Psychosomatics 2016:▮:▮▮▮–▮▮▮ Published by Elsevier Inc. on behalf of The Academy of Psychosomatic Medicine.

Original Research Reports

Capacity Evaluations of Psychiatric Patients Requesting Assisted Death in the Netherlands

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Background: *Euthanasia or physician-assisted suicide (EAS) of psychiatric patients is legal in some countries but remains controversial.* **Objective:** *This study examined a frequently raised concern about the practice: how physicians address the issue of decision-making capacity of persons requesting psychiatric EAS.* **Methods:** *A review of psychiatric EAS case summaries published by the Dutch Regional Euthanasia Review Committees. Directed content analysis using a capacity-specific 4 abilities model (understanding of facts, applying those facts to self, weighing/reasoning, and evidencing choice) was used to code texts discussing capacity. A total of 66 cases from 2011–2014 were reviewed.* **Results:** *In 55% (36 of 66) of cases, the capacity-specific discussion consisted of only global judgments of patients' capacity, even in patients with psychotic disorders. Further, 32% (21 of 66) of cases included evidentiary statements regarding capacity-specific abilities; only 5 cases (8%) mentioned all 4 abilities. Physicians frequently stated that psychosis or depression did or did not affect capacity but provided little explanation regarding their judgments. Physicians in 8 cases (12%) disagreed about capacity; even when no explanation was given for the disagreement, the review committees generally accepted the judgment of the physician performing EAS. In one case, the physicians noted that not all capacity-specific abilities were intact but deemed the patient capable.* **Conclusion:** *Case summaries of psychiatric EAS in the Netherlands do not show that a high threshold of capacity is required for granting EAS. Although this may reflect limitations in documentation, it likely represents a practice that reflects the normative position of the review committees.*
(Psychosomatics 2016; ▮:▮▮▮–▮▮▮)

Key words: assisted suicide, euthanasia, decision-making capacity, mental health, Netherlands.

Euthanasia or physician-assisted suicide (EAS) is legally protected in the Netherlands, Belgium, Luxembourg, Colombia, Switzerland, Canada, and 5 U.S. states.[1,2] Although EAS is regulated as an option of last resort for the terminally ill in some jurisdictions,[3] other jurisdictions[4] allow persons with nonterminal, psychiatric illnesses to receive EAS (hereafter, "psychiatric EAS").

Although still infrequent, rates of psychiatric EAS have been increasing. In the Netherlands, an estimated 2–5 cases per year in 1997 rose to 56 cases in 2015.[5,6] In Belgium, neuropsychiatric cases (which include nonterminal neurologic and psychiatric disorders) have increased from single digits until 2007 to 101

Received June 1, 2016; revised June 23, 2016; accepted June 26, 2016.
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cases during 2012–2013.[7] Given that psychiatric disorders are widespread, often chronic, and frequently associated with a desire to die, the controversy over psychiatric EAS is unlikely to subside.

A common concern about psychiatric EAS is the issue of mental competence or capacity (decision-making capacity) of those requesting it.[8] This is because, although psychiatric diagnoses should not be *equated* with incapacity, some neuropsychiatric conditions are known to increase its risk. These include psychotic illnesses,[9] neurocognitive disorders,[10,11] some forms of depression,[12,13] anorexia nervosa,[14,15] and mental retardation.[16,17]

The capacity of persons with such disorders, therefore, requires careful evaluation. Historically, approaches to capacity relied on ill-defined concepts such as "unsound mind" and the presence or absence of clinical diagnoses, but these constructs have been replaced by modern function-based frameworks that assess capacity-specific abilities such as the abilities to understand relevant facts, apply those facts to oneself, reason and weigh the facts, and evidence a stable choice.[18] With abilities-based constructs, however, evaluating the capacity of patients is not always straightforward and is widely recognized to be a complex, challenging task.[18–20] Capacity evaluations are guided by these broad criteria even in complex clinical situations and are influenced by the criteria used[21] and personal views of assessors.[22]

An especially important issue in the assessment of capacity is where to set the threshold for capacity. It is widely recognized[23,24] that the threshold should reflect contextual normative factors, especially the risk-benefit context of the decision at issue. There is evidence that psychiatrists in fact make judgments consistent with this norm.[25,26] As psychiatric EAS involves a life or death decision, the question of where to set the threshold for capacity is particularly sensitive to the values underlying the practice.

The Dutch EAS law[27] requires a "voluntary and well-considered" request from the patient, which is interpreted to contain a requirement of intact capacity by the Dutch euthanasia review committees (Regionale Toetsingscommissies Euthanasia [RTE]) (Box 1).[28] The RTE uses a modern abilities-based construct: "Decisional competence means that the patient is able to understand relevant information about his situation and prognosis, consider any alternatives and assess the implications of his decision."[29]

Summary reports of a majority of Dutch psychiatric EAS cases are available online on the RTE

BOX 1: Brief Background on Euthanasia and Physician-Assisted Suicide Practice and Regulation in the Netherlands

The practice of legally protected euthanasia or assisted suicide has been in existence for several decades in the Netherlands, although formal legislation was not enacted until 2002 with the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.[27] Under the law, the Dutch regional euthanasia review committees (Regionale Toetsingscommissies Euthanasie [RTE]) review all EAS reports regarding whether the notifying EAS physicians (physicians who perform EAS) have conformed to the due care criteria which require that the physician performing EAS must:

a. be satisfied that the patient's request is voluntary and well considered;
b. be satisfied that the patient's suffering is unbearable, with no prospect of improvement;
c. have informed the patient about his situation and his prognosis;
d. have come to the conclusion, together with the patient, that there is no reasonable alternative in the patient's situation;
e. have consulted at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled; and
f. exercise due medical care and attention in terminating the patient's life or assisting in his suicide.

The RTE publishes a selection of their reports in order to communicate findings "important for the development of standards" and to provide "transparency and auditability" of EAS practice.[28] These reports often use informal clinical terms (such as "depression" rather than "major depressive episode") to describe psychiatric conditions in the reports, and this is reflected in our article.

EAS physicians usually seek independent consultation from SCEN (Support and Consultation on Euthanasia in the Netherlands) physicians[30] who are specially trained to assist colleagues in the EAS process. Most SCEN physicians are general practitioners, but some are psychiatrists. Sometimes EAS physicians seek second opinions from other colleagues in addition to the official EAS consultations.

In March 2012, a new organization called the End-of-Life Clinic (Levenseindekliniek) began to provide EAS to patients whose own physicians had declined to perform EAS. It consists of mobile teams made up of a physician and a nurse funded by Right to Die NL (Nederlandse Vereniging voor en Vrijwillig Levenseinde [Dutch association for a voluntary end of life]), a euthanasia advocacy organization. In 2015, this clinic accounted for 59% (33 of 56) of psychiatric EAS cases.[6]