

Review Articles

The Role of Psychiatrists and Mental Disorder in Assisted Dying Practices Around the World: A Review of the Legislation and Official Reports

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Objective: To establish the role of psychiatrists and mental disorder in assisted dying practices in countries and states where such practices are legal. **Methods:** The authors reviewed the Assisted Dying Acts and official statistical reports from Belgium, The Netherlands, Luxembourg, and the states of Washington and Oregon in the USA. The data extracted related to the role of psychiatrists in assisted dying practices, and the relevance of capacity, 'suffering', and mental disorder.

Results: A psychiatry referral is recommended or required by all countries and states in certain circumstances. These circumstances include mental disorder 'impairing judgement' in Oregon and Washington, and cases of exclusive mental disorder in European countries. 'Exclusive mental disorder' refers to those with a mental disorder (e.g., major depression) who apply for

assisted dying in the absence of any terminal physical illness. Capacity/competence and necessary suffering must be present. On average, 5.4% (range 4.2%–6.7%) of applicants see a psychiatrist. Patients with exclusive mental disorder can apply for assisted dying in European countries but not in Oregon and Washington; actual figures are low. **Conclusions:** No country has a blanket policy of mandatory psychiatric review but the specialty contributes in circumstances of exclusive mental disorder or when there is doubt regarding capacity and sound judgement. The absence of a mandatory role for psychiatrists means that reversible psychopathology may be missed. As a result, the patient's decision to end his/her life may be more informed by treatable mental disorder than by his/her lifelong preferences.

(Psychosomatics 2012; 53:319–326)

Assisted dying usually encompasses the practices of active, voluntary euthanasia and/or assisted suicide (often physician-assisted). There are differing schools of opinion as to how these terms should be defined and how they are distinct from other end-of-life concepts (such as terminal sedation). The European Association for Palliative Care (EAPC) ethics task force have defined euthanasia as 'a doctor intentionally killing a person by the administration of drugs, at that person's voluntary and competent request' and physician-assisted suicide (PAS) as 'a doctor intentionally helping a person to commit suicide by providing drugs for self-administration, at that person's voluntary and competent request'.¹ The wide variety of available definitions for assisted suicide appears

to have led the legislatures of Oregon and Washington to openly distance themselves from this phrase; reference is instead made to 'death with dignity' or 'obtaining and self-administering life-ending medication'.^{2,3}

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Psychiatrists and Mental Disorder in Assisted Dying

The inter-relationship between psychiatrists, mental disorder, capacity, and assisted dying is complex. Psychiatrists are trained to assess and treat mental disorder, relieve mental suffering, and can assess capacity if asked to do so. Mental disorder does not automatically imply incapacity, but it can call capacity into question. Mental disorder is associated with suicidal ideation, and psychiatrists aim to prevent suicide by targeting relevant (typically modifiable) risk factors for completed suicide like major depression.

Few organizations representing psychiatrists have published comprehensive opinions on the role of psychiatrists in assisted dying. The American Psychiatric Association published an interim report on end-of-life care in 2001, but it contained no specific advice on assisted dying.⁴ The Royal College of Psychiatrists (in the UK and Ireland) has expressed 'concern', and proposes that assisted suicide is incompatible with the role of a psychiatrist in preventing suicide.⁵ If assisted dying is legalized, the College recommends that psychiatric advice is sought.⁵ The Royal Australian and New Zealand College of Psychiatrists maintains a neutral stance on assisted dying, except to oppose it in cases of exclusive mental disorder.⁶ This is due to the perceived difficulty in assessing capacity in these cases and because "unrelievable psychiatric suffering is rare." If assisted dying is introduced, they recommend mandatory psychiatric assessment for every applicant.⁶ The Academy of Psychosomatic Medicine (representing consultation-liaison psychiatrists) has published a position statement on end-of-life care, but it lacks a thorough discussion of assisted dying.⁷

In 2006, Naudts et al. published a paper focusing on the role of the psychiatrist in Belgian legislation with some reference to Dutch legislation.⁸ The paper did not, however, quote figures from assisted dying reports on the actual level of psychiatrists' involvement, nor was there a comparison with legislation in Oregon, Washington, or Luxembourg (the latter two becoming law later than 2006). Our authors sought to examine the current legislation and official reports from the relevant countries/states in Europe, the USA, Australia, and New Zealand (where applicable), in order to clarify the role of the psychiatrist and involvement of mental disorder in assisted dying applications.

METHOD

The countries or states included for the purposes of this study were: Belgium, The Netherlands, Luxembourg, and

the states of Oregon and Washington, USA. As of March 2012, all have legal Acts specifying circumstances under which assisted death can legally occur. Neither Switzerland nor the state of Montana was included as, although assisted dying is openly practiced, neither has an Act of legislation that comprehensively describes when assisted dying is definitely legal. Instead, lawfulness is suggested by article 115 of the Swiss Penal Code and the Supreme Court ruling in *Baxter v. Montana*, respectively.^{9,10}

For each country or state included, the authors obtained and reviewed (1) the relevant Assisted Dying Act, (2) any official published statistical report/s on assisted deaths occurring under the Act. The primary author anticipated that based on the countries or states included, the relevant texts would be in English or French. A second author was recruited to interpret any French texts.

The data extracted included: the name and year of the Act and applicable report, figures and excerpts from text and tables presenting data regarding the involvement of psychiatrists, capacity/competence, suffering, and mental disorder in assisted death practices. Excerpts of text were taken from both Act and Report, and these excerpts often contained the recommendations and advice published by the review/control committees. This advice was considered an extension of the law as it manifests in practice because these committees determine whether or not legislation has been enacted with the necessary 'due care'. Relevant data are presented country by country in the Results section of this review.

RESULTS

Acts and Reports

All included countries and states have an Assisted Dying Act, and all countries and states have to date (March 2012) produced at least one report on the conduct of deaths under the Act.^{2,3,11-18} Table 1 shows the names of the Acts and reports, with the date the Act entered into law and the dates covered by the latest report.

All of the Acts were available in English, as were the reports for Oregon, Washington, and The Netherlands.^{2,3,11,13-15,17,18} The reports for Belgium and Luxembourg were only available in French.^{12,16} The English translations of the Belgian and Dutch Acts were sourced from the Catholic University of Leuven and European Institute of Bioethics respectively, while the translation of the Luxembourg Act was sourced from an official publication by the Ministries of Health and Social Secu-

TABLE 1. Acts and Reports

Country/State	Name of Act	Date Act Entered into Law	Name of Official Report*	Years Discussed in Report
Belgium	The Belgian Act on Euthanasia ¹¹	28 May 2002	Commission Fédérale de Contrôle et d'Évaluation de l'Euthanasie: Quatrième Rapport aux Chambres Législatives (Années 2008 et 2009) ¹²	2008–2009
The Netherlands	Termination of Life on Request and Assisted Suicide (Review Procedures) Act ¹³	1 Apr 2002	Regional euthanasia review committees: 2010 annual report ¹⁴	2010
Luxembourg	Law of 16 March 2009 on euthanasia and assisted suicide ¹⁵	16 Mar 2009	Commission Nationale de Contrôle et d'Évaluation de la loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide: Premier rapport à l'attention de la Chambres des Députés (Années 2009 et 2010) ¹⁶	2009–2010
Oregon (USA)	The Oregon Death with Dignity Act ²	27 Oct 1997	Oregon's Death with Dignity Act Annual Report 2011 ¹⁷	1998–2011
Washington (USA)	The Washington Death with Dignity Act ³	5 Mar 2009	Washington State Department of Health 2010 Death with Dignity Report ¹⁸	2009–2010

* Most recent reports as of March 2012.

rity.^{11,13,15} An official English translation of the Dutch report was sourced from a publication by the supervisory Dutch Euthanasia Committee.¹⁴

Role Expected of Psychiatrists in Assisted Dying Applications

No country requires a psychiatry referral in every case under the terms of the law. In Belgium, The Netherlands, and Luxembourg it is possible to apply for assisted death in cases of exclusive mental disorder without physical illness.^{11,13-15} A psychiatrist can therefore be the referring doctor or the second opinion consulting doctor in applications for assisted death. In every country/state included, a psychiatrist can serve as an additional expert or specialist, but a psychiatry review is mandatory in certain circumstances.

In Belgium, according to section 3 of the Act, if 'the patient is clearly not expected to die in the near future', the initial doctor must 'consult a second physician, who is a psychiatrist or a specialist in the disorder in question', who must be 'certain of the constant and unbearable . . . suffering that cannot be alleviated, and of the voluntary, well-considered, and repeated character of the euthanasia request'.¹¹ The psychiatrist produces a report based on this consultation.

In The Netherlands, the Act does not specify a role for the psychiatrist. However, the review committee says in the report that a psychiatrist should be consulted in all cases of exclusive mental illness. In circumstances of comorbid depression, a psychiatry referral should 'often' be

considered if there is doubt about the presence of depression itself or its potential effect on mental capacity.¹⁴

In Luxembourg, in all cases, the initial doctor must consult another 'as to the severe and incurable nature of the disorder', a doctor who 'must be competent as to the pathology concerned', and this doctor again furnishes a report. If the treating doctor feels it necessary, he may choose to be 'advised by an expert of his choice' and the resulting report filed as part of the patient's application.¹⁵

Per Sections 3 and 6 of the Oregon and Washington Death with Dignity Acts (respectively), if the consulting or attending doctor believes the patient has 'a psychiatric or psychological disorder . . . causing impaired judgment', then that doctor 'shall refer the patient for counsel(l)ing' by a state licensed psychiatrist or psychologist.^{2,3} Medication to end the patient's life 'shall not be prescribed until . . . the patient is not suffering from a psychiatric or psychological disorder . . . causing impaired judgment'. In the event that this referral does take place, the psychiatrist/psychologist must produce a 'report of the outcome and determinations made' (Oregon), or fill out the 'Psychiatric/Psychological Consultant Compliance Form' (Washington).^{2,3}

Involvement of Psychiatrists in the Review Committee/Commission

Belgium, The Netherlands, and Luxembourg have review committees designed to ascertain if the Act is being used with 'due care' by involved clinicians. No country

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TABLE 2. Number of Psychiatry Referrals

Country/State	Belgium ¹²	The Netherlands ¹⁴	Luxembourg ¹⁶	Oregon (USA) ¹⁷	Washington (USA) ¹⁸
Psychiatry referrals	5.2% (<i>n</i> = 79/1526)	Not published	Not published	6.7% (<i>n</i> = 40/596)	4.2% (<i>n</i> = 5/119)
Years	2008–2009	na	na	1998–2011	2009–2010

specifies that a psychiatrist must take part. It is unclear if any country has taken the initiative to involve a psychiatrist on the review committee.

Refusal to Participate

If an individual doctor (including a psychiatrist) in any country/state chooses not to participate in a patient's assisted dying application (either in the application or consulting process), this would not result in any penalty. In all cases, however, it is incumbent on the professional to transfer the patient's health records to the new health provider chosen by the patient.

Actual Role of Psychiatrists in Assisted Dying Applications

Belgium, Oregon, and Washington have published official figures on the number of applications involving a psychiatry consultation.^{12,17,18} The Netherlands and Luxembourg have not. In the first three countries/states, a psychiatrist (or psychologist in Washington and Oregon) was, on average, consulted in 5.4% of cases (range 4.2%–6.7%). The individual figures can be seen in Table 2.

Mental Capacity

All countries/states dictate that the patient must possess capacity/decisional competence at the time of application. A psychiatrist is not required to determine capacity, although one can be consulted to confirm it. In Oregon and Washington, being capacitous or competent refers to the *'ability to make and communicate . . . a(n informed) . . . decision'*.^{2,3} No other Act/report specifies a definition for capacity as it applies in that country/state.

Degree of Suffering

A 'necessary' type and/or degree of suffering is required in all cases. In general, suffering must be constant/lasting, unbearable, and without 'reasonable' solution, or cannot be alleviated. A psychiatrist is not necessarily required to confirm this level of suffering except in Belgium,

The Netherlands, and Luxembourg in cases of exclusive mental disorder.

Mental Disorder

As mentioned above, Belgium, The Netherlands, and Luxembourg allow assisted death in cases of exclusive mental disorder (e.g., schizophrenia, bipolar affective disorder) without physical illness, once the patient has mental capacity and the requisite suffering.^{11,13–15} In Belgium in 2008–2009, 34 (2%) of 1526 patients who underwent assisted dying had primary neuropsychiatric disorder. This excludes neuromuscular disorder but presumably includes primary neurologic and primary psychiatric disorder, although the category is not further specified.¹² In The Netherlands in 2010, 25 patients (of 3136 total notifications) had dementia.¹⁴ Two patients in 2010 had exclusive mental disorder (depression) without terminal physical illness.¹⁴ In the report, 'great/additional caution' is advised in both cases and the necessity of a voluntary, well considered, competent, consistent patient request is reiterated. In the years 2009–2010, 5 patients died under the Luxemburger act and all had cancer.¹⁶ Therefore, no patient had exclusive mental disorder.

Both Oregon and Washington specify that the patient must have 'terminal disease', where terminal disease is defined as *'incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months'*.^{2,3} Therefore, exclusive mental disorder is not acceptable, although comorbid depression, for example, is possible.

DISCUSSION

The Psychiatrist's Role

Psychiatrists have an expert understanding of mental distress and the psychosocial factors that influence one's perceptions, decision making, and self-worth. They therefore have an important role in the debate on assisted dying. Two questions arise when one considers the role of psychiatrists in assisted dying legislation. The first is whether or not psychiatrists are prepared to participate in assisted dying practices. Table 3 lists some of psychiatrists' concerns.

TABLE 3. Controversial Questions: Should Psychiatrists be Involved in Assisted Dying?

1. Can a psychiatrist work to prevent suicide on one hand while participating in assisted dying practices on the other?
2. Would this participation compromise a patient's trust in his/her psychiatrist?
3. Is it responsible of a psychiatrist to agree with the perceived hopelessness of his/her patient's life?
4. Are psychiatrists willing to accept the moral responsibility of contributing (or not contributing depending on one's viewpoint) to the gate-keeping and approving of applications for assisted suicide?
5. Is there a sufficient legal framework and sufficient evidence for psychiatrists to feel comfortable making decisions about a patient's capacity to end his/her life?

If one takes The Netherlands as a template, psychiatrists are likely to be involved in any model of assisted dying, especially if exclusive mental disorder is considered reasonable cause for assisted death like it is in The Netherlands. According to Groenewoud et al., 36% of Dutch psychiatrists (as of 2004) have been consulted in cases of assisted dying, most frequently being asked if the patient has treatable mental disorder (68%) or if the request is 'well considered' (66%).¹⁹ Psychiatrists play a role in assisted dying in every country and state included in this study. When one averages figures from Belgium, Oregon, and Washington, 5.4% of patients see a psychiatrist.^{12,17,18}

If psychiatrists are prepared to participate in assisted dying, the next question is whether or not psychiatric assessment should be mandatory for all applicants. No country/state included in this study currently holds such a policy. The level of psychiatric involvement depends on the perceived severity and exclusivity of mental illness, and on the degree of concern regarding (the influence of mental illness on) competence and impaired judgement. Mandatory psychiatric assessment existed in the Northern Territory of Australia when assisted dying was briefly legalized in the 1990s. Under the Rights of the Terminally Ill Act 1995, each patient was required to attend a psychiatric assessment at least once.²⁰ This was, in part, to ensure the absence of 'treatable clinical depression'.

In the absence of mandatory review, a major concern is that one misses reversible psychopathologic processes influencing the patient's decision. It is important to establish that the patient's rationale is consistent with his/her character rather than the result of depressive cognitions or abnormal perceptions. It has been reported that primary care physicians fail to diagnose depression in a significant number of cases.²¹

Ryan and Parker presented opposing arguments in the *Australian and New Zealand Journal of Psychiatry* regarding mandatory referral.^{22,23} Ryan argued that this safeguard is necessary so that legalized euthanasia is not seen by the patient as 'an alternative to standard suicide'.²² He also emphasized the importance of recognizing serious mental illness and 'excavating' a patient's motives for an assisted dying request. Parker, on the other hand, cautioned against the medicalization of a patient's autonomous rational decisions about his/her own life (and death).²³ Further proponents of mandatory assessment suggest that psychiatrists are better equipped to detect problematic transference/counter-transference reactions, and Block and Billings point out that the psychiatrist should carefully seek out any potential dysfunction in the doctor-patient relationship.²⁴ An untrained practitioner could be readily influenced by the depressed patient's cognitive structure and conviction of his/her own worthlessness, helplessness, and hopeless existence.

Where one exists, no review/control committee currently requires that a psychiatrist take part. Psychiatrists may be uniquely placed to comment on mental suffering in the context of an assisted dying application, but this would further oblige the specialty to take part in assisted dying practices. Furthermore, although they may have expertise in mental suffering, not all psychiatrists routinely encounter and treat patients with terminal physical illness.

Capacity

Assessing decisional competence in these cases is difficult and requires considerable expertise. Thresholds for capacity are subjective, and can only be considered 'high' in life/death decisions. Most psychiatrists in Oregon believe that two independent doctors should be required to assess capacity and that a 'very stringent' standard should be applied.²⁵ The situation becomes all the more complex in situations of concurrent mental disorder. Mental disorder can affect a person's ability to weigh up available information and change the salience of certain available options (e.g., assisted suicide vs. palliative care). Studies of Oregon psychiatrists have shown a lack of confidence in teasing out the effect of mental disorder on capacity, with many believing that mental disorder should result in an automatic finding of incompetence.^{25,26} Of course, patients with a depressive episode may be considered competent to make other important but less far-reaching decisions (e.g., capacity to make decisions regarding medication).

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Mental Disorder

In patients with terminal illness, depression and hopelessness are highly correlated with the desire to hasten death. In fact, depression is more influential on the desire to hasten death than physical pain.^{27–30} The limited evidence available suggests that successfully treating depression in the terminally ill is effective in reducing the desire to hasten death.³¹ Given this, it is clearly important to recognize and treat any depressive disorder that could be influencing a patient's decision regarding assisted death. A recent cross-sectional survey of 300 palliative patients estimated that major depressive disorder was present in 19% of cases.³² The true prevalence may be even higher.³³

Despite this evidence, patients with comorbid mental disorder can undergo assisted death in all countries/states included, and patients with exclusive mental disorder can undergo assisted death in European countries. While a psychiatry review is necessary in exclusive mental disorder, there is no universal policy regarding comorbid mental disorder, and it depends on the circumstances; for example, Oregon and Washington only indicate a psychiatry review if psychopathology is thought to *impair judgment*.

'Suffering'—Nature and Severity

Both patient and doctor assess suffering in this context, and both must report it as sufficiently severe to satisfy legal requirements. From the patient's perspective, the suffering must be constant, unbearable, and refractory to trials of treatment. The doctor must judge that the suffering cannot be alleviated by reasonable measures. The suffering is not restricted in its nature or type, and it can be physical, psychological, or existential.

Suffering is a subjective experience, and it should be interpreted in the context of the patient's individual personality structure, coping mechanisms, and psychosocial environment. This backdrop is potentially malleable, and relevant opportunities could arise to improve coping strategies or modify adverse environmental conditions affecting quality of life. In addition to suffering being 'unbearable', the Dutch Euthanasia Committee advises that suffering should really be so severe as to be 'palpable' to the doctor.¹⁴ This 'poignancy' of suffering is also subjective, and again raises concerns about counter-transference.

The Future

Assisted dying is increasingly seen by Western populations as acceptable, particularly in cases of terminal illness. In

many places, however, the opinions of medical professionals, politicians and law-makers, and the general public, do not accord. For example, only a minority of medical professionals in the UK and wider USA are willing to participate in assisted dying practices.^{34,35} This has resulted in a widespread stalemate and is one of the reasons why so few Western states and countries have, so far, legalized assisted dying. Nonetheless, it is important for all psychiatrists to consider the roles adopted by colleagues in neighboring countries/states, and be prepared for the possibility that assisted dying may become legal in the future.

Limitations

This study did not seek to systematically review cross-sectional or other studies presenting *unofficial* data on psychiatrists' involvement in assisted death practices in included studies/states, nor did it intend to look at countries/states outside of Europe, USA, Canada, Australia, and New Zealand.

CONCLUSIONS

No country/state included has a policy of psychiatric review in all cases of assisted dying, although the absence of such a policy remains subject to debate. Psychiatrists are required to play a role in cases of severe comorbid or exclusive mental illness, and in cases where there is doubt regarding competence or necessary degree of suffering. In all cases, patients must have capacity. Suffering must be considered constant, unbearable, and refractory to treatment before an application for assisted death is accepted. It is important not to overlook psychopathologic processes that impact the patient's decision on assisted dying. Each doctor has a responsibility to ensure that such a significant decision is consistent with the patient's character and lifelong values.

Dr. Ruaidhri McCormack is an academic clinical fellow; the research is therefore partly funded by the National Institute for Health Research (NIHR) Specialist Biomedical Research Centre for Mental Health at the South London and Maudsley NHS Foundation Trust and Institute of Psychiatry, King's College London, UK.

Disclosure: The authors disclosed no proprietary or commercial interest in any product mentioned or concept discussed in this article.

References

1. Materstvedt LJ, Clark D, Ellershaw J, Forde R, Boeck Gravaard AM, Muller-Busch HC, et al: Euthanasia and physician-assisted suicide: a view from an EAPC Ethics Task Force. *Palliat Med* 2003; 17:97–101
2. The Oregon Death with Dignity Act. Available at: <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx>. Accessed March, 2012
3. The Washington Death with Dignity Act. Available at: <http://www.doh.wa.gov/dwda/>. Accessed March, 2012
4. The American Psychiatric Association. The Core Principles of End-of-Life Care, Position Statement June 2011. Available at: http://www.promotingexcellence.org/downloads/mass/APA_Position_Statement_200106.pdf. Accessed March, 2012
5. The Royal College of Psychiatrists. Assisted Dying for the Terminally Ill Bill: Statement from the Royal College of Psychiatrists on Physician Assisted Suicide April 2006. Available at: <http://www.rcpsych.ac.uk/pdf/14.07.11%20Enc%2005.pdf>. Accessed March, 2012
6. The Royal Australian and New Zealand College of Psychiatrists. Position Statement: Physician-Assisted Suicide May 2011. Available at: http://www.ranzcp.org/images/stories/ranzcp-attachments/Resources/College_Statements/Position_Statements/ps67.pdf. Accessed March, 2012
7. APM's Ad Hoc Committee on End-of-Life Care: Psychiatric aspects of excellent end-of-life care: a position statement of the Academy of Psychosomatic Medicine. *J Palliat Med* 1998; 1(2): 113–115
8. Naudts K, Ducatelle C, Kovacs J, Laurens K, Van Den Eynde F, Van Heeringen C: Euthanasia: the role of the psychiatrist. *Br J Psychiatry* 2006; 188:405–409
9. Schwarzenegger C, Summers SJ: Criminal Law and Assisted Suicide in Switzerland. 2005. University of Zurich, Faculty of Law. Available at: <http://www.rwi.uzh.ch/lehre/forschung/alphabetisch/schwarzenegger/publikationen/assisted-suicide-Switzerland.pdf>. Accessed March, 2012
10. Baxter et al. v. State of Montana and . . . Attorney General. Decision and Order. Cause No. ADV-2007-787. Available at: <http://community.compassionandchoices.org/document.doc?id=58>. Accessed March, 2012
11. The Belgian Act on Euthanasia of May, 28th 2002. Available at: <http://www.kuleuven.be/cbmer/viewpic.php?LAN=E&TABLE=DOCS&ID=23>. Accessed March, 2012
12. Commission Fédérale de Contrôle et d'Évaluation de l'Euthanasie. Quatrième Rapport aux Chambres Législatives (Années 2008 et 2009). Available at: <http://www.ieb-eib.org/fr/pdf/rapport-euthanasie.pdf>. Accessed March, 2012
13. Termination of Life on Request and Assisted Suicide (Review Procedures) Act. Available at: <http://www.ieb-eib.org/fr/pdf/loi-euthanasie-pays-bas-en-eng.pdf>. Accessed March, 2012
14. Dutch Euthanasia Committee: Regional euthanasia review committees: 2010 annual report. Available at: http://www.euthanasiecommissie.nl/Images/JV%20RTE%202010%20ENGELS%20%28EU12.01%29_tcm52-30364.pdf. Accessed March, 2012
15. Luxembourg Ministries of Health and Social Security: Law of 16 March 2009 on euthanasia and assisted suicide. Available at: <http://www.sante.public.lu/publications/sante-fil-vie/fin-vie/euthanasie-assistance-suicide-25-questions-reponses/euthanasie-assistance-suicide-25-questions-reponses-en.pdf>. Accessed March, 2012
16. Commission Nationale de Contrôle et d'Évaluation de la loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide: Premier rapport à l'attention de la Chambre des Députés (Années 2009 et 2010). Available at: <http://www.sante.public.lu/publications/sante-fil-vie/fin-vie/premier-rapport-loi-16-mars-2009/premier-rapport-loi-16-mars-2009.pdf>. Accessed March, 2012
17. Oregon Public Health Division: Oregon's Death with Dignity Act Annual Report 2011. Available at: <http://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx>. Accessed March, 2012
18. Washington State Department of Health: 2010 Death with Dignity Act Report. Available at: <http://www.doh.wa.gov/dwda/>. Accessed March, 2012
19. Groenewoud JH, Van der Heide A, Tholen AJ, Schudel WJ, Hengeveld MW, Onwuteaka-Philipsen BD, et al: Psychiatric consultation with regard to requests for euthanasia or physician-assisted suicide. *Gen Hosp Psychiatry* 2004; 26(4):323–330
20. Rights of the Terminally Ill Act 1995: Available at: <http://www.nt.gov.au/lant/parliamentary-business/committees/rotti/rotti95.pdf>. Accessed March, 2012
21. Mitchell AJ, Rao S, Vaze A: Can general practitioners identify people with distress and mild depression? A meta-analysis of clinical accuracy. *J Affect Disord* 2011; 130(1/2):26–36
22. Ryan CJ: Velcro on the slippery slope: the role of psychiatry in active voluntary euthanasia. *Aust N Z J Psychiatry* 1995; 29: 580–585
23. Parker M: Medicine, psychiatry, and euthanasia: an argument against mandatory psychiatric review. *Aust NZ J Psychiatry* 2000; 34:318–324
24. Block SD, Billings JA: Patient requests for euthanasia and assisted suicide in terminal illness: the role of the psychiatrist. *Psychosomatics* 1995; 36(5):445–457
25. Ganzini L, Leong GB, Fenn DS, Silva JA, Weinstock R: Evaluation of competence to consent to assisted suicide: views of forensic psychiatrists. *Am J Psychiatry* 2000; 157(4):595–600
26. Ganzini L, Fenn DS, Lee MA, Heintz RT, Bloom JD: Attitudes of Oregon psychiatrists toward physician-assisted suicide. *Am J Psychiatry* 1996; 153(11):1469–1475
27. Mystakidou K, Rosenfeld B, Parpa E, Katsouda E, Tsilika E, Galanos A, et al: Desire for death near the end of life: the role of depression, anxiety, and pain. *Gen Hosp Psychiatry* 2005; 27(4):258–262
28. O'Mahony S, Goulet J, Kornblith A, Abbatiello G, Clarke B, Kless-Siegel S, et al: Desire for hastened death, cancer pain, and depression: report of a longitudinal observational study. *J Pain Symptom Manage* 2005; 29(5):446–457
29. Mystakidou K, Parpa E, Tsilika E, Pathiaki M, Galanos A, Vlahos L: Depression, hopelessness, and sleep in cancer patients' desire for death. *Int J Psychiatry Med* 2007; 37(2):201–211
30. Breitbart W, Rosenfeld B, Pessin H, Kaim M, Funesti-Esch J, Galietta M, et al: Depression, hopelessness, and desire for death in terminally ill cancer patients. *JAMA* 2000; 284(22): 2907–2911

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31. Breitbart W, Rosenfeld B, Gibson C, Kramer M, Li Y, Tomarken A, et al: Impact of treatment for depression on desire for hastened death in patients with advanced AIDS. *Psychosomatics* 2010; 51(2):98–105
32. Rayner L, Lee W, Price A, Monroe B, Sykes N, Hansford P, et al: The clinical epidemiology of depression in palliative care and the predictive value of somatic symptoms: cross sectional survey with 4-week follow-up. *Palliat Med* 2011; 25(3):229–241
33. Hotopf M, Chidgey J, Addington-Hall J, Ly KL: Depression in advanced disease: a systematic review. Part 1. Prevalence and case finding. *Palliat Med* 2002; 16(2):81–97
34. McCormack R, Clifford M, Conroy M: Attitudes of UK doctors towards euthanasia and physician-assisted suicide: a systematic literature review. *Palliat Med* 2012; 26:23–33
35. Dickinson GE, Clark D, Winslow M, Marples R: US physicians' attitudes concerning euthanasia and physician-assisted death: a systematic literature review. *Mortality* 2005; 10(1):43–52