Author’s response to reviews

Title: Euthanasia and physician-assisted suicide in patients suffering from psychiatric disorders: A cross-sectional study exploring the experiences of Dutch psychiatrists.

Authors:

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Author’s response to reviews:

Dear dr. Brettschneider,

First of all, we would like to express our sincere thanks to the editor and the reviewers, who read our manuscript (BPSY-D-18-00547) and identified areas that needed corrections or clarification.

The page numbers and line numbers refer to the revised manuscript. Added sections are printed in bold font and removed sections are crossed out (Please see supplementary material attached)

Yours sincerely,

Kirsten Evenblij, on behalf of Roeline Pasman, Rosalie Pronk and Bregje Onwuteaka-Philipsen

Reviewer 1

The study reports the findings from a questionnaire survey of Dutch Psychiatrists concerning requests for Euthanasia or Physician-Assisted Suicide (EAS) among patients with psychiatric illness. The context of the study is the third evaluation of the Dutch Euthanasia act. The study attempts to shed light on the number of granted or denied requests for EAS among Dutch psychiatric patients and to characterise the patients requesting EAS. The subject of EAS requests in psychiatric patients has significant medico-legal connotations and the study can make an important contribution to the current debate over psychiatric EAS. I have the following concerns:

Comment 1:
Comment: From the title it is not entirely clear whether the study is focussed on psychiatric patients, psychiatrists, psychiatric practice, or a combination of the three.

Reply: The study is about euthanasia in psychiatric practice. To study this, we explored the experiences of psychiatrists (research subjects) with requests for euthanasia and with performing euthanasia in people with psychiatric disorders (patient population).

To clarify we changed the title, page 1 line 5-6, into: Euthanasia and physician-assisted suicide in patients suffering from psychiatric disorders: A cross-sectional study amongst exploring the experiences of Dutch Psychiatrists.

Comment 2.0:

Comment: According to the authors, the first aim of the study was: i) provide estimates of the incidences of EAS requests to psychiatrists and of compliance with such requests [lines 78-79]. For what time period(s) was this incidence calculated?

Reply: The time period concerned one year. In the questionnaire, physicians were asked: How many patients have made a request for euthanasia in the past year, and How many times did you perform euthanasia in the past year. In the instructions of the questionnaire, the past year was defined as the last 12 months prior to completing the questionnaire. After re-reading the Data collection section we noticed that we had not described that these two questions were included in the questionnaire. The data collection started May 2016 and closed September 2016. Therefore, strictly, the incidence concerns the period of May 2015 - September 2015 to May-September 2016, depending on when the physician completed the questionnaire. To make the procedure more clear, we made some changes to the text:

Data collection section, page 5, line 96-100: Responding psychiatrists were asked whether they had ever received an EAS request and had ever performed EAS, and how many patients had made an EAS request in the 12 months prior to completing the questionnaire and if so, whether how many times they had complied with this request/performed EAS in the 12 months prior to completing the questionnaire.

Analysis section, which was largely rewritten, page 6, line 108-114: Annual frequencies were estimated by averaging and weighing the numbers of requests for EAS and of actual instances of EAS. The number of unique patients requesting EAS and number of unique patients receiving EAS as reported by the participating psychiatrists were extrapolated to make an estimation for the number of EAS requests received and performed by all psychiatrists in the Netherlands for a one year period from 2015 to 2016. For this purpose, the number of unique patients requesting EAS and number of unique patients receiving EAS were multiplied with the weighing factor.

Results section, page 7, line 132-134: The total incidence of explicit requests number of patients explicitly requesting for EAS was estimated to be 1100 for all psychiatrists in the Netherlands in 2016a one year period from 2015 to 2016., of which estimated 60 (5.6%) were carried out patients received EAS in this period.
Also in other parts of the text we adapted the text to be more specific, please see Abstract, page 2, line 37-40

Discussion section, page 10, line 118-120

Discussion section, page 10, line 229-233

Comment 2.1:

Comment: The responding psychiatrists were asked whether they had ever received an EAS request and if so, whether they had complied with this request. [lines 91-93]. Were the physicians to provide all the EAS requests received over their entire career or only for a specified time period? If so, which time period was specified?

Reply: Physicians were asked whether they had ever received an EAS request, meaning ever in their career. Although this was not specified, the authors think it is unlikely that this was misunderstood especially given the follow-up questions about requests received and EAS performed in the last 12 months, please see Comment 2.0.

Comment 2.2:

Comment: The annual frequencies were estimated by averaging and weighing the numbers of requests for EAS and of actual instances of EAS [lines 98-99]. What does this mean? Was each EAS request considered unique or was each patient requesting EAS considered unique? Was the average done over each psychiatrist's career or over each calendar year or over a specific time period?

Reply: Weighing was performed to make an estimation for the number of EAS requests received and performed by all psychiatrists in the Netherlands for a one year period from 2015 to 2016. Psychiatrists were asked: 1) how many patients made a request for EAS in the 12 months prior to completing the questionnaire, and 2) how many times did you perform EAS in the 12 months prior to completing the questionnaire (Please see comment 2.0). The time period covered by these questions was thus one year. For these questions each patient requesting and receiving EAS was considered unique.

To clarify the procedure we rewrote the Analysis section, page 6, line 108-115: Annual frequencies were estimated by averaging and weighing the numbers of requests for EAS and of actual instances of EAS. The number of unique patients requesting EAS and number of unique patients receiving EAS as reported by the participating psychiatrists were extrapolated to make an estimation for the number of EAS requests received and performed by all psychiatrists in the Netherlands for a one year period from 2015 to 2016. For this purpose, the number of unique patients requesting EAS and number of unique patients receiving EAS were multiplied with the weighing factor. The weighing factor (12.40) was calculated by dividing the total number of
eligible psychiatrists in the Netherlands (n=2,566) by the number of responding psychiatrists (n=207).

Comment 2.3:

Comment: Of the responding psychiatrists, 46% had received an explicit request for EAS at least once and four percent performed EAS in his career at least on time. Sixty-two percent of the psychiatrists who had ever received an explicit request, had refused such a request at least one time. One-fourth of the psychiatrists had received at least one explicit request in the last year and three percent of them had actually performed EAS in this last year. The total incidence of explicit requests for EAS was estimated to be 1100 in 2016 of which an estimated 60 (5.6%) were carried out [lines 111-116]. This is confusing. Line 111 speaks of requests throughout the psychiatrists’ career while line 114 speaks of requests in the previous 12 months and the authors report the estimate for 2016 as 1100. Was the figure of 1100 estimated from career-long requests, requests in the previous year, or requests in 2016?

Reply: The first two sentences of this paragraph concern the psychiatrists’ whole career.

To clarify this we made some changes to the text, Results section, page 7, line 127-130: Of the responding psychiatrists, 46% had received an at least one explicit request for EAS at least once and four percent had performed EAS at least one time in throughout his career at least on time. Sixty-two percent of the psychiatrists who had ever received an explicit request throughout his career, had refused such a request at least one time.

The last two sentences of this paragraph concern the 12 months prior to completing the questionnaire (May-September 2015 to May-September 2016). To clarify this we made some changes, Result Section, page 6-7, line 130-134: One-fourth of the psychiatrists had received at least one explicit EAS request in the last year the previous 12 months and three percent of them had actually performed EAS in this last year the previous 12 months. The total incidence number of patients requesting explicit requests for EAS was estimated to be 1100 for all psychiatrists in the Netherlands in a one year period from 2015 to 2016. of which an estimated 60 (5.6%) were carried out patients received EAS in this period.

Comment 2.4:

Comment: The questionnaires were sent out in May 2016. Were the psychiatrists asked to respond on the number of EAS requests in the period January-May 2016 or the previous 12 months? Was the estimate of 1100 requests in 2016 based on the period January-May 2016 and extrapolated forward or on the time period May 2015-May 2016?

Reply: Please see previous comments as well. Indeed the questionnaire was sent May 2016 and physicians were asked for the number of patients requesting EAS in the previous 12 months. The time period covered was thus one year.
Comment 2.5:

Comment: The time taken for the decision-making process from the moment of the first explicit EAS request to its granting, ranged from 2 months to 2.5 years [lines 135-136]. Again, were repeat requests from the same patient over this time period considered unique or was each patient considered unique? If an EAS request was first made 2.5 years ago but was only granted in 2016, was this request counted as pertaining to 2016 or to 2.5 years ago?

Reply: The paragraphs under the subheading “EAS requests that were granted” and “EAS requests that were refused” concern unique patient cases of patients whose request was either granted or refused. Psychiatrists were asked to fill out questions about “the last time they granted an EAS request from a patient with a psychiatric disorder” and “the last time they refused an EAS request from a patient with a psychiatric disorder”. No time frame was provided so physicians could describe a case which happened years ago but the case might as well happened in the first months of 2016. 9 psychiatrists completed questions about the last case in which they granted the request. The question you refer to was phrased as following: “how long did the decision-making take from the first explicit request for EAS of this patient to the performance of EAS”. In one patient, it took 2 months from the first explicit request to the performance of EAS. In another patient it took 2.5 years. Only patients who pertained their wish for EAS could receive EAS as a stable wish for EAS is one of the due care criteria.

Comment 3:

Comment: Part of the second aim of the study was to describe the decision making process following requests for EAS [line 80]. The results however generally report the characteristics of, and the reasons for, the psychiatrists' decisions rather than the decision making process itself [see tables 1 & 3].

Reply: Indeed, we meant to describe characteristics of the decision making process including the duration of the decision making process, consultation of other physicians and reasons to refuse. We made some changes to explicate this:

Introduction section, page 5, line 82-84: and ii) to describe the demographic and clinical characteristics of patients requesting EAS because of psychiatric suffering, the characteristics of the decision making process and outcomes of these requests.

Results section, page 8, line 155: Characteristics of the dDecision-making and practice of EAS

Results section, page 9, line 187: Characteristics of the dDecision-making and reasons to refuse the EAS request

Table 3, page 19: Characteristics of the decision making process: dDuration of decision-making, consultation and reasons to refuse the request*
Comment 4:

Comment: A questionnaire was sent to the home or work addresses of a random sample of 500 psychiatrists [lines 86-87]. It is important to describe the process of randomization. Was the sample size calculated?

Reply: No sample size calculation was needed since this was a descriptive study. The number was based on previous nation-wide studies on euthanasia in the Netherlands. The random sample was obtained by IMS Health which manages a national databank of registered physicians. A file with the home or work addresses of the 500 psychiatrists that were randomly selected from this database was provided to the researchers.

We added the following sentence to clarify this procedure: Design and participants section, page 5, line 91-92: Addresses were obtained from a national databank of registered physicians (IMS Health).

Comment 5:

Comment: The fact that non-responders (51% of the original sample) seem to have been those with no experience with EAS and/or had principal objections to EAS [see lines 105-106], may have introduced an important bias as the responders would then tend to be only those who had granted a request for EAS.

Reply: Of the 218 psychiatrists who did not participate, only 29 returned a response card indicating the reason for non-participation. The majority (n=18) did not participate because of a lack of time. Nine did not participate because they did not have experience with EAS and only 2 because of personal objections. In the Netherlands, nation-wide studies researching the practice of EAS have been performed every five year since 1990. Over time we have noticed that the response rates are getting lower even though EAS (also in psychiatric practice) is increasingly being accepted and the incidence is increasing. It is likely that the lower response rate is due to the high work pressure and the substantial number of requests to participate in research received by physicians. Taking this into account, as well as the fact that the majority of the non-responders that gave a reason for their non-response did not participate due to a lack of time, we consider it unlikely that an important bias has been introduced. Also our results show that only 4% of the psychiatrists had ever performed EAS whilst 46% reported to have ever received a request. This shows that also physicians who did not perform EAS filled out the survey.

We added the numbers of respondents reporting each of the reasons for nonparticipation, Results section, page 6, line 118-120: Some non-responders (29 of the 218) sent a response card providing the reason for not participating, including: lack of time (n=18), no experience with EAS (n=9) and principal objections to EAS (n=2).

Comment 6:
Comment: Experiences with EAS [lines 110-116]. It would have been very informative to provide the breakdown of the characteristics of the psychiatrists who granted a request for EAS versus those who refused to grant a request for EAS. Were there any associations between the granting/denial of a request for EAS and the age, gender, professional experience, religious tendency, previous experience of EAS, etc. of the psychiatrists?

Reply: We agree with the reviewer that this would indeed be very interesting. Unfortunately, this is not be feasible because psychiatrists granting a request for EAS is rare. Only 9 psychiatrists completed the questions on a case in which they granted a request. Given the small numbers, associations would be unreliable.

Comment 7:

Comment: A questionnaire was sent to a random sample of 500 Dutch psychiatrists (response 49%) [lines 32-33]. The response rate of 49% actually refers to the 425 who met inclusion criteria and not to the initial 500 - see lines 103-104.

Reply: Thank you for pointing this out to us. We added the following sentence to the Abstract section, page 2, line 32-33: A questionnaire was sent to a random sample of 500 Dutch psychiatrists. Of the 425 eligible psychiatrists (response 49%) responded.

Comment 8:

Comment: In practice however only one percent of all reported EAS cases in the Netherlands in 2017 concerned people with psychiatric disorders [lines 54-55]. It would be useful to include the actual number of EAS cases.

Reply: As requested, we added the total number of reported EAS cases in the Netherlands to the Introduction section, page 4, line 57-59: In practice however only one percent of all 6585 reported EAS cases in the Netherlands in 2017 concerned people with psychiatric disorders

Comment 9:

Comment: Between 2008 and 2017, the annual number of EAS cases reported to the Regional Euthanasia Review Committees increased from 0 to 83 cases [lines 65-66]. I assume these are EAS cases in psychiatric patients?

Reply: This is correct. We added ‘in psychiatric patients’ to this sentence, see Introduction section, page 4, line 68-69: Between 2008 and 2017, the annual number of EAS cases in psychiatric patients reported to the Regional Euthanasia Review Committees increased from 0 to 83 cases.
Comment 10:

Comment: [lines 103-109]: It would have been useful to include the place of work of responders: private practice vs institutional/hospital, urban vs rural practice, etc.

Reply: Psychiatrists were asked where they worked and could provide more than one answer: 72.8% worked in a private practice, 29.6% in a mental health facility, 11.1% on a psychiatric ward in a general hospital, and 12.3% in another place (more than one answer possible). Unfortunately, we do not have information on their work or geographic location.

We added the place of work of responders to the Results section, page 6, line 120-122: Of the 207 responding psychiatrists, 72.8% worked in a private practice, 29.6% in a mental health facility, 11.1% on a psychiatric ward in a general hospital, and 12.3% in another place (more than one answer possible).

Comment 11:

Comment: Nine of the psychiatrists who filled out the questionnaire described a case in which they granted an explicit EAS request [line 118]. Is this 100% of the psychiatrists who granted EAS? If so, it would be useful to state it.

Reply: Unfortunately, we cannot provide a clear-cut answer to this question. Based on the answers provided by the respondents, it appears that not all psychiatrists who completed questions on the most recent case in which they granted a request, actually performed the EAS themselves as some of them reported to never have performed EAS. It is likely that in case the psychiatrist did not perform the EAS him/herself, the EAS was performed by a general practitioner or someone of the End-of-Life Clinic. However, in the questionnaire we did not ask whether the psychiatrist had performed the EAS him/herself. In addition, not all who reported to have performed EAS have completed the questions on the most recent case, possibly due to time constraints. We added this explanation to the

Data collection section, page 6, line 103-105: Note that granting an EAS request is not tantamount to actually performing EAS. This may lead to a discrepancy in the number of psychiatrists who filled out questions on a granted cases and the number psychiatrists reporting to have ever performed EAS.

Results section, page 7, line 138-140: Based on the answers provided by the respondents, it appears that not all psychiatrists who completed questions on the most recent case in which they granted a request, actually performed the EAS themselves.

Comment 12:
Comment: Of the 66 patients whose request was refused…[line 145]. Were all the original 93 requests [line 142] refused or only 66? It would be very helpful to have a flow-chart of some sort to show the numbers of responders-non-responders, EAS granted-EAS refused, alive-dead, etc.

Reply: Unfortunately we found out that we made a mistake in the analysis resulting in a lower total number of psychiatrists who had ever received an explicit request for EAS. After correction for this mistake, the total number of psychiatrists who had ever received an explicit request for EAS was found to be 112 (instead of 93). Below an overview of some key numbers:

- 500 psychiatrists invited
  - 75 did not meet the inclusion criteria
  - 425 did meet the inclusion criteria
- Of the 425 eligible psychiatrists
  - 218 did not participate
  - 207 did participate
- Of the 207 respondents
  - 95 psychiatrists had never received an explicit request
  - 112 psychiatrists had ever received an explicit request
- Of the 112 psychiatrists who had ever received an explicit request:
  - 66 completed questions about the most recent case in which they refused the request
  - 9 completed questions about the most recent case in which they granted a request. 5 out of 9 psychiatrists had also filled out questions on the most recent case in which they refused a request, therefore 112 + 9 + 42 = 117 instead of 112.
  - 42 did not fill out questions on a granted case nor a refused case. Possibly because of filling out all these questions would be too time consuming or because the psychiatrists did not remember all the details of the case.

The authors are of the opinion that these numbers have been described clearly in the text (note some numbers were corrected):

In the Results section, page 6, line 117-120: Of the 500 selected psychiatrists, 75 did not meet the selection criteria after all. Of the remaining 425 psychiatrists, 207 responded (response 49%). Some non-responders (29 of the 218) sent a response card providing the reason for not
participating, including: lack of time (n=18), no experience with EAS (n=9) and principal objections to EAS (n=2).

In the Results section, page 7, line 127: Of the 207 [this number was added for clarity] responding psychiatrists, 46%54% had received at least one explicit request for EAS.

In the Results section, page 7, line 136-138 we added the number of patients requesting EAS: Of the 112 responding psychiatrists who ever received a request for EAS, nine of the psychiatrists who filled out the questionnaire described a answered questions on the most recent case in which they granted an explicit EAS request made by a patient with a psychiatric disorder (Table 1).

In the Results section, page 8, line 163-165: Of the 93112 responding psychiatrists who ever received a request for EAS, 71%58.9% (n=66) answered questions about the last request that they refused on the most recent case in which they refused an explicit EAS request.

As you requested (comment 16), we choose to only report percentages but the absolute number of psychiatrists who ever received an explicit request can be easily be calculated based on the information provided.

Comment 13:

Comment: I suggest changing the heading of this section [line 180]: After refusing the EAS request // outcomes following refusal of EAS request

Reply: We changed the heading as suggested, Results section, page 10, line 207: After refusing the EAS requestOutcomes following refusal of EAS request

Comment 14:

Comment: The data show, however, a shift in the nature of suffering underlying the request [line 206]. The authors should comment on possible causes for this shift.

Reply: Due to the verdicts of the euthanasia review committees, a position paper of the Royal Dutch Medical Association and the guideline of the Dutch Association for Psychiatrists, it has become more commonly known that EAS in patients suffering from (solely) psychiatric disorders is legally possible. Psychiatric patients without somatic comorbidity are now more aware that they can request EAS and that their request can be granted. Psychiatrists may also be more willing to perform EAS in patients without somatic comorbidity now that they are aware that these patients can be eligible. Moreover, many cases of EAS in psychiatric patients are performed by the End-of-life clinic which specializes in complex cases such as requests from people with psychiatric disorders.

This explanation was added to the Discussion section, page 11, line 239-245
Comment 15:

Comment: In the discussion on limitations of the study, the authors comment that physicians other than psychiatrists may also receive requests for EAS from psychiatric patients [lines 250-251]. Some discussion of this fact together with any relevant literature/figures would be appropriate in the background section to give a better context for the incidence of EAS requests from psychiatric patients restricted to psychiatric practice.

Reply: Unfortunately there is no literature on requests from psychiatric patients outside psychiatric practice. The only figures we know of are from the Dutch euthanasia review committees who report on EAS cases that were carried out and reported to them. In 2017, 36 out of 83 cases of EAS in psychiatric patients the EAS were reported by a psychiatrist (43%), 22 (26%) were reported by a general practitioner, 6 by a specialist elderly care (17%), and 19 (23%) by another physician (for example a resident in psychiatry). However, it is unknown to what extent these percentages can be extrapolated to the requests.

We rephrased the following sentence and added that there is no literature available in the Discussion section, page 13, line 188-291: We know practice indicates, however, that other physicians (e.g. general practitioners), also receive EAS requests from psychiatric patients. This may have led to an underestimation of the number of requests and the frequency of compliance with these requests in psychiatric patients, although there is no literature available on requests from psychiatric patients outside psychiatric practice to support this.

Comment 16:

Comment: In the results section concerning the main reasons for the EAS request [lines 152 and following], consistency should be maintained in reporting the results as either percentages, actual numbers, or both.

Reply: Although we would prefer to report percentages everywhere, we chose to report only actual numbers in the section on granted cases because the total n is so low. In the section on requests that were refused we have deleted the actual numbers and use only the percentages to improve consistency as suggested by the reviewer, see Results section, page 8-10, line 163-215.

Comment 17:

Comment: There are a number of grammatical errors.

Reply: Although, the original manuscript was checked by a native speaker, it was checked again after completing this revision.

Reviewer 2
This is a useful paper. Apart from a number of non standard uses of English which can be a little confusing (requires proofing), there are a number of more serious examples where the meaning requires clarification.

Comment 1:

Comment: P54 presumably refers to psychiatric disorder as a reason for granting EAS.

Reply: This line is indeed confusing. We deleted the second part of the sentence: In practice however only one percent of all 6585 reported EAS cases in the Netherlands in 2017 concerned people with psychiatric disorders.4 even though the Dutch Act on termination of life on request and assisted suicide (2002) does allow them to receive EAS if they meet the statutory due care criteria as stipulated in the Act (Box 1).1

Comment 2:

Comment: P105 it is unclear if 'no experience with EAS' means they received no requests, or turned all requests down due to lack of familiarity with the process/law

Reply: The responses of psychiatrists were very general. Most reported something like: I do not have experience with this / with this topic, or I was never involved in this. Some others were more specific and reported: I have never received a request for EAS. No psychiatrists reported to have turned down a request due to lack of familiarity.

Comment 3:

Comment: P112 'performed EAS' seems inappropriate

Reply: The term “performing EAS” is commonly used in papers on this topic.

Other points:

Comment 4:

Comment: P115 it is unclear how the estimate of 1100 was reached; authors should show their working

Reply: Please see also Reviewer 1, comment 2.0 & 2.2. The estimate of 1100 was reached by multiplying the weigh factor with the number of requests of unique patients received by the participating psychiatrists in the 12 months prior to completing the questionnaire. The estimated numbers were rounded to make clear that they are estimations. This procedure was also applied by to calculate the number of patients who received EAS how many times they had performed EAS in the 12 months prior to completing the questionnaire.
We rewrote the Analysis section, page 6, line 108-115 to clarify the procedure: The survey data were analyzed using IBM SPSS Statistics Software version 22. Annual frequencies were estimated by averaging and weighing the numbers of requests for EAS and of actual instances of EAS. The number of unique patients requesting EAS and number of unique patients receiving EAS as reported by the participating psychiatrists were extrapolated to make an estimation for the number of EAS requests received and performed by all psychiatrists in the Netherlands for a one year period from 2015 to 2016. For this purpose, the number of unique patients requesting EAS and number of unique patients receiving EAS were multiplied with the weighing factor. The weighing factor (12.40) was calculated by dividing the total number of eligible psychiatrists in the Netherlands (n=2,566) by the number of responding psychiatrists (n=207).

Comment 5:

Comment: P122 and p208: 'somatic….diagnosis'; meaning physical diagnosis rather than somatiform symptoms? Does this include or exclude functional somatic syndromes such as fibromyalgia?

Reply: Of the 9 patients whose request was granted, 5 had an important secondary diagnosis according to the reporting psychiatrist. In 2 cases it concerned a psychiatric secondary diagnosis (1 borderline, 1 cognitive disorder) and in 2 cases it concerned one or more somatic secondary diagnosis (1 severe infection and arthrosis, 1 brain tumor). One patient had both a psychiatric and a somatic secondary diagnosis: bipolar disorder and osteoporosis. To ensure anonymity of the patients, it is not possible to include their specific diagnoses in the paper.

Comment 6:

Comment: 'for unknown reasons' - unknown to whom? Did they decline to state a reason, or was the reason unknown due to some other cause?

Reply: The question concerned a multiple choice question. Psychiatrists could choose from the following categories:

- Not applicable, there were no relatives involved
- They adopted a neutral position
- They supported the patient’s request
- They did not support the patient’s request
- Opinions were divided

There was no room for explanation. Therefore, the authors do not have knowledge about why relatives did not support the patient.
We understand this phrase might be confusing. Therefore, we deleted this: Results section, page 7, line 153-154: In one case, relatives adopted a neutral position and in one other case they did not support the patient’s request for unknown reasons.

Comment 7:

Comment: Pp161-163 and 165-168: totals do not add up to 48 and 100%. They should be explicit about all categories.

Reply: Thank you for pointing this out to us. We made the following changes to the text:

Results section, page 8, line 183-186: The patients’ relatives varied in the extent they supported the request. In 28.1% (n=18) of the cases, they did not support the patient’s request, in 18.8% (n=12) they did. In another 18.8% (n=12) they the opinions were divided and in 9.4% (n=6) of the cases they relatives adopted a neutral position. In 25.0% of the cases, no relatives were involved.

Results section, page 9, line 190-193: Of the responding psychiatrists, 40.6% consulted one other physician, 17.2% consulted two other physicians and 6.3% consulted three or more physicians. Yet, 35.9% of the psychiatrists did not consult another physician. In most cases (82.9%) the consulted physician was a psychiatrist. Other physicians consulted were SCEN physicians (12.2%), SCEN physicians who were also a psychiatrists (9.8%), and/or another physician (24.4%).

Comment 8:

Comment: P175: the reasons given in the list of 'personal objections' are not personal objections, this list should be relabeled.

Reply: As suggested, we relabeled personal objections that could be relabeled and corrected the percentages in the table and text accordingly.

Results section, page 9, line 191-203: The most frequently (73.875.4%) reported reason for refusing the EAS request was that at least one of the due care criteria was not met. In 53.1% of these cases the criteria ‘no reasonable treatment alternatives’ was not met. Almost 70% of these patients could still be treated with psychotropic medication, 55.9% with psychotherapy and 29.4% with electroconvulsive therapy. The criteria ‘suffering without prospect of improvement’ was not met in 289.17% of cases. Moreover, according to the psychiatrists, the request was not ‘voluntary and well-considered’ in 207.37% of cases and the suffering not ‘unbearable’ in another 10.9%.

A substantial percentage (23.1%) of the psychiatrists refused the request because of personal objections to EAS in general (not further specified). One quarter (n=16) Twelve percent of the psychiatrists indicated that they refused the request because of personal objections, including the
patient’s suffering being insufficiently evident to them, doubts about the consistency of the patient’s wish to die which mostly concerned the absence of a (good) treatment relationship, and the lack of experience with EAS. A substantial percentage (23.1%) of the psychiatrists refused the request because of personal objections to EAS in general (not further specified). Other reasons to refuse a request were ‘objections of the family’ (1.5%) and ‘other reasons’ (6.3%)

Comment 9:

Comment: With these caveats the paper is a competent report of an important survey, and the discussion on p11 provides a useful commentary on the reasons for the high percentage of requests for EAS in psychiatric patients that are turned down.

Reply: Thank you for your compliments on our paper.