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The Legal and Practical Framework for Psychiatric Diagnoses as Bases for Requests for Euthanasia and Physician-Assisted Suicide in the Netherlands

Kasey Joyce

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THE LEGAL AND PRACTICAL FRAMEWORK FOR PSYCHIATRIC DIAGNOSES AS BASES FOR REQUESTS FOR EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE IN THE NETHERLANDS

*Kasey Joyce**

Abstract

There is not a clear answer on what kinds of cases are the kinds that cause successful requests for euthanasia or assisted suicide (EAS), but most of them are diagnoses that hold severe and terminal physical symptoms or those that have chronic and severe psychiatric issues. A lingering question—one that is now being debated and revisited—is whether a diagnosed mental illness falls into the requisite terminal illness definition to pass through the procedure to get the end-of-life care available in the Netherlands. This Note will analyze the standards around what kinds of cases will pass through the Physician Review Board and whether psychiatric cases specifically can be an adequate diagnosis for physician-assisted euthanasia in the Netherlands. Further, it analyzes which kinds of psychiatric cases would pass through if they are indeed the basis for a successful physician-assisted suicide request. The Netherlands has widely been known to be the most accepting of physician-assisted euthanasia in the world; this Note aims to discover how accepting that legal framework is in the case of illnesses that are not necessarily accompanied by physical symptoms.

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INTRODUCTION

I. THE MISINFORMATION AND PUBLIC DIALOGUE AROUND
NOA POTHOVEN

In June 2019, international media was abuzz with debate over the right to die.¹ Before her death on June 2, Noa Pothoven had already become famous for her published critiques of the mental health system in the Netherlands.² In her novel, she discussed her hospitalizations for PTSD stemming from rape, her struggle with depression, self-harm, anorexia, and her wish to have physician-assisted euthanasia.³ The widespread discussion of Noa Pothoven was sparked by her death in June as it was reported that “she approached Levenseindekliniek, an end-of-life clinic in The Hague, requesting euthanasia.”⁴ Her request was denied on the basis of age—she was seventeen years old—and the absence of parental consent.⁵ But, the temporal proximity of her request and her death led to an inaccurate report that her death was caused by physician-assisted euthanasia.⁶ After this initial news article went public, the news went viral, and the story was reported by several international news stations,

* Kasey L. Joyce is a 2020 graduate of the University of Florida Levin College of Law. She is a double Gator with a dual undergraduate degree in Political Science and Russian with a certificate in International Relations. During her time at the Levin College of Law, she was a research assistant to Professor E. Lea Johnston studying Mental Health Law and its effect on the criminal justice system. She has recently joined the Construction Defect Litigation practice group at Ball Janik in Orlando, Florida.

1. Anna Bianca Roach, *Her Death Made Headlines. We Should Learn from Her Life Instead*, WASH. POST (June 11, 2019, 8:15 PM), <https://www.washingtonpost.com/opinions/2019/06/12/her-story-isnt-about-euthanasia-its-about-failing-mental-health-systems/>.

2. NOA POTHOVEN, WINNEN OF LERE (Boekscout 1st ed., 2018).

3. *Id.*

4. Roach, *supra* note 1.

5. Iliana Magra, *Dutch Teenager’s Death Sets Off Debate, and Media Corrections*, N.Y. TIMES (June 6, 2019), <https://www.nytimes.com/2019/06/06/world/europe/noa-pothoven-instagram-euthanasia.html>.

6. Roach, *supra* note 1.

including the Washington Post,⁷ the New York Times,⁸ CBS,⁹ and CNN.¹⁰

The question that these news outlets focused on was whether the right to die should extend to youth and whether the Netherlands was over-treating with physician-assisted euthanasia (EAS).¹¹ The question then posed in the many corrections was about the quality and availability of proper mental health treatment for youth in the Netherlands, finally focusing the spotlight on the topic Ms. Pothoven spent years championing.¹² A lingering question—one that is now being debated and revisited—is whether a diagnosed mental illness falls into the requisite terminal illness definition to pass through the procedure to get the end-of-life care available in the Netherlands. This Note will analyze the standards around what kinds of cases will pass through the Physician Review Board and whether psychiatric cases specifically can be an adequate diagnosis for physician-assisted euthanasia in the Netherlands. Further, it analyzes which kinds of psychiatric cases would pass through if they are indeed the basis for a successful physician-assisted suicide request. The Netherlands has widely been known to be the most accepting of physician-assisted euthanasia in the world; this Note aims to discover how accepting that legal framework is in the case of illnesses that are not necessarily accompanied by physical symptoms.

II. HISTORY OF THE LEGAL FRAMEWORK AROUND PHYSICIAN-ASSISTED SUICIDE IN THE NETHERLANDS

A. *The Postma Case*

Before any statutory framework was created, the *Postma* case sparked the conversation surrounding the Right to Die in the Netherlands in the 1970s.¹³ In 1971, Andries Postma and his wife were practicing physicians in the village of Noordwolde.¹⁴ Postma's elderly mother-in-law repeatedly requested that her daughter help euthanize her, and finally, her

7. Roach, *supra* note 1.

8. Magra, *supra* note 5.

9. *Euthanasia Deaths Becoming Common in Netherlands*, CBS NEWS (Aug. 3, 2017), <https://www.cbsnews.com/news/euthanasia-assisted-suicide-deaths-netherlands/>

10. Eliza Mackintosh, *Misinformation Swirling Around Dutch Teenager's Death Ignites Debate over Euthanasia*, CNN (June 8, 2019), <https://www.cnn.com/2019/06/08/europe/noa-pothoven-euthanasia-debate-intl/index.html>.

11. Magra, *supra* note 5; Roach, *supra* note 1.

12. Magra, *supra* note 5.

13. Tony Sheldon, *Andries Postma*, 334 BRIT. MED. J. 7588 (2007), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1796690/>.

14. *Id.* at 7588.

daughter complied.¹⁵ Postma's wife was convicted of murder but given a suspended sentence of one week in prison and one year of probation,¹⁶ and the court set out criteria that allowed for a doctor not to have to keep his or her patient alive against her will.¹⁷ Postma founded Right to Die-NL in 1973, and in 1984 the highest court in the Netherlands reversed the conviction of the physician stating that "the physician was untenably torn between the requirements of the law and his medical duty to relieve his patient's suffering."¹⁸ From 1984 to 2002, physician-assisted suicide was still practiced in the Netherlands but officially remained illegal. Many studies were done on the practice at the time, which included one extensive study in the 1990s, which was the first to fully encompass the overview of medical decisions regarding end-of-life in one country.¹⁹

As the country more openly accepted physician-assisted suicide, the more prevalent the practice became, and concurrently, a new procedure for reporting these kinds of cases was established.²⁰ Most likely related, the number of reported cases of euthanasia increased, from 486 in 1990 to 1466 in 1995.²¹ As the practice spread, the need for more regulation became necessary, and the proliferation of the common practice of physician-assisted end-of-life care led to the legislative creation of the Termination of Life on Request and Assisted Suicide Act of 2002.²² This act was what started the current review process for applications for end-of-life care in the Netherlands, and it legalized both physician-assisted suicide and euthanasia.²³

15. Sheldon, *supra* note 13, at 7588; Ezekiel Emanuel, *Euthanasia: Historical, Ethical, and Empirical Perspectives*, 154 ARCH. INTERN. MED. 1890, 1896 (1994).

16. SUSAN STEFAN, RATIONAL SUICIDE, IRRATIONAL LAWS: EXAMINING CURRENT APPROACHES TO SUICIDE IN POLICY AND IN LAW 195 (American Psychology Law Society Series, 1st ed. 2016).

17. *Id.* at 195.

18. *Id.*

19. Paul J. van der Maas et al., *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990–1995*, 335 NEW ENG. J. MED. 1699 (1996).

20. *Id.*; Gerrit van der Wal & Robert JM Dillman, *Euthanasia in the Netherlands*, 308 BMJ 1346, 1348 (1994); Paul J. van der Maas et al., *Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands*, 335 NEW ENG. J. MED. 1706, 1710 (1996).

21. van der Maas et al., *supra* note 19, at 1699.

22. See *Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding* [hereinafter Termination of Life on Request and Assisted Suicide Act], Wet van 1 April 2001, Staatsblad 2001, 194.

23. *Id.*

*B. Termination of Life on Request and Assisted Suicide
(Review Procedures) Act*

The Termination of Life on Request and Assisted Suicide Act decriminalizes the practice of physician-assisted suicide and euthanasia and rewrites the requirements to consider in the process.²⁴

The requirements of due care, referred to in Article 293 second paragraph Penal Code mean that the physician:

- a. holds the conviction that the request by the patient was voluntary and well considered;
- b. holds the conviction that the patient's suffering was lasting and unbearable;
- c. has informed the patient about the situation he was in and about his prospects;
- d. and the patient hold the conviction that there was no other reasonable solution for the situation he was in;
- e. has consulted at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts a–d; and
- f. has terminated a life or assisted in a suicide with due care.²⁵

The requirements listed from the excerpt of the statute above provide an ability for suspension of prosecution of physicians who perform euthanasia. The listed requirements state that:

the patient's suffering must be unbearable with no prospect of improvement; the patient's request for euthanasia must be voluntary and persist over time (the request cannot be granted when under the influence of others, psychological illness or drugs); the patient must be fully aware of his or her condition, prospects, and options; there must be consultation with at least one other independent doctor who needs to confirm the conditions mentioned above; the death must be carried out in a medically appropriate fashion by the doctor or patient, and the doctor must be present; the patient is at least 12 years old (patients between 12 and 16 years of age require the consent of their parents).²⁶

24. *Id.*

25. *Id.*

26. *Id.*

These sections of the statute provide that the person electing to get palliative care, physician-assisted suicide, or euthanasia must be at least 12 years old, but any person between 12 and 16 years old must have parental consent to the procedure.²⁷ If the patient is between 16 and 18 years old, the patient's parents must be involved in the decision process.²⁸ This is the part of the statute that the Hague had a problem within Noa Pothoven's case as she was 17 years old and approached the clinic on her own.²⁹ Regardless of the age, "the person must have a reasonable understanding of his interests going into the end of life application process."³⁰

If the patient is 16 years old but is no longer capable of expressing his will, but prior to reaching this condition was deemed to have a reasonable understanding of his interests and has made a written statement containing a request for termination of life, the physician may not deny this request.³¹

C. *The Assen Case*

In 1994 the Dutch Supreme Court ruled that euthanasia may be performed in cases of mental suffering.³² Through the *Assen* case, the Dutch Supreme Court recognized that mental suffering can be grounds for assisted suicide.³³ The patient was severely mentally distressed but had no physical symptoms of a terminal illness.³⁴ She refused treatment for her depression, claiming that her mental suffering was such that nothing would help.³⁵ Dr. Chabot, the psychiatrist, in this case, was not prosecuted for helping with the euthanasia but was found guilty of not having a psychiatric consultant see the patient.³⁶ "The case was seen as a triumph by euthanasia advocates since it legally established mental suffering as a basis for euthanasia."³⁷

27. *Id.*

28. Termination of Life on Request and Assisted Suicide Act, *supra* note 22, at 194.

29. Roach, *supra* note 1.

30. Termination of Life on Request and Assisted Suicide Act, *supra* note 22, at 194.

31. *Id.*

32. H.J. Leenen, *Dutch Supreme Court about Assistance to Suicide in the Case of Severe Mental Suffering*, 1 Eur. J. Health L. 377 (1994).

33. HERBERT HENDIN, MD, *SUICIDE IN AMERICA*, 266, 266–67 (New and Expanded ed. 1995).

34. John Griffiths, *Assisted Suicide in the Netherlands: The Chabot Case*, 58 MOD. L. REV. 232, 234 (1995).

35. *Id.* at 235.

36. HENDIN, *supra* note 33, at 267.

37. *Id.*; See also, Johanna H. Groenewoud et al., *Physician-Assisted Death in Psychiatric Practice in the Netherlands*, 336 NEW ENG. J. MED. 1795 (1997), (discussing end-of-life decision making in Dutch psychiatric practice.).

III. THE CORE FOCUS OF THE DUE CARE ANALYSIS IN THE NETHERLANDS

The focus of this Note will look at the requirement that the pain and suffering must be “hopeless and unbearable” and the central question under this analysis is whether certain psychological illnesses and terminal mental illnesses fall into the “hopeless and unbearable” suffering requirement.

This Note also considers whether having a mental illness involving psychosis or any sort of schizoaffective disorder—any mental illness that would surpass the unbearable suffering standard—would allow for the requisite voluntariness or reasonable understanding to request euthanasia. This Note will look at studies of the kinds of psychiatric cases that have been passed through the review process and how each specific case meets the specific requirements for a successful request.

A. Analysis

Per the Termination of Life on Request and Assisted Suicide Act, physicians must establish that the patient’s suffering is “unbearable, with no prospect of improvement.”³⁸ But, physicians are encouraged to review the patient’s reported suffering in relation to the rest of the aspects of the patient’s life—from the patient’s point of view.³⁹ The severity of one patient’s suffering might be more than another patient’s suffering, even under the same conditions. The analysis of a patient’s “unbearable suffering” and “hopelessness” in the future outlook depends on the individual’s perception of his or her own situation. A patient’s perception of his or her suffering and hopelessness is dependent upon each patient’s individual life history, medical history, personality, values, and physical and mental stamina.⁴⁰ Because of the individual and personal nature of this psychiatric and medical analysis, it is important for physicians to consider the patient’s history and personal makeup when assessing his or her suffering.⁴¹

Under current Dutch law, physician-assisted suicide or doctor-based euthanasia is only legal when there is “hopeless and unbearable” suffering.⁴² In practice, this means that it is typically limited to those suffering from serious medical conditions.⁴³ These conditions would

38. Termination of Life on Request and Assisted Suicide Act, *supra* note 22, at art. 2.

39. Candace T. Player, *Death with Dignity and Mental Disorder*, 60 ARIZ. L. REV. 115, 126 (2018).

40. *Id.*

41. REGIONAL EUTHANASIA REVIEW COMMITTEES, ANNUAL REPORT 2015 14 (Apr. 2016).

42. Termination of Life on Request and Assisted Suicide Act, *supra* note 22, at 194.

43. G. K. Kimsma, *Death by Request in the Netherlands: Facts, the Legal Context and Effects on Physicians, Patients and Families*, 13 MED. HEALTHCARE & PHIL. 355, 355 (2010).

include severe pain, exhaustion, or asphyxia.⁴⁴ In a typical review of a request for physician-assisted euthanasia, physicians typically look at whether the patient was clear-headed and/or they had repeated the request several times.⁴⁵ Additionally, the prong of unbearable suffering was often substantiated with physical symptoms, function loss, dependency, or deterioration.⁴⁶ The study found that physicians “substantiate their adherence to the criteria in variable ways with an emphasis on physical symptoms.”⁴⁷

*B. The Study Results Regarding Reports that Symptoms were
“Unbearable” and “Hopeless”*

In this specific study, review board physicians looked at what was causing the symptoms to be “unbearable” or “hopeless,” and the report was as follows:

Table 2 presents the arguments given why the patient’s suffering was considered to be ‘unbearable’ or ‘hopeless.’ In 62%, physicians reported that the patient’s suffering was ‘unbearable’ because there were one or more physical symptoms; they most frequently mentioned pain (32%), dyspnea (22%), fatigue (15%) or nausea (15%). A third of all physicians reported that function loss had contributed to unbearable suffering, such as being bedridden (19%) or having a decreased appetite or capacity to eat or swallow (10%). In 63%, physicians mentioned ‘other aspects’; these included increased dependency (28%), deterioration (15%), and more rare aspects (16%), such as loneliness, being a burden to relatives, and being mentally exhausted. Physicians most often based the ‘hopelessness’ of the suffering upon the “absence of treatment alternatives” (32%), “absence of curative treatment alternatives” (28%), or “absence of treatment alternatives to relieve the patient’s symptoms,” or combinations of these (14%).⁴⁸

Although the study shows these requests are successful in cases that involve persistent and ongoing pain, the study considered additional factors such as the lack of prospect of improvement and the patient’s loss of dignity as opposed to isolating the persistence of pain factor.⁴⁹ In reporting, patients’ requests for euthanasia are also often stated to be

44. *Id.* at 356.

45. Hilde Buiting et al., *Reporting of Euthanasia and Physician-Assisted Suicide in the Netherlands: Descriptive Study*, 10 BMC MED. ETHICS 1, 3–9 (2009).

46. *Id.*

47. *Id.*

48. *Id.*

49. Buiting et al., *supra* note 45, at 3–9.

grounded in fear of losing dignity or autonomy and, to a lesser extent, pain.⁵⁰ Physicians' reviews, however, seldom reported the loss of dignity and often referenced physical impacts such as pain and dyspnea.⁵¹ The article argues that physicians prefer using physical symptoms as support because these symptoms can be more easily and objectively judged with their medical knowledge.⁵²

C. Concerns in Psychiatric Euthanasia Requests

Part of the process in getting a required second opinion from another doctor is that the patient's primary physician and a consultant are required to confirm the diagnosis of a terminal condition and the prognosis.⁵³ The outside practitioner must determine that the patient is capable and, if she believes that the patient's judgment is impaired by depression or another psychiatric or psychological disorder, she must refer the patient to a psychiatrist or clinical psychologist for further evaluation.⁵⁴

While there are many of these evaluations, most of the cases that successfully pass review are based in untreatable physical conditions. Sometimes, however, psychiatric patients that have proven to be untreatable can get euthanasia.⁵⁵

Additionally, there has been discussion about people with early dementia who have previously stated in a written will that if they ever got dementia, they would want to get euthanasia.⁵⁶ Per medical studies in the Netherlands: "One in three doctors considers it justified to respond to a request for help with suicide in people with chronic depression or early dementia. A third of the doctors (33%) think it is 'personally correct' to make a written euthanasia statement for patients in an advanced stage of dementia."⁵⁷

An argument for psychiatric-based requests euthanasia and assisted suicide is that, again as stated in Medisch Contact, "Quite a few doctors mistakenly think that physical suffering is 'mandatory' to be able to provide assistance: 'They do not know that assistance due to loss of direction, chronic depression or early dementia is permitted in principle.'"⁵⁸

50. *Id.*

51. *Id.*

52. *Id.*

53. *Id.*

54. Buiting et al., *supra* note 45, at 3–9.

55. Joost Visser, *Artsen Steunen Euthanasie Bij Dementie* [Doctors Support Euthanasia in Dementia], MEDISCH CONTACT (June 30, 2011), <https://www.medischcontact.nl/nieuws/laatste-nieuws/artikel/arsen-steunen-euthanasie-bij-dementie.htm>.

56. *Id.*

57. *Id.*

58. *Id.*

Most Dutch psychiatrists, doctors that study psychiatric euthanasia and assisted suicide, and the Dutch public typically disapprove of psychiatric euthanasia.⁵⁹ Although there is outward-facing disapproval for the practice of psychiatric euthanasia, the numbers seem to contradict public opinion.⁶⁰

In the last twenty years, there has been a steady increase in psychiatric euthanasia cases, culminating in eighty-three cases in 2017. The per-capita equivalent in the United States would be about 1,600 cases a year.⁶¹ Most of the requests for psychiatric euthanasia are women, and most had a history of attempted suicides, hospitalizations, and chronic, severe mental illness.⁶² Many women in the Netherlands went to the End of Life Clinic in the Hauge for their psychiatric euthanasia requests.⁶³ (Noa Pothoven sought euthanasia there but was refused.)⁶⁴

D. *The Consideration of Competency*

While the practice of psychiatric euthanasia and assisted suicide is legal in the Netherlands, the two central questions that Dutch physicians and lawmakers ask in creating policy guiding the practice are:

- (1) How do physicians assess that the symptoms of this mental illness are persistent without alleviation;⁶⁵ and
- (2) How can one prove that there is no other medical alternative?⁶⁶

Beyond the medical review considerations, can someone with a severe mental illness adequately consent to this procedure with the level of thought and reasonableness that a person should have when making a successful request for euthanasia or assisted suicide? In consideration of whether a patient has the requisite competence to have a successful request for euthanasia or assisted suicide, the Regional Euthanasia Review Committee uses a modern, abilities-based construct: “Decisional competence means that the patient is able to understand relevant

59. Pauline SC Kouwenhoven et al., *Opinions of Health Care Professionals and the Public After Eight Years of Euthanasia Legislation in the Netherlands: A Mixed Methods Approach*, 27 PALLIATIVE MED. 273, 274 (2012).

60. Scott Kim, *How Dutch Law Got a Little Too Comfortable with Euthanasia*, ATLANTIC (June 8, 2019), <https://www.theatlantic.com/ideas/archive/2019/06/noa-pothoven-and-dutch-euthanasia-system/591262/>.

61. Kouwenhoven et al., *supra* note 59, at 275.

62. Scott Y.H. Kim et al., *Euthanasia and Assisted Suicide of Patients with Psychiatric Disorders in the Netherlands 2011 to 2014*, 73 J. AMA PSYCHIATRY 362, 362 (2016).

63. *Id.*

64. Roach, *supra* note 1.

65. REGIONAL EUTHANASIA REVIEW COMMITTEES, CODE OF PRACTICE 13–14 (Apr. 2015).

66. *Id.* at 15.

information about his [or her] situation and prognosis, consider any alternatives and assess the implications of his decision.”⁶⁷

To comply with the requirements of the Dutch Euthanasia Act, physicians must thoroughly believe that patients making end of life requests are competent to make decisions, such that they are able to understand their diagnosis, their prognosis, and the consequences of their decision to move forward with euthanasia or physician-assisted suicide.⁶⁸ Patients must make the request themselves, but Dutch law does not require a written request; a verbal request is sufficient.⁶⁹ The Dutch Euthanasia Act also does not require more than one request or require a time period between any euthanasia request.⁷⁰

According to the Code of Practice, “the physician must be satisfied that the request is unequivocal and consistent,” although “a request need not . . . have persisted for a long time in order to be granted.”⁷¹ The physician must show that request was made free from undue influence and that physicians exercise caution if a relative becomes too involved in the patient’s decision.⁷²

The physician must inform the patient of his or her prognosis, and when the patient is informed of such, the patient must be able to comprehend the gravity of the prognosis, and both the physician and patient must conclude that “there is no reasonable alternative” to euthanasia.⁷³

Physicians consider whether there is a reasonable alternative to euthanasia by looking at the number of treatments the patient has already undergone, possible side effects of treatment, and “the patient’s age and mental stamina.”⁷⁴ Patients are allowed to refuse treatment, and their refusal does not necessarily preclude a request for euthanasia or assisted suicide to be granted.⁷⁵

E. *The Right to Die with Dignity*

The alternative argument to the regulation of this kind of psychiatric euthanasia and assisted suicide is one for the right to die with dignity. The Netherlands’ whole program around the Right to Die is that the patients seeking euthanasia, assisted suicide, or palliative care are looking to help

67. *Id.* at 8.

68. *Id.* at 6.

69. *Id.*

70. CODE OF PRACTICE, *supra* note 65, at 6.

71. *Id.*

72. *Id.*

73. Termination of Life on Request and Assisted Suicide Act, *supra* note 22, at art. 2(1)(c)–(d).

74. CODE OF PRACTICE, *supra* note 65, at 15.

75. *Id.* at 16.

ease the pain in their terminal illness. Should the case also be for terminal illnesses that do not have physical symptoms? The Netherlands does allow for the Right to Die with dignity for persons with severe and terminal mental illnesses,⁷⁶ but the practice is exercised with extreme caution and trepidation due to the nature of mental illnesses and some of the symptoms of these diseases, such as depression, are a persistent and unbearable desire to die.⁷⁷

A study done on behalf of the Academy of Psychosomatic Medicine stated that:

A common concern about psychiatric EAS is the issue of mental competence or capacity (decision-making capacity) of those requesting it. 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, neurocognitive disorders, some forms of depression, anorexia nervosa, and mental retardation.

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. With abilities-based constructs, however, evaluating the capacity of patients is not always straightforward and is widely recognized to be a complex, challenging task. Capacity evaluations are guided by these broad criteria, even in complex clinical situations, and are influenced by the criteria used and personal views of assessors.⁷⁸

These authors go on to discuss that the core aims of psychiatry are to prevent suicide and to treat those whose psychological symptoms drive them to the idea of ending their own lives.⁷⁹ This strange divergence becomes problematic when long-term patients with severe and unrelenting psychiatric diagnoses see no available treatment or no possible alleviation of their symptoms. Psychiatrists “want to avoid a poorer quality of life for the patient but they also do not want to succumb

76. *Id.*

77. AM. PSYCHIATRIC ASS'N, AMERICAN PSYCHIATRIC ASSOCIATION: DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (6th ed. 2013).

78. Samuel N. Doernberg et al., *Capacity Evaluations of Psychiatric Patients Requesting Assisted Death in the Netherlands*, 57 PSYCHOSOMATICS 556, 565 (2016).

79. *Id.* at 565.

to a request of a patient whose decision-making may be impaired or, even if it is only partially impaired, may have problems making prudent decisions relating to their long-term desires.”⁸⁰ The doctors in this study do not believe that a palliative approach in psychiatry does not mean giving up on a patient but rather involves redefining the goals of care.⁸¹ Sometimes these doctors do indeed recognize that these mental illnesses are fatal, but they believe that with the improvement of mental health care, there might be fewer requests for euthanasia and assisted suicide—is likely what Noa Pothoven was trying to illustrate all along.⁸²

Studies in Belgium have looked at the model for psychiatric based euthanasia and assisted suicide requests and, similarly, found issues with the widespread practice.⁸³ Lawmakers and doctors in Belgium, similar to the approach taken in the Netherlands, find that clinical assessment of the “unbearable” and “hopeless” aspect of symptoms are very difficult.⁸⁴ These physicians note that extreme care should be required before a request for euthanasia or assisted suicide for psychological suffering from a psychiatric patient is granted.⁸⁵ In reviewing cases from the Netherlands, these Belgian physicians noted that some of these psychiatric cases were handled “suboptimally.”⁸⁶

F. *Comparison—The Belgian Factors for Due Care*

The study coming from Belgium focused on five significant concerns regarding the assessment of due care for psychiatric patients, and they are:

- 1) the patient’s mental competence, as this might be affected by a psychiatric disorder;
- 2) the requirement for the psychiatric disorder to be incurable, as some (symptoms of) psychiatric disorders tend to change over time;
- 3) the requirement for the well-considered nature of the request, as a death wish may be a symptom of a psychiatric disorder;

80. Martina A. Hodel & Manuel Trachsel, *Euthanasia or Assisted Suicide in Patients with Psychiatric Illness*, 316 J. AMA 2153, 2154 (2016).

81. *Id.* at 2154.

82. *Id.*; Roach, *supra* note 1.

83. Monica Verhofstadt et al., *Psychiatric Patients Requesting Euthanasia: Guidelines for Sound Clinical and Ethical Decision Making*, 64 INT’L J.L. & PSYCHIATRY 150, 151 (2019).

84. *Id.* at 151.

85. *Id.*

86. *Id.*

4) the constant and unbearable nature of the psychological suffering, given that a clear definition and an effective assessment instrument are still lacking; and

5) the requirement of the non-alleviability of the psychological suffering.⁸⁷

Currently, physicians are trepidatious to move forward with euthanasia and physician-assisted suicide based on psychiatric claims because of the nature of the coherence of the patient making a claim, and because there is no clear definition of “unbearable suffering” in relation to a psychiatric condition.⁸⁸ Physicians are cautious because the desire to die, even the repeated and continuous request for euthanasia, might be a symptom of the psychiatric disorder.⁸⁹ Physicians are not certain that these symptoms may be alleviated with an alternative kind of care in the future, but it’s possible that these symptoms may only get worse.⁹⁰

The uncertainty of the future of the diagnoses related to mental illnesses makes a good argument for not allowing euthanasia and assisted suicide requests to pass through review because the symptoms could possibly improve with time and treatment. Alternatively, some mental illnesses only get worse as time progresses, and the desire to die, the “unbearable pain,” delusions, or mind-altering symptoms related to severe mental illnesses might cause a more convincing case for psychiatric physician-assisted suicide and euthanasia.⁹¹

G. The Demographics Actually Receiving This Treatment

In a study done by Departments of Bioethics and The National Institute of Health, results show that:

the patients receiving EAS are mostly women and of diverse ages, with various 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 (but not always), and disagreement among physicians—especially regarding

87. *Id.*

88. Hilde Buiting et al., *Reporting of Euthanasia and Physician-Assisted Suicide in the Netherlands: Descriptive Study*, 10 BMC MED. ETHICS 1, 3–9 (2009).

89. AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION: DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013).

90. CODE OF PRACTICE, *supra* note 65, at 16.

91. *Id.*

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 the physicians who perform and report EAS. Whether the system provides sufficient regulatory oversight remains an open question that will require further study.⁹²

This specific study states that while all euthanasia and assisted suicide cases should be reviewed carefully and decided with great weight, cases involving psychiatric euthanasia and assisted suicide require special scrutiny.⁹³ The major discussion around the scrutiny about psychiatric euthanasia and assisted suicide cases deals with the fact that psychiatric disorders are a major public health problem,⁹⁴ can impair decision making⁹⁵ as mentioned in the analysis above, and psychiatric disorders are stigmatized.⁹⁶ Because of the concerns about undue influence, clarity of thought, and ability to treat symptoms to alleviate symptoms of chronic mental illnesses, the regulation of psychiatric euthanasia and physician-assisted suicide is of great interest to lawmakers and important to public policy.⁹⁷

There is seemingly no clarity for the legal due care criteria regarding psychological euthanasia and assisted suicide, so most of the policy regarding this issue has been left to hospitals developing their own protocols.⁹⁸

CONCLUSION

According to a study done by the American Medical Association, the disorders diagnosed for successful psychiatric based euthanasia and assisted suicide requests were: depression, including depression with psychotic features (35%); anxiety other than PTSD, including generalized anxiety disorder, phobias, obsessive-compulsive disorder, panic disorder, and social phobia (13%); PTSD or post-traumatic stress

92. Kim et al., *supra* note 62, at 367.

93. REGIONAL EUTHANASIA REVIEW COMMITTEES, ANNUAL REPORT 2013 (Sept. 2014).

94. WorldHealth Organization, Public health action for the prevention of suicide: a framework (2012), http://apps.who.int/iris/bitstream/10665/75166/1/9789241503570_eng.pdf.

95. SCOTT Y.H. KIM, EVALUATION OF CAPACITY TO CONSENT TO TREATMENT AND RESEARCH 34 (2010).

96. Arthur H. Crisp et al., *Stigmatisation of People with Mental Illnesses*, 177 BRIT. J. PSYCHIATRY 4, 4–7 (2000).

97. Kim et al., *supra* note 62, at 365.

98. Monica Verhofstadt et al., *Psychiatric Patients Requesting Euthanasia: Guidelines for Sound Clinical and Ethical Decision Making*, 64 INT'L J.L. & PSYCHIATRY 150, 151 (2019).

residua (11%); psychotic disorders, including schizophrenia, schizoaffective disorder, psychosis not otherwise specified, psychosis due to a medical condition (8%); somatoform disorders, including pain disorders, somatization disorder, hypochondria (7%); bipolar depression (6%); substance abuse (5%); eating disorders (3%); neurocognitive impairment, including mental retardation, incipient dementia, brain tumor surgical sequelae, stroke (3%); prolonged grief (2%); autism spectrum (2%); and various other disorders (5%).⁹⁹ These conditions were typically co-occurring with other psychiatric conditions but were all part of the cases that were approved for euthanasia or assisted suicide.¹⁰⁰

Most of the patients in this study had extensive prior treatment, and 56% of the subjects refused further treatment.¹⁰¹ Fifteen of the sixty-six patients in the study were coming from End of Life Clinics.¹⁰² Physicians found that most of the patients in this study had a long history of psychiatric disease and that had been treated at one time.¹⁰³ In the study, most of the patients were women,¹⁰⁴ and the ratio of women requesting euthanasia or assisted suicide was the reverse ratio of women to men attempting suicide in the Netherlands.¹⁰⁵

There is not a clear answer on what kinds of cases are the kinds that cause successful requests for euthanasia or assisted suicide, but most of them are diagnoses that hold severe and terminal physical symptoms or those that have chronic and severe psychiatric issues.¹⁰⁶ Even so, there is still no clear legal standard for how the lawmakers in the Netherlands or hospitals within the Netherlands should deal with cases regarding psychiatric euthanasia or assisted suicide.¹⁰⁷ The Termination of Life on Request and Assisted Suicide Act legalizes the Right to Die, and euthanasia and assisted suicide do not outline the requirements for psychiatric based requests beyond the requisite understanding of the consequences of the request the patient is making, the underlying symptoms cause unbearable suffering causing hopelessness, the patient understands the prognosis and the physician and patient agree there is no alternative treatment, and that there is a second outside opinion and review.¹⁰⁸

Studies, much like the aforementioned study in this conclusion, illustrate the kinds of psychiatric cases that have passed through regional

99. Kim et al., *supra* note 62, at 365.

100. *Id.*

101. *Id.*

102. *Id.*

103. *Id.*

104. Kim et al., *supra* note 62, at 365.

105. *Id.* at 366.

106. *Id.*

107. *Id.*

108. See Termination of Life on Request and Assisted Suicide Act, *supra* note 22.

euthanasia committee (RTE) review,¹⁰⁹ but these studies are not the established law on how to create a successful request for EAS based on a chronic and severe psychiatric condition. Noa Pothoven's request was denied based on her age, and despite the ambiguities in the age analysis¹¹⁰ (she was 17, and her request was denied based on age), it is uncertain whether Ms. Pothoven's request would be approved based on the merits of her claim. She seemingly did fit into the profile of the successful patient EAS request in the study (PTSD, multiple suicide attempts, eating disorder, depression, self-harm, and desire to die),¹¹¹ but there is no legal directive on how a psychiatric based case should get approved or denied. Theoretically, if age was not taken into account, she could have successfully undergone physician-assisted euthanasia. But public opinion and physician opinion argue against the "slippery slope" that is allowing EAS case approval for reasons beyond terminal illnesses.¹¹² Ms. Pothoven passed away peacefully in her own home, and her message for a better framework for mental healthcare went viral, much like her story did.¹¹³ Regardless of whether euthanasia and assisted suicide should be allowed for psychiatric reasons, as it is more of a moral debate rather than a scientific one, there is widespread agreement that a better framework and more widespread availability for mental health support would help reduce these requests in the future.¹¹⁴

109. Kim et al., *supra* note 62, at 365.

110. Termination of Life on Request and Assisted Suicide Act, *supra* note 22; Roach, *supra* note 1.

111. *Id.*

112. Lois Snyder, *Bioethics, Assisted Suicide, and the "Right to Die,"* 13 ANNALS CLINICAL PSYCHIATRY 13, 17 (2001).

113. Roach, *supra* note 1.

114. Scott Kim, *How Dutch Law Got a Little Too Comfortable with Euthanasia*, ATLANTIC (June 8, 2019), <https://www.theatlantic.com/ideas/archive/2019/06/noa-pothoven-and-dutch-euthanasia-system/591262/>.

