Depression in the context of a request for medical assistance in dying

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Learning objectives

- Understand the legal framework of medical assistance in dying in Canada and Québec
- Understand the concept of intolerable and enduring or constant suffering
- Discuss the concept of capacity in a context of mental illness

Background

At the federal level, the *Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, also called Bill C-14, was enacted in June 2016. It stipulates that medical assistance in dying may be administered to a person who requests it if they meet a number of criteria, including a grievous and irremediable medical condition, which is defined by the following:

- “They have a serious and incurable illness, disease or disability;
- They are in an advanced state of irreversible decline in capability;
- That illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
- Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.”

In Quebec, an *Act Respecting End-of-Life Care* was passed by a vote in the National Assembly in June 2014, and came into force on December 2015. The eligibility criteria differ in certain respects from those of the federal act. They are as follows:

- “Be an insured person within the meaning of the *Health Insurance Act*;
- Be of full age and capable of giving consent to care;
- Be at the end of life;
- Suffer from a serious and incurable illness;
- Be in an advanced state of irreversible decline in capability; and

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1 In addition to having a grievous and irremediable medical condition, the person “must be eligible for health services funded by a government in Canada; be at least 18 years of age and capable of making decisions with respect to their health; have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.”
• Experience **constant and unbearable physical or psychological suffering** which cannot be relieved in a manner the patient deems tolerable.”

We note that prognosis is approached differently in the two laws: The Quebec law refers to the “end of life” (a concept that is not clearly defined), while the federal act refers to “reasonably foreseeable death”. The difference in the use of the French terms “psychique” [in the Quebec law] and “psychologique” [in the federal law]² may be explained by the intention of the Quebec legislator to highlight the various possible aspects of suffering, whether psychological, spiritual, existential, etc. (Gupta 2017).

The Canadian legislator sought to exclude requests for medical assistance in dying based solely on suffering caused by a psychiatric pathology.³ In so doing, Canada adopted a position similar to that of Belgium and contrary to that of the Netherlands.

In the literature, it is estimated that the prevalence of depressive symptoms in cancer patients ranges from 15% to 50%. Five somatic symptoms were reported in more than half of cancer patients (several of which are also diagnostic criteria for major depressive disorder): fatigue, pain, loss of energy, weakness and loss of appetite (Rosenstein 2011). It is reported that 5% to 20% of cancer patients will meet the criteria for major depressive disorder at some point in the course of their disease.

Finally, in the general population, only 28% of patients treated for major depression experience remission with a single antidepressant. The remission rates decrease with each successive treatment failure, such that after four antidepressant trials, only 60% of patients would be considered in remission (Lipsman 2014). Therefore, as treatment-refractory depression is far from being an exception, it is pertinent to examine the ethical implications of this illness as relates to medical assistance in dying.

**Case description**

Mr. B. is a 55-year-old man. He has been divorced for about 15 years and has no children. He does not have any close friends. He worked as an IT specialist from age 21 to 45, but has been off work on long-term disability for 10 years due to treatment-refractory depression. Several classes and combinations of antidepressants have been tried, without much success. He is currently taking venlafaxine 375 mg, aripiprazole 15 mg and quetiapine 150 mg. He has never attempted suicide, but expressed suicidal ideation without a specific plan several years ago. On his current treatment, he continues to have residual signs and symptoms of depression: moderate sadness, social dysfunction and sleep often disturbed by nightmares, but his self-esteem and appetite are preserved, and his cognitive functions are intact. He does take pleasure in certain activities (fishing, reading, hiking).

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² Translator’s note : the English version of both acts uses the term “psychological”.
³ That being said, people with a mental illness are not explicitly excluded from the medical assistance in dying regime, but very few clinical cases would be able to fulfill the existing criteria (Department of Justice, 2016).
A few months ago, Mr. B. consulted his family physician for rectal bleeding combined with weight loss. Following investigations, a diagnosis of stage IV colon cancer with liver metastases was made. He was assessed by an oncologist, who recommended liver surgery (metastasectomy) followed by Folfox chemotherapy, a treatment with a 5-year survival rate of approximately 13%. He refused this therapeutic option and instead requested relief of his symptoms as they appear.

At his last appointment with his oncologist, Mr. B. requested medical assistance in dying, citing the suffering that he has been experiencing for years, which has worsened to the point of becoming intolerable since he was diagnosed with cancer. He has once again begun to suffer from terminal insomnia, has less and less energy and his appetite has declined. He has been experiencing constant intense sadness and feels no pleasure. He has no hope for the future and does not see any meaning in his life. He does not have a suicide plan. Apart from his lack of energy and appetite, he does not yet have any physical symptoms of his cancer.

Questions

1. According to the criteria set out in a) the federal law and b) the Quebec law, is this patient eligible to receive medical assistance in dying?

2. Should this patient be considered incapable to make such a request on the basis of his depression?

3. If a person asserts that his/her suffering is intolerable, should a physician be able to judge whether or not it is? If so, how?

4. Let us imagine the following hypothetical situation. The patient’s psychiatrist suggests treatment with electroconvulsive therapy, which has demonstrated good results in patients with treatment refractory depression. Mr. B. says that he has no reason to believe that this treatment would work when the others have failed and that he dislikes the idea of electroconvulsive therapy and refuses to try it. Does the fact of refusing an alternative treatment for depression – which might relieve his psychological suffering – mean that he should not have access to medical assistance in dying?

Discussion

Q1. According to the criteria set out in a) the federal act and b) the Quebec act, is this patient eligible to receive medical assistance in dying?

a) The Federal act

Mr. B. does indeed have an incurable illness, i.e. stage IV colon cancer. His medical situation is characterized by two distinct conditions. First, as described in the case, cancer is causing an advanced state of irreversible decline in capability. Second, major depression was already causing functional impairment prior to the diagnosis of cancer. Without having tried all the treatments, it is impossible to know for certain whether this aspect of his functional impairment is irreversible; however, the unsuccessful trials of several treatments in the past is not encouraging with respect to the efficacy of a potential new pharmacological trial (Lipsman 2014). In the case
of electroconvulsive therapy, the response rate is improved compared to patients without prior therapeutic failure. That being said, given the temporal relationship between Mr. B’s functional decline and his cancer diagnosis, cancer can be considered the predominant factor and the criterion of irreversible decline in capability can be considered to be met.

To determine whether his current situation causes him enduring suffering that is intolerable and cannot be relieved, it is necessary to start by defining suffering. Suffering occurs when a person interprets an experience as a threat to his/her integrity (Cassell 1991). It is not a sign that can be objectively observed, such as rectal bleeding, and it is experienced differently from one person to another. Suffering therefore does not depend on a diagnosis or a degree of severity. For example, we can imagine two individuals suffering from the same cancer at the same stage, one of whom has values or beliefs that will help him tolerate a degree of suffering that would be perceived as intolerable by the other individual who does not share those values or beliefs. In addition, although suffering has many dimensions, they influence and shape each other (Svenaeus 2014). Therefore, Mr. B’s suffering cannot be separated into distinct categories; the sadness that he is experiencing is being caused simultaneously by his major depression, by the loss of functioning associated with the physical symptoms of fatigue and loss of energy, and by the fact that he is aware that his symptoms and his functional state will only deteriorate.

In the literature, we note that intolerable suffering experienced by patients can be attributed to several problems: pain, weakness, functional impairment, dependency, being a burden, indignity, intellectual deterioration, perception of loss of oneself, loss of autonomy, being tired of life (Dees 2010). The intolerability of suffering stems from the inexorable decline experienced by the patient and the loss of hope that the situation will improve (Dees 2010).

Mr. B.’s suffering is enduring in the sense that it is continuous. It is intolerable in the sense that his condition is deteriorating and he does not believe that it can be improved. The loss of hope may be a depressive symptom; however, the reality of his condition (colon cancer) provides little hope apart from a treatment with a high risk of complications and a low probability of success.

Finally, the criterion of reasonably foreseeable death is met given the grave prognosis associated with his colon cancer.

b) The Quebec act

The criteria of enduring intolerable suffering and of serious and incurable illness, as detailed above, are met.

The difference compared to the federal act mainly concerns the question of prognosis. Mr. B.’s death is reasonably foreseeable; however, can we say that he is at the end of life, as required by the Quebec act? The exact prognosis would have to be known; however, given his diagnosis of advanced cancer and the decision not to try surgical treatment or chemotherapy, we can consider that he is at the end of life.

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4 The effectiveness of ECT in patients without prior therapeutic failure is 65% and diminishes to 50% in patients with known resistance to pharmacological or psychological treatment (Milev 2016).
In conclusion, Mr. B. could be eligible for medical assistance in dying according to the criteria of the federal act; in order for him to be eligible according to the criteria of the Quebec act, it would be necessary to more accurately determine his short-term prognosis without treatment in order to determine that he is at the end of life.

Q2. Should this patient be considered incapable to make such a request on the basis of his depression?

Let’s begin by defining capacity. According to the Nova Scotia criteria, the person must be capable of understanding and appreciating (a) the condition for which the treatment is proposed, (b) the nature and purpose of the proposed treatment, (c) the risks and benefits involved in undergoing the proposed treatment and (d) the risks and benefits involved in not undergoing the proposed treatment. It is also necessary to evaluate whether the patient is suffering from a mental illness affecting his/her ability to appreciate the consequences of making the treatment decision.

A diagnosis of major depression does not necessarily render a patient incapable. However, it is necessary to determine whether this depression is affecting his ability to understand and appreciate.

The influential MacArthur Treatment Competence Study addresses capacity by defining it in terms of four distinct abilities. This is helpful for carefully analyzing the case of Mr. B., in whom certain abilities are intact, while others are at risk of being affected because of his psychiatric pathology. The four abilities are: ability to state a choice, ability to understand the issues (including risks/benefits and alternatives to treatment), ability to appreciate the situation and its probable consequences (cognitively and affectively), and ability to reason with information. One way of evaluating and documenting Mr B’s capacity in greater detail would be to have him complete the MacArthur Competence Assessment Tool for Treatment, a 15-20 minute questionnaire that is used to determine whether he has these four abilities. (Appelbaum and Grisso 1995). However, these four abilities do not correspond exactly onto the legal capacity criteria in each province and territory.

In the case of Mr. B., it is first necessary to evaluate whether his appreciation of the consequences of each decision is distorted because of his major depression; for example, the cognitive distortions described in depression could be such that he sees only negative outcomes as possible (Soliman and Hall 2015). Appreciation requires that the patient apply the information to his own situation. However, in Mr. B’s situation, the prognosis is objectively grave; to consider it as such does not necessarily reflect a cognitive distortion, but rather an accurate appreciation of the situation.

Next, it is necessary to ensure that the cognitive symptoms associated with either the depression or the cancer (difficulty concentrating, comprehension problems, etc.) do not prevent him from

5 In the absence of legislation concerning competence (capacity) in Quebec, Quebec case law has relied on the Nova Scotia criteria set out in the Hospitals Act. However, depending on which Canadian province you are in, there may be criteria for capacity defined in the legislation.
clearly understanding the situation, i.e. his medical conditions (depression and cancer) and the risks/benefits of treatment alternatives, including non-treatment.

In summary, if his abilities to appreciate and understand are intact, his major depression is not a sufficient reason for declaring Mr. B. incapable.

Q3 If a person states that his/her suffering is intolerable, should a physician be able to judge whether or not it is? If so, how?

This raises the question of the subjectivity of suffering. Is it possible to evaluate the suffering of others? From a legal perspective, the fact that this is a criterion for eligibility that must be assessed implies yes.

Although an experience (e.g. suffering) can only be experienced by its subject, it does not necessarily follow that only this subject can have access to his/her experience in order to evaluate it (Wijsbek 2012). The subject obviously has privileged access, but it is possible for a third party (e.g. the evaluating physician) to have partial access to the subject’s experience, either through observations or from what the subject tells him/her about it. The physician must interpret the patient’s objective symptoms and losses in light of his/her own subjective point of view, which is influenced by his/her life experiences and personal values. If physician and patient share common life experiences and values, this would facilitate this interpretation, although it is not absolutely necessary (Kahn and Steeves 1986).

The criterion of intolerability of the suffering does not mean that it must concretely be impossible to tolerate. In fact, this criterion is rather a function of social norms which determine the point at which suffering becomes incompatible with leading a meaningful life (Wijsbek 2012). If need be, it would therefore be possible for a physician, within the confines of the legislation permitting medical assistance in dying, to determine that the suffering of a patient is not intolerable if the physician considers that it does not exceed this threshold (Gupta 2017).

This question addresses a different ethical issue from question 2. One of the objectives of C-14 is to establish a balance between two important ethical principles: autonomy and the protection of vulnerable persons. A person considered capable (which is a legal concept) could nevertheless request medical assistance in dying for suffering that physicians might consider not intolerable, in which case the person’s request would be denied (on the basis of the ethical principle of non-maleficence).

Q4. Let’s imagine the following hypothetical situation. The patient’s psychiatrist suggests treatment with electroconvulsive therapy, which has demonstrated good results in patients with refractory depression. Mr. B. replied that he has no reason to believe that this treatment would work when the others have failed and he dislikes the idea of electroconvulsive therapy and refuses to try it. Does the fact of refusing an alternative treatment for depression – which might relieve his psychological suffering – mean that he should not have access to medical assistance in dying?

This is question deals with two of the issues discussed above, namely capacity and the intolerability of the suffering.
First, it would be necessary to determine if Mr. B is capable – always bearing in mind that capacity is “task-specific,” i.e. that it is determined separately for each treatment (Neilson 2014). If Mr. B. understands the risks and benefits of electroconvulsive therapy and appreciates the impact of not receiving this therapy – that he is capable to refuse it, he cannot be forced to try it. It must also be pointed out that the fact that he is capable to refuse ECT does not mean that he is necessarily capable to consent to medical assistance in dying. His understanding of the side effects of ECT (anterograde amnesia, persistent cognitive impairments, etc.), is not necessarily affected and these effects are well documented in the literature (Lipsman 2014). However, we might suspect that Mr. B.’s ability to appreciate is affected when he says that he has no reason to believe that this treatment will work – indeed, electroconvulsive therapy has been demonstrated to have a response rate around 50% in patients with prior pharmacological resistance (Milev 2016).

Second, is it possible to say that suffering is intolerable if everything has not been tried to relieve it? In this case, the suffering results from the interaction between the depressive symptoms, the cancer symptoms and Mr. B’s current ability to cope with his illness. How much does each factor contribute to the intolerability? Even if Mr. B.’s psychological suffering is partly attributable to his pre-existing major depression and not to the medical condition that makes his death reasonably foreseeable, his depressive symptoms have worsened significantly since he was diagnosed with cancer and the onset of the associated symptoms, particularly fatigue and loss of energy. Therefore, we cannot reasonably assume that electroconvulsive therapy would be effective in relieving the suffering attributable to the new clinical situation.

Let us return to the wording of the federal and Quebec laws, which points out that the patient’s suffering, in addition to being intolerable, “cannot be relieved under conditions that they consider acceptable” (S.C. 2016) or “[…] tolerable” (R.L.R.Q. S-32.0001). Mr. B. considers the potential side effects of electroconvulsive therapy to be unacceptable. If his understanding of the situation and his appreciation are not affected, there is no reason why refusal to undergo electroconvulsive therapy would have an impact on his request for medical assistance in dying.

**Conclusion**

In conclusion, the case of Mr. B. raises several questions, both legal and ethical. To resolve them, we must attempt to strike a balance between the competing ethical principles involved, namely, respect for autonomy and dignity at the end of life on the one hand, and non-maleficence on the other, in the form of protecting a vulnerable patient from the consequences of such a request. In order to decide which of the principles takes precedence, an in-depth review of the situation is required. It will be necessary to carefully determine whether Mr. B. is capable of consenting to medical assistance in dying, particularly in terms of his appreciation and understanding of his situation, and whether we can really determine that his suffering is intolerable and that it is not the reflection of emotional or psychological vulnerability. If, and only if, these conditions are met, will respect for autonomy take precedence.
References


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