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:

Kirsten Evenblij (k.evenblij@vumc.nl)
H. Roeline Pasman (hrw.pasman@vumc.nl)
Rosalie Pronk (r.pronk@amc.uva.nl)
Bregje Onwuteaka-Philipsen (eol@vumc.nl)

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Response to the reviewers

Reviewer 1

Pablo Requena Meana (Reviewer 1): I commend the authors on the work put into revising their paper. They have addressed most of the issues raised in the previous review. I have a few remaining queries and/or observations.

Comment 1: Lines 130-133 states: One-fourth of the psychiatrists had received at least one explicit EAS request in the previous 12 months and three percent of them had actually performed EAS in the previous 12 months. Is the author's estimate of requests for EAS based on this figure? If I understand the argument of the authors correctly, if 25% received a request and using the authors' weight factor of 12.4, then the estimated incidence should be 0.25 x 207 x 12.4 = 641.7 and the estimated number of granted requests would be 0.03 x 207 x 12.4 = 77.0. If however, the estimate is based on the '112 who received a request for EAS' (line 136), then I assume the incidence would be simply 112 x 12.4 = 1388.3. However it appears that this last figure of 112 is for requests received over the whole career and not just the previous 12 months (see line 127). Is this assumption correct? Further, as neither of these estimates of incidence approaches that reported by the authors, there may be some figure which is not included in the results - i.e. the actual number of unique patients who requested EAS in the preceding 12 months.

Reply: Of all respondents, 25% received a request (n=51). In total these 51 psychiatrists received 91 requests of which 7 were granted in the previous 12 months. The weight factor was 12.4.

The estimated number of requests and the estimated number of requests granted were calculated as following:
The estimated total number of requests received by all psychiatrists in the Netherlands for a one year period was: $91 \times 12.40 = 1128.4$

The estimated total number of requests granted by all psychiatrists in the Netherlands for a one year period was: $7 \times 12.40 = 68.8$.

We rounded it down because we believe that these numbers are small overestimations, especially the number of granted cases as the estimation is based on 7 cases.

To be more accurate we changed the estimations into: between 1100 and 1150 requests and between 60 and 70 granted requests. See Abstract, page 2, line 37-39; Results, page 7, line 129-130; Discussion, page 10, line 206-208.

For transparency, we added the number of unique patients requesting (n=91) and receiving (n=7) EAS to the Analysis section, page 6, line 108-109.

Comment 2: I would move lines 103-105 to the discussion.

Reply: Lines 103-105 were moved to the Discussion section, page 13, line 278-279.

Comment 3: Lines 109-111: I would clarify by adding the time period 'in the previous 12 months': The number of unique patients requesting EAS and number of unique patients receiving EAS in the previous 12 months as reported by the participating psychiatrists.

Reply: We added ‘in the previous 12 months’ as suggested (Line 104-106)

Reviewer 2

Steve Pearce (Reviewer 2):

Comment 1: First point on first review labelled p54: the deletion has not helped. The point is that psychiatric disorder is the reason for the request, rather than that people with psychiatric disorders are eligible.

Reply: We made the following changes to the Background section, page 4, line 56-58: Only in the three European countries and Canada people who request EAS because of suffering from psychiatric disorders can be eligible for EAS.1-3 In practice, however, EAS is rarely performed in people with psychiatric disorders. In the Netherlands, only one percent of all 6585 reported EAS cases in 2017 concerned people with psychiatric disorders in the Netherlands.

We hope this change has helped. If not, could you please be more clear about the problem as we do not understand it.
Comment 2: Comment labelled P105: the authors should amend the MS to clarify to readers.

Reply: We made the following changes as suggested, see Results, page 6, line 114-117: Some non-responders (29 of the 218) sent a response card providing the reason for not participating: lack of time (n=18), no experience with receiving EAS requests or performing EAS (n=9) and principal objections to EAS (n=2). No psychiatrists reported to have turned down a request due to lack of familiarity with the process/law.

Comment 3: Comment 8: the author's reply is confusing. As before, the second incidence of 'personal objections' should be relabelled, as it has to do with the lack of a good treatment relationship and other factors. More serious is that two important answers which were significant enough to note in the original ms (suffering insufficiently evident, and consistency of the wish to die) have now disappeared.

Reply: We have misunderstood your comment earlier. In the questionnaire, psychiatrists were asked for the reason to refuse the request. They could choose from: 1) ‘Personal objections to EAS in general’, 2) ‘objections of the family’, 3) ‘the patient did not meet the due care criteria’, 4) ‘personal objections specifically for this case’ and 5) ‘other’.

If the psychiatrist chose: ‘the patient did not meet the due care criteria’, ‘personal objections to this case’ or ‘other’, the psychiatrist was asked to explain their answer. We thought that you meant with relabeling personal objections that some of the reasons such as: “the suffering was insufficiently evident” or “doubts about the consistency of the patients wish to die” labelled by the psychiatrist as ‘personal objections to this case’ should actually have been labelled as ‘the patient does not meet the due care criteria’ (i.e. criteria of suffering without prospect and criteria of voluntary and well-considered request). So the two answers did not disappear but were relabeled into ‘not meeting the due care criteria’. After relabeling, the majority of the ‘personal objections’ left, were about the absence of a (good) treatment relationship. Relabeling also affected the percentages of psychiatrists who answered to have refused because of ‘not meeting the due care critiera’ and ‘personal objections specific to this case’.

We hope we have now sufficiently clarified the process and rationale. Because the term ‘personal objections’ was used in the questionnaire we feel we cannot change this term. If you would prefer us to use the original labels (and thus going back to the original table), please let us know. We feel however that the new categorization of the answers is more clean.