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Requests for euthanasia or assisted suicide of people without (severe) illness

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ABSTRACT

Background: Some people request euthanasia or assisted suicide (EAS) even though they are not (severely) ill. In the Netherlands the presence of sufficient medical ground for the suffering is a strict prerequisite for EAS. The desirability of this 'medical ground'-boundary is currently questioned. Legislation has been proposed to facilitate EAS for older persons with "completed life" or "tiredness of life" in the absence of (severe) illness.
Objectives: To describe the characteristics and motivations of persons whose requests for EAS in the absence of (severe) illness did not result in EAS and the decision-making process of medical professionals in these types of requests.
Methods: Analysis of 237 applicant records of the Dutch Euthanasia Expertise Center. We studied both the perspectives of applicants and medical professionals.
Findings: The majority of the applicants were women (73%) aged 75 years and older (79%). Applicants most often indicated physical suffering as element of suffering and reason for the request. Medical professionals indicated in 40% of the cases no or insufficient medical ground for the suffering.
Conclusions: Physical suffering plays an important role in requests for EAS even for persons who are not (severely) ill. From the presence of physical suffering it does not necessarily follow that for medical professionals there is sufficient medical ground to comply with the 'medical ground'-boundary.

1. Introduction

The Dutch termination of life on request and assisted suicide review procedures Act (WTL) came into force in 2002 [1]. This Act holds legislation on the voluntary termination of life (euthanasia; the physician administers the lethal substances to the patient) and assisted suicide (the patient himself takes the lethal substances provided by the physician) [2] According to the WTL, a physician has to comply with six due care criteria for euthanasia or assisted suicide (EAS) to be legally permissible. One of the due care criteria is that the physician should "be satisfied that the patient's suffering is unbearable, with no prospect of improvement" [2]. A specification of this due care criterion resulted from a Dutch Supreme Court ruling stating that the patient's suffering has to predominantly stem from one or more medically classifiable somatic or psychiatric diseases or conditions [2,3]. Since then, case law determines that the presence of sufficient medical ground for the suffering is a strict prerequisite for EAS [2,4].

The vast majority of requests for EAS are based on suffering from cancer or other medical diseases or conditions [5,6]. Research among physicians from 2016 shows that the nature of the suffering associated with - granted or not granted - requests for EAS was cancer in 67% of the cases, another somatic illness (21%), a psychiatric illness (4%), or dementia (3%) [5]. However, there are also people who wish help from a physician to end their lives while they are not (severely) ill. For instance, persons with an accumulation of health problems associated with aging (multiple geriatric syndromes) [5,7,8] and persons who are relatively healthy but consider their lives to be "completed" or are "tired of life" [9–13].

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Requests for EAS based on "completed life" or "tiredness of life" alone are in principle not granted, while a number of requests for EAS of persons who suffer from multiple geriatric syndromes are granted every year [5–8,11,12,14]. From 2013 to 2020 between 172 and 293 cases of EAS for multiple geriatric syndromes were notified to regional review committees each year (172 was 2.7% of the total number of 6361 notifications in 2019 and 293 was 4.4% of the total number of 6,585 notifications in 2017) [6,7]. This is in line with the assumption that multiple geriatric syndromes can involve unbearable suffering without prospect of improvement based on sufficient medical ground, whereas "completed life" or "tiredness of life" in relatively healthy persons cannot [2]. At the same time, far from all requests for EAS based on multiple geriatric syndromes are granted [5,8,14,15]. This corresponds with research showing that physicians consider it less likely to grant EAS to persons with multiple geriatric syndromes compared to persons with severe illness [8,16,17].

Currently, the desirability of the 'medical ground'-boundary is questioned [18]. This is not only reflected in the establishment of citizens' initiatives and organizations that plea for widening EAS legislation but also in the highly political debate. In an effort to expand the possibility for assisted dying, a bill concerning a new legal framework, that will operate next to the existing law, has been proposed in Dutch parliament to facilitate EAS for older persons with "completed life" or "tiredness of life" who are not (severely) ill [19]. The possible implications and ethical considerations of this proposal have been addressed by Florijn [4].

A well-informed debate about the 'medical ground'-boundary has been hampered by the fact that arguments for and against are mainly ideological and theoretical in nature [20,21]. After all, there are only a few empirical studies available about the characteristics and motivations of specifically those persons without (severe) illness whose requests did not result in EAS and the decision-making process on these requests [8,11,12]. The studies that are available are all written from the physician's perspective only.

Hence, debate about the 'medical ground'-boundary could benefit from a study into the perspective of persons without (severe) illness who are not eligible for EAS in the current situation. In this way, arguments and future policy could be more in line with the realities of the people in question instead of being based on ideological and theoretical views only. Furthermore, the reports of medical professionals who bear the responsibility for the decision-making process on EAS in these cases are relevant for the debate. For instance, because they may point out existing difficulties and hesitations in their assessments of requests for EAS of persons without (severe) illness. It is important to take these into account since future policy also requires actors (such as medical professionals) for whom it needs to be feasible and acceptable to carry out the policy. Therefore, this paper includes both the perspectives of persons without (severe) illness who are not eligible for EAS in the current situation and medical professionals to answer the questions: what are the characteristics and motivations of persons without (severe) illness whose requests did not result in EAS? And how are these types of requests for EAS currently decided upon by medical professionals in the Netherlands?

An answer to these questions is not only relevant in the Dutch context, as also more widely in the Western world, death wishes associated with "completed life" or "tiredness of life" are increasingly encountered by medical professionals, publicly discussed, and debated in law, academia, and politics as a social issue [22–25]. Moreover, there are studies suggesting the occurrence of death wishes of older persons who are not (severely) ill outside the Western world as well [26–29]. Our study may provide insights relevant for other countries that wish to carefully reflect on and develop (their existing) legal options for EAS.

2. Methods

We performed an analysis of applicant records of the Dutch Euthanasia Expertise Center (EEC) [30]. This organization comprises a network of 140 physicians and nurses. It originated from Right-to- Die Netherlands and its guiding principle is that everyone with a request for EAS should have the opportunity to get an assessment of their case in light of the law. This assessment is done by a team consisting of a physician and a nurse. Requests are only declined when EAS is not legally permissible. In all other cases, the physicians of EEC are willing to grant EAS. This is in contrast to other physicians who might have personal considerations to decline requests for EAS [5,16,31]. Furthermore, EEC typically receives complex, less common requests for EAS, in which many physicians outside EEC have reservations, such as requests for EAS from persons with multiple geriatric syndromes and persons with "completed life" or "tiredness of life" who are relatively healthy [5,6,14,32]. Because of these differences between EEC and other physicians, EEC not only seems to be a suitable place to gain insight into how limitations of law and case law are carried out in practice but also to trace specifically those cases of persons who request EAS while they are not (severely) ill.

On receipt of the request for EAS at EEC all applicant records are categorized by a medical manager and a physician based on the grounds for the request. In our study we included all requests in the category "multiple geriatric syndromes" that did not result in EAS and all requests in the category "no medical ground" from 01-01-2016 up to 28-09-2020. We only included these specific requests because of our aim to study cases of persons without (severe) illness who are currently excluded from EAS.

2.1. Data collection

The applicant records of EEC generally include an application form completed by the applicants themselves or their representative, the medical record of the applicant, and, if applicable, minutes of contact moments between the applicant and EEC, minutes of contact moments between EEC and medical professionals from outside EEC, and a letter explaining the reasons for declining the request. From these documents we extracted characteristics of the applicants and information about the motivations behind their requests. With regard to motivations, one question in the application form concerned elements of suffering. In the majority of the application forms (approximately 90%) this was a closed-ended question with a prescribed list of answer options, sometimes including the open field: "other, namely:…". In approximately 10% of the application forms this was an open-ended question. Also with regard to motivations, a second question in the application form concerned reasons for the request. This was an open-ended question in all application forms. Furthermore, with regard to the decision-making process of EEC, we gathered information concerning (number of) contacts as well as the reasons for the request not resulting in EAS. A format to arrange this information was developed by EW and GT. It consisted of the four fields general characteristics, application form, process, and decision-making. These fields were subdivided in line with the variables that are displayed in the Tables in the results section to target our search for information. Data were collected by GT, SM, SW, VB and MZ.

2.2. Data analysis

This study is an example of a document analysis in which elements of content analysis and thematic analysis are combined [33]. We (VB and MZ) used inductive coding to organize the data in categories. As the content analysis part of the document analysis allowed to quantify the data, we entered the categorization of each applicant record in SPSS Statistics 26.0.0.1 [34]. For the thematic analysis part of the document analysis, we carefully re-read and reviewed the data to recognize patterns (themes) within the data [33,35].

During analysis, four files in the category "multiple geriatric syndromes" were excluded: one because the applicant concerned did not suffer from an accumulation of health problems associated with aging,

one because the application did result in EAS, and two because the decision-making process of EEC was not yet completed. Besides, two files in the category "no medical ground" were excluded: one because there was no application form and one because it was a duplicate.

2.3. Ethics approval

As a standard procedure at EEC, applicants are asked to give their written informed consent for the use of their records for scientific purposes.

3. Results

A total of 237 files of requests that did not result in EAS were analysed; 167 in the category "multiple geriatric syndromes" and 70 in the category "no medical ground".

3.1. Characteristics

Table 1 shows the characteristics of the applicants at EEC[1]. Nearly three-quarters of the applicants were women. Age ranged from 28 to 101 and more than half of the applicants were 85 years or older. More than four-fifths of the applicants lived without a partner. Most applicants had children (71%) and three-quarters of the applicants lived independently.

3.2. Motivations

Table 2 provides insight into what motivations underlie the

Table 1
Characteristics of the selected applicants at EEC.

Characteristics	N = 237 (%)
Gender	
Female	173 (73)
Male	64 (27)
Age (years)	
Median (Q1-Q3)	85 (78-91)
Younger than 55	13 (6)
55-74	37 (16)
75-84	56 (24)
85 or older	131 (55)
Marital status	
Widow(er)	131 (55)
Single	67 (28)
Married	37 (16)
Living together	2 (1)
Children	
One or more	168 (71)
None	59 (25)
Unknown	10 (4)
Living conditions	
Independent house	179 (76)
Healthcare institution/protected residence	49 (21)
Other[1]	9 (4)

Results are presented as N (%) unless "Median (Q1-Q3)" is reported. The median is reported with 25th-75th percentiles. Percentages may not add up to 100% because of rounding.
Information in this table is derived from the application form completed by the applicants themselves or their representative. Sporadically, if a certain question in the application form was not present or not answered by the applicant, we extracted the required information - if available - from the other documents in the applicant's record.
[1] Namely: homeless; temporary place to stay; temporary place to rehabilitate; penitentiary institution; residence for disabled people; retirement home; detention center; no right to residence without 'assistance'.

[1] For characteristics by categories see supplementary file.

Table 2
Motivations of the selected applicants at EEC.

Motivations	N = 237 (%)
Elements of suffering[2]	
Physical decline/loss of strength	173 (73)
Tiredness	145 (61)
Loss of autonomy/loss of control over own life/dependence	142 (60)
Loneliness[2]	131 (55)
No prospect of improvement	128 (54)
Psychological suffering (long lasting)	127 (54)
Pain	115 (49)
Loss of capacity to maintain social contacts	112 (47)
Loss of dignity	90 (38)
Loss of sensory functions (e.g. deaf- or blindness)	85 (36)
Shortness of breath	56 (24)
Loss of mental capacities	55 (23)
Confusion	52 (22)
Bedriddenness	43 (18)
Nausea	38 (16)
Disconnectedness	32 (14)
Reasons for the request[3]	
Physical problems/suffering	133 (56)
Poor quality of life/life is a burden/being done with life	85 (36)
"Completed life"/ "tiredness of life"[4]	58 (25)
Psychological problems/suffering	48 (20)
(Fearing) loss of independence/dignity[5]	43 (18)
Loneliness[2]	43 (18)
No prospect of improvement	29 (12)
Old age	26 (11)
Spouse/closed ones are deceased/will die soon	23 (10)
Meaninglessness/lack of purpose	22 (9)
Not answered	5 (2)
Relatives/close ones informed about application	
Yes	171 (72)
No	47 (20)
Unknown	19 (8)
Desired moment for granting the request	
In the short term[6]	159 (67)
Not in the short term	23 (10)
Other[7]	32 (14)
Unknown	23 (10)

Results are presented as N (%). Percentages may not add up to 100% because of rounding. Percentages below "Elements of suffering"and "Reasons for the request" do not add up to 100% because applicants could name more than one of the categories.
Information in this table is derived from the application form completed by the applicants themselves or their representative. Sporadically, if a certain question in the application form was not present or not answered by the applicant, we extracted the required information - if available - from the other documents in the applicant's record. This was, however, never the case for Elements of suffering and Reasons for the request.
[1]We included all answer options that occurred in the application forms as categories of elements of suffering. We also added some categories in order to classify all given answers as specific as possible. Elements of suffering that were mentioned by 20 applicants or less are in order of frequency (from most frequently to least frequently mentioned): Other/undefined physical problems e.g. tinnitus; Mourning; Incontinence; Anticipated wish to end one's life/fearing or dreading the future; Poor quality of life/life is a burden/being done with life; Meaninglessness/lack of purpose; Limited capabilities/limited range of motion; "Completed life"/"tiredness of life" (literally described with these words). Elements of suffering that were mentioned by 5 applicants or less were not categorized.
[2]Statements about having limited social contact or feeling alone were also classified as loneliness.
[3]Reasons for the request that were mentioned by 20 applicants or less are in order of frequency (from most frequently to least frequently mentioned): Lack of lust/zest for life; General practitioner not willing to grant EAS/not willing or able to do it myself; Aspiring a good death; Not wanting to receive help/not wanting to move (to a healthcare institution); Looking back on a long/satisfied life; Anticipated wish to end one's life/fearing or dreading the future; Limited capabilities/limited range of motion; Self-determination is important for me; Negative events in the past. Reasons for the request that were mentioned by 5 applicants or less were not categorized.
[4]Literally described with these words.

[5]Those who described current or threatening loss of independence/dignity as well as those who feared this loss.
[6]The answer "as soon as possible" and terms within approximately one year were also categorized as in the short term.
[7]Such as: when the applicant named a specific date or when the applicant answered that it depended on, for instance, a specific expected situation, the development of one's physical and psychological health, or something that needs to be done first.

applicant's request for EAS at EEC. One question in the application form concerned elements of suffering. Physical decline/loss of strength was listed most often (73%). Among the most listed elements of suffering were also tiredness (61%) and loss of autonomy/loss of control over own life/dependence (60%). Besides, approximately half of the applicants listed: loneliness, no prospect of improvement, psychological suffering (long lasting), pain, and/or loss of capacity to maintain social contacts.

A second question concerned reasons for the request. Physical problems/suffering was described most often (56%) and followed by poor quality of life/life is a burden/being done with life (36%), "completed life"/"tiredness of life" (25%), and psychological problems/suffering (20%). Of all applicants, 11% referred to old age when they were asked for the reason for their request. Only a few applicants expressed their reasons for the request in a positive way e.g. having had a good life and wanting a good death. In general, applicants motivated their request for EAS with negative expressions e.g. having enough of life and being sick of life. The answers to reasons for the request contained both elaborations of and additions to the listed elements of suffering.

In most cases, relatives/close ones were informed about the application (72%). The applicant's reason for not informing relatives/close ones was in most cases: having no or few relatives/close ones (anymore) or having no or little contact with them.

3.3. Decision-making process

Table 3 describes features of the decision-making process of EEC. Approximately three-quarters of the applicants had between one to three contact moments with EEC. In nearly four-fifths of the cases the decision-making process of EEC did not include an extra consultation with a medical professional from outside their organization. If another medical professional was consulted, this was most often a geriatrician/geriatric specialist or psychiatrist.

The most often mentioned reason for the request not resulting in EAS was "Not meeting one or more of the due care criteria for EAS" (165 cases; 70%). Thereafter followed "No or insufficient medical ground for the suffering" (95 cases; 40%) and "No (current) request for EAS" (61 cases; 26%). Remarks about no or insufficient medical ground for the suffering were frequently accompanied by remarks about the absence of unbearable suffering and/or the absence of no prospect of improvement.

Twenty-nine (one out of eight) cases were reopened at a later moment in time. For instance, when the applicant's situation had changed and he or she reapplied at EEC. In 10 of these 29 cases, reopening of the case resulted in a granted request.

4. Discussion

Most applicants without (severe) illness at EEC whose requests for EAS did not result in EAS were women (73%) aged 75 years and older (79%). Over the last years an increasing part of the requests for EAS in general was requested by persons of 75 years or older [36]. Moreover, most records we studied (167 out of 237) concerned those of applicants within the category "multiple geriatric syndromes", a category in which it is logical to find older persons. Yet, the thirteen cases of persons younger than 55 years, indicate that requesting EAS without being (severely) ill is not strictly reserved for older persons.

The overrepresentation of women older than 75 years is in line with

Table 3
Decision-making process of EEC.

Decision-making process	N = 237 (%)
Number of contact moments between applicant and EEC	
None[1]	32 (14)
One to three	173 (73)
Four to six	22 (9)
Seven or more	3 (1)
Unknown	7 (3)
Extra consultation with medical professional from outside EEC	
None	188 (79)
Geriatrician/geriatric specialist	19 (8)
Psychiatrist	15 (6)
SCEN-physician[2]	4 (2)
Other medical specialist	1 (<1)
Psychologist	1 (<1)
Combination of two or three from above	3 (1)
Unknown	6 (3)
Reasons for the request not resulting in EAS[3]	
Solely no or insufficient medical ground for the suffering[4]	19 (8)
Solely not meeting one or more of the due care criteria for EAS[5]	71 (30)
Solely no (current) request for EAS[6]	28 (12)
Both no or insufficient medical ground for the suffering and not meeting one or more of the due care criteria for EAS	64 (27)
Both no or insufficient medical ground for the suffering and no (current) request for EAS	3 (1)
Both not meeting one or more of the due care criteria for EAS and no (current) request for EAS	21 (9)
Combination of all three reasons mentioned above	9 (4)
Authorization of applicant to request medical record is lacking	11 (5)
Contact information is lacking	1 (<1)
Natural death	1 (<1)
Unknown	9 (4)
Decision made by	
Physician	79 (33)
Team	70 (30)
Triage	45 (19)
Nurse	13 (6)
Other[7]	24 (10)
Unknown	6 (3)
Reopening of case at a later moment in time	
No	208 (88)
Yes	29 (12)
Not resulting in EAS	14
Resulting in EAS	10
Unknown if reopening resulted in EAS	5

Results are presented as N (%). Percentages may not add up to 100% because of rounding.
Information in this table is derived from the documents written by the medical professionals at EEC.

[1] For example, because the applicant did not deliver the needed information or authorization to further process the application, or on receipt of the request for EAS the delivered documents clearly indicated no current request for EAS.

[2] According to the WTL, before performing EAS, the physician must consult at least one other, independent physician who must see the patient and assess whether the statutory due care criteria are met. The independent physician consulted is often a SCEN-physician. SCEN-physicians are trained by the Royal Dutch Medical Association (RDMA, or in Dutch KNMG) and are available to make an independent, expert assessment of a request for EAS.

[3] How many times the reasons "No or insufficient medical ground for the suffering", "Not meeting one or more of the due care criteria for EAS", and "No (current) request for EAS" were mentioned in total is described in the text.

[4] Reasons were classified into this category if it was literally stated that there was no or insufficient medical ground for the suffering or if there were doubts about sufficient medical ground for the suffering. Also more implicit to (unclarity about) no or insufficient medical ground for the suffering were included, such as: "completed life", "tiredness of life", without (severe) illness, or suffering that was not in the first place or predominantly related to something somatic or psychiatric.

[5] Also doubts about meeting the due care criteria were included in this category. There were remarks about the following due care criteria: "be satisfied that the patient's request is voluntary and well considered"; "be satisfied that the patient's suffering is unbearable, with no prospect of improvement"; "have informed the patient about his situation and prognosis"; "have come to the

conclusion, together with the patient, that there is no reasonable alternative in the patient's situation" [2].

[6] Reasons were classified into this category if it turned out there was in fact no death wish but need for other help than EAS, if there was no current request for EAS anymore, or if the request for EAS was anticipatory from the beginning. Also doubts about these issues were included in this category.

[7] Such as: by the applicant or by the system (if record status had been more than six months on hold).

previous studies into requests for EAS in the categories "tired of living, no severe disease" [12] and "multiple geriatric syndromes" [7]. The question arises why women outnumber men in these types of requests for EAS, while an almost 50-50 distribution is seen in requests for EAS in general [37]. The fact that women generally tend to live longer than men, although relatively more years with deficits and functional limitations is probably part of the answer to this question [38,39].

Our study supports studies indicating that loneliness and both the subjective feeling and objective condition of being alone are related to having death wishes and suicidal outcomes [40–43]. For example, the majority of the applicants lived without a partner (84%) in an independent house (76%). Furthermore, despite the fact that the majority of the applicants had children (71%), part of them indicated feelings of loneliness, having limited social contact, or feeling alone. The finding that one-fifth of the applicants did not inform their relatives/close ones about their application at EEC suggests that for some the eventual step towards requesting end of life may be a lonely experience.

Only a few applicants expressed their reasons for the request in a positive way e.g. having had a good life and wanting a good death. In most cases, existential suffering came to the fore though. Of the applicants, about one third referred to poor quality of life/life is a burden/being done with life and one quarter to "completed life"/"tiredness of life". In general, applicants motivated their request for EAS with negative expressions e.g. having enough of life and being sick of life. Different types of loss were mentioned as elements of suffering and part of the applicants referred to old age as reason for their request for EAS. These findings point to experiences of meaninglessness in the daily lives of older people as a result of the process of ageing and age-related losses such as loss of loved ones, health, and social roles [44].

All dimensions of suffering, the physical, psychological, social, and existential, were clearly present [45]. This finding corresponds with previous research showing that suffering leading to a request for EAS relates to various aspects of personhood [7,46]. Physical suffering was indicated most often by the applicants not only as element of suffering but also as reason for the request (the latter was an open-ended question and therefore completely open for applicants to express the key point of their suffering in their own wording). Thus, even in the absence of (severe) illness, physical suffering played an important role in requests for EAS. This finding is remarkable, as previous research indicates that people requesting EAS predominantly associate psychosocial, psycho-emotional, and existential problems with their unbearable suffering [46,47]. Even patients with (severe) diseases and illnesses mainly evoke non-physical suffering when they describe their suffering [46].

This finding is also remarkable because, from the medical professional's perspective, in a significant part (40%) of the cases there was no or insufficient medical ground for the suffering. This reveals that medical professionals may not associate the physical suffering of applicants with suffering that predominantly stems from one or more medically classifiable somatic or psychiatric conditions. Hence, from the presence of physical suffering it does not necessarily follow that for medical professionals there is sufficient medical ground to comply with the 'medical ground'-boundary.

Previous research indicates that physicians relate unbearable suffering to physical suffering [46]. In line with this, we noted in the files of medical professionals at EEC that remarks about no or insufficient medical ground for the suffering were frequently accompanied by remarks about the absence of unbearable suffering. Besides, there were accompanying remarks about the absence of no prospect of improvement. These findings underline the fact that the 'medical ground'--boundary is a specification of the due care criterion "be satisfied that the patient's suffering is unbearable, with no prospect of improvement" [2]. In practice, reflection upon this due care criterion and the 'medical ground'-boundary seems to be intertwined. Moreover, the fact that also other reasons for the request not resulting in EAS were found in combinations, suggests that intertwining factors play a role in the decision-making process.

Comparison with granted requests for EAS in cases of multiple geriatric syndromes might shed light on why some persons with multiple geriatric syndromes are eligible for EAS and others are not. If our study is compared to a study into granted requests for EAS in cases of multiple geriatric syndromes, similar findings are found concerning an over-representation of older women with physical suffering but also suffering in the psychological, social, and existential dimensions [7]. Dependence, fears, social isolation, and loss of meaning in daily life were found in both studies as elements of suffering. There are also differences between both studies though. Loss of mobility, the occurrence of falls, and the presence of a tipping point played an important role in the results of the study into granted requests for EAS, while these factors do not specifically come to the fore in this study. These factors may, therefore, hint towards causes for medical professionals to consider granting EAS. However, we cannot exclude that these factors are also implicit in the physical suffering as shown in our present study.

In the absence of (severe) illness, it might be difficult to exactly point out why some persons with physical suffering are eligible for EAS and others are not. For multiple geriatric syndromes is described: "These syndromes, which are often degenerative in nature, generally occur in elderly patients. It is the sum of these problems, in conjunction with the patient's medical history, life history, personality, values and stamina, that may give rise to suffering which that particular patient experiences as being unbearable and without prospect of improvement" [2]. Hence, differences in eligibility might be a matter of individual context-dependent nuances.

4.1. *Strengths and limitations*

This study is to our knowledge the first to examine cases of persons without (severe) illness whose requests for EAS did not result in EAS and in which both the perspectives of applicants and medical professionals were taken into account. A limitation of this study is that we did not study our research questions in cases outside EEC. We are aware that an examination of applicant records of EEC does not provide a complete overview of all requests for EAS of people who are not (severely) ill. It is likely though that our study provides insight into a great part of such requests, since EEC typically receives complex, less common requests for EAS [6,14]. Another limitation is related to the fact that the studied documents had a different original purpose than scientific research. The application forms and letters of decline from which we extracted information about characteristics, motivations, and the decision-making process slightly changed over the years. For example, the prescribed list of answer options to identify elements of suffering. This may have impact on the frequencies of some answers. Yet, as we also included and thoroughly studied open fields and open-ended questions, we believe these slight changes have only small impact on the results as a whole. Further, our study is partly based on closed-ended questions. This may be considered as a limitation. Since we were aware of the fact that closed-ended questions might direct persons in their answers and leave no room for specification, we drew only careful conclusions and took the added value of open fields and open-ended questions into account. A final limitation could be that some applicants may have been aware of what factors could increase their chances of being eligible for EAS under the current jurisprudence and law, which might have influenced their answers [48]. For instance, they may have emphasized their physical

suffering or may have chosen to express their reasons for the request in a negative way. Nonetheless, while this possibility is described in literature, to our knowledge there is no evidence of its actual (frequent) occurrence in practice.

5. Conclusions and recommendations

In the absence of (severe) illness, suffering manifests itself in physical, psychological, social, and existential dimensions. Motivations behind the request for EAS are mostly expressed in a negative way and point to experiences of meaninglessness in the daily lives of older people as a result of the process of ageing and age-related losses. Even in the absence of (severe)illness, physical suffering plays an important role in requests for EAS. However, from the presence of physical suffering it does not necessarily follow that for medical professionals there is sufficient medical ground to comply with the 'medical ground'-boundary. The 'medical ground'-boundary is reflected upon and applied as a reason to decline requests for EAS by medical professionals at EEC. Reflection upon this boundary and the due care criterion of unbearable suffering, with no prospect of improvement seems to be intertwined.

In the absence of (severe) illness, it might be difficult to exactly point out why some persons with physical suffering are eligible for EAS and others are not. Differences in eligibility might be a matter of individual context-dependent nuances. Future research might provide some more insight into these differences though. For instance, by means of a qualitative interview study with medical professionals who assess requests for EAS of people without (severe) illness. Or by means of a comparison study in which the reasons of medical professionals to grant requests for EAS in some cases of persons with multiple geriatric syndromes are analyzed together with their reasons to decline such requests in other cases.

Our study provides a picture of the group, except for those below the age of 75 years, for whom the proposed bill without 'medical ground'-boundary is intended [19]. Based on the multidimensional suffering our study unraveled, it seems important that in future policy there is also attention for the help and support the people in question might need. Are there perhaps ways in which their suffering could be relieved other than by EAS? Future research could focus on what help and support would be needed and welcomed by persons with a wish to die without (severe) illness, and who could provide this.

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Ethics committee approval

The Medical Research Ethics Committee METC Utrecht confirmed that this study was exempt from further ethical review (dossier no. 19-156/C).

Declaration of Competing Interest

None.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.healthpol.2022.06.004.

References

[1] Termination of Life on Request and Assisted Suicide (Review Procedures). Dutch: Wet Toetsing Levensbeeindiging op verzoek en hulp bij zelfdoding (WTL). 2001. 12 april 2001.
[2] Regional Euthanasia Committees. Euthanasia code: review procedures in practice. 2018. Available from: https://english.euthanasiecommissie.nl/the-commitees/documents/publications/euthanasia-code/euthanasia-code-2018/euthanasia-code-2018/euthanasia-code-2018.
[3] Supreme Court The Netherlands 24th of December 2002, ECLI:NL:HR:2002:AE8772.
[4] Florijn BW. Extending' euthanasia to those 'tired of living' in the Netherlands could jeopardize a well-functioning practice of physicians' assessment of a patient's request for death. Health Policy 2018;122:315–9.
[5] Onwuteaka-Philipsen B, Legemaate J, van der Heide A, et al. Derde evaluatie Wet Toetsing Levensbeëindiging op verzoek en hulp bij zelfdoding. Den Haag: ZonMw; 2017.
[6] KNMG. Euthanasie in cijfers, KNMG infographics 2016, 2020, 2021. Available from: https://knmg.nl/advies-richtlijnen/dossiers/euthanasia.htm and https://www.euthanasiecommissie.nl.
[7] Van den Berg V, van Thiel G, Zomers M, et al. Euthanasia and physician-assisted suicide in patients with multiple geriatric syndromes. JAMA Intern Med 2021;181:245–50.
[8] Evenblij K, Pasman HRW, van der Heide A, et al. Factors associated with requesting and receiving euthanasia: a nationwide mortality follow-back study with a focus on patients with psychiatric disorders, dementia, or an accumulation of health problems related to old age. BMC Med 2019;17:39.
[9] Hartog ID, Zomers ML, van Thiel GJ, et al. Prevalence and characteristics of older adults with a persistent death wish without severe illness: a large cross-sectional survey. BMC Geriatr 2020;20:1–14.
[10] Van Den Noortgate N, van Humbeeck L. Medical assistance in dying and older persons in Belgium: trends, emerging issues and challenges. Age Ageing 2021;50:68–71.
[11] Rurup ML, Muller MT, Onwuteaka-Philipsen BD, et al. Requests for euthanasia or physician-assisted suicide from older persons who do not have a severe disease: an interview study. Psychol Med 2005;35:665–71.
[12] Rurup ML, Onwuteaka-Philipsen BD, et al. When being 'tired of living' plays an important role in a request for euthanasia or physician-assisted suicide: patient characteristics and the physician's decision. Health Policy 2005;74:157–66.
[13] Van Wijngaarden E, Leget C, Goossensen A. Ready to give up on life: the lived experience of elderly people who feel life is completed and no longer worth living. Soc Sci Med 2015;138:257–64.
[14] Expertisecentrum Euthanasie. Feiten en cijfers patiëntenzorg 2019. 2020. Available from: EE_feiten-en-cijfers_web.pdf (expertisecentrumeuthanasie.nl).
[15] Van den Ende C, Bunge EM, van de Vathorst S. Wish for euthanasia persists for at least one year after the request was declined by Euthanasia Expertise Center. Health Policy 2021;122:315–9.
[16] Bolt EE, Snijdewind MC, Dl Willems, et al. Can physicians conceive of performing euthanasia in case of psychiatric disease, dementia or being tired of living? J Med Ethics 2015;41:592–8.
[17] Kouwenhoven PS, Raijmakers NJ, van Delden JJ, et al. Opinions of health care professionals and the public after eight years of euthanasia legislation in the Netherlands: a mixed methods approach. Palliat Med 2013;27:273–80.
[18] Van Wijngaarden EJ, Klink A, Leget C, et al. Assisted dying for healthy elderly people in the Netherlands: a step too far? BMJ 2017;357:j2298.
[19] Dijkstra P. Voorstel van een wet, Wet toetsing levenseindebegeleiding van ouderen op verzoek [Bill proposal, The Termination of Life of Older Adults on Request (Review Procedures) Act], in vergaderjaar 2019-2020, 35 534, nr 2. Tweede Kamer, Editor. 2020.
[20] Finitude Gilleard C. choice and the right to die: age and the completed life. Ageing Soc 2020:1–11.
[21] Thomas HL. Demedicalisation: radically reframing the assisted dying debate—an essay by Lucy Thomas. BMJ 2020:371.
[22] McCue RE, Balasubramaniam M. Rational suicide in the elderly: clinical, ethical, and sociocultural aspects. Springer; 2016.
[23] Richards N. Old age rational suicide. Sociol Compass 2017;11:e12456.
[24] Span P. The new old age: a debate over 'rational suicide'. New York: The New York Times; 2018.
[25] Van Humbeeck L, Dillen L, Piers R, Van Den Noortgate N. Tiredness of life in older persons: a qualitative study on nurses' experiences of being confronted with this growing phenomenon. Gerontologist 2020;60:735–44.
[26] Cavalcante FG, de Souza Minayo MC. Qualitative study on suicide attempts and ideations with 60 elderly in Brazil. Cien Saude Colet 2015;20:1655–66.
[27] Gutierrez DMD, Sousa ABL, Grubits S. Suicidal ideation and attempted suicide in elderly people–subjective experiences. Cien Saude Colet 2015;20:1731–40.
[28] Nie Y, Hu Z, Zhu T, Xu H. A cross-sectional study of the prevalence of and risk factors for suicidal ideation among the elderly in nursing homes in Hunan Province. China. Front Psychiatry 2020;11:339.

[29] Xu H, Qin L, Wang J, et al. A cross-sectional study on risk factors and their interactions with suicidal ideation among the elderly in rural communities of Hunan, China. BMJ Open 2016;6:e010914.
[30] expertisecentrumeuthanasie [internet], cited 12th of December 2021. Available from: https://expertisecentrumeuthanasie.nl.
[31] Ten Cate K, van Tol DG, van de Vathorst S. Considerations on requests for euthanasia or assisted suicide; a qualitative study with Dutch general practitioners. Fam Pract 2017;34:723–9.
[32] Snijdewind MC, Willems DL, Deliens L, et al. A study of the first year of the end-of-life clinic for physician-assisted dying in the Netherlands. JAMA Intern Med 2015; 175:1633–40.
[33] Bowen GA. Document analysis as a qualitative research method. Qual Res J 2009; 9:27–40.
[34] Vaismoradi M, Turunen H, Bondas T. Content analysis and thematic analysis: implications for conducting a qualitative descriptive study. Nurs Health Sci 2013; 15:398–405.
[35] Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Res Psychol 2006;3:77–101.
[36] Nivel. Ontwikkelingen in het aantal euthanasiegevallen en achterliggende factoren. Nivel 2019:14–5. Available from, https://documenten/rapporten/2019/07/03/ontwikkelingen-in-het-aantal-euthanasiegeveallen-en-achterliggende-factoren.
[37] Regionale Toetsingscommissies Euthanasie. Jaarverslag 2020. 2021. Available from https://www.rijksoverheid.nl/documenten/rapporten/2021/04/20/regionale-toetsingscommissies-euthanasie-jaarverslag-2020.
[38] Carmel S. Health and well-being in late life: gender differences worldwide. Front Med 2019;6:218.
[39] Hubbard RE, Rockwood K. Frailty in older women. Maturitas 2011;69:203–7.
[40] Van der Heide A, Onwuteaka-Philipsen BD, van Thiel G et al. Kennissynthese Ouderen en het zelfgekozen levenseinde. 2014. Available from: https://www.tgle.nl/van%20heide%20et%20al%202014%k20kennissynthese%20ouderen%20zelfgekozen%20levenseinde.pdf.
[41] Briggs RM, Ward M, Kenny RA. The 'Wish to Die' in later life: prevalence, longitudinal course and mortality. Data from TILDA. Age Ageing 2021;50:1321–8.
[42] Calati R, Ferrari C, Brittner M, et al. Suicidal thoughts and behaviors and social isolation: a narrative review of the literature. J Affect Disord 2019;245:653–67.
[43] Rurup M, Deeg D, et al. Wishes to die in older people: a quantitative study of prevalence and associated factors. Crisis 2011;32:194–203.
[44] Derkx P, Bos P, Laceulle H, et al. Meaning in life and the experience of older people. Int J Ageing Later Life 2020;114:1–30.
[45] Cassell EJ. The nature of suffering and the goals of medicine. N Engl J Med 1982;8: 129–42.
[46] Pasman HR, Rurup ML, Willems DL, et al. Concept of unbearable suffering in context of ungranted requests for euthanasia: qualitative interviews with patients and physicians. BMJ 2009;339:b4362.
[47] Dees MK, Vernooij-Dassen MJ, Dekkers WJ, et al. Unbearable suffering': a qualitative study on the perspectives of patients who request assistance in dying. J Med Ethics 2011;37:727–34.
[48] Van Tol D, Van de Vathorst S, Keizer B. Euthanasie voor beginners. Tien suggesties voor een succesvolle stervenswens. Medisch Contact 2008;63.