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Euthanasia and Assisted Suicide of Patients with Psychiatric Disorders in the Netherlands 2011–2014

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Abstract

Importance—Euthanasia and/or physician assisted suicide of psychiatric patients is increasing in some jurisdictions such as Belgium and the Netherlands. However, little is known about the practice and it remains very controversial.

Objective—To describe the characteristics of patients receiving euthanasia/assisted suicide for psychiatric conditions and how the practice is regulated in the Netherlands.

Design and Setting—A review of psychiatric euthanasia/assisted suicide case summaries made available online by the Dutch Regional Euthanasia Review Committees, as of 1 June 2015. Two senior psychiatrists used directed content analysis to review and code the reports. 66 cases from 2011–14 were reviewed.

Main Outcomes—Clinical and social characteristics of patients, physician review process of the patients' requests, and the Review Committees' assessments of the physicians' actions.

Results—70% (46 of 66) of patients were women, 32% were over 70 years-old, 44% were between 50–70, and 24% were 30–50. Most had chronic, severe conditions, with histories of attempted suicides and psychiatric hospitalizations. A majority had personality disorders and were described as socially isolated or lonely. Depressive disorders were the primary issue in 55% of cases. Other conditions represented were psychotic, PTSD/anxiety, somatoform, neurocognitive, and eating disorders, as well as prolonged grief and autism. Co-morbidities with functional impairments were common. A minority (41%) of physicians performing euthanasia/assisted suicide were psychiatrists. 18 (27%) patients received the procedure from physicians new to them, 15 (23%) of whom were physicians from the End-of-Life Clinic, a mobile euthanasia clinic. Consultation with other physicians was extensive, but 11% of cases had no independent

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psychiatric input and 24% of cases involved disagreement among consultants. The Review Committee found one case to have failed to meet legal due care criteria.

Conclusions and Relevance—Persons receiving EAS for psychiatric disorders in the Netherlands are mostly women, of diverse ages, with complex and chronic psychiatric, medical, and psychosocial histories. The granting of their EAS requests appears to involve considerable physician judgment, usually involving multiple physicians who do not always agree (and sometimes without independent psychiatric input) but the Review Committees generally defer to the physicians performing the EAS.

Some form of assisted death (euthanasia or assisted suicide, EAS) receives legal protection in Belgium, the Netherlands, Switzerland, Luxembourg,[1] and Canada[2] as well as in several U.S. states.[3] Although the origins of legalization of EAS centered on terminally ill patients, many do not believe that the principles of autonomy and beneficence (relief of suffering) limit EAS to terminal conditions and argue that EAS should be extended to psychiatric conditions.[4,5] EAS for such persons in Belgium and the Netherlands[6–8] has received increasing attention.[9] The recent Canadian Supreme Court ruling permitting physician assisted death does not limit it to the terminally ill[2]; no such limit exists in Switzerland.[10] Although the numbers remain small, psychiatric EAS is becoming more frequent. In the Netherlands, a 1997 study[11] estimated that annual number was between 2 and 5; in 2013, there were 42 reported cases.[7]

Although the debate over psychiatric EAS typically focuses on persons with treatment resistant depression,[4,5,12] little is known about persons receiving EAS for psychiatric conditions. Aside from a 1997 report[11] describing 11 cases, there is one review of 100 psychiatric EAS requestors evaluated by a Belgian psychiatrist.[13] Further, requests for EAS to relieve suffering from psychiatric conditions require special scrutiny.[7] Psychiatric disorders contribute to suicides (a major public health problem[14]), can sometimes impair decision-making,[15] and are stigmatized.[16] Thus, the regulation of psychiatric EAS is of great interest, as courts cite evidence from countries with established practices.[2] In the US, the trend of legalizing physician-assisted death is already accompanied by discussions about broadening the practice beyond the terminally ill.[17]

Because of the Dutch system's commitment to transparency, summaries of a majority of cases of psychiatric EAS are available online.[7] (See Table 1) Our study sought to address two questions: One, what are the clinical, personal, and social characteristics of persons who receive EAS for psychiatric conditions? Two, how are the rules that regulate such EAS cases (Table 2) applied by physicians and by the Dutch euthanasia review committees?

METHODS

We reviewed all online reports identified by the Regional Euthanasia Review Committees (RTE) as psychiatric cases, available as of 1 June 2015. At that time, there were 85 reported cases of psychiatric EAS mentioned on the RTE website for years 2011–14 (13 cases in 2011, 14 in 2012, 42 in 2013 and 16 in 2014 without a final number for that year given), with 66 of those cases published online. (After completion of our study, on October 7, 2015, the total number of psychiatric EAS cases for 2014 was reported as 41[18] bringing the total

for 2011–2014 to 110. The RTE has changed their publication practice [Table 1] and this is reflected in only one more case from 2014 being published). Translations were obtained through the National Institutes of Health Library's Translation Services which uses companies to provide certified medical translations. Subsequent questions about specific passages were addressed by a Dutch-speaking member of the research team who further conferred with native Dutch-speaking academics.

The case reports were analyzed using directed content analysis.[19] The coding scheme was developed iteratively by a bioethicist-psychiatrist (SK) and a consultation psychiatrist (JP) as they independently read the reports, repeatedly comparing variables of interest in light of the main research questions of the project. SK read and coded all of the reports and JP confirmed the coding by reading through the reports again; discrepancies were resolved by discussion. The data were entered into SPSS 21.0 software. Analysis consisted of frequencies and ad hoc cross-tabulations, without hypothesis testing given the descriptive goals of the study.

RESULTS

Characteristics of Patients

70% of the patients were women, 32% were 70 or older, 44% were between 50 and 70, and 24% were 30–50 years old. The majority (52%) had made suicide attempts and 80% had been psychiatrically hospitalized in the past; many had multiple attempts or admissions.

Most patients had more than one condition (37 had at least 2, 11 had at least 3, and 4 had 4). Depressive conditions were the primary psychiatric issue in 36 cases (55%). Eight cases with depression had psychotic features; thus 17 of 66 (26%) patients had some form of psychosis. PTSD-related and other anxiety disorders were prominent (28 of 66 patients, 42%). Notably 4 persons (6%) had cognitive impairment; one patient (2014-83) had a legal guardian (but was judged competent by 2 independent consultants, including one psychiatrist). Four women had a chronic eating disorder with borderline personality disorder.

The nature of symptoms and suffering varied. There were patients with chronic, severe, difficult-to-treat depressions who had received repeated electro-convulsive therapy (ECT) treatments, with one patient (2012-26) even receiving experimental DBS (deep-brain stimulation; another patient [2013-04] with OCD received DBS). On the other hand, a woman (in her seventies without health problems, 2011-120044) and her husband had decided some years before that they would not live without each other. She experienced life without her husband (who had died a year prior) as a "living hell" and "meaningless." A consultant reported that she "did not feel depressed at all. She ate, drank and slept well. She followed the news and undertook activities."

The patients' psychiatric conditions were chronic. In 10 patients (15%), the duration of their illness was described qualitatively ('years,' 'decades,' or 'longstanding'). In the remaining cases, only approximations were possible. In 5 patients (7.6%) the psychiatric history was approximately 5 years or less, in 6 patients (9·1%) approximately 6–10 years, in 27 patients (41%) approximately 11–30 years, and in 18 patients (27%) longer than 30 years.

34 patients (52%) had personality-related problems, sometimes without a formal diagnosis but indicating significant impact on the EAS evaluation (e.g., “damaged development” resulting in “low tolerance for frustration” and “reduced ability to… cope”, 2014-77). Personality disorders were more common in persons under 60 years (66% vs 41%, Fisher’s exact test, p=0.05).

38 patients (58%) had at least one co-morbid medical condition; 22 patients (33%) had at least 2 co-morbidities; 12 patients (18%) had at least 3. The co-morbid conditions included cancer, suspected malignancy, COPD, cardiac disease, diabetes, stroke, status post brain tumor surgery, arthritis, orthopedic problems, chronic fatigue, fibromyalgia, migraines, neurologic disorders (stroke, Meniere’s, pain syndrome, Parkinson’s disease, diaphragm paralysis, gait disturbance), pancreatitis, medical complications of severe weight loss, vision loss, hearing loss, incontinence, and decubitus and other ulcers.

The case reports contained little social history. They often mentioned family members in passing (61%) but we could not reconstruct anyone’s immediate family structure. Marital status, occupation, education level, race, ethnicity, or nationality were rarely mentioned. In 37 patients (56%), the reports mentioned the patients’ social isolation or loneliness, some with striking decriptions: “The patient indicated that she had had a life without love and therefore had no right to exist” (2012-46) and “[t]he patient was an utterly lonely man whose life had been a failure.”(2013-21)

Treatment and Refusal

26 patients (39%) received ECT at some point. Monoamine oxidase-inhibitor treatment was mentioned (or implied where the report explicitly said all medications in the Dutch Psychiatric Association Guidelines were tried) in 7 cases (11%). Although most patients had extensive treatment histories, most (56%) also refused at least some treatment, due to no motivation in 18 cases, concern about side effects or risk of harm in 12 cases, and doubts about efficacy in 10 cases (some gave multiple reasons).

The circumstances of refusal varied. In two patients who had clearly undergone very extensive treatments, one patient (2012-20) rejected non-standard treatment (DBS); another (2012-26) decided to stop it after one year. It was common for a personality disorder to play a role in refusals. Patients refused a variety of treatments, including ECT, medications, and various psychotherapies.

EAS Refusal History and End-of-Life Clinic

21 patients (32%) had been refused EAS at some point. In 3 cases, their physicians changed their minds; in the remaining 18, the physician performing the EAS was new to the patient. In 14 cases, the new physician was affiliated with the End-of-Life Clinic.(Table 1) (There was one additional case involving the End-of-Life Clinic, for a total of 15 End-of-Life Clinic cases.) The time from first meeting with the Clinic’s physician to death ranged from 3 weeks in one case (“due care not met” case), less than 3 months in 7 cases, and 5–12 months in 7 cases. The End-of-Life Clinic cases increased: 1 of 12 cases in 2012, 6 of 32 in 2013, and 8 of 16 in 2014.

Consultations and Second Opinions

In 27 cases (41%), the physician performing EAS was a psychiatrist; the rest were usually general practitioners. In half the cases, more than one official EAS consultant was involved; all except one official consultant were SCEN physicians (Table 1). Psychiatrists served as one of the official independent EAS consultants in 39 cases (59%). Consultation with an independent psychiatrist either as EAS consultant or as second opinion occurred in 59 cases (89%). In 7 cases (11%), no independent psychiatric expert was involved; in 5 of these cases, the EAS physician was not a psychiatrist; in 4 of these 5 cases, psychiatric input came from clinicians already involved in the patient's care.

Disagreement Among Physicians

There were disagreements among the physicians in 16 cases (24%). There was one disagreement about the unbearable suffering criterion. The remaining disagreements were about competence (8 of 16) and futility (13 of 16; once case could have more than one). In a few cases the disagreement was provisional (the first consultant, a general practitioner, did not feel that due care criteria were met and recommended a second, specialist consultation) but for most cases EAS proceeded with the disagreements unresolved. In 8 cases, a psychiatrist consultant believed due care criteria were not met while a primary care consultant believed that the criteria were met. In 7 of these 8 cases, the EAS physician was a psychiatrist.

Review Committee Actions

The RTE found that only one of the 110 (0.9%) of all reported psychiatric cases failed to meet due care criteria: a woman (2014-01) in her eighties with chronic depression who sought help from the End-of-Life Clinic. The Clinic physician met her two times (the first time 3 weeks prior to her death), neither time saw the patient alone (family present). The physician was not a psychiatrist, did not consult psychiatrists, was not aware of the Psychiatric Association Guidelines, and yet "had not a single doubt" about the patient's prognosis. The consultant in the case, a SCEN general practitioner, agreed with the physician that all due care criteria were met.

In another case, the RTE was critical yet judged the physician acted with due care. The patient (2013-27) had attempted suicide that led to a broken thigh. The patient refused all treatments and requested EAS. The RTE was "puzzled" by the fact that this physician "complied with the patient's [EAS] wish almost at once" and criticized the physician for prematurely opting for EAS evaluation as the RTE could "not exclude the possibility that the patient might yet have accepted treatment..." However, in the end the RTE decided that the case met due care criteria "at the moment" the euthanasia was implemented.

The mean number of words (in Dutch, excluding abstracts) per report declined yearly from 2011 to 2014: 1573, 1248, 1154, 1117. The Assessment section of the case report—which discusses whether the notifying physician's actions conform to the due care criteria—employed language without any case-specific elements in 43 reports (65%). In the 7 cases without independent psychiatric opinion, the Assessment section addressed that issue in 3

cases. In 16 cases with physician disagreements, the RTE specifically addressed the disagreement in their Assessment in 2 cases.

The RTE exercised case-specific flexibility. For example, although the RTE's stated view is that the intervening time from EAS consultation to death should be less than a "few weeks,"[7] a lag of 3 months without a revisit by a consultant in one case (due to a vacation) was, due to case-specific reasons, deemed acceptable.(2013-09)

DISCUSSION

A social-demographic characterization of Dutch psychiatric EAS patients proved difficult because data on education, occupation, marital and family status, ethnicity/nationality, and race were lacking. However, one striking finding is that the women/men ratio is 2.3 which is the reverse of the women/men suicide ratio in the Netherlands[20] and almost identical to the ratio of women/men suicide attempts.[21] It also contrasts with 43% women/57% men ratio in overall Dutch EAS recipients.[22] It is possible that EAS makes the desire to die in women psychiatric patients more effective. This is consistent with the fact that the majority in the study had previous suicide attempts and in several instances the request for EAS followed a suicide attempt.

Although the ethical arguments concerning EAS for psychiatric disorders generally focus on the otherwise healthy person with severe treatment-refractory depression,[4,5,12] the reality is more complicated. First, although depressive disorders were indeed the most common problem, there were many other psychiatric conditions, including psychotic disorders, cognitive impairment, eating disorders, and prolonged grief, among others. Second, even among those with depression, the typical person had at least one of the following characteristics: age over 70, at least one co-morbidity, physical dependence or institutionalization, or prominent personality disorder or problem. Among 29 persons whose primary psychiatric issue was non-bipolar depression, 25 had one of the above co-factors. Thus, the cases we studied were only somewhat younger than the Dutch EAS recipients overall and 60% are still over the age of 60.[22] The findings appear consistent with a previous report from 1997.[11] Dutch physicians, in spite of their open attitude toward EAS, may be self-regulating to limit EAS to such complex cases; or, it may be that psychiatric patients with those features may disproportionately seek EAS. A recent report of 100 consecutive persons requesting psychiatric EAS referred to one Belgian psychiatrist[13] showed that most of her patients were women (77%) with high rates of depression (58%) and personality disorders (50%) but were much younger (only 6% over 70, 59% younger than 51, 11% under 31), with lower rates of co-morbidity (23%), and a surprising 19% with autism spectrum disorder. Although any comparisons are tentative given the Belgian report concerns requestors referred to a single psychiatrist rather than recipients of EAS in an entire jurisdiction, it appears the Belgian psychiatrist attracted younger psychiatric patients with fewer co-morbidities.

The Dutch practice of EAS is regulated by a set of broad criteria. Applying some of these criteria to persons with terminal illness (cancer accounts for over 83% of reported EAS in the Netherlands[22]) arguably requires less judgment than in psychiatric cases since the

eventual prognosis of the terminally ill is not in question. For psychiatric cases, one might expect more variability in judgments, given the potential impact of some neuropsychiatric conditions on decision-making capacity[15,23,24] and the more complicated determinations of medical futility that must incorporate patients' treatment refusals in the context of less than certain prognosis even among persons with treatment resistant depression.[25,26] The variability of physician judgments may be reflected in almost a third of the patients having been refused EAS and a quarter of the cases engendering disagreements among involved physicians. In 7 cases, the EAS performing physicians apparently felt the need to seek 3 official EAS consultations (the law requires one) and in a third of cases (22 of 66) there were 3 or more physicians (in various roles, not counting the EAS physician) involved in the evaluation.

Only one of 110 psychiatric EAS cases did not meet due care criteria; in 2014, 4 of 5306 (0.1%) EAS cases were judged not to meet due care.[18] Further, although the RTE often cites the Dutch Psychiatric Association Guidelines, it accepts practices less strict than the Guidelines (but consistent with the RTE's Code of Practice[27]). In 41% (29 of 66) of cases, there were no official EAS consultants who were psychiatrists; and in 11% (7 of 66) of cases, there were no independent psychiatrists involved as EAS consultants or second opinion consultants. When consultants disagreed, the RTE gives deference to the opinion of the treating psychiatrists.

The primary limitation of our study is that because the RTE reports are intentionally written in "plain language,"[28] there is a limit to what can be inferred clinically. Further, although we focused on variables likely to be reliable and valid to code, the results still rely on coding judgments and approximations of quantities that are described imprecisely. Because the publication practice of the RTE changed during 2013–2014, the results cannot be generalized to the entire 2011–14 period, although we did capture a window during which vast majority of cases were published. Nevertheless, unpublished cases may be less controversial. Further, the results may not generalize to other countries that allow euthanasia for mental disorders[6] because reporting compliance rate and review procedures[29,30] as well as availability of mental health services and insurance may be different than in the Netherlands.

Despite the limitations, an important strength of our study is that we examined reports of actual psychiatric EAS cases across an entire jurisdiction, rather than asking physicians to recollect their experiences or opinions. The results show that the patients are mostly women, of diverse ages, with a variety of chronic psychiatric conditions accompanied by personality disorders, significant physical problems, and social isolation or loneliness. Refusals of treatment were common, requiring challenging physician judgments of futility. Perhaps reflecting the complexity of such situations, the physicians performing EAS generally sought multiple consultations, although not always, and disagreement among physicians—especially regarding competence and futility—was not unusual. Despite these complexities, a significant number of physicians performing EAS were new to the patients. We conclude that the practice of EAS for psychiatric disorders involves complicated, suffering patients whose requests for EAS often require considerable physician judgment. The retrospective oversight system in the Netherlands generally defers to the judgments of physicians who

perform and report EAS. Whether it provides sufficient regulatory oversight remains an open question that will require further study.

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- All authors had independence from funder in determining all aspects of the study. All authors qualify for all four of the authorship criteria below:
  - Substantial contributions to the conception or design of the work (SK, JP, RDV); or the acquisition (SK), analysis (SK, JP), or interpretation (SK, JP, RDV) of data for the work; AND
  - Drafting the work or revising it critically for important intellectual content (SK, JP, RDV); AND
  - Final approval of the version to be published (SK, JP, RDV); AND
  - Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved (SK, JP, RDV).
- This study did not require an ethics review and no patients were involved and thus no consents were needed.

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At a Glance

- Euthanasia and/or physician assisted suicide (EAS) of persons suffering from psychiatric disorders is increasingly practiced in some jurisdictions such as Belgium and the Netherlands but very little is known about the practice.
- This study's aim was to describe the practice by reviewing all available case summaries of psychiatric EAS in the Netherlands from 2011 to 2014 (66 cases).
- Most patients who receive psychiatric EAS are women, of diverse ages, with a variety of chronic psychiatric conditions accompanied by personality disorders, significant physical problems, and social isolation/loneliness, often in the context of refusals of treatment. A minority who are initially refused EAS ultimately receive EAS through a mobile euthanasia clinic.
- Given that the patients have chronic, complicated histories requiring considerable physician judgment, extensive consultations are common. But independent psychiatric input does not always occur; disagreement among physicians occurred in one in four cases; and the euthanasia review committees generally defer to the judgments of the physicians performing EAS.

Table 1

Brief background on euthanasia and physician assisted suicide (EAS) practice and regulation in the Netherlands.

The practice of legally protected EAS has been in existence for several decades in the Netherlands although formal legislation was not enacted until 2002—the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.[1] Under the law, the Dutch Regional Euthanasia Review Committees (Regionale toetsingscommissies euthanasia, or **RTE**) review all EAS reports regarding whether the notifying physicians (physicians of record for performance of EAS) have conformed to the due care criteria laid out in legislation.(See Table 2) There are five regional committees but the goal is to provide uniform guidance. The RTE has a strong commitment to transparency and its Publication Committee publishes a selection of case reports that are deemed "important for the development of standards" in order to provide "transparency and auditability" of EAS practice and "to make clear what options the law gives physicians."[7] Given the controversial nature of psychiatric EAS, barring any special confidentiality reasons, the RTE published large majority of the cases (available at https://www.euthanasiecommissie.nl/oordelen/). In fact, in early 2014,[18] the Minister of Health prompted the publication of all psychiatric EAS cases from 2013 that had been reviewed at the time to be published. However, the RTE has since decided to make the number of published psychiatric EAS smaller, so that going forward it will be more proportional to the fraction of psychiatric cases in the overall EAS cases (0.8% of 5306 cases in 2014) (personal communication, N. Visee, general secretary of RTE). Our study, by capturing 66 of 67 published cases from 2011–2014, therefore covers an opportune window in which vast majority of psychiatric EAS cases were published.

SCEN (Support and Consultation on Euthanasia in the Netherlands)[31] doctors are physicians specially trained to assist colleagues in the EAS process. They usually serve as the official independent physician EAS consultant but can dispense less formal advice and assistance. Most SCEN are general practitioners but some are psychiatrists.

In March of 2012, a new organization called the End-of-Life Clinic (Levenseindekliniek, sometimes referred to as **SLK**) began to provide EAS to patients whose own physicians had declined to perform EAS. It consists of mobile teams of a physician and a nurse funded by Right to Die NL (Nederlandse Vereniging voor een Vrijwillig Levenseinde – The Dutch Association for a Voluntary End of Life), a euthanasia advocacy organization. A review of their activity has recently been published.[32]

The Dutch Psychiatric Association (Nederlandse Vereniging voor Psychiatrie, **NVvP**) has published guidelines regarding how to evaluate psychiatric EAS requests (Richtlijn omgaan met het verzoek om hulp bij zelfdoding door patiënten met een psychiatrische stoornis [Guidelines for responding to the request for assisted suicide by patients with a psychiatric disorder]).[33] The Guidelines are professional practice recommendations (not law) but are frequently referenced by the RTE. The NVvP Guidelines, for example, outline when a patient's refusal of treatment is compatible with providing EAS and recommends independent psychiatric EAS consultation when patients request EAS for suffering due to mental disorders.

Table 2

Dutch euthanasia and physician assisted suicide due care criteria.[7]

The committees examine retrospectively whether the attending physician acted in accordance with the statutory due care criteria laid down in section 2 of [the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.] These criteria determine that physicians 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;
f. exercise due medical care and attention in terminating the patient's life or assisting in his suicide.

Table 3

Characteristics of 66 patients who received euthanasia or assisted death for psychiatric disorders.

Characteristic	N	%
Women	46	70
Age[1]		
30–40	9	14
40–50	7	11
50–60	11	17
60–70	18	27
70–80	15	23
80–90	6	9.1
Personality disorder or difficulties prominent	34	52
History of suicide attempt(s)	34	52
History of psychiatric admissions	53	80
Functional status: patients with some degree of dependence[2]	30	46
Institutionalized (specifically mentioned)	16	24
Social isolation or loneliness explicitly mentioned	37	56

[1]The reports use a non-overlapping convention, e.g., 30–39, 40–49, etc. in 2011 cases but thereafter changed their convention to one shown; the 2011 cases have been converted to the later format.

[2]Report mentions bed or wheelchair bound, needing daily home or institutional assistance, difficulty ambulating, poor vision impairing independence, etc.

Table 4

Psychiatric conditions of 66 psychiatric EAS patients.

Psychiatric Condition[1]	**Number**[2]	**%**[2]
Depression (including depression with psychotic features)	41	35
Anxiety [other than PTSD] (GAD, phobias, OCD, panic disorder, social phobia)	15	13
PTSD or post-traumatic residua	13	11
Psychotic disorders[3] (schizophrenia, schizoaffective disorder, psychosis NOS, psychosis due to medical condition)	9	8
Somatoform disorders (pain disorders, somatization disorder, hypochondria)	8	7
Bipolar depression	7	6
Substance abuse	6	5
Eating disorders	4	3
Neurocognitive impairment (due to mental retardation, “incipient” dementia, brain tumor surgical sequelae, stroke)	4	3
Prolonged grief	2	2
Autism spectrum	2	2
Other: alexithymia; Cotard’s syndrome; dissociative disorder; factitious disorder; reactive attachment disorder; kleptomania	6	5

[1]The descriptions of conditions in the table reflect the fact that RTE reports sometimes use informal terms such as, for example, “depression” rather than “major depressive episode.” In the above table, the actual translated terms in the reports are used, except for: “neurocognitive impairment,” “psychotic disorders,” and “other” are labels we use to group conditions; “post-traumatic residua” where past trauma issues played a prominent part but the report did not explicitly use the term PTSD.

[2]Numbers do not add to 66 because many patients had multiple conditions. Denominator is number of conditions.

[3]Excluding depression with psychotic symptoms who are included under ‘depression.’

Table 5

Physician roles in evaluation of EAS requests from patients (N=66) with psychiatric disorders.

Variable	Frequency	%
EAS physician[1] is a psychiatrist		
Y	27	41
N	36	55
Unable to code	3	4.5
Number of official EAS consultants[1]		
1	33	50
2	26	39
3	7	11
Number of SCEN consultants[1]		
0	1	1.5
1	52	79
2	10	15
3	3	4.5
Psychiatrist is one of EAS consultants	39	59
Psychiatrist second opinions[1]		
1	31	46
2	5	7.6
No independent psychiatrist involved (no EAS consultant psychiatrist and no second opinion)	7	11
Number of physicians engaged in discussion of the case (not counting EAS physician)		
1	11	17
2	31	46
3	17	26
4	4	6.1
5	1	1.5
Unable to code	2	3.0
Disagreement among experts giving opinion	16	24
Nature of disagreement (some cases had more than one)		
Unbearable suffering	1	n/a
Well considered request/competent request	8	
Hopeless or no reasonable treatment	13	
Psychiatry EAS consultant says due care ‘not met’ but primary care EAS consultant says due care ‘met’	8	12

[1]EAS physician is the physician performing EAS who also submits the EAS report to the RTE; EAS consultant is the consultant engaged by EAS physician specifically for purpose of meeting the ‘independent consultation’ due care criterion; SCEN (Support and Consultation on Euthanasia in

the Netherlands) are physicians who have been trained to provide EAS consultations. Second opinion physicians provide a clinical expert opinion on the case but are not specified as official EAS consultants in the case.