Capacity Assessments as a Safeguard for Psychiatric Patients Requesting Euthanasia

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Capacity assessment is most difficult when a patient can intellectually absorb information and communicate a choice, but whose decision-making process in between is at issue. For example, a person might absorb what a doctor is describing and recommending but does not believe her because of a delusion that the doctor is actually not a doctor—a delusion that the patient will likely keep hidden (Scott Y. H. Kim). Or a person might refuse a beneficial treatment, despite seeming to absorb the relevant information, due to an unconscious fear (Jonsen, Siegler, & Winslade, 1998). Or a severely depressed but cognitively intact patient whose very ability to value anything is severely impaired (Kim, 2016). In such cases, we must use standards such as ‘appreciation,’ ‘reasoning,’ ‘using or weighing information’ to probe whether there is some decisional ability that is not intact.

Combining these two points, one can easily see that the threshold of capacity used (the level of functioning of the relevant abilities necessary for capacity) and the parallel need to justify and document the capacity assessments will be particularly sensitive to the evaluator’s understanding of “what the decision is and what the import of its potential consequences are.” This is, of course, a perfectly defensible practice that is part of standard teaching: an evaluator should use a very high threshold with a clearly articulated rationale for her capacity judgment when the stakes are very high (Buchanan & Brock, 1989; Grisso & Appelbaum, 1998).

With the above background, consider two competing views of what the decision to receive PAD is and what the import of its potential consequences are.

On one understanding, human beings have an inherent worth not conditioned upon or diminished by a person’s social status, gender, race, ethnicity, family origin, disease, disability, or balance of personal experiences. The society’s obligation to those who endure...
serious mental illness is to affirm their inherent worth by providing resources commensurate with that worth. Serious mental illnesses are not terminal illnesses. It is difficult to judge someone’s mental illness “untreatable.” And given that some mental illnesses can distort one’s perception, thinking, and judgment, the capacity to request and receive psychiatric PAD should be assessed with a very high threshold—the evaluator must test for and document that the person’s decisional abilities are functioning at a high level.

On another understanding, living with serious, difficult to treat mental illness is deemed to be a fate that is ‘worse than death.’ Given how much suffering such illnesses can cause and given the net benefit (eliminating experiences that are worse than death), if a person persistently asks for PAD, then there should be a benefit of doubt given to such requests. On this view, what the person is choosing seems, on balance, so rational that setting a high threshold is unnecessary.

The impact of legalization of PAD on how decisional capacity is conceptualized

It is not difficult to see which of the two understandings would become more influential in practice once PAD for psychiatric disorders is legalized. As a formal and enforceable manifestation of society’s values, the law provides a powerful social endorsement. The legal uncertainty about whether psychiatric PAD is a good thing will have been settled. Over time, the medical profession will be pressured to align with these values (Kimsma, 2015; Snijdwend, van Tol, Onwuteaka-Philippsen, & Willems, 2016).

Also, as a practical matter, psychiatrically ill persons with persistent wish to die will naturally seek out and find willing doctors (even mobile clinics especially designed for PAD, if their own doctor is reluctant) (Kim, De Vries, & Peteet, 2016). After receiving PAD, they will not be able to voice an objection or a complaint. Since most psychiatric patients requesting PAD will be socially disconnected (Kim et al., 2016), their deaths may not receive much scrutiny as the post-hoc reviews will generally defer to the physicians who write the reports (Kim et al., 2016). The system will eventually have less and less reason to use very high capacity thresholds, since the system’s overall goal is to make psychiatric PAD accessible as a social good.

In the jurisdictions that perform psychiatric PADs, there is evidence that, both prescriptively and empirically, high capacity thresholds are not the norm. As Charland et al note in regard to Belgian practice, the only published study shows that none of the 100 consecutive persons referred for evaluation of psychiatric PAD was found to be incompetent to make the request, despite patients having diagnoses known to increase the risk of incapacity (Thienpont et al., 2015).

In the Netherlands, the Dutch Psychiatric Association explicitly endorses the view that not all the usual criteria for capacity need to be met when “the patient is clearly suffering so unbearably...” (Tholen, 2009). Another indication that capacity assessments for PAD need not require highest thresholds is the Dutch Euthanasia Review Committees (RTE) code of practice statement that patients in the “early stages” of dementia are usually competent to make PAD requests (Regional Euthanasia Review Committees, 2015), which seems to imply a presumption of competence. Given that there is ample evidence that patients with even mild cognitive impairment—i.e., persons who have milder symptoms than those who actually meet criteria for dementia—have significant likelihood of decisional impairment for health decisions (Jefferson et al., 2008; Okonkwo et al., 2007), this seems to be another indication that when it comes to PAD requests, the Dutch system does not require that capacity thresholds be very high.

In Dutch practice, an examination of the case summaries written by the RTEs reveal that in 55% (36/66) of cases, there are only simple global assertions of capacity (“...the patient was mentally competent”), even though 22% of them had psychotic conditions (Doernberg, Peteet, & Kim). Only about a third of the case reports (21 of 66) provided specific evidence in support of or against at least one capacity-specific ability. In 8 cases there was disagreement about the patient’s capacity among the physicians involved; in 4 of those cases, the RTE does not comment on the disagreement or request any further information from involved physicians (Doernberg et al.).

Even when physicians did agree, the details of their agreement were sometimes surprising. For example, in a case of a woman in her 70s with severe personality disorder, multiple suicide attempts, mental retardation, and psychotic symptoms, two physicians agreed that the patient possessed intact capacity. The first physician appealed especially to her ability to “weigh pros and cons” as evidence of intact capacity. The second physician, however, specifically noted that the patient’s ability to “use information in a rational way was doubtful.” In effect, the two physicians agreed on the outcome but with contradictory reasoning. The review committee did not address this discrepancy (Doernberg et al.).

Conclusions

The hope that we can protect psychiatric patients sufficiently by imposing a strict system of safeguards is based on a perspective prior to legalization of psychiatric PAD. But we fail to note that the legalization itself will likely change the social and practice context of how the safeguards are applied. The very act of legalizing psychiatric PAD provides strong support for it as a social good; this then becomes the context for capacity determinations and the idea of a strict capacity threshold will begin to seem unnecessary, even obstructive. This is not a claim about a slippery slope of abuses and errors; the point is that the very norm of what an abuse or an error means will be recalibrated to the new reality, an apparently reassuring reality (Emanuel, Onwuteaka-Philippsen, Urwin, & Cohen, 2016) with no evidence of abuses and errors.

References


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