

## **Depression and the Desire to Die – Implications for Medical Assistance in Dying**

Elyse Platt BAH, MA, MD  
Department of Psychiatry, Queen's University,  
Kingston, Canada

### **Introduction**

In June of 2016, Canada passed Bill C-14 which legalized Medical Assistance in Dying (MAiD) (Government of Canada, 2021). This year, the government has made changes to the eligibility criteria but continues to exclude Canadians whose sole underlying condition is a mental illness from accessing MAiD (Government of Canada, 2021). Some advocates argue that this restriction unjustly excludes those with mental illness from accessing a health care service that would relieve them of their suffering (Schuklenk & van de Vathorst, 2015). Others hold that, among those with mental illness, the desire to die is best understood as a symptom of the disease, rather than as a reasonable judgment about one's circumstances that would make MAiD appropriate (Appelbaum, 2017). How ought health care professionals to interpret MAiD requests among those whose sole underlying condition is a mental illness: are these autonomously made treatment decisions, or pathological symptoms of disease? This paper will focus in particular on the case of depression. This is partly because mental illness is a heterogeneous category, and depression provides a useful test case for the questions at issue here. Additionally, however, suicide is a symptom of depression, and this makes the interpretation of the depressed person's desire to die an especially pressing problem. Approaching this question will involve exploring concepts of capacity, authenticity, autonomy, rational suicide, and, finally, questions about what makes a life worth living. Although not exhaustive, these questions are at the crux of the matter and are questions health care practitioners must become familiar with if they are to make justifiable decisions about who is eligible for MAiD.

## Definitions and Preliminary Points

To begin, it is important to be clear on a few key definitions and preliminary points. On March 17, 2021, changes to the Canadian MAiD legislation became law. A person who wishes to receive MAiD in Canada must satisfy the following criteria:

- be 18 years of age or older and have decision-making capacity
- be eligible for publicly funded health care services
- make a voluntary request that is not the result of external pressure
- give informed consent to receive MAiD, meaning that the person has consented to receiving MAiD after they have received all information needed to make this decision
- have a serious and incurable illness, disease, or disability (excluding a mental illness until March 17, 2023)
- be in an advanced state of irreversible decline in capability
- have enduring and intolerable physical or psychological suffering that cannot be alleviated under conditions the person considers acceptable (Government of Canada, 2021).

Furthermore, Canadians whose sole underlying condition is a mental illness, but who otherwise meet criteria, will not be able to access MAiD in Canada until March 17, 2023. The Government of Canada states that the temporary exclusion will allow the government to study how MAiD on the basis of mental illness “can be safely provided to ensure appropriate safeguards are in place” (Government of Canada, 2021). Thus, the question of how to interpret requests for MAiD among persons whose sole underlying condition is a mental illness is a particularly pressing question in Canada.

The *Diagnostic and Statistical Manual of Mental Disorders-5th Edition* (DSM-5) (American Psychiatric Association, 2013), the resource most widely used in mental health care in Canada, defines Major Depressive Disorder (MDD) as consisting of five or more of the following symptom criteria: depressed mood or anhedonia (either of these must be at least one of the symptoms), weight loss or gain, psychomotor agitation or retardation, fatigue, feelings of worthlessness or guilt, decreased concentration, and thoughts of death or suicide. In addition, symptoms must cause clinically significant distress or impairment, and cannot be attributable to any other kind of disorder (American Psychiatric Association, 2013, p. 160-161).

It is worth noting that the DSM-5 states that these symptoms need only be present for two

weeks in order for a person to be diagnosed with MDD (American Psychiatric Association, 2013). However, most advocates for access to MAiD where depression is the sole underlying condition wish to restrict access to MAiD to those who have *treatment-resistant* depression (Schuklenk & van de Vathorst, 2015). What counts as “treatment-resistant depression” (TRD) is a contentious topic in its own right and beyond the scope of this paper (Centre for Addiction and Mental Health [CAMH], 2020). However, the Council of Canadian Academies (CCA, 2018) Expert Panel describes “treatment-resistant,” in its broadest sense, as referring to “situations in which symptoms of a person’s mental disorder have not been meaningfully reduced following a certain number or type of treatments under appropriate conditions” (pp. 39-40).

To sum up, what we have in mind is a person suffering from five or more of the above symptoms, for whom multiple attempts at treatment have not meaningfully reduced their symptoms, who desires to die, and asks for MAiD as the means to this end. Disagreement remains on how to interpret this desire to die in the context of TRD. The CCA Expert Panel puts the problem in the following terms:

The Working Group disagrees about whether it is possible to have a valid and reliable method of distinguishing between individuals who have made an autonomous, well-considered decision for MAiD [where a mental disorder is the sole underlying condition] and individuals whose desire to end their lives is due to suffering [that] is pathological, and due to a symptom of their mental disorder (CCA, 2018, p. 197)

This phrasing of the problem suggests that there are two different kinds of people with mental illness who may request MAiD – those who have made an autonomous and well-informed decision, and those whose desire to die is pathological. The problem is in distinguishing between the two. To be clear, the focus of this paper will not be to address the ethics of MAiD requests or providing MAiD in general, but, rather, how to interpret requests for MAiD from someone whose sole underlying condition is depression.

Part of the question here regards whether or not suicidality can be distinguished from depression. The lifetime risk of completed suicide is approximately two percent for people with affective disorders like depression (Bostwick & Pankratz, 2000). Approximately ninety percent of people who die by suicide have a diagnosable psychiatric disorder (Cavanagh et al., 2003). However,

suicidality is associated with disorders other than depression such as schizophrenia, substance use, and personality disorders (CCA, 2018, p. 42). In addition, some suicide occurs in the absence of mental illness. A community study by Fairweather-Schmidt et al. (2009) found that people can experience suicidal thoughts and behaviours independently of depression (p. 213). However, even though suicidality can be distinguished from depression, it remains the case that desiring to die can be a symptom of depression, and thus the question remains whether we should interpret a request for MAiD from a depressed person as a capable and autonomous request, or as a pathological symptom of her disease. In the following sections, arguments for and against providing MAiD where depression is the sole underlying illness due to reasons of capacity, authenticity, and autonomy will be explored.

## Capacity

For many, the question whether a person with depression should be eligible for MAiD relies on determinations of capacity. If depression affects capacity, then the desire to die cannot be understood as a capable, informed, and autonomous request, but should instead be seen as a pathology of the disease. In Canadian law and healthcare, all adults are presumed to have capacity to make medical decisions, and the burden of proof is on the one who challenges the presumption of capacity to prove that it is lacking (CCA, 2018, p. 56).<sup>1</sup> The physician or healthcare practitioner who is proposing the treatment is responsible for determining whether or not a patient lacks capacity to consent to that treatment. Learning to assess capacity is a skill set that requires training and clinical experience. To assist in this process, there are several different tools for physicians to use, including the MacArthur Assessment Tool. In general, a person is thought to have capacity if they fulfill the following four criteria:

1. Understand information relevant to their situation;
2. Appreciate the situation and its consequences;
3. Reason about treatment options;
4. Communicate a choice (Appelbaum, 2007, p. 1836).

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<sup>1</sup> I will note here that the terms “competence” and “capacity” are often used interchangeably in the literature, as well as in medical practice, and I will continue to use them interchangeably in this paper.

The MacArthur Criteria is an example of how capacity assessments are typically performed in healthcare. Limitations of current capacity assessments will be discussed later in this paper. However, the bottom line is that if depression is found to impair any of those four criteria, then it would entail that a person with depression would not be eligible for MAiD in Canada.

Some argue that there is evidence to suggest that depression does in fact impair capacity, and this gives us reason to exclude people with depression from MAiD. In the *MacArthur Treatment Competence Study III*, Grisso and Appelbaum (1995) found that in the measures of understanding, appreciation, and reasoning, as a group, patients with mental illness (depression and schizophrenia) more often manifested deficits than their counterparts in the medically ill and non-ill control groups (p. 169). The CCA Expert Panel also found that “depressed mood was found to be strongly associated with incapacity in patients with non-psychotic disorders” (CCA, 2018, p. 65). In a systematic review, Hindmarch et al. (2013), found that “the transition from simply understanding medical facts, to the actual application of those facts by an individual to their own situation, can be impaired in the depressed individual.” From this evidence, there is reason to believe that depression can impair a person’s ability to understand and appreciate her own situation, and apply medical reasoning to her own case, thus impairing capacity.

However, the evidence does not suggest that depression necessarily impairs capacity. In fact, Candia and Barba (2011) argue that most studies indicate that up to seventy-to-eighty percent of involuntarily hospitalized mental health patients are capable of making treatment decisions. Furthermore, we need to be careful not to equate mental illness in general with incapacity. Most studies indicate that capacity is more often impaired in those with psychotic disorders such as schizophrenia than in those with non-psychotic disorders (CCA, 2018, p. 65).<sup>2</sup> Dembo et al. (2018) argue that capacity must be assessed on an individual basis and “to exclude all individuals requesting MAiD for psychiatric illness in the absence of a terminal condition falsely implies that everyone in that category lacks capacity” (p. 453). Stewart et al. (2018) argue that “the presence of a mental disorder does not necessarily mean that a patient cannot provide informed consent and be eligible for MAiD if

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<sup>2</sup> Depression with psychotic features is a diagnosis in the DSM-5 (American Psychiatric Association, 2013, p. 186). However, this is a specific qualifier of the diagnosis of MDD and not all MDD has psychotic features. For the purposes of this paper, when I use the term “depression” or “MDD,” I am referring to MDD without psychotic features unless otherwise specified.

the mental disorder does not exert undue influence, impair voluntariness or capacity". Therefore, it is quite possible that a person may both experience depression and be capable. Thus, arguments against allowing those with TRD as their sole underlying condition to access MAiD on the basis of incapacity will not hold in the general case; it is possible that there are capable people whose sole underlying condition is depression who may wish to access MAiD. Nevertheless, resistance remains from some who argue that the altered cognition present in depression makes the desire to die in a depressed person necessarily pathological in a significant way.

### **Cognitive Distortions and Authenticity**

Although depression may not always affect capacity according to the standard definition, there are some who argue that it leads to cognitive distortions which are significant for understanding the treatment decisions – including requests for MAiD – among depressed people. Sheehan et al. (2017) argue that “symptoms of cognitive distortions commonly occurring in clinical depression include a negative view of the self, the world, and the future, loss of hope, and loss of expectation for improvement” (p. 28). They argue that these cognitive distortions complicate assessments of capacity and propose that this should be an area of attention for psychiatrists in the future (Sheehan et al., 2017, p. 29). In an online study comparing the accuracy of participant’s future life predictions with their self-reported depressive symptoms, Strunk et al. (2006) report that participants with higher scores of depressive symptoms were more likely to have a pessimistic bias in their future predictions, and that their predictions were actually less accurate than their counterparts with fewer depressive symptoms (p. 876). These findings suggest that depression distorts one’s view of reality and, therefore, we ought to be careful how we understand wishes expressed by the depressed person, such as the desire to die, because they may be the outcomes of the pathology of the disease, rather than an accurate view of the world.

The desire to die in particular may appear to be rooted in cognitive distortions present in depression such as negative self-worth and hopelessness. In an article discussing depression and competence to refuse psychiatric treatment, Rudnick (2002) argues that standard capacity assessments are not sufficient to capture the cognitive distortion present in depression. He argues that our standard notion of competence is cognitively skewed, and consideration of emotion may be required to supplement it (Rudnick, 2002, p. 152). He says, “pervasive emotional states or moods impact on preferences by regulating their relative weights, and perhaps less commonly by generating

new preferences” (Rudnick, 2002, p. 153). Rudnick argues that because depression is associated with a pervasive mood, it may modify the preferences held by the patient. He suggests that instead of conducting a standard capacity assessment, as mentioned previously, the clinician should try to establish what the patient’s treatment preferences were before the depressive episode, and then try to determine if past preferences are consistent with present ones. If they are consistent, he suggests that clinicians should respect the patient’s treatment refusal. However, if inconsistent, he suggests that we ignore the current refusal, and attempt a therapeutic trial (Rudnick, 2002, p. 153). Although Rudnick’s argument focuses on treatment refusal among depressed patients, it can be extrapolated to cover treatment decisions by depressed people, since both refusing treatment and requesting treatment can be considered treatment decisions. Therefore, if his suggestion is to be taken seriously, we should be suspicious that depression is skewing the patient’s cognition, and thereby adversely affecting her decisions regarding treatment. Furthermore, if Rudnick is right, when assessing a depressed person’s request for MAiD, we should do our best to investigate her past preferences regarding MAiD prior to her depressive episode. If the patient expressed a desire for MAiD if depressed, prior to her depressive episode, and had a premorbid understanding of how depression might affect her cognition and preferences, then her preferences can be considered consistent. If not, then her MAiD request should be seen as a pathological feature of her depression and ignored in favour of further treatment for depression.

This “past and present coherence view” is problematic for a number of reasons. First, it seems to posit that there is some kind of “authentic self” underlying the depression which, once the depression is treated, will come back again. On the one hand, this view minimizes the significance of depression in a person’s life as it supposes that a person will go back to being the same person she was prior to developing depression. This view precludes the possibility that a person’s thoughts and values can reasonably change over time in light of new information, circumstances, and experiences. If a person were to develop cancer and then subsequently be treated, we do not require that she maintain the same thoughts, values, and feelings that she had prior her experience of cancer in order to respect her preferences regarding treatment. We would expect that her experience with cancer would shape her thoughts, values, and feelings and, therefore, her treatment decisions. As Schuklenk and van de Vathorst (2015) argue: “A TRD person’s authentic self is by necessity defined to a significant extent by her illness...but this does not render her expressions of her views any less authentic or less plausible” (p. 580). Even if a depressed person did not desire MAiD prior to her

depression, this is not a reason to think that her decision is inconsistent with her values and beliefs in light of what she knows now.

On the other hand, the “past and present coherence view” assumes that mental illness is significantly different than other forms of cognitive bias. What influences our decision making and behaviour is a huge, multidisciplinary question beyond the scope of this paper. We have no reason to believe that our decision making is ever entirely free from bias and distortion, but we hold each other accountable for our decisions anyway (Smith, 2018). It is not clear why the “past and present coherence view” regards depression as different from other kinds of cognitive bias or distortions. Hewitt (2013) responds to the charge that mental illness prevents a person from possessing cognitive coherence, autonomous reasoning, and accurate judgment by arguing that:

a much weaker claim is true, that people are likely to be influenced by their illness but that does not necessarily amount to coercion in all cases. It is arguable whether it is ever possible to be completely free of external influence on one’s thoughts and actions (p. 362).

Moreover, it is not clear that the kind of authenticity demanded by the “past and present coherence view” is ever possible or desirable. Gerald Dworkin (1988) argues that “If the notion of self-determination is given a very strong definition – the unchosen chooser, the uninfluenced influencer – then it seems as if autonomy is impossible” (p. 12). The MAiD criteria ask that the decision be voluntary and free from external pressures, but authenticity is not a requirement. Depression does influence and may even determine a person’s view of her reality (Schuklenk & van de Vathorst, 2015, p. 580), but this does not mean that it is necessarily problematic or an influence that should in all cases disqualify her from access to MAiD. For a person requesting MAiD whose sole underlying condition is depression, depression *is the reason* that she wants to die. Depression is very much at the centre of her decision making about MAiD, but it is not clear that depression shapes a person’s view of reality in a way that is significantly different from other sources of cognitive bias, or in a way that is more problematic.

### **Depression and Autonomy**

It may not ever be possible to determine if a medical decision is truly “authentic” and undistorted by cognitive bias. However, we do value autonomy in medical decision-making. Dworkin (1988)



argues that seeking informed consent for a medical procedure is an expression of respect for autonomy (p. 120). Therefore, if depression impairs autonomy, then we cannot regard the depressed person's desire to die as an autonomously formed decision and, thus, we may be skeptical that her request for MAiD is voluntary and made with informed consent. It is worth noting here that although autonomy is a very commonly discussed concept in health care ethics, it is a concept with many definitions and little agreement (Dworkin, 1988; Radoilska, 2012; Heal, 2012). One definition is autonomy as authenticity, with respect to which I have already provided reasons to be skeptical. Bolton and Banner (2012) agree that autonomy as authenticity is an untenable position to hold; however, they argue that when autonomy is understood as freedom to carry out one's own affairs, then mental illness can impair autonomy (p. 96). They argue that mental illness refers to an episode in which normal functioning is disrupted or lost, and to this extent, "the person is not being themselves" for reasons of illness (Bolton & Banner, 2012, p. 96). They argue that this disruption of the state of the self could be described as a loss of autonomy as authenticity but reject this view, finding the notion of autonomy as authenticity to be problematic (Bolton & Banner, 2012, p. 96). Instead, they offer a simpler explanation. They say that "people in an illness episode are not as they usually are" (Bolton & Banner, 2012, p. 96). Furthermore, the distress and disabilities fundamental to a mental disorder typically involve a loss of freedom to act. This constitutes a loss of autonomy, they say, not because of any outside interference, but because the character of one's inner state prevents one from carrying out one's own affairs (Bolton & Banner, 2012, p. 96).

There are two main objections to the argument depicted by Bolton and Banner. First, one could criticize Bolton and Banner for using a relatively thin view of autonomy in their argument. More importantly, however, their argument rests on a view of mental illness as "episodic". There is reason to believe that a person with treatment-resistant depression has a mental illness that is not episodic, but persistent. Returning to Schuklenk and van de Vathorst (2015), they argue that "People with TRD are not just depressed in the colloquial sense...they experience no joy in life and have not for a long time, and they *are right* to think that this will not change, based on everything that is known at the time of their decision making" (p. 581). This is part of the idea of treatment resistance: the depression has become the "new normal" for the person. Her life has become one of suffering, with no reason to believe that there will be an end to the suffering prior to death. In cases of chronic mental illness "psychological suffering...is not transitory, nor can it be said to reflect a distorted view of present reality

or future” (Hewitt, 2013, p. 363). If we accept Bolton and Banner’s narrative view of the self,<sup>3</sup> then we have reason to believe that the person with treatment-resistant depression is not simply going through an “episode.” Rather, the depression has become part of her narrative. Therefore, it does not make sense to characterize the TRD-sufferer as “not being herself” because of her illness – her illness is now a part of her self.

How this affects autonomy on Bolton and Banner’s view is unclear. They may argue that even if the depression is a particularly long episode, it is still the case that the person is not acting as herself, and she is, therefore, unable to make autonomous decisions. This sounds suspiciously like the autonomy as authenticity view. Alternatively, they may argue that even if depression becomes part of the narrative, it is still an internal force that does not allow a person to pursue her projects. Again, this sounds suspiciously like the autonomy as authenticity view because it assumes the person has some other projects outside of, and uninfluenced by, the depression. As Hewitt (2013) notes, “[p]eople with mental disorder are not the only group of persons who are influenced by the effects of illness – but these people would not usually be categorized as non-autonomous” (p. 362). Perhaps we have to accept that for a person with TRD, the depression does influence her choices, values, and worldview, but not as something that has distorted her authentic self, but something that has shaped her narrative.

### **Rational Suicide**

It might be helpful to look at this problem from a different angle. Thus far, we have been discussing cases where a mental illness – depression in particular – is a person’s sole underlying condition. However, mental illness is not an exclusion criterion for MAiD in Canada. A person who has *both* mental illness, such as depression, and a physical illness meeting the Bill C-14 criteria, may be eligible for MAiD. Indeed, there are patients such as this who have already received MAiD in Canada (Perreault et al., 2019). If our concern is that depression distorts a person’s cognition in such a way that it makes her request to die unacceptable for reasons of capacity, authenticity, or autonomy, then these concerns should also apply to the person who has a physical illness *and* depression, not only to the person whose sole underlying condition is depression. Thus, the real crux of the dilemma

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<sup>3</sup> Again, views of the self are many and controversial and it is beyond the scope of this paper to forward a particular view. I use Bolton and Banner’s narrative view of the self because it is internal to their argument.

appears to stem from judgments about suffering and whether the desire to die is understandable.

For Kant, the concept of “rational suicide” was a contradiction in terms (Kant, 1981). Many, like Kant, would question whether actively terminating life is ever morally appropriate or appropriately the role of the physician. Nevertheless, it would be an understatement to say that the debate has really taken off since Kant, and much of the underlying justification for the legalization of MAiD is that in some cases, the desire to die is understandable. Again, the focus of this paper is not to determine the moral rightness or wrongness of MAiD in general, but, rather, to address how to understand requests for MAiD where the sole underlying condition is depression. Matthews (1998) reflects that “[i]n a sense, the motive for all suicide is despair, the abandonment of all hope for the future.” He argues that the question about whether suicide can ever be rational becomes a question about whether or not such despair is justifiable. In the case of someone suffering from severe depression, he says, it is not. He argues “someone driven to take her own life for example, because of her belief that she is incapable of doing anything worthwhile, is almost certainly suffering from clinical depression – not because she is suicidal, but because nothing could rationally justify such an exaggerated sense of her own incapacity” (Matthews, 1998). Matthews is not the only one to point to tensions between depression and rationality. Conwell and Caine (1991) also argue that to make a “rational” decision about ending one’s life, a person cannot be “unduly influenced by mental disturbances such as depressive illness.” The kind of despair one experiences with depression is, therefore, not rational or justifiable.

It is worth noting at this point that to be eligible for MAiD in Canada, there is no requirement that a person’s suffering must be justifiable to other people. Suffering is a subjective interpretation of one’s experience that only the patient need deem intolerable (CCA, 2018, p. 75). Therefore, one would have good grounds to dismiss Matthews, Conwell, and Caine’s arguments as not being applicable in the Canadian context. Canadian patients do not need to justify their suffering or despair to anyone. Furthermore, Matthew’s characterization of the despair experienced in depression may rest on the common but unfounded assumption that suffering in the face of physical pain is more justifiable than suffering from psychological pain. In her paper “Why Are People with Mental Illness Excluded from the Rational Suicide Debate?” Hewitt (2013) argues that in discussions about rational suicide, psychological suffering is rarely given equal weight as physical suffering. Hewitt (2013) argues that mental suffering is seen as transient or caused by a weakness of character – a remnant from classic dualistic accounts of mind and body (pp. 360-362). Resistance to allowing MAiD where mental illness

is the sole underlying condition may be due to a poor understanding of psychological suffering and mental illness in general.

The fact that suffering is subjectively defined in the Canadian context is interesting. It speaks to an appreciation of procedural justice that is value neutral. We often like to think of ourselves as a “cultural mosaic” where a plurality of values can coexist harmoniously. In a similar vein, there is an underlying assumption that capacity assessments are content-neutral (Holroyd, 2012). The aim of capacity assessment is not to prevent patients from making bad treatment decisions per se, but only prevent decisions which flow from incapacity. This is because, in general, we want people to be free to pursue the good life and its contents as they see fit. That being said, there is reason to believe that capacity assessments are not in fact all content-neutral. For example, having insight into or appreciating one’s situation is value-laden, and depends on evaluative judgments about health and disease, and what good health involves (Holroyd, 2012, p. 152). Similarly, understanding information relevant to the context requires a person to assign relative weights to options and information. Holroyd (2012) concludes “[i]f over-valuing some option is taken as evidence that an individual cannot weigh information, some ‘unwise’ decisions will be relevant to ascertaining whether an individual meets conditions for capacity. Therefore, whether an individual’s values are unorthodox may be relevant to capacity” (p. 160). We should be careful not to mistake capacity assessments for a completely content-neutral exercise. In part, we are assessing a person’s values and judgements about her pursuit of the good life, or the decision to end it in this case. We may not always be incorrect in doing so, but it is important to highlight that part of the discomfort surrounding MAiD where mental illness is the sole underlying condition is due to a difficulty in understanding the worldview and values of the depressed person. This is a discomfort many do not feel when they consider MAiD in the context of suffering due to physical illness. In order to defend this position, a more substantive view of judgements regarding what makes a life worth living would be required. This may be particularly important when the treatment decision in question is the irreversible decision to end one’s life at the hands of a physician, and may prompt physicians to reassess a one-size-fits-all approach to capacity assessments across a variety of treatment decisions.

### **Concluding Remarks**

In this paper, arguments against allowing MAiD where depression is the sole underlying condition for reasons of capacity, authenticity, and autonomy have been explored and found wanting.

It is possible for a depressed person to make a capable decision about the desire to die. Asking for an “authentic self” unhindered by influences or biases like depression is neither realistic nor desirable. Furthermore, it is not clear how depression could be considered a threat to autonomy once we have abandoned the “authentic self” view. Finally, all of these concerns apply equally to the person who is depressed and to the person who has both a physical illness and depression. Hesitation regarding MAiD where mental illness is the sole underlying condition likely stems from discomfort regarding substantive disagreements about the good life and what makes a life worth living. Although there is a place for these arguments, we should be clear that they are value-laden, and not value-neutral.

Going forward, physicians and health care practitioners need to be clear about when and how they are making these judgments about what makes a life worth living, and how they interact with their patients’ values and preferences. If a physician is under the mistaken perception that her capacity assessments – along with her assessments about eligibility for MAiD – are entirely value-neutral, then she is doing a disservice not only to her patient, but also to herself and her own professionalism. When we make judgements about what makes a life worth living and, therefore, which lives should be eligible for assistance in dying, we are making substantive ethical claims with substantial ethical implications. Therefore, we need to be clear that what we are doing is not a procedural evaluation, but a substantive one, and put the work into doing this appropriately. If not, we allow suffering to continue without justification. A variety of larger issues are pertinent to this project. These issues include understanding the nature of mental illness, the self, and autonomy. In addition, many have pointed to the deficiencies in defining treatment-resistant depression and flaws in capacity assessments as they are currently performed. Finally, issues regarding value pluralism in liberal, democratic societies and justifying views of the good life are also central to understanding how to treat requests for MAiD. The question put by the CCA of how to reliably distinguish between those who have made an autonomous decision for MAiD and those whose desire to die is due to pathological illness has not been answered in this paper. Rather, there is reason to believe that these kinds of requests are not mutually exclusive.

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Address for Correspondence: 8emp1@queensu.ca

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