COMMENTARY

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Commentary on Charland et al., "Decision-Making Capacity to Consent to Medical Assistance in Dying for Persons with Mental Disorders"

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Commentary in Response to: "Decision-Making Capacity to Consent to Medical Assistance in Dying for Persons with Mental Disorders" by Charland, Lemmens, & Wada

Introduction

Against the background of recent developments in Canada, which open the way for Medical Assistance in Dying (MAID), Charland and colleagues raise concerns about possible inclusion of the option to obtain MAID on the basis of mental disorders (Charland et al., 2016). They especially question the lack of reflection on difficulties in assessing mental capacity in psychiatric patients asking for their lives to be ended. They argue that without a thorough and workable theory on decision-making capacity, MAID will be open to abuse. They also refer to experiences in the Netherlands, which in their view are problematic.

In this paper we will comment on the claims of Charland et al., both concerning the difficulties in assessing mental capacity in psychiatric patients, and concerning the Dutch situation. We agree that assessing mental capacity in patients requesting MAID (both somatic and psychiatric patients) is important. Yet, we will argue that mental capacity in psychiatric patients can be assessed, and that the Dutch practice, in which the patient's mental capacity is not only judged by the treating physician, but also by a second, independent physician, and, in the case of MAID on the basis of a mental disorder, by an independent psychiatrist, provides a safeguard against possible arbitrariness and abuse.

Assessing mental capacity

Mental capacity is a prerequisite for informed consent. Informed consent is only valid if the patient has the ability to make a decision. There is disagreement about the constituents of decision-making capacity. According to the standard approach, mental capacity entails understanding information, being able to apply the information to one's own situation ('appreciation'), being able to reason, and being able to communicate the decision (Appelbaum & Grisso, 1995). Several authors have criticized the cognitive bias of the standard approach and argued for further requirements, such as adequate emotions (Charland, 1998), values (Tan et al., 2006), and practical wisdom (Widdershoven et al., 2016). These requirements are especially relevant to refusals of treatment by psychiatric patients. Although these patients may be able to understand information and to reason, they may have difficulties in balancing various values. Patients with Anorexia Nervosa, for instance, may understand that their behavior is life-threatening, but refuse treatment because they value being thin over being healthy (Tan et al., 2006). Likewise, patients with Obsessive Compulsive Disorder may appreciate the burden of their disease, but refuse treatment because they don't want to give up compulsive behavior (Widdershoven et al., 2016).

According to Charland et al., these controversies around the concept of mental capacity are especially relevant to the situation of patients requesting MAID on the basis of mental disorders. They argue that such patients may be judged as having mental capacity, based on the standard approach, but may lack mental capacity if their decision-making process is judged using an approach which does not focus solely on cognitive abilities. In order to evaluate this argument, it is important to distinguish between various ways in which mental capacity is relevant in patients requesting MAID. In the first place, mental capacity is needed for a valid request for assistance in dying. In the second place, mental capacity is relevant if the request is accompanied by a refusal of treatment. We will examine how these two aspects are dealt with in the Dutch regulation and practice of MAID.

The Dutch Termination of Life on Request and Assisted Suicide (Review procedures) Act

According to the Dutch Criminal Code, euthanasia (defined as terminating life on request) is a criminal offence, but physicians are exempt from liability if they report their actions and show that they have satisfied the due criteria formulated in the Act. This is to be assessed by review committees, which focus on the decision-making procedures followed by the physician. When dealing with a patient's request for euthanasia, physicians must observe the following due care criteria. They must:

a. be satisfied that the patient's request is voluntary and well-considered;

b. be satisfied that the patient's suffering is unbearable and that there is no prospect of improvement;

c. inform the patient of his or her situation and further prognosis;

d. discuss the situation with the patient and come to the joint conclusion that there is no other reasonable solution;

e. consult at least one other physician with no connection to the case, who must examine the patient and state in writing that the attending physician has satisfied the due care criteria listed in the four points above;

f. exercise due medical care and attention in terminating the patient's life or assisting in his/her suicide.

The law does not distinguish between requests based on somatic and mental diseases. In jurisprudence, a further requirement is made concerning the latter: in case of a request based on a psychiatric disorder, an independent psychiatrist should be asked for a second opinion on mental capacity, diagnosis, treatment options, and unbearable suffering. This requirement is also part of the guideline on Assisted Suicide of the Dutch Society for Psychiatry.

Requests for MAID

The issue of mental capacity is relevant for the first due care criterion mentioned in the Dutch Act, which says that the physician should ascertain that the request is voluntary and well-considered. It implies that the request should not be caused by a psychiatric condition; for example, a depression. This is highly relevant, not only when the request is based on a mental disease, but also when it is related to a somatic condition, such as cancer. In general, the physician should rule out that the patient suffers from a treatable depression. Treating physicians and consulting physicians are specifically focused on this. In case of a somatic disease, often anti-depressants have been tried before a request for euthanasia is granted. When the request is related to a mental disorder, for instance a depression, the physician has to be sure of the absence of a prospect of improvement (b.). The independent psychiatrist, who is asked for a second opinion, will have to affirm this.

Both in legal regulation and in practice, assessing the mental capacity of the patient who requests MAID is not merely a matter of cognitive abilities. The physician not only has to investigate the cognitive capacities of the patient, but also has to address his or her emotions and values. As mentioned in the Act, the physician has to be satisfied that the patient's suffering is unbearable. This implies addressing feelings (such as pain and sorrow) and values (such as dignity and peace), and assessing whether the patient's description of suffering matches the situation and fits in with his or her life-story. The consulting physician also will address these issues. Thus, the risk that a mere cognitive assessment of mental capacity opens the way to easy MAID is not warranted.

Refusals of treatment

The issue of mental capacity will specifically arise when the patient refuses additional treatment. A refusal of treatment is problematic, since the physician has to be satisfied that there is no prospect of improvement (b.). Moreover, the physician, together with the patient, has to come to the conclusion that there is no other reasonable solution (d.). If further treatment options are available, and the patient refuses, MAID is not allowed, unless the physician agrees that the refusal is reasonable. In the context of a somatic disease, intensive interventions with a high burden and limited effectiveness can be refused by the patient, in agreement with the physician. Also in psychiatric diseases, a treatment option may entail a high burden with a limited expectation of success, and MAID may follow after refusal of treatment. But this will require an assessment of the refusal by the treating physician, the consulting physician, and, in the case of a request for MAID based on a mental disorder, an independent psychiatrist. They will not only address the cognitive abilities of the patient, investigating whether the patient has the ability to reason, but also judge whether the refusal is actually reasonable. Thus, the criteria for mental capacity will entail more than just checking the elements distinguished in the standard approach. This also means that the worries of Charland et al. concerning the risk that ending of life might result from a refusal for which the reason 'would by most standards be considered 'unreasonable" are not valid for the Dutch situation.

The requirement that physician and patient should come to a joint conclusion that there is no other reasonable solution (d.) also shows that the concept of autonomy underlying Dutch euthanasia regulation and practice is not based on an individualist approach to decision-making. Rather, it entails a relational view on how to deal with crucial events in life, emphasizing that neither the patient nor the physician has the sole right to decide. The communicative view of reaching decisions is also visible in the role of the consulting physician, who adds another perspective to the process.

'Evidence' from the Netherlands

Charland et al. refer to evidence from Belgium and the Netherlands. In this comment, we will restrict ourselves to the Dutch situation. In the Netherlands, the number of cases of MAID on the basis of a mental disorder is growing, but it is still very limited, namely 1 percent: 56 (on a total of 5516) in 2015 (Annual Report of the Regional Review Committees, 2015). In a study by Kim et al. (2016), sixty cases of euthanasia in psychiatric patients, of which the

summary of the reports of the review committees were published between 2011 and 2014, were analyzed. The study shows that there was regularly disagreement between physicians whether the criteria for euthanasia were met. Disagreement between physicians is, of course, a sign that it may be difficult to establish whether all criteria for euthanasia are met. Yet, disagreement need not be problematic. Consulting physicians should be critical, and may suggest other solutions. It is up to the treating physician to consider these solutions, and either try them, or give arguments as to why they are not appropriate. In a second consultation, this may lead to agreement of the consulting physician. The study also showed that an independent psychiatrist was not involved in all cases. This is indeed problematic, since it goes against jurisprudence and the guidelines of the Dutch Society for Psychiatry.

Charland et al. also refer to a television documentary in which three cases of euthanasia were presented, performed by physicians of a specialized end-of-life clinic. The patients who were followed suffered from dementia, being weary of life, and chronic Obsessive Compulsive Disorder. All three cases had been approved by a review committee. The documentary raised debate, and was intended to do so by the end-of-life clinic. The aim was explicitly not to hide difficult cases. Although the documentary led to debate, the general reaction, contrary to the suggestion of Charland et al., was not one of public outrage.

The case of the demented patient led to a lot of comments, as it was not clear for the viewers that she really wished to die, when she referred to the act of MAID as 'Huppakee gone'. The treating physician was clearly convinced that this was her way to express her wish to die. This case showed that the process of reaching a joint conclusion between physician and patient that there is no alternative is not always easy to grasp from the outside. The case of the patient who was weary of life concerned a 100-year old lady who had several non-fatal health problems, and suffered from being lonely. In this case, one could raise the question whether there were no alternatives which could have made her less lonely. The case of the patient with very severe OCD, who had been treated for forty years without success, raised relatively little debate.

From the documentary it certainly cannot be concluded that the Dutch practice of euthanasia in cases of psychiatric disorder is based on a cognitive view of mental capacity. All three cases show that the treating physician interpreted the wish of the patient against the background of the patient's emotions and values, and deemed these as clear and convincing enough for providing euthanasia. Although this was not shown, it may be assumed that their judgment was shared by a consulting physician and, in the case of the patient with OCD, an independent psychiatrist. So even in difficult cases, determining mental capacity is not an arbitrary judgment of an individual physician, but a process of understanding the patient's reasons, emotions, and values, based on interaction between various physicians involved.

Conclusion

We agree with Charland et al. that mental capacity is important in MAID, both in somatic and psychiatric diseases. Actually, active ending of life by the physician in the case of a psychiatric disease is morally comparable to euthanasia in case of a somatic disease (Berghmans et al., 2013). The Dutch regulation and practice of euthanasia contain specific warrants regarding mental capacity. The treating physician, the consulting physician, and, in case of a request based on a psychiatric disease, an independent psychiatrist, have to judge whether the request is well-considered and, if the patient refuses treatment, whether the refusal is reasonable. This entails an assessment of mental capacity which goes beyond the cognitive approach, taking into account emotions and values. MAID in case of a mental disorder requires utmost carefulness. Any regulation should be attentive of difficulties and make sure that an in-depth investigation of patient capacity is guaranteed. The contribution of Charland et al. is helpful in pointing out difficulties and emphasizing the need for careful practice. Yet, the suggestion that MAID in case of a mental disorder is fundamentally problematic because of controversies about mental capacity is unwarranted, and their assessment of the Dutch experience does not do justice to the nuances in Dutch regulation and practice.

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