

ARTICLE

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Can the Depressed Appreciate the Choice to Die?

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Abstract

In this article, I argue that some irremediably depressed patients have the decision-making capacity to consent to medical treatment even when they want to die. These patients are said to have deficits in appreciative capacity because they lack insight into their condition. I argue that some patients have insight if they can cognize and articulate a range of future possibilities regarding their health. The argument requires a phenomenological lens. Phenomenology captures something fundamental about depression, such as temporal experience, which is needed for a more thorough assessment of capacity for medical assistance in dying (MAiD).

Résumé

Dans cet article, je soutiens que certains patients irrémédiablement dépressifs ont la capacité décisionnelle de consentir au traitement même s'ils veulent mourir. On dit que ces patients ont des déficits de capacité appréciative parce qu'ils manquent de compréhension quant à leur condition. Je soutiens que certains de ces patients acquièrent une telle compréhension s'ils peuvent connaître et articuler une gamme de possibilités futures concernant leur santé. Cet argument nécessite une lentille phénoménologique. La phénoménologie saisit quelque chose de fondamental au sujet de la nature des conditions psychiatriques, comme l'expérience temporelle, qui est sans doute nécessaire pour une évaluation plus approfondie de la capacité requise pour recevoir l'aide médicale à mourir (AMM).

Keywords: major depressive disorder; decision-making capacity; medical assistance in dying; phenomenology; narrative

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1. Introduction

There is some agreement in the literature on decision-making capacity (hereafter, capacity) that patients with major depressive disorder severe enough to elicit a wish to die cannot have decisional authority over their treatment options because they lack insight into their condition (depression).¹ The standard account of capacity includes four cognitive requirements, which a physician assesses when there are doubts about a patient's ability to provide informed consent: (1) *communicating* a choice — clearly indicating a preferred treatment outcome; (2) *understanding* the relevant information — grasping the fundamental meaning of information communicated by the physician, for example, side effects and symptoms; (3) *appreciating* the situation and its consequences — acknowledging the medical condition and the relevant consequences of treatment; and (4) *deliberating* on the pros and cons — engaging in a rational process of manipulating the relevant information (Appelbaum, 2007, p. 1836).² To have insight in the clinical context is to rationally *understand* and adequately *appreciate* how a medical condition impacts one's life, for example, how one's condition might respond to treatment.

Patients who suffer from depressive hopelessness might be unable to consider a positive treatment outcome despite treatment being well within reach (Sullivan & Youngner, 1994, p. 976). Such patients cannot imagine a world where their health improves, and they could be said to lack “appreciative insight” into their depression, i.e., how their depression will likely respond to treatment in the future. In this article, I consider what it means for a patient to be severely depressed — depressed enough to have a coinciding wish to die — and retain appreciative insight. I claim that a capable patient who wants to die can conceive of a world without depression, acknowledge that it is reasonably out of reach, and articulate this insight to a capacity assessor.

To defend my claim, I consider the extent to which a standard capacity assessment like the MacArthur Competence Assessment Tool (MacCAT) suffers from a cognitive bias, meaning it should be supplemented. My revision includes Matthew Ratcliffe's phenomenological study of depression, i.e., that there is a general sense of detachment from the world in depression, which he notes has a temporal aspect, and arguably reveals what is fundamental about depressive experiences in a way that other theories of capacity do not (Ratcliffe, 2015, p. 33). Further, I examine depressed patients' temporal abilities as they coincide with their narrative skills — for example, imagination — to show that some patients can conceive of a positive future despite this detachment.

According to Gareth S. Owen et al. (2015), even severely depressed patients retain temporal abilities, but a closer look at depression's underlying structure shows severe deficits in capacity. Structure is a concept in phenomenology referring to the

¹ Depression is defined in the DSM-5 (American Psychiatric Association, 2017) as having nine different symptoms, of which the patient must have five or more. These symptoms are (1) depressed mood most of the day, (2) marked diminished interest or pleasure in activities, (3) significant weight loss without dieting or weight gain, (4) insomnia or hypersomnia, (5) psychomotor agitation or retardation, (6) fatigue or loss of energy, (7) feelings of inappropriate worthlessness or guilt, (8) diminished ability to concentrate, and (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

² “Informed consent” concerns a patient's mental competence, i.e., a legal term arguably interchangeable with “clinical capacity” (Appelbaum, 2007, p. 1834).

non-causal essence of a thing, which emerges from a pre-reflective first-personal perspective (Husserl, 2013, p. 45). When this temporal structure is present, patients cannot compare possible modes of living in narrative terms (Owen et al., 2015, p. 177). Put another way, these patients might be able to answer assessors' questions about future outcomes superficially, but a "closed" future prevents them from navigating the possibility of things working out for them, thereby indicating reduced appreciative capacity (Owen et al., 2019, p. 373). I suggest that it is conceivable to have patients who *can* tell their stories about future outcomes — i.e., narratively articulate them despite having severe depression — because they have previously taken treatment seriously and have decided that they are likely to not respond to further treatment. Such patients' presumed unwillingness to consider things working out might be a reasonable response to the refractoriness of their condition. Assessors engaging in respectful listening might help stimulate such patients' sense of positive treatment outcomes, which could result in these patients imagining and articulating lives of preferred adequate quality, i.e., lives they would hope to have but for their depression. The implication is that depression's structure is not always all-encompassing and can make room for self-narrativity. Narrative is agent-relative and involves the self-directed way one tells the story of one's own life and comes to revise it when needed: "The device of self-narrative can free up individuals' imaginations without cutting them off from reality" (Meyers, 2004, p. 299).

2. Decision-Making Capacity and Mental Disorders

The MacCAT is the "gold standard" for assessing capacity (Charland et al., 2016, p. 4). Physicians could use the MacCAT if patients exhibit increased signs of confusion due to diabetes (Appelbaum, 2007, p. 1836). MacCAT assessments are usually straightforward and should take around 20 minutes to complete (Appelbaum, 2007, p. 1837).

Paul S. Appelbaum and Thomas Grisso's (1995, pp. 111–112) oft-cited MacCAT study shows that patients with mental disorders — for example, depression and schizophrenia — have decision-making abilities similar to those without mental disorders.³ Some researchers claim that Appelbaum and Grisso's findings are inaccurate because the MacCAT (a tool concerning cognitive abilities) leaves out context-sensitive features needed to accurately assess patient capacity, for example, emotions and values, especially in tricky or ambiguous cases of capacity (on capacity and emotions, see, e.g., Hermann et al., 2016). Those ambiguous cases include patients with mental disorders (Berghmans et al., 2004). The source of ambiguity is the cognitive criterion of appreciation, which is said to be unduly "narrow" (Tan et al., 2009, p. 346). The worry is that patients can appreciate in the narrow or cognitive sense but lack capacity because appreciation is compromised in other context-sensitive ways.

³ The original MacCAT study was conducted in psychiatric hospitals and community groups in the United States. The demographic characteristics include three socioeconomic groups (mostly poor), a median age of about 30 for schizophrenia and depression, and half of the sample being non-white for schizophrenia, 37% for depression, and 7% for angina (control group).

One way to explore the appreciative capacity, i.e., insight, of patients with mental disorders is to examine their wish to die in the context of assisted suicide, i.e., medical assistance in dying (MAiD).⁴ Depression is particularly contentious in the literature on capacity and MAiD because suicidal ideation can be a symptom; it is assumed that depressed patients who want to die should be treated instead of granted access to MAiD because the choice is a pathological expression of their condition (even if they “appear rational”). The concern is that the MacCAT cannot track the distortive influence of pathological feelings in depression — for example, hopelessness — which are feelings anchored in symptoms rather than accurate appraisals about the condition. This concern overlooks that some depressed patients are reasonably rather than pathologically hopeless due to repeatedly failing to respond to treatment (on treatment-resistance in depression, see, e.g., Seemüller et al., 2014).⁵ It is conceivable to think of patients whose insight into their chronic depression may have a constructive impact on perspective-taking. In agreement with Jeanette Hewitt (2013) and Ryan Tanner (2018), I think that the concern fails to consider that some depressed patients are rational in their choice to die and do not merely “appear” to be rational.

Putting aside the MacCAT’s empirical validity, there might be other grounds for revising the cognitive tool. In high-stakes cases of MAiD where patients might be vulnerable, assessors should take more time to listen to patients, i.e., focus on their stories, which might include considering context-sensitive features, such as emotions and values (on vulnerability, see, e.g., Lemmens, 2016; on listening to MAiD patients, see, e.g., Waring, 2019). However, I do not think that emotions and values get to the heart of the depressive experience. What is more fundamental than emotions and values is depression’s underlying structure, which is a general sense of detachment or alienation regarding one’s possibilities.

3. Ratcliffe’s Phenomenology of Depression

Phenomenological traditions are entrenched in varied historical contexts. Ratcliffe’s exploration of depression draws on phenomenological precedents such as Ludwig Binswanger, Ronald Laing, Edmund Husserl, and Alfred Schütz (Ratcliffe, 2015, p. 17). The phenomenal field, i.e., a direct experience of the world, does not negate causal frameworks of science or psychology but precedes them (Merleau-Ponty, 1962, p. 48). There is contention about what counts as phenomenological study, but Ratcliffe wants to grasp things as they are, their underlying reality or structure. Thus, he characterizes depression’s underlying reality as existential feelings, i.e., “variants of and changes in a ‘sense of reality and belonging’ that shapes all experience and thought” (Ratcliffe, 2015, p. 10). Existential feelings have different aspects,

⁴ This is active voluntary euthanasia, meaning physicians kill patients with, for example, lethal doses of morphine, rather than letting them die by withholding, for example, life support or ventilation. By “voluntary euthanasia,” I mean the patient communicates a wish to die due to grievous suffering resulting from an irremediable condition.

⁵ The psychiatric literature on depression as being irremediable is contentious (one might say there is always a potential treatment around the corner). The term “treatment-resistant” could be used instead, but I propose that a physician and a patient can draw a line in the sand when it comes to treatments left to try.

including “bodily discomfort, hopelessness, guilt, diminished agency, and altered temporal and interpersonal experience” (Ratcliffe, 2015, p. 33). These aspects refer to experiences of possibilities that imbue the world with meaning.

Ratcliffe explains that a depressed patient will experience an “erosion” of future possibilities (Ratcliffe, 2015, p. 66). This patient will not be enticed toward the world and the possibilities within that world. He writes, “Possibilities invite us to realise them, and perception lays out a course for itself” (Ratcliffe, 2015, p. 45). Later he notes, “To find oneself in a world is to have a sense of the various *ways* in which things might be encountered — as perceptually or practically accessible, as somehow significant, as available to others” (Ratcliffe, 2015, p. 51). The notion of enticement is perceptual and should not be thought of as being enticed to do something pleasurable. Enticement is how we are moved to accept the invitation of possibilities as we perceive the world. An object, for instance, pulls us toward it as we see it as useful, threatening, practical, and useable by someone else. A severely depressed patient is not enticed to discover the world; this is how Ratcliffe unifies the myriad causal accounts of depression. The pre-reflective loss of possibilities could provide the underlying structure for the multiplicity of depressive experiences in assessments of capacity if these experiences involve hard-to-pin-down existential feelings. Ratcliffe notes that the loss refers to a loss in ability and does not concern a specific kind of intentional thought or belief, i.e., it is not “about anything”; it is a general and hard-to-pin-down sense of losing the ability to be enticed (Ratcliffe, 2015, p. 34).

In depression, there is a change in existential feelings, which is existential change and alienates the patient from possibilities. Further, existential feelings in depression “can erode the ability to experience and entertain certain types of possibility, making some scenarios seem inevitable and others impossible” (Ratcliffe, 2020, p. E-1). He writes, “if one’s current existential feeling or *way of finding oneself in the world* renders one impervious to its own contingency and potential for change, this will inevitably impact on the capacity to make decisions that are explicitly concerned with manipulating the feeling in question” (Ratcliffe, 2020, p. E-7). For that reason, Ratcliffe believes that depressed patients who want to die cannot have capacity because they cannot consider an alternative future outcome (for example, they cannot imagine a world where they could respond to treatment). A capable patient must navigate the opposite being possible — this determines the patient’s “strength of conviction” (Ratcliffe, 2020, p. E-8). Ratcliffe believes that conviction forms the basis of capacity. Severely depressed patients presumably lack capacity and feel certain about dying because they cannot consider anything else.

Ratcliffe brushes aside the case of patients whose depression is refractory and says they likely do not have capacity. He notes that such patients have something comparable to partial capacity, which could be bolstered by a physician’s consensus regarding the clinical facts. He says capacity is partial because patients might have good reasons to want to die, but the “affective pull” of the possibility of treatment working for them is lacking (Ratcliffe, 2020, p. E-6). I have a different view. Some patients have the strength of conviction needed for capacity because they have taken treatment seriously for years and decided to draw a line in the sand with their physicians’ support. They might not envision treatment working for them because they appreciate that their condition is refractory. Further, under the right

conditions, they can imagine and compare modes of living during capacity assessments because their futures are not entirely closed.

4. Narrative and the Temporal Self

When determining appreciative insight, what is relevant are patients' experiences of their health, tracked in terms of the past and the eventual future, which they must be able to convey to their physicians. The standard account of appreciation requires patients to temporally project themselves, i.e., to anchor themselves in temporally oriented experiences of their health. Thus, some of the MacCAT's questioning already highlights the role of the temporal self, for example, "What do you believe will happen if you are not treated?; What do you believe is wrong with your health?; Do you believe you need treatment?" The MacCAT is a good starting point for determining capacity in cases of MAiD. However, Duff R. Waring notes, "There is a life story behind every wish to die, and that story can tell us much about a patient's response to suffering that clinical rating scales and inventories of symptoms will not" (Waring, 2019, p. 4). In order to capture the story of depressed patients, all of the relevant facts are needed, including an assessment of capacity and patient narrative.

What are MAiD patients' narratives conveying, and how should they be assessed? First, there is a difference between "narrative" and "story." John Paley and Gail Eva define narrative as a first-personal account of a causally linked sequence of events. A story is richer than narrative insofar as it has plots, thematic elements, characters, and a specific goal to elicit strong emotional reactions in the audience or reader (Paley & Eva, 2005, p. 83). All stories are narratives, but not all narratives are stories since they might lack the components required to be stories. A physician taking the time to get to know a patient's narrative in an "attentive and responsive" way might allow for exploring the details of that patient's situation, which uniquely belong to that person (e.g., Verkerk, 2015, p. 144). Narrative stories could inform physicians of their patients' motivations, whereas standard capacity assessments could only scratch the surface (Greenhalgh & Hurwitz, 1999; Waring, 2019, p. 3).

The narrative debate lies outside the scope of this article, but I agree with narrative theorist Marya Schechtman, who explains that behaviour "cannot be captured in purely naturalistic terms" (Schechtman, 2011, p. 398). We tell stories about our experiences, becoming "intelligible to ourselves and to others" (Schechtman, 2011, p. 396). Thus, she claims that narratives are integral to understanding the self. Diana T. Meyers notes that narrative is "the output of processes that mobilize a wide range of human capacities — skills that enrich human experience and provide material for stories and skills that enable people to compose insightful stories and to revise stories that prove to misrepresent their experience and understandings" (Meyers, 2004, p. 301). The narrative skill of imagination — although other narrative skills exist and are useful in capacity assessments, for example, Meyers' narrative skill set includes introspection and communication (Meyers, 2004, pp. 301–302) — might help assessors track depressed patients' appreciative capacities, e.g., "Imagine a world where treatment did work for you, what might your life look like?"

Catriona Mackenzie notes that autonomy can be explored in terms of imagined selves. She claims that we tend to over-rationalize autonomy and related mental

activities, such as self-reflection and self-understanding, meaning that the skill of imagination has been neglected (Mackenzie, 2000, p. 124). Putting the idea of autonomy aside, suppose that various concepts, including the clinical concept of capacity, are over-rationalized. She goes on to explain that in imagining, we have a point-of-view blending past, present, and future perspectives (Mackenzie, 2000, p. 125). She explains that imagining results in emotions, which result in “reactive emotions,” or emotional responses to the original emotions, and those reactions result in self-reflection. Self-reflection allows us to determine what really matters to us (Mackenzie, 2000, p. 136). Perhaps self-reflection emerging from imagination could help patients convey to their physicians what matters to them in capacity assessments.

The role of imagination in depression is salient given what we know about severely depressed patients and their temporal deficits, not only insofar as they have lost future possibilities but also as they might have memory problems — for example, being so enveloped by the depressive mood, i.e., existential feelings, that they cannot remember life before the symptoms worsened. Still, depressed patients should not have to remember life before their depression in a precise way for a capacity assessment to be successful. In other words, they need not recall with perfect accuracy what their life plans were like before their symptoms worsened, namely because longstanding depression may result in patients losing a sense of life without the condition, making a boundaries distinction otiose (on the lost sense of self in depression, see, e.g., Browne, 2019). Further, we know that depressed patients tend to have dampened emotional reactions, which might make the idea of reactive emotions leaning toward self-reflection unrealistic. However, there are cases of depressed patients who have expressed some affective pull toward what matters to them. For instance, according to a clinical case, Aaron, who suffered from anorexia and depression, conveyed to his physician that he could imagine his parents’ grief, which allowed him to grasp the extent to which his family mattered to him. Aaron did not receive MAiD but died of malnourishment in palliative care with the support of his medical team:

Throughout the course of his eating disorder, every family connection had felt fraught. He summarized his collective family’s response to this pre-terminal phase as, “They were very supportive. They recognize the gravity of this situation. They aren’t angry, sad but not fearful.” As he chose to spend his days talking with his parents and sleeping, he noted that he was thinking about others “rather than being so self-absorbed.” Imagining his parents’ distress made him sad, and he wanted his parents to keep getting support after his death. “This is one of the hardest things they’ve had to deal with in their lives.” (Gaudiani et al., 2022, p. 4)

Imagination can make room for creative thinking while still being fettered to reality, i.e., what family members have said about the patient, the patient’s clinical file regarding past treatment attempts, and the patient’s accurate appraisals about having chronic depression. Respectful listening and focusing on narrative skills in capacity assessments could help patients understand and appreciate what matters by reinforcing a widening of their temporal horizon. Gerben Meynen writes that the perception of future possibilities can be encouraged clinically by providing depressed patients

with new cues since much of this perception is limited by previous experiences (Meynen, 2011, p. 191). Physicians engaging in respectful listening might help to stimulate patients' perceptions of future possibilities so that they can imagine lives without depression and determine the extent to which they are out of reach.

To be able to confront a more open future could mean that some capable depressed patients will change their minds about MAiD (this outcome presumes that they have undergone a range of treatments and are given an option to "give it another go"). Or, these patients might decide that attempting further treatment will prolong their suffering, which they cannot endure (these patients recognize that they are unlikely to respond to another treatment, given their history).

5. Choosing to Die and the Temporality of Hope

Ron Berghmans, Guy Widdershoven, and Ineke Widdershoven-Heerding refer to the case of Janet to discuss hopelessness and MAiD. Janet had tried various treatments, i.e., psycho-therapeutic and medical interventions, but her symptoms did not improve, and she wanted to die. She did not prize anything in her life. She had no interests, joy, or hope for the future. Her psychiatrist eventually agreed to help her die (Berghmans et al., 2013, p. 440). Did Janet have existential feelings that profoundly changed how she was enticed toward the world and the possibilities within that world to the extent that she was so hopeless that she could not conceive of things ever improving in her life? Did she lack capacity if she did suffer from existential hopelessness? If we apply Ratcliffe's argument to Janet's case, she could not have capacity as she was not enticed by the pull of alternate outcomes (Ratcliffe, 2015, p. 13).

I think a patient like Janet can conceivably have capacity despite her hopelessness — the general feeling of not being drawn toward the future and what it has to offer — if she can articulate what her depression has cost her. She might not be ignoring within-reach treatment if she can appreciate the impact of the chronicity of her condition on her life, how it robs her of a life she would prefer to lead, etc. Hopelessness makes sense in such a case, considering the refractoriness of her condition (also, patients with mental disorders face other challenges, including institutionalization and unwanted side effects of drugs, all of which can reduce quality of life). The loss of possibilities with coinciding narrative skills could imply that the wish to die is not always pathological because the depression is not all-encompassing, i.e., so severe that the patient cannot even fathom life without depression. It is worth noting that Ratcliffe does not claim that all forms of depression are all-encompassing (Ratcliffe, 2015, p. 36). Thus, capable patients must be enticed toward a positive future to articulate their MAiD requests. It might seem unreasonable for there to be enticement and a wish to die. While wanting to die could indicate all-encompassing depression, since the wish to die can emerge from having a closed future, I think it is conceivable to have a case where there is some pre-reflective enticement toward the future but not enough for life to be meaningful.

Aurelia Brouwers' case can help illustrate all-encompassing depression and lack of enticement. Brouwers' physician and psychiatrist initially refused her request for MAiD. She eventually applied to the End of Life Clinic in The Hague. The approval rate is only 10%, and the application process can take years. She would eventually be

granted access to MAiD in her late twenties. In that last week of her life, one journalist notes:

“She was really not as stable during the day,” remembers Sander Paulus, the RTL Nieuws journalist who spent much of that last fortnight with her. “You just felt there was a lot of pressure in her head. She didn’t speak that well any more — except when we talked about euthanasia. She was very clear on that.” (Pressly, 2018)

Before consuming the lethal drug, she claimed in her final moments that she was ready for the journey and death.

What is noteworthy about Brouwers’ case is her inability to speak and communicate in the last weeks of her life. Given the deficits just noted, i.e., instability regarding being able to communicate the wish to die, this could easily indicate pathology (i.e., life is so bereft of hope that she cannot speak). Perhaps her request for MAiD should have been denied. Ratcliffe draws on Brouwers’ case to demonstrate clear-cut incapacity in depression (Ratcliffe, 2020, p. E-5).

There is a difference between Janet, a patient who communicated her wish to die at every point of the MAiD process, and Brouwers, who lacked the stability of choice needed for capacity. In both cases, there is a concern that having MAiD as an option can increase depressive hopelessness, motivating the wish to die (Berghmans et al., 2013). The opposite could also be possible. It might mean that having hopelessness caused by the unrelenting chronicity of one’s condition can serve as a backdrop for what I call “partial hope.” This hope is expressed toward a life of adequate preferred quality, one they would hope to have but for their depression. Physicians might be interested in helping patients articulate partial hopes to pinpoint what their condition has cost them and why MAiD is a reasonable option of last resort. However, Ratcliffe claims that one cannot be hopeful about dying. Hoping to die is impossible because death is the end of all possibilities; one cannot hope for nothingness (Ratcliffe, 2015, p. 113). What I am claiming is different. What MAiD patients hope for might not necessarily be death but relief from suffering insofar as they can imagine different possibilities about modes of living and the extent to which they are out of reach. If patients who have undergone various treatments over time eventually accept that their conditions are unrelenting, hope could be about a release from suffering as they have come to grips with what they have lost. The case of Adam Maier-Clayton illustrates my notion of partial hope. MAiD activist Maier-Clayton, diagnosed with anxiety, depression, Obsessive-Compulsive Disorder, and somatic symptom disorder, had been prescribed different medications and had tried various therapies with no significant symptom alleviation:

At this point in my life, I always thought I’d be on Bay Street or trying to get to Singapore to live in a commerce hub. I personally love life. I don’t want to leave. If I could snap my fingers and all these illnesses could be cured, we wouldn’t be sitting here today. (Xing, 2016)

While Maier-Clayton’s life was devoid of pleasure before committing suicide, he appreciated what life could have been without his mental disorders. If Ratcliffe is

right about a depressed patient's narrowed horizon of possibilities, appreciative insight in such a case, which requires one to envisage different future possibilities, seems unlikely. However, Maier-Clayton's story suggests that he was still drawn to the world in a limited or partial way because he could imagine a life of adequate preferred quality. He was a successful business graduate and athlete and he longed for that life while accepting that he lacked the motivation to pursue it as his suffering was too great and treatment failed to be effective. Thus, the loss of possibilities need not be all-encompassing when patients can demonstrate that they are at least partially enticed toward the world like Maier-Clayton.

That hope is filtered through the lens of mental disorder does not make it any less insightful. Margaret U. Walker refers to hope as having a future to value, i.e., having something to work toward in one's future, something to achieve (Walker, 2006, p. 43). In depression, this is a future to value from the perspective of an imagined life of preferred quality. If depression is chronic, hope is not efficacious, as Walker defines it, because suffering inhibits the activity of hope. That it will not be realized does not mean these patients cannot narratively articulate hope as a longing for what could have been. Aaron's case is noteworthy for illustrating the partial pull of hope toward his family life; it is partial as he is aware that his preferred mode of living cannot be realized. That it cannot be realized does not indicate failing to conceive of alternative outcomes, i.e., reduced appreciative capacity, since he has undergone various treatments and does not wish to continue (with his physician's support). Further, it is salient that Aaron's physician took the time to listen to his story to help him make sense of his decision, eventually providing him with the option of palliative and hospice care in his final weeks, rather than imposing tube feeding.⁶ Ratcliffe notes that capacity is not merely about individual ability; it also has an interpersonal dimension (Ratcliffe, 2020, p. E-10). That Aaron could share his story, demonstrating an openness to exploring possibilities, indicates appreciative insight.

Respectful and attentive listening by physicians assessing capacity could allow depressed patients to better envisage a range of temporal possibilities. Having a renewed sense of the future would allow them to gain some narrative control over their mental disorders. Such possibilities arise from the acknowledgement, the appreciative insight, that they have a depression that has not responded to treatment in a reasonable timeframe and, more importantly, that they have some pre-reflective partial enticement, or hope, toward the future; this enticement does not adequately improve their lives. Thus, capable depressed patients see MAiD as an end to their suffering through the lens of the lives they have lost, not a manifestation of suicidal ideation.

⁶ This was a patient who had tried different treatments over two decades. Aaron's last attempt at treatment was in outpatient care, which failed, as he eventually refused to eat altogether, only drinking water. Aaron initially told his doctor that he did not really want to die, but his anorexia was in charge. The doctor agreed, suggesting palliative care and hospice support to ensure he could live comfortably. Eventually, after consulting with a religious leader and with his family, Aaron was more certain about his decision, claiming, "It's time to do things only if I want them" (Gaudiani, 2022, p. 4). Aaron wanted to do this for himself and his family to process feelings of sadness and grief. He signed a Do Not Resuscitate (DNR) order and died of malnourishment two weeks later.

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