

# Considering MAID in Severe, Refractory Mental Illness

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# Disclosures

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- No financial disclosures
- Member of:
  - Physician Advisory Council, Dying With Dignity Canada
  - Joint Centre for Bioethics group and Mental Health Task-Force for MAID
  - Ontario Shores MAID Working Group
  - Physician Advocacy group, Compassion & Choices California

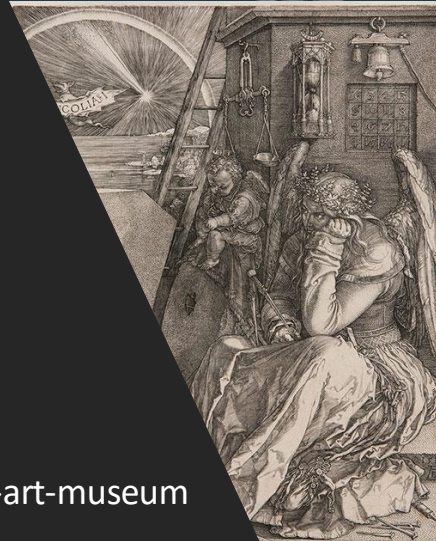
# Outline

- Brief Case
- Defining “refractory”
- Questioning “physical” vs. “mental” illness distinction
- Suffering is suffering
- The problem of “vulnerability”
- Three common arguments among psychiatrists
- Conclusions

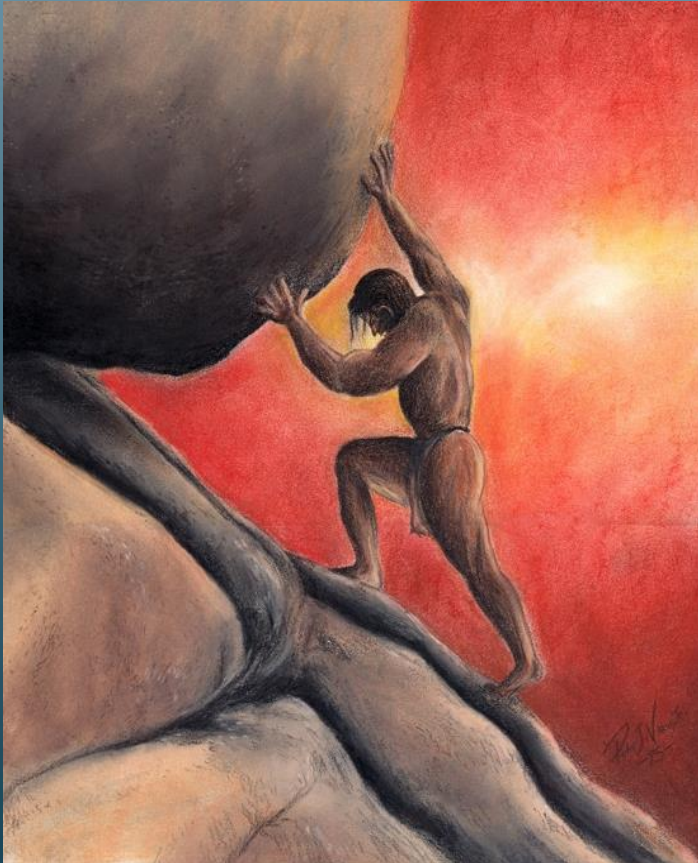
# Brief Case: Mrs. S.

- 84-year-old married woman.
- Severe MDD, chronic for 65 years.
- In constant mental agony. Multiple medically unexplained physical symptoms.
- Has failed all available treatments (over 30) including ECT x 2.
- Husband cannot care for her anymore.
- Capable, not cognitively impaired.
- Only prospect is chronic institutionalization.

Artwork: "Melencolia" engraving, Albrecht Durer. Available at:  
<http://www.mustdobrisbane.com/archives/five-centuries-melancholia-ug-art-museum>



# “Refractory” Mental Illness: Definition



## General:

Mental illness that does not respond to treatment.

*But:\* What kinds of treatments? How many? What duration? Time frame?*

- *Definitions in the literature differ widely. (Trevino K., et al. Defining treatment-resistant depression: A review of the literature. Annals of Clinical Psychiatry. 2014; 26(3): 222-32)*

# And With Respect to Carter:

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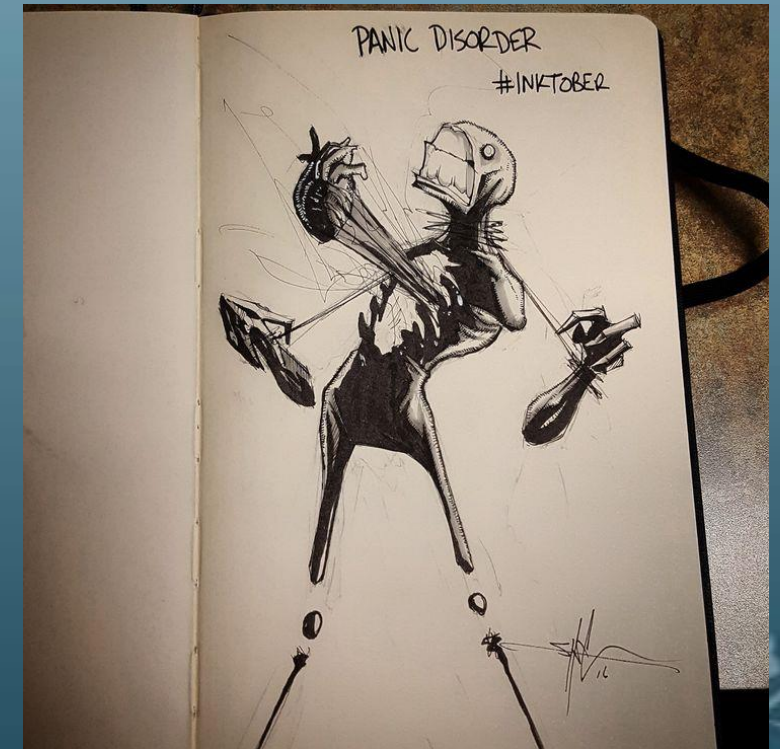
“Treatments acceptable to the patient” is problematic, because we can’t deem mental illness “refractory” without attempting a sufficient number, or sufficient types, of treatment.





# “Physical” vs. “Mental” Illness

- Impossible to separate.<sup>1,2,3</sup>
- Symptoms of mental illness can occur as a result of physical illness, and physical pain and disability occur as a result of mental illness.
  - Eg. “Trying to cut my heart out because it hurts too much.”
  - Eg. Patient E.F. in Alberta (conversion disorder)
    - Her request for MAID was granted, for physical symptoms due to a mental illness.<sup>4</sup>



1. Cassell E. Diagnosing suffering: a perspective. *Ann Intern Med.* 1999;131:531-534.
2. Rooney W, Schuklenk U, Van de Vathorst S. Are concerns about irremediableness, vulnerability, or competence sufficient to justify excluding all psychiatric patients from medical aid in dying? *Health Care Anal* 2017; full ref. not yet available.
3. Downie J & Dembo J. Medical assistance in dying and mental illness under the new Canadian law. *Journal of Ethics in Mental Health* 2016; Open Volume.
4. *Canada (Attorney General) v EF*, 2016

# Suffering is Suffering

- The reasons for requesting PAD in terminal physical illness are the same as they would be in non-terminal or psychiatric illness.
  - Inability to enjoy life; loss of autonomy; fear of burdening others.<sup>1</sup>
  - Illness-related experiences; threats to sense of self; fears about the future.<sup>2</sup>
  - Oregon 2016 Data:<sup>3</sup> Loss of autonomy 89.5%, decreased ability to participate in activities that make life enjoyable 89.5%, and loss of dignity 65.4%.
- Carter, and C-14 refer to “physical or psychological” suffering as legitimate reasons for MAID requests.

1. Li M. et al. Medical assistance in dying – implementing a hospital-based program in Canada. NEJM. 2017; 376(21):2082-8.

2. Vollman et al study cited in Pearlman & Starks 2004, p. 94, in Quill T & Battin M. (Ed.'s) 2004. Physician Assisted Dying: The Case for Palliative Care & Patient Choice. The John Hopkins University Press, Baltimore.

3. Published online at: <http://www.oregon.gov/oha/PH/ProviderPartnerResources/Evaluationresearch/deathwithdignityact/Pages/index.aspx>



# Defining Suffering:

*“A specific state of distress that occurs when the intactness or integrity of the **person** is threatened or disrupted.”<sup>1</sup>*



1. Cassell E. Diagnosing suffering: A perspective. Annals of Internal Medicine 1999; 131: 531-4.

# Who Is Most Vulnerable?

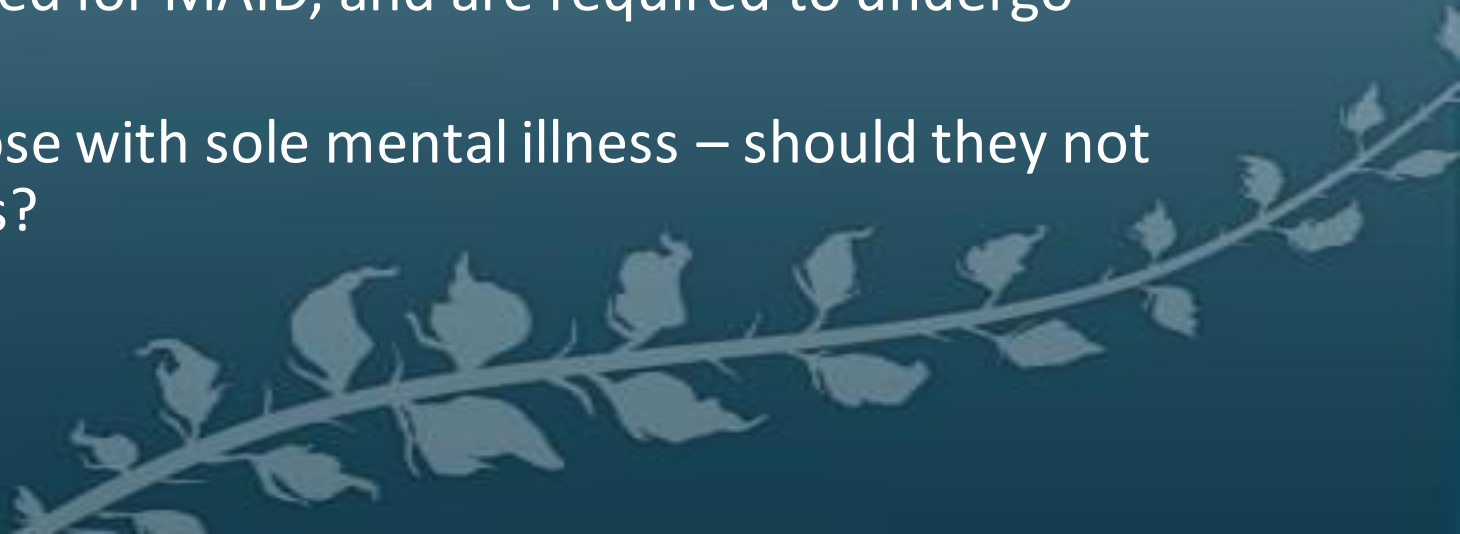
- **Common argument:** people with mental illness requesting MAID are more “vulnerable” than their physically ill counterparts.<sup>1,2,3</sup>
  - Psychosocial factors (isolation, poverty)
  - Cognitive distortions
  - Demoralization due to failed treatment attempts
- **However:**
  - Aren’t these factors present in both groups of patients?
  - Shouldn’t we then consider requests on a case by case basis rather than denying MAID to an entire population of patients?
  - Physical pain, like psychic pain, can compromise decision making and true informed consent; end of life desperation can do the same. In both situations, it is the individual that needs to be assessed.

1. Charland LC, Lemmens T, & Wada K. Decision-making capacity and consent to medical assistance in dying for persons with mental disorders. *Journal of Ethics in Mental Health*. 2016; Open Volume

2. Gaid KS. How mental illness complicates medically assisted dying. *The Globe and Mail*, 2016, Opinion, available at: <https://www.theglobeandmail.com/opinion/how-mental-illness-complicates-assisted-dying/article30193498/>

3. Guioy IM & Sisti D. Medical assistance in dying as an adaptive preference in individuals with mental illness. *Journal of Ethics in Mental Health*. 2016; Open Volume

# Who Is Most Vulnerable?

- Don't we render people more vulnerable still, and more stigmatized, by denying them the same rights afforded to individuals without mental illness?
  - What about comorbid mental and physical illness?
    - Those with both are considered for MAID, and are required to undergo capacity assessment.
    - This discriminates against those with sole mental illness – should they not receive the same due process?
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# Addressing Three Common Psychiatric Arguments: 1

“Suicide prevention and MAID are irreconcilable.”

## (Erroneous) Assumptions:

1. There is no difference between suicide and MAID
2. There is no such thing as rational suicide.
3. Psychiatrists cannot differentiate between impulsive and rational suicide.
4. There would be no requirement for the request to be “enduring” for patients with mental illness.
5. MAID means we devalue life.

## Rebuttals:

1. Suicide as we know it occurs during an acute episode, and is often impulsive. MAID is a well-considered request in a capable patient.
2. Suicide can be rational, in capable patients who face a very poor prognosis and enduring poor QOL.<sup>1,2</sup>
3. Psychiatrists differentiate between this already for MAID in somatic illness and in the ER. Trust our training.
4. Criteria for MAID already require that the request be enduring. We can create different/more stringent criteria in the case of mental illness.
5. MAID means we value life. We value QOL, the person’s values, and a good death. Availability of MAID increases quality of care.

1. Hewitt J. Rational suicide: philosophical perspectives on schizophrenia. *Med Health Care and Philosophy* 2009; 13: 25-31.)

2. Matthews E. Choosing death: Philosophical observations on suicide and euthanasia. *Philosophy, Psychiatry, & Psychology* 1998; 5.2: 107-11.

# Addressing Three Common Psychiatric Arguments: 2

“We abandon our patients by considering MAID (by even allowing it to be a possibility).”<sup>1</sup>

## Assumptions:

1. All patients derive comfort from psychiatrists who refuse to consider futility.
2. The role of psychiatrists is to never give up hope, no matter what.
3. All patients with severe, refractory mental illness should be expected to accept their current QOL even if no hope of improvement.

## Rebuttal:

1. Often, patients feel abandoned by physicians who refuse to acknowledge the possibility of futility. Acknowledgment of futility can strengthen the therapeutic alliance (protective against suicide).<sup>2</sup>
2. The role of psychiatrists is much more broad: accompany patients no matter what the journey; provide a connection, caring therapeutic alliance. Also hope can be harmful when false.
3. This relates to the “recovery model.” But surely just as in somatic illness, patients should be able to choose not to accept, if they are capable and rational.

1. Maher J. What troubles me as a psychiatrist about the physician assisted suicide debate in Canada. *Journal of Ethics in Mental Health*. 2016; Open Volume

2. Personal communication with Dr. Paulan Stärcke (psychiatrist), Netherlands, End-of-Life Clinic, August 2015



# Addressing Three Common Psychiatric Arguments: 3

“The desire to die is a symptom of depression; therefore it is always irrational in patients with depression.”

- **Rebuttal:**
  - We would not make a parallel argument for any somatic illness.
  - Denying MAID because the symptom that causes the request for MAID is part of the illness fails to recognize situations in which:
    - The patient is capable and rational.
    - The MAID request originates due to the fact that this exact symptom is refractory to treatment, and that the illness causing the symptom is refractory to treatment.



# Note on Appropriate Safeguards:

- Formally define “refractory.”
- Length of reflection period/time between requests.
- Duration of illness.
- Consistency of this requests with patient’s narrative and values.<sup>1</sup>
- Number of assessments and health care professionals involved.
- Detailed capacity assessments (as with somatic illness).
- Accountability.

1. Lachmann M. Capacity to consent to MAID. Journal of Ethics in Mental Health. 2016; Open Volume.

# Conclusions:

- We cannot necessarily differentiate between “pure physical” and “pure mental” illness.
- All requests for MAID derive from psychological distress.
- All requests for MAID are complex, and should be considered on an individual basis – not categorically denied to an entire group of patients.
- It is impossible to categorically state that all patients with mental illness are more vulnerable than all patients with physical illness.
- Considering MAID is not patient abandonment and does not undermine the role of psychiatrists.
- We are capable of developing appropriate safeguards.

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# Thank You!

