**MAiD in Canada: Appendix 2**
**Treatment Resistant Depression (TRD)**

The provision of Medical Assistance in Dying (MAiD) is under review in Canada with debate about access for patients with mental illness.

An amendment to the draft legislation eliminating the exclusion of people with mental illness was proposed by Senator Stan Kutcher, arguing mental illness is as real as physical illness, that it can lead to great distress and people taking their own life in any event.

In recent years in some European countries patients have accessed MAiD for Treatment Resistant Depression (TRD). The most notable cases have been younger women.

Arguments against this amendment express concern that people with mental disorders may be pressured to opt for death, essentially for the convenience of others and of services that are not adequately funded.

Some have argued that mental disorders are somehow immaterial in contrast to physical disorders. Major medical groups in response claim mental disorders are as physical as any other disorders.

The position adopted here is that mental illnesses are real illnesses. By this is meant that conditions like schizophrenia and manic-depressive illness involve physiological dysfunction and are not immaterial in some way, attitudinal, or simply distress.

Before 1980, mainstream psychiatry did not regard personality disorders or what used to be called neurotic disorders as biological illnesses. The Third Edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM III) published in 1980, attempting to bridge a divide between psychodynamic and biological psychiatry and claiming to be agnostic about the nature of mental conditions, collapsed distinctions between neuroses and diseases into the category of disorders.

Some of what are now called mental disorders involve conditions that have been traditionally viewed as underpinned by physiological disturbances as much any physical illness. Others do not. Disorders like schizophrenia and manic-depressive illness are as much brain illnesses as epilepsy. The personality disorders and neurotic disorders also coded in DSM III are not brain illnesses like epilepsy. If illness in the sense of physiological dysfunction is a key criterion for MAiD, a case can be made for excluding these disorders. But there is a complicating factor.

**Curability**

Bearing in mind the hazard of diagnostic imprecision, unlike other psychoses, schizophrenia has traditionally been viewed as incurable. (It is possible that a patient diagnosed as having schizophrenia might present to a doctor who correctly suspects the diagnosis is wrong and the patient can be cured).

Hardcore schizophrenia is now somewhat remediable. Patients with other psychoses can show complete recovery between episodes as much as patients with arthritis for instance.

Schizophrenia is at present declining in frequency for reasons that are unclear but probably link to an environmental factor such as lead (this illness was not present before the mid-nineteenth century).

Manic-depressive illness is an episodic illness with patients making a full recovery between episodes. A century of admissions to asylums before we had any treatments for either mania

or depression offer enough data to work out whether these conditions ever failed to recover. Essentially none failed to recover. Even the most severe psychotic depressions that had to be tube-fed recovered on average in 5-6 months, with fewer relapses than happen now.

TRD was an unknown concept before the advent of modern pharmaceuticals. The examples of Enduring Sexual Dysfunctions induced by treatment (See MAiD and PSSD) and the protracted withdrawal syndromes people trying to get off antidepressants suffer attest to the risks of treatments creating conditions that never existed before.

TRD is a retread of Treatment Resistant Schizophrenia (TRS). TRS originally referred not to a treatment resistant condition but a group of patients more likely to respond to clozapine than other antipsychotics. This was a polite way to tell doctors that giving their patients clozapine, which could not be safely given in high doses, would stop them poisoning patients, who as a result would benefit, sometimes significantly.

The radical step of stopping doctors poisoning patients is not an option with antidepressants in that several million Canadians now on them are simply unable to stop. Many of these patients do not benefit from treatment other than in so far it staves off withdrawal.

TRD is a marketing construct aimed at adding additional treatments to the mix the patient is already on. Pharmaceutical companies are using conditions their products have created to market yet further products that far from alleviating the index conditions are more likely to aggravate the problems, which companies will use to create further markets.

**MAiD and TRD 1**

The group of conditions subsumed under the heading of TRD are a set of serious and incurable physical illnesses.

They are the physical consequences of treatments some of which are given for mental disorders (personality disorders and neuroses) and others for physical conditions.

The distress TRD causes appears to be as intense as is the distress caused by conditions that have hitherto led people to seek out MAiD.

There are at present no clear prospects for a cure of the condition or for relief from distress.

**MAiD and TRD 2**

There have been concerns that people may be pushed toward the irrevocable step that is MAiD because families or the State do not offer supports that might make a difference and these supports are less likely to be developed if MAiD is made too easy.

TRD suggests another factor should be considered.

These conditions result in part because the entire medical literature on on-patent drugs is ghost-written and there is no access to the data from healthy volunteer and clinical trials that were undertaken to bring these drugs on the market.

The data make it clear that these conditions were foreseeable. With access to the data the conversations between doctors and patients would likely have been quite different.

The core issues are laid out in a Healy lecture for the Therapeutics Initiative on Feb 10th, the video of which, along with text and slides can be accessed here:

https://davidhealy.org/sex-and-evidence-based-medicine/

Senator Kutcher was an ‘author’ on a famous study of paroxetine given to adolescents commonly referred to as Study 329. The paper was ghostwritten. It is unlikely Dr Kutcher has had access to the trial data other than the patients he himself entered into the study. Study 329 led New York State to file a fraud action against GlaxoSmithKline, the makers of paroxetine, and in 2012 the US Department of Justice to take an action against GlaxoSmithKline that resulted in the then largest sum handed over to resolve a corporate case of this kind - $3 Billion (USD).

The process of ghostwriting articles and sequestering clinical trial data began in earnest a little over 30 years ago and since then the time between doctors becoming aware of and generally accepting the hazards of their treatments has increased from roughly a year to several decades. The aggressive marketing of TRD meanwhile makes it very difficult for anyone now to recognize these conditions for the treatment induced conditions they are.

In the case of adolescents given antidepressants, there have been 30 trials undertaken all negative, but mostly portrayed in the medical literature as positive, with the trial Dr Kutcher was involved in being the most striking example of a negative trial of an unsafe drug that was written up as effective and safe.

The upshot of this is that on the one hand we have the greatest concentration of Evidence against a set of treatments ever assembled but those treatments are now quite possibly the second most used drugs by adolescent girls who are unlikely to benefit and highly likely to be harmed.

This is the group of patients with ‘mental illness’ now most notably accessing MAiD in Europe. Young Canadian women with TRD, put in this position at least in part by practices that prioritize commercial considerations over scientific, moral or clinical considerations, are likely to turn to the same option. Any extension to current legislation should ideally address this question.

**David Healy MD February 17th 2021.**