Reviewer’s report

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

Version: 0 Date: 24 Oct 2018

Reviewer: Pablo Requena Meana

Reviewer’s report:

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:

Major issues

1. 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.

2. 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?

   2.1. 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?

   2.2. 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?

2.3. 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?

2.4. 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?

2.5. 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?

3. 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].

4. 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?

5. 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.

6. 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?

Minor issues
7. 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.

8. 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.

9. 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?

10. [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.

11. 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.

12. 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-nonresponders, EAS granted-EAS refused, alive-dead, etc.

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

14. 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.

15. 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.

16. 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.

17. There are a number of grammatical errors.

Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

Yes
Does the work include the necessary controls?
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Are the conclusions drawn adequately supported by the data shown?
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