude towards life and death would consequently change, at least in less severe cases. Steinbock does not mention or address this issue whatsoever. So the topic

remains controversial and can be resolved only by providing clear criteria for judging a person's decision-making abilities, i.e., whether they can rationally decide if they want to live or die.

The current research focused on cognitive abilities suggests that depressed patients have limited abilities when it comes to rational decision-making. One of the studies related to this phenomenon gathered medicated manic patients, depressed patients, and normal healthy controls and had them all complete a computerized decision-making task (Murphy et al., 2001). Both patient groups have shown significant impairments of decision-making abilities and cognitive abilities in general. The obtained results support the "growing consensus that manic and depressed patients are characterized by significant impairments in cognitive and particularly executive, functioning" (Murphy et al., 2001, p. 679). The results also suggest that a typically depressed person has not only weakened decision-making and cognitive abilities, but cognitive processing needed for controlling behavior as well (Malenka et al., 2009, p. 155). The term "executive functioning", according to Raymond Chan and his coauthors (2008), is an umbrella term for a variety of cognitive and behavioral processes which includes verbal reasoning, planning, problem-solving, the ability to sustain attention, multitasking, cognitive flexibility, dealing with novelty. The mentioned processes are called "cold" elements of executive functions because they do not involve emotions, but only rational mechanics and logic. Executive functions that include desires and sentiment, namely decision-making process filled with emotions, are called "hot" components. However, a patient's performance on executive functioning test does not have significant amount of predictive value. In other words, it cannot justify any conclusion concerning patient's performance on another test or in a real-life situation (pp. 201–202). Other authors like Adele Diamond (2013) differentiate lower and higher level of executive functioning skills, with reasoning, planning and problem solving being the latter (pp. 151–152). Cognitive functioning impairments are relevant because, as stated above, they can significantly affect numerous abilities linked with rational-decision making. If we take the cited study into consideration, it raises a serious amount of doubt about the rationality of the decisions made by depressed patients.

In addition, a study by Cella et al. (2010) on flexible decision-making revealed that patients suffering from depression show impairment in decision-making behavior in both static and dynamic environments. Impairments of flexible-decision making, given that "flexibility and adaptability to changing environments are essential for successful behavior" (p. 208), amplify these doubts, since it is dubious whether the patient suffering from impaired flexibility and adaptability can competently make a life ending decision, considering everything that a healthy person can. Studies like these suggest that depressed patients' relevant cognitive abilities are on a lower level than those of a healthy person and, therefore, provide strong arguments *against* depressed patients having the necessary competence for rational decision-making.

3.5. Theory of Weakened Rationality

It is not only psychiatrists and psychologists that show interest in the problem of rational-decision making impairments and impairments co-appearing with depression and other mental disorders. Philosopher George Graham, in his book *The Disordered Mind: An Introduction to Philosophy of Mind and Mental Illness* (2010), states that rational impairments linked with psychological disorders are very serious, making an analogy with a loss of a major limb. Impairments remove a crucial "something" required for a person to lead a decent life. He also points out that incapacitation regarding one's rationality should not be confused with failed performance:

> Humans have an underlying competence for rational decision-making, for instance, despite various common performance errors in reasoning (like committing the gambler's fallacy) and even if most of us cannot describe the rationality norms that govern our decisions. […] Poor performance does not imply disability or incapacity. (p. 132).

What Graham considers to be a general criterion for ascribing impairment is "whether a non-performer (or performer) can be persuaded by reasons for performance (or for non-performance)". If the person can be persuaded into performance, there is no need for attributing impairment. If the person could not be persuaded or stimulated to take certain action, regardless the reasons offered, we can expect impairment (2010, p. 132). In the light of some severe physical disabilities, i.e. quadriplegia, a patient who is completely paralysed from the neck down

could never get out of bed – considering his condition and impairment – regardless of the reasons for his rising, which is why we consider a quadriplegic impaired.

Mental disorders are different. Person suffering from depression, put in the same situation, may behave diversely. For instance, a depressed person might not get out of bed considering their normal everyday reasons for getting out of bed – preparing breakfast for children, taking a shower, the postman knocking on the door etc. But if a fire starts, they might not just get out of their bed but also run out of their house to save their own life. This is why Graham refers to the cognitive impairments in mental disorders as a "truncation and not obliteration". Not only does he argue to the effect that some kind of logic and rationality resides in depressed patients, or in people suffering from some other mental disorder; he also points out the "portion of continued or ongoing reason-responsiveness", concluding that rationality impairments in mental disorders are affected by contextual circumstances and parameters (2010, p. 133).

Given this theory, and the empirical data cited in the preceding section, it is possible to argue for serious impairments to the cognitive abilities and rationality in patients suffering from depression. It may also be inferred that healthy abilities and a full capacity rationality have a crucial role in a decision-making process, especially when serious, life ending decisions are at stake. So, we should conclude that the depressed patients are unable to deliver fully considered and rational decisions about their death, at least not as competent as their mentally healthy counterparts are able to do. On the contrary, following Graham s example, it is possible that mentally ill people are aware of the consequences regarding euthanasia and that their will somehow results from the logic and rationality still available to them. In other words, since their logic and rationality is not obliterated, it is possible that the request for death is not as ultimately irrational as opponents of euthanasia would have it.

4. The Paradox

Upon analyzing the criteria set in the *Stanford Encyclopedia of Philosophy* we can categorize them in two groups: the first group of criteria has to do with the mortality, curability and the suffering in depression (i–iii), while the second one regards the patients' competence of making rational and considered life-ending decisions (iv). When assessing the justifiability of euthanasia under these two groups of criteria, a certain paradox occurs. This paradox is nicely displayed in the following citation:

> The more severe the depression, the greater suffering imposed and the more justifiable the offering of PAD. At the same time, the more severe the depressive disorder, the greater the likelihood that decision-making capacity is impaired and the less justifiable it is to provide PAD. (Broome and de Cates, 2015, p. 586–587; cited in Steinbock 2015, p. 36)

Accordingly, Matthew Broome and Angharad de Cates argue that "it is very unlikely that there is such a patient with TRD who is both competent to make decisions about ending their own life, and that the same individual has no prospect for relief of their suffering" (Broome and de Cates, 2015, p. 587; cited in Steinbock, 2017, p. 36). In other words, the two authors suggest that it is almost impossible for TRD patients to meet all criteria set forth for qualifying for, and being granted the right to, euthanasia. That is, qualifying for euthanasia under one group of criteria does not mean to satisfy the other group of criteria, which makes it very difficult to determine whether TRD patients should ever be granted the right to end their life voluntarily.

To find a way out of this paradox it is necessary to prove that there is a TRD patient who, with constantly and irreversibly experiencing severe pain and suffering, is nevertheless competent of making a rational and considered life-ending request for euthanasia. However, it seems that no author has provided such a proof. All attempts to justify euthanasia or to deem it morally unacceptable have failed in addressing this paradox properly. The proponents of voluntary euthanasia in psychiatry often focus on the first group of criteria, i.e. pain, suffering, longevity and (alleged) incurability of some mental disorder(s) or illness(es). While trying to prove that mental disorders can be as intolerable as somatic illnesses and conditions (like terminal cancer or quadriplegia) or even more unbearable, they totally ignore the fact that cognitive impairments are one of the essential characteristics of depression. Some authors, like

Steinbock (2017), actually refer to the impairment, but only briefly, just to conclude that pain and suffering in depression present a stronger argument for granting euthanasia rather than not granting it. Although I have – for methodological reasons – categorized the criteria for justifying euthanasia in two groups, the symptoms of depression in relevant cases do not appear separately. According to studies, cognitive impairments are highly related to depression and symptoms of pain, anxiety, worthlessness and suicide ideation. Selectively separating the symptoms or giving one group priority over the other is rather negligent, especially in cases of voluntary euthanasia – a type of euthanasia implying the patients' voluntariness and their ability to reach rational and considered decisions. Arguing in support of granting the right to or, even worse, practicing voluntary euthanasia without addressing patients' competence underlying the voluntary request is not only ethically wrong but also makes one blind to the previously mentioned paradox.

I see only two ways of dealing with the paradox: (1) to make sure that patients' rationality is not beyond the point of being able to make considered decisions, while experiencing irremediable suffering with no prospect of improvement (due to their condition); or (2) to conclude that more severe types of TRD, along with aggravating pain-related symptoms, also show significant and constant cognitive impairments. As to the first solution, it would require a counterexample and some kind of insurance that granting the right of euthanasia to a mentally ill patient will not violate the ethical principle "ought implies can". I can imagine two types of cases which would satisfy this requirement. In the first case – let us call it 'Type A Case' – a patient is somehow less affected cognitively, but still experiences unbearable symptoms of depression and has no prospect for relief or improvement. Hence, their death wish is undisputed in terms of rationality. In the second imagined case – let us call it 'Type B Case' – there is a temporary improvement in patient's condition. Let us further assume that the patient has experienced such improvement before and that the depression has always returned, which has led them to a decision to end the suffering. Since the Belgian Act on Euthanasia of May 28 (2002) requires at least one month in between a person's request for euthanasia and the very execution of the request, it is highly probable that a psychiatrist would thoroughly investigate and eventually estimate the strength of the patient's death wish and deem it either to be rationally based or an

irrational and impulsive act. In type A case, as Broome and de Cates suggest, there really is not much to discuss. If severe depression symptoms, which make the disorder intolerable and life not even close to decent, are always accompanied by serious cognitive impairments, then we ought to reject the possibility of granting these patients the right to euthanize themselves – at least regarding voluntary euthanasia. Even though I consider option (1) probable, especially if patients experience temporary remission and improvement, my guess is that this scenario would apply to a minority of cases. Therefore, the decision to generally grant euthanasia to depressed patients is, as it seems, a decision to ignore, at least to some extent, morally relevant facts and to subdue to political correctness.

Since some concerns about moral implications of letting a depressed patient suffer by denying them the right to euthanasia are expected, a debate on whether depressed patients should qualify for any (other) type of euthanasia is imminent. However, I will not argue other types of euthanasia further since this lies beyond the scope of the present thesis.

5. Conclusion

I hope to have shown that major depressive disorder and treatment resistant depression are serious and burdening mood disorders characterized by aggravating mental and physical suffering. Apart from that, it is hard to predict the outcomes of therapy, possible remission or remedy for patients. By all means, depression is a severe condition that, in many respects, requires the same attention as its somatic "counterparts". However, being a mental disorder, depression affects both cognitive and executive functions, causing significant impairments to the patients' rational decision-making ability. Since such impairments result in a truncated logic and a weakened sense of rationality, many authors – including myself – consider depressed patients to be less capable of delivering rational, considered decisions. Specifically, once their cognitive impairment and overall condition are taken into account, it is questionable whether depressed patients are capable of not only making competent, rational decisions about their death, but making rational decisions as such. Given that voluntary euthanasia's principal tenet, both in philosophy and legislative, is that the request for ending life must come from patients themselves, it is crucial to properly address the criterion of competence behind a patient's voluntary decision to die. Depressed patients show a significant level of cognitive impairment both in their executive functioning and their decision-making abilities. While some authors suggest that their rationality is only truncated but nevertheless extant, I argue that competent life-ending decisions among depressed patients are rare and the cases of morally justified euthanasia of such patients exceptional. Besides, if one considers the statistical and medical evidence, it becomes extremely hard to show how depression can meet the criteria regarding curability and tolerability of the condition.

Therefore, when approaching the issue of voluntary euthanasia of depressed patients, it is crucial to take the following circumstances into account: the disease is not terminal, and it does not usually lead to inevitable death; it is effectively treatable even in its worst forms, and it sometimes leads to a complete remission; the pain and suffering caused by depression is difficult to measure and declare more unbearable than the pain experienced by patients with terminal

somatic illnesses (e.g., terminal brain cancer); after adequate therapy is applied, depressed patient's life quality is typically higher than the life quality of a physically disabled patient.

In conclusion, I find voluntary euthanasia due to depression an extremely morally questionable practice. It is not only the weakened rationality of the depressed patients that makes the issue difficult; as the present thesis suggests, there are other circumstances that should be considered too. This is why the problem of any type of euthanasia due to depression should be approached with greater care, by focusing on accurate and morally relevant facts and data.

6. References

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