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Just let me die with dignity
It’s not suicide, simply mercy

Life Is Killing Me – Type O Negative

6

A study of the first year of the End-of-Life Clinic for physician-assisted dying in the Netherlands

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ABSTRACT

Background

Right to Die-NL, an organization in the Netherlands that advocates for the option of euthanasia, founded the End-of-Life Clinic in 2012 to provide euthanasia or physician-assisted suicide for patients who meet all legal requirements but whose regular physicians rejected their request. Many patients whose requests are rejected have less common situations, such as a psychiatric or psychological condition, dementia, or being tired of living.

Aim

To study outcomes of requests for euthanasia or physician-assisted suicide received by the clinic and factors associated with granting or rejecting requests.

Methods

Analysis of application forms and registration files from March 1, 2012, to March 1, 2013, the clinic's first year of operation, for 645 patients who applied to the clinic with a request for euthanasia or physician-assisted suicide and whose cases were concluded during the study period. A request could be granted, rejected, or withdrawn or the patient could have died before a final decision was reached. We analyzed bivariate and multivariate associations with medical conditions, type of suffering, and sociodemographic variables.

Results

Of the 645 requests made by patients, 162 requests (25.1%) were granted, 300 requests (46.5%) were refused, 124 patients (19.2%) died before the request could be assessed, and 59 patients (9.1%) withdrew their requests. Patients with a somatic condition (113 of 344 [32.8%]) or with cognitive decline (21 of 56 [37.5%]) had the highest percentage of granted requests. Patients with a psychological condition had the smallest percentage of granted requests. Six (5.0%) of 121 requests from patients with a psychological condition were granted, as were 11 (27.5%) of 40 requests from patients who were tired of living.

Conclusion

Physicians in the Netherlands have more reservations about less common reasons that patients request euthanasia and physician-assisted suicide, such as psychological conditions and being tired of living, than the medical staff working for the End-of-Life

Clinic. The physicians and nurses employed by the clinic, however, often confirmed the assessment of the physician who previously cared for the patient; they rejected nearly half of the requests for euthanasia and physician-assisted suicide, possibly because the legal due care criteria had not been met.

INTRODUCTION

In 2002, the Termination of Life on Request and Assisted Suicide Act came into force in the Netherlands, allowing euthanasia, the administering of lethal medication by a physician at the request of the patient, and assisted suicide, providing lethal medication to a patient at his or her request to patients who meet the legal due care criteria (Box 1).(1-2) These criteria include a voluntary and well-considered request from the patient, who must be suffering unbearably without prospect of improvement. Of all deaths in the Netherlands, 1.7 to 2.8% result from euthanasia or physician-assisted suicide, according to a study published in 2012.(3) Certainly not all requests are granted: studies conducted between 1990 and 2011 report rates of granting requests between 32% and 45%.(3-6) Because some of these studies were based on a sample of patients who had already died, the percentage of requests granted in the general population may be lower. The reasons that requests did not result in euthanasia or physician-assisted suicide were that the patient died before a decision could be made, the patient withdrew the request, and that the treating physician refused to provide euthanasia or physician-assisted suicide, either based on principle or because in his or her opinion the due care criteria had not been met.(6-8) A prior study indicated that patients whose requests were rejected continue to have a wish to die.(9)

Box 1 Legal Due Care Criteria for Euthanasia and Assisted Suicide in the Netherlands(1)

1. *The attending physician has to come to the conviction that the request from the patient is voluntary and well considered.*
2. *The attending physician has to come to the conviction that the suffering of the patient is unbearable and without prospect of improvement.*
3. *The physician must inform the patient about his/her situation and prospects.*
4. *There are no more reasonable alternatives for the patient.*
5. *The physician must consult at least one other, independent physician.*
6. *The physician must terminate the patient's life or provide assistance with suicide with due medical care and attention*

Right to Die-NL (Nederlandse Vereniging voor een Vrijwillig Levenseinde), an organization that advocates for the option of euthanasia in the Netherlands, founded the End-of-Life Clinic (Levenseindekliniek) in March 2012 to provide euthanasia or physician-assisted suicide for patients who meet all legal requirements but whose request is rejected by their regular physician (See Box 2 for information on the clinic's

operating procedures). Patients apply to the clinic by completing an application form. The clinic operates throughout the country, with mobile teams consisting of a physician and nurse. The mobile teams visit patients at home, and assess their requests. The clinic requires patients to authorize review of their medical record.

Box 2 Operating Procedures for the End-of-Life Clinic in the Netherlands

When an application is received, the End-of-Life Clinic creates a registration file for the patient that includes the application form. When authorized by the patient, the clinic obtains the medical files from the treating physician or physicians. Based on the application form and the medical files, a nurse makes a first classification. Some applications are rejected. A mobile team — consisting of a nurse and physician working for the clinic — further assesses the others. During the study period, there were approximately 15 mobile teams. Reasons for rejection are as follows: [1] the patient won't authorize the clinic to view his or her medical files; [2] the patient has not spoken (and will not speak) with the treating physician about his or her request for euthanasia or physician-assisted suicide, or the application to the End-of-Life Clinic; [3] the available information clearly reveals that the patient's request will not meet the due care criteria; and [4] the patient has no current wish for euthanasia of physician-assisted suicide.

If a case is further assessed, the mobile team contacts the treating physician to discuss their reasons for rejecting the request and visit the patient (most often multiple times). In this stage, a case can be rejected if it seems unable to meet the due care criteria. If the mobile team decides that the due care criteria can be met, a SCEN-physician (Steun en Consultatie bij Euthanasie in Nederland) — a physician specifically trained to give independent consultations about requests for physician-assisted dying — is consulted, as is required by Dutch law.(1) A meeting then follows with the mobile team, another physician working for the clinic, and a lawyer. If all those participating in the meeting agree that the due care criteria can be met, a request for euthanasia or physician-assisted suicide is granted. During the entire process, the patient can withdraw his or her request at any time.

Physicians and nurses are part-time employees of the End-of-Life Clinic. Initially, the End-of-Life Clinic was financed by donations, during 2013 insurance companies started to finance care provided by the clinic. According to the clinic's annual reports(10-11), the End-of-Life Clinic received 749 applications in 2013, and 1035 in 2014. The number of mobile teams increased in 2013 from 15 to 30, and in 2014 from 30 to 39.

During its first year, the End-of-Life Clinic expected to receive approximately 1,000 applications, many of which would be about less common situations, such as requests from psychiatric patients, and patients with dementia or who were tired of living(12), and for whom, according to the clinic's chair, extra caution is required.(13) It was anticipated that in many instances the due care criteria would be met but the regular physician's own criteria were stricter than the law required.(12) Such cases, however, are inherently controversial; the terms used in the law are open to interpretation and there are ongoing discussions about how they should be interpreted. The Royal Dutch Medical Association had serious concerns about the clinic, arguing that its founding was undesirable and would create the false impression that euthanasia or physician-assisted suicide is a patient's right.(14-17) In light of the concerns and to monitor its operations, the clinic keeps records of all applications and the ensuing decision process.

In this study, we report on all applications made in the first year of the End-of-Life Clinic's operations. We address the following research questions: 1) How often do the different possible outcomes of applications for euthanasia or physician-assisted suicide occur (grant, reject, die before decision making is finalized, patient withdrawal)?, and 2) Which factors are associated with the outcome of an application? The factors that were studied were sociodemographic patient characteristics (sex, age, marital status, children, living situation), clinical characteristics (medical condition, type of suffering) and other circumstances (time since the application was filed, willingness of the regular physician to perform euthanasia).

METHODS

Data collection

We included data from all the End-of-Life Clinic's unique registration files created from 1 March 2012, to 1 March 2013. Each file contained the original application form completed by the patient, relatives or regular physician, and the final outcome. Application forms and outcome decisions were both dated which allowed us to calculate the time between application and final decision.

Variables

In addition to questions about sociodemographic information, the application form had questions about diagnosis, type of suffering, how long the patient had been wishing for euthanasia or physician-assisted suicide, discussion of the request with family

physician and/or specialist, and whether the regular family physician and/or specialist was willing to perform euthanasia or physician-assisted suicide.

Based on the information about diagnosis, we coded all cases as having one or more of the following medical conditions: cancer, cardiovascular diseases, neurologic (physical), neurologic (cognitive), pulmonary, rheumatoid, other physical discomfort, psychiatric or psychological condition, or being tired of living. We separated neurologic conditions that affected the cognitive function of a patient, such as dementia, since this may influence the assessment of the physician; we suspected that patients deemed to lack mental competence often have their requests rejected. A case was coded 'tired of living' if patients stated their condition in such words and if no other medical condition was found. With the exception of being tired of living, a combination of conditions could occur. If the application form did not contain a clear diagnosis, two researchers (M.C.S. and K.C.) discussed the case until consensus was reached. If no agreement was reached or no indication of a diagnosis was found, the medical condition was coded as missing.

We further grouped medical conditions into five categories: 1) somatic suffering, i.e., patients who had as their condition cancer, cardiovascular diseases, neurologic (physical), pulmonary, rheumatoid, other physical discomfort or a combination thereof; 2) psychological suffering, i.e., patients whose only medical condition was a psychiatric or psychological condition; 3) somatic and psychological suffering, i.e., patients who had both a psychiatric or psychological condition and one of the somatic conditions; 4) cognitive decline, i.e., patients whose condition was neurologic (cognitive); and 5) tired of living, i.e., patient who had only the condition of being tired of living.

We identified four different outcomes of a request: the patient had received euthanasia or physician-assisted suicide, the request had been refused by the clinic, the patient had withdrawn the application, or the patient had died from a cause other than euthanasia or physician-assisted suicide (natural or self-inflicted). Reasons that requests were withdrawn were not recorded in the registration files.

Statistical analysis

We performed bivariate crosstab analyses with Chi-squared or Fisher Exact (for 2x2 tables) significance testing ($P<0.05$). Multivariate logistic regression analyses were done using the backward stepwise conditional method, with no interaction effects. All analyses were performed with SPSS statistical software, version 22.0 (SPSS Inc).

Ethics

According to the Medical Research Involving Human Subjects Act (Wet medisch-wetenschappelijk onderzoek met mensen)(18), the study did not require review by an ethics committee. The researchers ensured that the results precluded any identification of patient or physician.

RESULTS

During the one- year study period, the End-of-Life Clinic received 709 unique applications. We excluded cases that had not been concluded (n=53), cases where the application form could not be retrieved (n=4), cases where the outcome was unknown (n=4), and those where there was not an actual euthanasia or physician-assisted suicide request (n=3). Thus, 645 applications (91.0% of those received) were included. Table 1 lists the characteristics of applicants.

Table 2 lists the outcome of the requests, and the elapsed time between the application to the clinic and the outcome. It took a mean of 5.7 months for a request to be granted. The mean time it took the clinic to handle a request was longer in the first than the second half of the year (4.7 vs 3.6 months) owing to the lower capacity of mobile teams in the first half of the year and a large number of applications in the clinic's first month. In its first month, the clinic received 154 (21.7%) of the 709 application forms.

Of the 645 requests made by patients, 162 (25.1%) were granted, 300 requests (46.5%) were refused, 124 patients (19.2%) died before the request could be assessed, and 59 patients (9.1%) withdrew their request. The 162 granted requests comprised 92 cases in which the clinic performed euthanasia or physician-assisted suicide (56.8%), 23 cases in which the regular physician performed euthanasia or physician-assisted suicide (14.2%), and 47 cases in which the regular physician agreed to perform euthanasia or physician-assisted suicide in the (near) future (29.0%). Patients with a somatic condition, or with cognitive decline had the highest percentage of granted requests. Patients with a psychological condition had the smallest percentage of granted requests. Six (5.0%) of 121 from patients with a psychological conditions were granted, as were 11 (27.5%) of 40 requests from patients who were tired of living.

Table 1 Characteristics of the study patients

Characteristic	Study patients (N=645) %
Sex	
Female	61.9
Male	38.1
Age	
< 40 years	10.2
40-60 years	21.9
60-80 years	29.1
> 80 years	38.8
Marital status	
Married or living together	27.2
Single	42.7
Widow(er)	30.1
Number of children	
None	34.8
1	13.9
> 1	51.3
Living Situation	
Independent housing	69.3
Care facility	19.8
Assisted living	3.6
Mental health care institution or hospital	3.3
Sheltered facility	3.1
Other	0.9

Table 2 Outcomes of requests to the End-of-Life Clinic of euthanasia or physician-assisted suicide, according to medical conditions

Outcome[a]	Running time of request at End-of-Life Clinic, Median (Range) in months (n=576)[b,c]	No. (%) of requests[d]					
		Somatic (n=344)	Somatic and psycho-logical (n=51)	Psychologi-cal (n=121)	Cognitive decline (n=56)	Tired of living (n=40)	Total n=645)[e]
Request granted[f]	5 (0-15)	113 (32.8)	7 (13.7)	6 (5.0)	21 (37.5)	11 (27.5)	162 (25.1)
Request rejected	4 (0-17.2)	117 (34.0)	31 (60.8)	89 (73.6)	20 (35.7)	23 (57.5)	300 (46.5)
Patient died before decision	1.5 (0-16.1)	89 (25.9)	9 (17.6)	9 (7.4)	7 (12.5)	3 (7.5)	124 (19.2)
Request withdrawn	2.7 (0-17.4)	25 (7.3)	4 (7.8)	17 (14.0)	8 (14.3)	3 (7.5)	59 (9.1)

a $P<0.001$ denotes significant differences in mean months to decision between outcomes, and significant differences in outcomes among medical conditions.

b Date of death is often unknown in cases in which the regular physician performed euthanasia or physician-assisted suicide and in cases in which the patient died before assessment.

c Mean running times: euthanasia or physician-assisted suicide granted, 5.7 months; request rejected, 4.2 months; patient died before decision, 2.5 months; request withdrawn, 4.4 months; and total, 4.2 months.

d Percentages may not total 100% because of rounding.

e Because of missing medical conditions, the numbers do not total.

f Euthanasia or physician-assisted suicide granted or already performed by either the End-of-Life Clinic or the patient's regular physician.

Table 3 lists the outcomes of the requests, according to the patient's sociodemographic and clinical characteristics, living situation, and other circumstances. Patients whose request were granted had an older mean age than those whose requests were rejected (77 years (n=162) vs 61 years (n=300); *P*<0.001) at the time of application; 32 (19.8%) were younger than 65 years, whereas 82 (53.7%) were 80 years or older. Within the group of patients with a granted request, patients often had a somatic condition and most often stated they suffered from physical decline or loss of strength (89.4%)(n=144).

Compared with granted requests, patients whose requests were rejected were significantly more often single (174 [58.2%] vs. 42 [25.9%]) and without children (148 [49.5%] vs. 31 [19.1%]). Their medical condition was often psychiatric or psychological (122 [43.6%]). Within the group of patients whose requests were rejected, psychological suffering (249 [83.6%]) and loneliness (213 [71.5%]) were mentioned most as the type of suffering.

Table 4 lists the factors that were independently associated with a request being granted in multivariate analysis. We compared granted requests to rejected requests (n=417, owing to missing data for multiple variables). Factors independently associated with a request being granted included having more than one child, and suffering from tiredness or loss of autonomy. Factors associated with a request being rejected included being single, a psychological condition, and suffering from loneliness or loss of mental capacity. The multivariate model explained 37.8% of the total variance in outcome.

Table 3 Outcome of requests for euthanasia or physician-assisted suicide according to patient characteristics and other circumstances

Characteristic	No. (%) of requests		*P* value (comparison of request granted and request rejected)	No. (%) of patients	
	Request granted[a] (n=162)	Request rejected (n=300)		Patient died before decision (n=124)	Request withdrawn (n=59)
Sex					
Male	57 (35.2)	111 (37.0)	0.76	48 (38.7)	30 (50.8)
Female	105 (64.8)	189 (63.0)		76 (61.3)	29 (49.2)
Age, mean (SD), y	77 (14)	61 (22)	<0.001	76 (13)	66 (18)
Marital status					
Married or living together	52 (32.1)	61 (20.4)	<0.001	40 (32.3)	22 (37.3)
Widow(er)	68 (42.0)	64 (21.4)		47 (37.9)	15 (25.4)
Single	42 (25.9)	174 (58.2)		37 (29.8)	22 (37.3)
No. of children					
None	31 (19.1)	148 (49.5)	<0.001	27 (22.3)	17 (28.8)
1	23 (14.2)	40 (13.4)		17 (14.0)	9 (15.3)
> 1	108 (66.7)	111 (37.1)		77 (63.6)	33 (55.9)
Accomodation					
Independent housing	107 (66.0)	218 (73.4)	<0.001	77 (62.1)	43 (72.9)
Sheltered accomodation	1 (0.6)	14 (4.7)		4 (3.2)	1 (1.7)
Care facility	43 (26.5)	34 (11.4)		39 (31.5)	11 (18,6)
Mental health care institution or hospital	2 (1.2)	18 (6.1)		0	1 (1.7)

Table 3 Outcome of requests for euthanasia or physician-assisted suicide according to patient characteristics and other circumstances (continued)

Characteristic	No. (%) of requests		*P* value (comparison of request granted and request rejected)	No. (%) of patients	
	Request granted[a] (n=162)	Request rejected (n=300)		Patient died before decision (n=124)	Request withdrawn (n=59)
Assisted living	8 (4.9)	8 (2.7)		4 (3.2)	3 (5.1)
Other	1 (0.6)	5 (1.7)		0	0
Duration of request for euthanasia or physician-assisted suicide up to application at End-of-Life Clinic					
< 6 months	42 (27.1)	35 (12.0)		41 (34.2)	12 (20.7)
6 months to 1 year	50 (32.3)	51 (17.5)	<0.001	28 (23.3)	15 (25.9)
> 1 year	63 (40.6)	205 (70.4)		51 (42.5)	31 (53.4)
Medical condition[b]					
Cancer	36 (22.8)	27 (9.6)	<0.001	35 (29.9)	1 (1.8)
Neurological (physical)	36 (22.8)	42 (15.0)	0.05	22 (18.8)	14 (24.6)
Neurological (cognitive)	21 (13.3)	21 (7.5)	0.06	7 (6.0)	8 (14.0)
Pulmonary	15 (9.5)	12 (4.3)	0.04	8 (6.8)	1 (1.8)
Cardiovascular	11 (7.0)	13 (4.6)	0.38	16 (13.7)	0
Psychiatric or psychological	13 (8.2)	122 (43.6)	<0.001	18 (15.4)	21 (36.8)
Tired of living	11 (7.0)	23 (8.2)	0.71	3 (2.6)	3 (5.3)

Table 3 Outcome of requests for euthanasia or physician-assisted suicide according to patient characteristics and other circumstances (continued)

Characteristic	No. (%) of requests		*P* value (comparison of request granted and request rejected)	No. (%) of patients	
	Request granted[a] (n=162)	Request rejected (n=300)		Patient died before decision (n=124)	Request withdrawn (n=59)
Reumatoid related diseases	14 (8.9)	22 (7.9)	0.72	6 (5.1)	3 (5.3)
Other, somatic	43 (27.2)	81 (28.9)	0.74	42 (35.9)	21 (36.8)
Type of suffering[c]					
Physical decline or loss of strength	144 (89.4)	196 (65.8)	<0.001	112 (90.3)	40 (67.8)
Tiredness	135 (83.9)	207 (69.5)	0.001	101 (81.5)	43 (72.9)
Loss of autonomy	131 (81.4)	180 (60.4)	<0.001	93 (75.0)	42 (71.2)
Loss of dignity	119 (73.9)	192 (64.4)	0.05	89 (71.8)	37 (62.7)
Psychological suffering	103 (64.0)	249 (83.6)	<0.001	85 (68.5)	53 (89.8)
Loneliness	79 (49.1)	213 (71.5)	<0.001	54 (43.5)	41 (69.5)
Shortness of breath[d]	30 (33.7)	35 (21.3)	0.04	39 (49.4)	5 (14.7)
Loss of sensory functions	53 (32.9)	67 (22.5)	0.02	38 (30.6)	12 (20.3)
Loss of mental capacity	46 (28.6)	113 (37.9)	0.05	31 (25.0)	23 (39.0)

Table 3 Outcome of requests for euthanasia or physician-assisted suicide according to patient characteristics and other circumstances (continued)

Characteristic	No. (%) of requests		*P* value (comparison of request granted and request rejected)	No. (%) of patients	
	Request granted[a] (n=162)	Request rejected (n=300)		Patient died before decision (n=124)	Request withdrawn (n=59)
Willingness regular physician to grant EAS request before application[e]					
Family physician and/or specialist are willing	22 (14.8)	27 (9.7)		20 (16.9)	5 (8.9)
No regular physician is willing	126 (84.6)	214 (77.0)	<0.001	94 (79.7)	41 (73.2)
Not discussed with regular physician	1 (0.7)	37 (13.3)		4 (3.4)	10 (17.9)

a Euthanasia or physician-assisted suicide granted or already performed by the End-of-Life Clinic or the regular physician of the patient.

b Patients can have more than one medical condition, so percentages do not total 100%.

c Items that were not statistically significantly associated with a granted or rejected request are not listed in the table: pain, loss of capacity to maintain social contacts, detachment, nausea, hopelessness, bedridden and confusion.

d n=366 (because of adaptations in the application form).

e n=601.

Table 4 Factors associated with granting a request for physician-assisted dying[a]

Factor	*P* value	Odds ratio (95% CI)
Marital status	0.06	
Married or living together		1 [reference]
Single	0.008	0.41 (0.21-0.80)
Widow(er)	0.90	1.04 (0.56-1.94)
No. of children	0.01	
None		1 [reference]
1	0.46	1.35 (0.61-2.98)
> 1	0.004	2.35 (1.31-4.23)
Condition	0.001	
Somatic		1 [reference]
Somatic or psychological	0.03	0.32 (0.12-0.87)
Psychological	0.001	0.20 (0.08-0.52)
Cognitive decline	0.14	1.95 (0.80-4.74)
Tired of living	0.34	0.64 (0.26-1.59)
Type of suffering		
Tiredness	<0.001	3.62 (1.88-6.97)
Loss of autonomy	<0.001	3.41 (1.89-6.16)
Loneliness	0.01	0.52 (0.31-0.87)
Loss of metal capacity	0.001	0.37 (0.20-0.68)

a Backward stepwise conditional logistic regression model, factors that were not significant are not listed in the table (sex, age, accommodation, period of the request for euthanasia or physician-assisted suicide, and type of suffering, including physical decline or loss of strength, pain, psychological, loss of capacity to maintain social contacts, loss of sensory functions, loss of dignity, hopelessness, detachment, bedridden). Nagelkerke R^2=0.378. A total of 417 patients were analyzed because of missing data for multiple variables.

DISCUSSION

During the first year of the End-of-Life Clinic in the Netherlands, about a quarter of all requests for euthanasia or physician-assisted suicide were granted and slightly less than half were rejected, particularly requests that involved psychological suffering. The clinic thus in these latter cases confirmed the assessment of the physician or physicians who had previously cared for the patient. Other patients withdrew their requests or died while their requests were still being assessed.

We included all available application forms. Thus, the likelihood of bias owing to the provision of socially desirable answers by patients was low. A limitation is that the patient or a relative usually completed the application form; information on the medical condition relied on the patient's own report, not on a review of the medical records held by the treating physician. The clinic's decisions about whether to grant a request relied on review of the medical records, as well as interviews and discussions with the patient and family (Box 2). We only had access to the information in the registration file, which included the application form, the decision and the final outcome. We lacked information about whether patients whose requests were granted had euthanasia or physician-assisted suicide as the method for physician-assisted dying, and whether patients who died before their requests could be assessed died of natural causes or committed suicide. We also lacked information on the reasons why requests were withdrawn or were still in process at the end of the study period. It is also possible that patients who were classified as 'tired of living' suffered, in fact, from a medical condition. Because we only had access to the registration file, however, we were unable to determine whether this was the case.

The End-of-Life Clinic granted fewer requests for euthanasia and physician-assisted suicide than are granted in the Netherlands on the whole (25% vs. 32-45%).(3-6) The large proportion of less common cases that the clinic received may explain this finding. Patients may have searched for a long time for a physician willing to grant their request. If a request for physician-assisted dying has been rejected by several physicians, the case may have been less likely to meet the due care criteria. This reasoning may also help to explain why the clinic was less likely to grant requests that had been ongoing for more than a year than those that had been initiated more recently.

Generally, patients with cancer are the most common group to request and receive euthanasia. Patients with cancer, however, were underrepresented in the requests granted

by the clinic, compared with the overall percentage of patients with cancer receiving euthanasia or physician-assisted suicide in the Netherlands (23% vs. 79%).(3) This was to be expected since physicians are most often willing to grant a request for physician-assisted dying for patients with advanced cancer, so only a small group of these patients applies at the End-of-Life Clinic. In addition, of the applicants receiving euthanasia or physician-assisted suicide, the proportion from those older than 80 years was considerably higher than in the Netherlands as a whole (53.7% vs. 25%).(3) This finding might be explained by the clinic receiving many applications from patients with non-life-threatening multimorbidity, and patients who were tired of living, groups who were likely to have had more problems finding a physician prepared to accept their request.

As the clinic anticipated, many patients who applied had psychological issues.(12) Only a small percentage of these patients had their requests granted, and the likelihood was significantly lower than for patients with a somatic illness. This finding suggests that physician-assistance in dying for people with psychological suffering — in the absence of a serious physical illness — is difficult for the teams of the clinic just as it is for general medical practitioners and Dutch society. Euthanasia and physician-assisted suicide are controversial in the Netherlands for patients with psychiatric suffering.(19-20) About two-thirds of physicians find it inconceivable to assist in dying when the patient suffers from a psychiatric disease.(21) Compared with physical suffering, physicians are less likely to regard psychosocial suffering as unbearable(22); in those cases, one of the legal due care criteria is not met. A more detailed study of decisionmaking in such cases is warranted. The very low likelihood of a request being granted could discourage patients with a psychiatric disorder or chronic depression from applying in the future. Applications at the clinic should be monitored to determine whether fewer applicants with psychosocial suffering apply and what the outcome of such requests is.

The finding that patients who were married or living together and those who had more than one child were more likely to have requests granted suggests that the views of family and domestic partners are important, and that their involvement and support influence the clinic's decisions. Previous studies(23-24) have found that relatives have important roles in the process, and can be a source of information when assessing the due care criteria.(8) These prior studies, however, did not reveal the actual effect on the outcome of a request. For end-of-life decisions, a good physician-patient relationship is of great importance.(24-26) Family physicians, who perform most of euthanasia or physician-assisted suicide in the Netherlands(3), often have long-standing relationships with their patients. In the absence of a long-lasting care relationship, as is the case

for the clinic's mobile teams, the role of relatives may become more prominent, as they can elucidate the patient's history and change in circumstances over time.
Some patients died before the clinic had completed its assessment and some withdrew their requests. A physician does not want to unduly postpone the decision about whether to provide assistance with dying, but should also reserve enough time for the patient to be able to reconsider the request. This is in line with previous research.(4) In the future, the percentage of patients who die before the clinic's assessment is completed may decrease because the number of mobile teams increased in 2013 and 2014 (Box 2).

Conclusion

Based on these results, we draw the conclusion that Dutch physicians in general have more reservations regarding less common cases than the medical staff working for the End-of-Life Clinic. At the same time many uncommon cases don't seem to meet the due care criteria since even the End-of-Life Clinic rejected nearly half of the requests for euthanasia and physician-assisted suicide.

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