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Capacity Evaluations of Psychiatric Patients Requesting Assisted Death in the Netherlands

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Abstract

Objective—Euthanasia or physician-assisted suicide (EAS) of psychiatric patients is legal in some countries but remains controversial. 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. 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. 32% (21 of 66) of cases included evidentiary statements regarding capacity-specific abilities; only 5 cases (8%) mentioned all four abilities. Physicians frequently stated that psychosis or depression did or did not impact capacity but provided little explanation regarding their judgments. Physicians in 8 cases (12%) disagreed about capacity; even when no explanation is 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.

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Euthanasia or physician-assisted suicide (EAS) is legally protected in the Netherlands, Belgium, Luxembourg, Colombia, Switzerland, Canada, and five 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 non-terminal, psychiatric illnesses to receive EAS (hereafter, 'psychiatric EAS').

Although still infrequent, rates of psychiatric EAS have been increasing. In the Netherlands, an estimated two to five cases per year in 1997 rose to 56 cases in 2015.(5, 6) In Belgium, neuropsychiatric cases (which include non-terminal neurologic and psychiatric disorders) have increased from single digits until 2007 to 101 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). Since 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; or 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 website [https://www.euthanasiecommissie.nl]. Our study sought to address the

following questions: How prominently does the issue of capacity figure in psychiatric EAS cases? How is capacity evaluated by physicians when a patient has a disorder known to increase the risk of incapacity? Do clinicians disagree about capacity, and what is the nature of the disagreement? Finally, given that the case reports are intended to serve as educational 'case law' documents, how does the RTE review and address capacity issues?(28)

Methods

We reviewed all published cases of EAS identified by the RTE as psychiatric cases as of June 1, 2015. At that time, the RTE website showed that 85 cases of psychiatric EAS had been reported to the RTE during 2011-2014, 66 of which were available online.(4) The case reports were translated through the National Institutes of Health Library's translation services which uses professional vendors to provide certified medical translations. Subsequent questions about specific passages were addressed by conferring with native Dutch-speaking academics or clinicians.

The case reports were analyzed using directed content analysis (31) as described previously. (4) In addition to a coding scheme developed by SK and JP (4), additional codes were developed iteratively by SD and SK as they independently read the reports, comparing variables of interest in light of mentions of capacity and surrounding texts. SD and SK independently coded all capacity-relevant texts, JP reviewed and confirmed the coding, and discrepancies were resolved by discussion. Data were entered into SPSS 21.0 software; in keeping with the descriptive nature of the study, no hypothesis testing was done and only descriptive statistics were tabulated.

We separated the capacity discussion texts into two domains. The first domain had to do with statements that refer to the capacity-specific abilities, sometimes mentioned by Dutch physicians in the case reports as "Appelbaum's criteria."(9) These are the abilities to understand relevant facts, apply those facts to oneself (appreciating the consequences of those facts), reason and weigh the facts, and evidence a stable choice. We identified three types of statements reflecting the amount and type of detail in the text (See Table 1): 1) simple global assertions of capacity or incapacity without mention of capacity-specific abilities; 2) statements regarding intact or impaired capacity-specific abilities but without further explanation; and 3) statements of specific evidence regarding an intact or impaired capacity-specific ability.

The second domain covered texts that refer to clinical descriptions in the context of a capacity discussion. These texts referred to the presence or absence of clinical symptoms or diagnoses, as well as to elements of a general mental status exam (e.g. orientation, level of consciousness, intelligence, memory etc.). Although insufficient as the sole basis for modern capacity assessment—e.g. the mere presence of delusions or other symptoms does not by itself determine capacity status—these descriptions can provide important information in guiding the capacity interview.(18)

Other elements that the coding scheme captured include physician disagreements about the capacity status of patients, and texts in which the RTE specifically addressed capacity issues.

Results

The personal and clinical characteristics of the 66 patients have been described previously. (4) Of note, 62% (41 of 66) of patients had some form of depressive disorder (including 8 with psychotic features), 14% (9 of 66) had psychotic disorders, 6% (4 of 66) had cognitive impairment with one patient having a legal guardian (case 2014-83), and 6% (4 of 66) had severe eating disorders.

All 66 patients were deemed competent by the EAS physician as is required under the due care criteria.

Table 1 groups the 66 case reports according to the most detailed level of discussion found in each report regarding capacity-specific abilities. All 66 cases (not shown in Table 1) provided evidence of the ability to communicate a choice for EAS, e.g., “[the patient] had a longstanding desire to die, which she had frequently discussed with the specialists who treated her” (2014-71). In 55% (36 of 66) of cases, the most detailed capacity-specific discussion consisted of global judgments by physicians that the patient had capacity (or did not, when a consultant disagreed with the EAS physician). Of these 36 cases, 8 (22%) involved persons with psychotic conditions, including 3 patients with schizophrenia and 5 who had depression with psychotic features, as well as 2 patients who had eating disorders.

In 14% of cases (9 of 66) the most detailed capacity discussion was assertions of intact or impaired capacity-specific abilities. Among these 9 patients were 3 persons with psychotic conditions, specifically paranoid schizophrenia, a psychotic disorder not further specified, and a case of depression with psychotic features, as well as one patient with neurocognitive impairments resulting from a stroke.

The remaining 32% of case reports (21 of 66) provided specific evidence regarding at least one capacity-specific ability. Among these 21 cases, 6 included a psychotic condition: psychosis NOS, chronic paranoid schizophrenia, depression with psychotic features (2 patients), and 2 cases of schizoaffective disorder. An additional 3 of 21 patients had neurocognitive impairment due to mental retardation, suspected incipient dementia, and brain tumor surgery, while 2 of 21 patients had eating disorders.

In total, 30 cases referenced at least one capacity-specific ability, either as simple assertions or by providing evidence regarding an ability (i.e., combining rows 2 and 3 in Table 1). Of the 30 cases, only 5 mentioned all of the abilities relevant to capacity (we conservatively include here 3 reports that mentioned “Appelbaum's criteria” even though they did not enumerate the abilities). A further 10 cases referenced two abilities, while 17 cases referenced one ability (in addition to ability to communicate a choice, reported as intact in all).

Clinical symptoms, diagnoses, and mental status elements in capacity discussions

41 of 66 (62%) of cases mentioned clinical symptoms, diagnoses, or general mental status elements in the context of capacity discussions (some cases had multiple codes). In 28 cases, the capacity discussion referenced depression symptoms or diagnosis (Table 2). Three

different types of relationship between depression and capacity were reported. First, 8 cases included statements of intact capacity referring to the absence of depression in the patient; second, 17 cases included statements that capacity was intact despite the presence of depression; and third, 3 cases included statements that the EAS request could be a symptom of depression and therefore raised questions about capacity (Table 2). In general, statements regarding whether depression did or did not affect capacity were not explained further.

References to psychotic symptoms or disorders were present in capacity discussions in 15 cases. In 8 cases there were statements of intact capacity that mentioned the absence of psychotic symptoms. In 7 cases the discussion noted capacity was intact despite the presence of psychotic symptoms; in 2 of these 7 cases, there were specific explanations as to how the presence of psychosis did not affect capacity.

Of the 36 cases with only simple global assertions of competence, 16 cases also mentioned clinical factors in their capacity discussions. Thus in the remaining 20 of 36 cases, the capacity discussion was limited to a global assertion that the patient did or did not have capacity. Among these 20 were 3 cases of patients with psychotic conditions; these patients are briefly described in Box 2.

Physician Disagreement

In 8 of 66 cases (12%), physicians involved in the case disagreed over whether the patient was competent to consent to EAS (that is, among the EAS physician, official EAS consultants, or other ‘second opinion’ consultants). In an additional 2 cases, the EAS consultants advised the EAS physician to obtain further expert consultations because they were not sure about the patients’ capacity (2011-134404 and 2014-83).

In 4 of 8 disagreement cases, the reports describe conflicting global statements regarding capacity without further explanations on the nature of the disagreement. For example, in case 2013-12, the report states that “the psychiatrist [second opinion consultant] believed the mental competency of the patient was doubtful. The [EAS] physician did not share this opinion” but no further explanation is given. In all 4 cases of disagreement without further explanation, the EAS physician was a psychiatrist. The consultant who disagreed was also a psychiatrist. The EAS physician then sought another consultation; the second consultant was a primary care physician who agreed with the EAS physician and the EAS was carried out. The RTE did not comment on the disagreement in any of these 4 cases or request any further information from involved physicians.

Physicians disagreed in some highly complex cases regarding capacity. Three such cases are summarized in Box 3. One case involved a patient under legal guardianship, another a patient with chronic psychotic disorder NOS, and a third with mental retardation and psychotic symptoms.

RTE actions and comments

The RTE found that one case failed to meet due care criteria (2014-01).(4) The patient, a woman in her 80's, had sustained ECT-induced memory loss and experienced “multiple

changes of moods and emotions." The EAS physician "did not consult a psychiatrist to verify if the request for euthanasia could possibly be inspired by a vital depression."

The RTE made specific comments regarding capacity evaluations in 18 of 66 cases. In 14 of these, the RTE either commended EAS physicians for involving appropriate experts or agreed with an explanation that the patient was competent, e.g., "physician proceeded with great caution with respect to whether there was a mentally competent patient.... The physician consulted three consultants and on the basis of their findings came to the conviction that... there was a mentally competent patient." (2013-23) In the other 4 cases, the RTE found the EAS physician's initial report insufficient and requested (in writing or in person) further information from an involved physician regarding the capacity issue (including the 'due care not met' case).

Discussion

A frequently raised concern regarding psychiatric EAS is the issue of decision-making capacity of patients since some neuropsychiatric conditions increase the risk of incapacity and the evaluation of capacity is known to be quite challenging. Thus the published reports of Dutch psychiatric cases provide an important opportunity to examine how physicians evaluate the capacity of psychiatric patients requesting EAS, and how the euthanasia review committees address the issue in their reports.

There are several notable findings. First, in over half of cases (36 of 66), the most detailed discussion is a simple global assertion of capacity, without reference to specific capacity criteria. For some of these cases, the patients' clinical presentations may have felt sufficiently obvious so that the presumption of intact capacity was allowed to stand. This is consistent with the fact that not all psychiatric disorders raise the risk of mental incapacity. However, this does not explain the lack of functional ability-based discussion in those patients who had conditions known to increase the risk of incapacity. In these cases, more explicit discussion of how such patients were able to meet the various capacity-specific criteria, despite their symptoms, would be expected.

Second, even in cases that reference a function-based capacity framework, the capacity discussions were relatively sparse. Only 5 cases (8%) even mentioned all the relevant capacity-specific abilities, and in only a third of cases was there discussion of evidence for capacity-specific abilities. Rather, there seemed to be considerable weight placed on one of the criteria for capacity—the criterion of communicating a stable choice. Evidence of a stable choice is well documented in all 66 cases. However, although a stable choice is necessary for capacity, it is insufficient as the main basis for judging someone's capacity.

Third, the physicians often seemed to rely on presence or absence of clinical symptoms or conditions as evidence for or against capacity, usually without further explanation. In numerous cases, an evaluator says the EAS request is, or is not, driven by depression (e.g. "the patient's desire to die could be a symptom of [depression]" [2013-11]), but without supporting explanation as to how this judgment was reached or how it was assessed that depression did or did not impact the capacity-specific abilities. Since so much hinges on

whether the desire to die is a pathologically determined wish versus a rational choice, simply asserting a judgment one way or the other does not help the reader of these reports, which are intended to provide guidance to physicians. Although there were examples of better explanations (e.g., “patient was not guided by her ‘voice’ in regard to her request for assistance with suicide” [2012-46]), they were rare.

Fourth, perhaps because of reliance on clinical impressions, there were disagreements among physicians in at least 8 cases. This likely underestimates the diversity of physician judgments on capacity, given that 21 patients had been earlier refused EAS but later received it, usually from other physicians.(4) The descriptions of some of the complex cases of disagreement show why such disagreements might occur, especially given the relatively sparse evidence base regarding assessment of capacity in the EAS context. Indeed, consultation psychiatrists—specialists most experienced in capacity evaluations in the clinical setting—find capacity evaluations particularly challenging.(19) A study of another group of subspecialists with expertise in capacity assessments (forensic psychiatrists) revealed that a physician's personal ethical beliefs will affect their opinions on capacity.(22)

Finally, the RTE's commentaries on the capacity issue for the most part emphasized procedural fidelity rather than scrutinizing substantive aspects of capacity judgments. This is understandable given that RTEs (which consist of a lawyer, an ethicist, and, usually, a non-psychiatrist physician) are probably not equipped to evaluate the clinical aspects of complex capacity judgments, but are able to comment on procedural aspects such as whether a psychiatrist should have been involved. Notably, the single case of ‘due care not met’ was the only case lacking a psychiatrist's input. Also, in regard to the issue of whether an EAS request is depression-driven or not—a distinction that the RTE itself invokes—it appears the RTE ultimately accepts clinical impressions and attestations by physicians, rather than judgments with evidentiary or explanatory descriptions that support one view or another.

It appears that the practice of capacity assessment in psychiatric cases does not involve EAS physicians setting high thresholds for capacity. Instead, in over half the cases, capacity is presumed, despite the presence of disorders known to increase the risk of incapacity. Thus, although the RTE recommends that “a request for assisted suicide in a case involving psychiatric problems must be handled with great caution” (2014-59), the RTE seems to accept the threshold used by EAS physicians (as compared to the higher thresholds used by some consulting psychiatrists and other physicians) so long as procedural criteria are met.

This normative position regarding thresholds for capacity is evident in other ways. The RTE does not require a patient to exhibit all abilities in the “Appelbaum model” (the model referred to by physicians and the RTE) in order to be deemed competent. Only 5 cases mention all four abilities in the report. Further, the RTE accepted cases in which one consultant judged the patient competent despite explicitly doubting she was able to “use information in a rational way.”(2013-22) This lower threshold view is explicitly endorsed by the Dutch Psychiatric Association: “It is possible that one criterion has not been fully met, but that the patient is clearly suffering so unbearably that in case of an emergency the practitioner may still defer to force majeure.”(32) Such appeals to a lower threshold of competence for psychiatric EAS evaluation is endorsed by advocates of psychiatric EAS.

(33) A lower threshold view is also implied in the RTE Code of Practice statement that patients in the “early stages” of dementia are usually competent to make EAS requests despite ample evidence that patients with even mild cognitive impairment have substantial likelihood of decisional impairment for medical decisions.(10, 34)

This study's main limitation is that the case summary reports do not contain all of the text from the actual medical records of the patients. Thus it is possible that physicians performed and recorded extensive capacity evaluations not conveyed in the case summaries. This seems unlikely, however, since the capacity of psychiatric EAS patients is an especially important due care criterion and the stated purpose of publishing the case summaries is to provide guidance in future cases: “By making the ‘case law’ accessible in this way, the committees want to make clear what options the law gives physicians.”(28) On the other hand, if there are extensive capacity discussions in the medical records but the RTE simply chose not to include that supporting documentation in its published case reports, it is still consistent with our conclusion that the RTEs do not seem to expect physicians to exercise extensive scrutiny using a high threshold for capacity. These conclusions about the capacity threshold are consistent with the practices that evaluating physicians use in specific cases (case 2013-22), the Dutch Psychiatric Association's guidance document (32), and the RTE's other documents.(29)

Second, not all psychiatric EAS cases are published. At the time of this review, the RTE website indicated 85 cases of psychiatric EAS, of which 66 had been published. It is likely that, from the viewpoint of the RTE, the unpublished cases are more straightforward and not as complex. Third, we did not examine the relationship between some conditions and capacity, such as personality disorders. Although extreme manifestations of personality disorders may at times compromise capacity, it is more likely that such persons make unwise yet competent choices, and the primary clinical task in such situations is to help patients in their decision-making rather than labeling them incompetent. Finally, it is important to note that although the case summaries provide useful descriptions of the complexity of some of the cases and the physicians’ and the RTE's actions and statements regarding capacity, they cannot be used to form independent judgments of the patients’ actual capacity status.

Conclusion

This study provides insight into how the capacity of those making requests for psychiatric EAS is conceptualized, evaluated, and reviewed in the Dutch system. The Dutch practice of psychiatric EAS does require the use of a modern, function-based capacity framework. Although our conclusions must be tempered by potential limitations of the case summaries, EAS requests from psychiatric patients do not seem to receive a high level of scrutiny to ensure a high threshold for capacity, even in cases of disorders known to increase the risk of incapacity, and this is recognized and endorsed by the RTE. The practice seems to rely on a presumption of capacity in over half the cases, on strong emphasis on one aspect of capacity (persistent choice), on clinical impressions about the relationship between key clinical symptoms and capacity, and on procedural fidelity. Thus, overall, it seems to be a procedural protection system that puts priority on ensuring access to EAS (i.e., reducing false negatives). A system that prioritizes reducing false negatives must accept a higher rate of

false positives, i.e., people who lack capacity receiving EAS.(35) Given the highly controversial nature of psychiatric EAS, with the majority of the public and health professionals in the Netherlands disapproving of psychiatric EAS,(36, 37) this practice is surprising and may need further study.

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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;
- **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 manuscript.

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% (33/56) of psychiatric EAS cases.(6)

Box 2. Three Case Reports of Psychiatric EAS of Patients with Psychotic Conditions in Which Only Global Assertions of Intact Capacity Were Given

Case 2014-76: A man, 60-70 years old, with a 34-year history of paranoid schizophrenia with “increasing disintegration.” The report notes: “He became increasingly aware that he lived an important part of his life under the influence of his psychotic beliefs... He was lonely, but could not stand having anybody around. He foresaw that he would become more and more dependent, but expected that he would not be able to accept help. Patient had lost control of his life and was afraid of losing his dignity in the final phase of his life.” There was no discussion of what his psychotic beliefs were.

Case 2013-31: A woman in her 70's with history of psychotic depression with suicidal ideation, repeated ECT treatments, and multiple recent suicide attempts.

Case 2014-80: A woman in her 70's with “schizophrenia since her childhood” who felt that “her head was continuously occupied by voices other than her own and these voices commenting on everything and commanded her to do things. She felt like she was staying in some sort of labor camp and ‘was possessed by the enemy.’” Neither her primary care doctor nor psychiatrist would agree to EAS; she received EAS via the End-of-Life Clinic.

Box 3. Three Examples of Psychiatric EAS in Complex Cases in Which Physicians Disagreed about Patient Competence

Case 2014-83: A woman in her 50's who had “plurality of psychiatric and somatic” problems, with “intellectual disabilities, impaired memory, and aphasic problems” and was under “guardian ship with a mentor” for the previous year and a half. Her primary physician (a geriatrician) “did not want to proceed with her euthanasia request due to the complexity of the case.” Thus the patient and her mentor registered at the End-of-Life Clinic where she met a non-psychiatrist physician. The first consultant “questioned whether there was deliberate and voluntary request, given the psychological state” and “could not determine” whether due care criteria were met given the complexity of case and his lack of psychiatric expertise. Second (psychiatrist) and third (geriatrician) consultants deemed patient competent; the psychiatrist noted intact mental status element (orientation, ‘thinking coherently,’ no delusions or perceptual problems, ‘not overly depressed’) and stated the “Appelbaum criteria” were met. The geriatrician noted “there was no evidence of depression or hallucinations and/or delusions” and “considered her mentally competent.” The mentor was present for all capacity evaluations.

Case 2013-03: A woman in her 30's who had had traumatic experiences in her youth and was emotionally neglected suffered from chronic psychotic disorder NOS (“demons wanted to destroy her”). The first EAS consultant, a geriatric specialist, felt “insufficiently capable of determining the patient's mental competency” and felt the due care criteria had not been met. A second EAS consultant (a SCEN general practitioner) felt the patient was incompetent. Then a third consultant (a SCEN psychiatrist, who evaluated the patient once, two days prior to euthanasia), noted that the patient experienced “tactile and acoustic hallucinations” but, “using Appelbaum's criteria,” found the patient “not depressed and fully mentally competent.” When the RTE requested more information, the EAS physician felt the second consultant's report contained factual errors and doubted the consultant's expertise. The second EAS consultant was then asked by the RTE “why he considered himself capable” of assessing a psychiatric case, to which the consultant replied that he “had always been very much interested in psychiatry...” and explained that the patient's medical record was incomplete, and “mistrusted certain diagnoses... [and] felt the patient had a tunnel vision.”

Case 2013-22: A woman 70-80 years of age with severe personality disorder, multiple suicide attempts, mental retardation, and psychotic symptoms. The patient had mental retardation by history as well as by recent testing. A psychiatrist consultant had found her incompetent to consent to EAS (report contains no details). The poor performance on neuropsychological testing was explained by the EAS physician as due to patient's lack of education, and the consultant psychiatrist's earlier determination of incompetence was attributed to the patient's poor ability to tolerate frustration and regulate emotion in her encounter with him. The EAS physician (a psychiatrist) and a second consultant (a primary care SCEN physician) evaluated the patient separately and both found her competent using “Appelbaum criteria.” The EAS physician provided extensive evidence and discussion regarding the patient's mental capacity, concluding that the patient was “fully competent,” appealing especially to her “level 4” ability to “weigh pros and cons.”

The SCEN consultant (non-psychiatrist) found that the patient was “in general... mentally competent” despite noting specifically that the patient's ability to “use information in a rational way was doubtful.” The patient was also noted to lack insight about a key delusion and hallucination that was a source of much distress to her: “[patient] claimed that other people kept shining lights into her house ...could not be convinced that these light flashes were caused by her eye disease.” The consulting psychiatrist who found the patient incompetent was not asked to provide further information or explain his position before the RTE.

Table 1

Levels of Mental Capacity-Specific Criteria Discussion in 66 Case Reports of Psychiatric EAS.

Level* of capacity-specific discussion	N	%	Comments and examples.
Global assertion of capacity status without appeals to specific capacity-relevant abilities	36	55	e.g. “consultant believed the request was voluntary and well-considered”; “independent psychiatrists...came to the conclusion...that the patient was mentally competent.” (2014-81)
Simple statement regarding at least one capacity-specific ability**	9	14	2 cases (3%) mentioned the understanding ability – e.g. “capable of fully understanding information.” (2013-28)
			10 cases (15%) mentioned appreciation – e.g. “she understood the consequences of her request.” (2013-23)
			3 cases (6%) mentioned the ability to reason – e.g. “the euthanasia request of the patient was well thought-out.” (2014-78)
Evidence regarding at least one capacity-specific ability**	21	32	6 cases (9%) provided evidence of understanding – e.g. “could state her medical history, remained capable of discussing her illness and all the treatments she had undergone.” (2012-20)
			11 cases (17%) provided evidence relevant to appreciation – e.g. “aware of her delusion and depressive disorder...capable of reflecting on her situation and could put into words that psychiatrists considered what she felt was a delusion. She could say: ‘I have a delusion; it bothers me.” (2012-20)
			12 cases (18%) provided evidence of reasoning – e.g. “perfectly able to indicate what were the pros and cons to her of the alternatives offered, thus it was assessed that she was able to weigh information.” (2013-22)

*These refer to the highest level of detail provided in the report. For example, capacity discussions that included simple assertions of abilities *and* evidence for at least one element of capacity are counted in the category ‘evidence of at least one capacity-specific ability’.

**Some cases mentioned more than one capacity-specific ability.

Table 2

Mentions of Depression and Psychosis in Capacity Discussions in 66 Case Reports of Psychiatric EAS.

Clinical Symptom or Diagnosis Mentioned	N (%)	Comments and Examples
Depression	28 (42%)	8 cases (12%) indicated the patient was competent as there was no depression—e.g. “[consultant] tested the patient's mental competency using Appelbaum's criteria. He found the patient to be not depressed and fully mentally competent.” (2013-03)
		17 cases (26%) indicated the patient was competent despite depression—e.g., “a depressive mental health state was present; however, the patient was capable of reflecting on his situation” (2013-20); or the EAS request “did not originate from the depression.” (2014-71)
		3 cases (5%) stated the request for EAS could be a pathological symptom of depression and raised questions about competence—e.g., “first consultant believed that the patient's mental competence was doubtful, as the patient had a serious depressive disorder, which possibly impeded the [patient's] free will. According to the first consultant the patient's desire to die could be a symptom of this disorder.” (2013-11)
Psychosis	15 (23%)	8 cases (12%) indicated the patient was competent as there was no psychosis—e.g., “there was no formal thought disorder, delusion or perception disorder. On the basis of his assessment the third consultant regarded the patient as fully mentally competent.”(2013-23)
		7 cases (11%) indicated the patient was competent despite psychosis — e.g., “patient was not guided by her ‘voice’ in regard to her request for assistance with suicide.” (2012-46)