Does Euthanasia Have a Dampening Effect on Suicide Rates?
Recent Experiences from the Netherlands

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Abstract
It is often argued that the option of euthanasia will keep patients from attempting suicide. Although there is some plausibility in this argument (the option of euthanasia may cause some patients to refrain from suicide and instead wait for a doctor to help them, and it may lead others to refrain from wanting to die altogether), there seems to be no causal link between the possibility of euthanasia and lower suicide rates. The opposite seems to be the case: the suicide rates in the Netherlands are the fastest growing when compared to surrounding European countries, most of which lack the option of euthanasia.

Key words: euthanasia, psychiatry, suicide, Netherlands

1. Introduction

In many public discussions, it is argued that the option of euthanasia will keep patients from attempting suicide. According to many, it provides the better alternative to (often violent) suicide attempts. This argument can be articulated in four sub-arguments with a high *prima facie* plausibility.

1. The availability of an ‘emergency exit’ will help patients to wait for professional assistance in suicide and thus refrain from doing it themselves.
2. When assistance in suicide is professionally given, that may rule out premature, involuntary, and/or ill-informed decisions in patients. The professional that offers assistance in suicide may thus save the patient’s life.
3. The option of euthanasia (irrespective of whether it will be effectuated) may contribute to the well-being of patients who suffer from severe chronic diseases. The option alone may

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1 In this article, I will follow the Dutch habit of using the term, ‘euthanasia’ so as to include both euthanasia and assisted suicide, unless there is reason to make a distinction.
have a reassuring effect, it may paradoxically encourage patients to go on, and may thus keep them from wanting to die altogether.

(4) Failed suicide attempts may cause serious trauma in patients with some of them becoming totally care-dependent afterwards. The risk that an attempt will fail and result in a patient being heavily handicapped, is minimized when euthanasia is provided by a physician.

(5) In the case of euthanasia, relatives are often asked to be present at the moment of dying. That facilitates a proper and much more ‘tender’ goodbye.

(6) Compared to a violent suicide, death brought about (or facilitated) by a physician, may be much less traumatizing for relatives and for immediate witnesses.

The latter aspect is an especially forceful argument in favor of euthanasia. Remarks such as, ‘Would you rather that they jump in front of a train?’ are recurring reproaches made to those with objections to an assisted death. An impressive documentary film is the Dutch production ‘Moeders springen niet van flats’ (‘Mothers do not jump down high rise buildings’, Lindemans 2014). The traumatizing effect of a violent and utterly tragic death on the immediate survivors cannot be underestimated. That explains the pressure from many patients and their relatives on physicians to provide euthanasia for patients who are suicidal.

2. Moral Concerns

As in many other moral dilemmas, however, there are strenuous arguments to be made against offering euthanasia as an alternative option to suicide.

(1) Euthanasia is not an alternative to a violent death in all cases

Many suicides and suicide attempts are made in a state of panic, depression, psychosis, etc., in which there is little room for a rational decision. In some cases of a mental illness, an acute death includes a wish for an instantaneous end to this suffering as well as an element of aggression. Moreover, procedures preceding a euthanasia can be lengthy, since they take months or years, especially in the case of psychiatric illnesses. Of 36 cases of euthanasia in psychiatric patients reviewed in the period 2010-14, the time frame between the first and the most recent request of a patient is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Month (8-31 days)</th>
<th>Half a year (32-183 days)</th>
<th>One year</th>
<th>2 years</th>
<th>5 years</th>
<th>10 years</th>
<th>20 years</th>
<th>More than 20 years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>First euthanasia</td>
<td>1 (2.8%)</td>
<td>9 (25%)</td>
<td>10 (27.8%)</td>
<td>4 (11.1%)</td>
<td>7 (19.4%)</td>
<td>3 (8.3%)</td>
<td>1 (2.8%)</td>
<td>1 (2.8%)</td>
<td>100%</td>
</tr>
<tr>
<td>request</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final, most</td>
<td>7 (19.4%)</td>
<td>12 (33.3%)</td>
<td>12 (33.3%)</td>
<td>1 (2.8%)</td>
<td>2 (5.5%)</td>
<td>Unknown: 2</td>
<td>(5.5%)</td>
<td></td>
<td>99.8%</td>
</tr>
<tr>
<td>recent</td>
<td>request</td>
<td></td>
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</tr>
</tbody>
</table>

Table 1. Time between the euthanasia request and dying
N=36
Seven out of ten patients thus had to wait at least one year after their first euthanasia wish was expressed. After having expressed their final euthanasia request, five in ten patients had to wait at least a year before their request was effectuated. Even patients with the capacity for a more rational approach, but who experience acute and unbearable suffering, will find these lengthy time frames hard to accept. Thus, far from all suicide attempts will be prevented by the possibility of euthanasia, especially not so called impulsive suicides.

(2) Not all psychiatric patients who die from euthanasia would take their own lives
In the context of suicide, three sorts of fears may be distinguished. First, there is a fear of being dead: ‘how can I be sure that this really puts an end to my suffering?’ ‘What will come after death?’ Second, there is fear of dying: ‘will it be painful, traumatizing, scary?’ Finally, there is fear of killing oneself: ‘do I dare to do this?’, ‘will killing myself affect my soul?’

In this section I want to concentrate on the fear to kill oneself. Evidence from the Netherlands suggests that fear of killing oneself is a powerful force even in patients who do not fear death or dying itself. During the period 2005-2016 the numbers of assisted suicide went up by 67 on a year to year comparison (from 168 to 235), whereas the numbers of euthanasia went up by 4,061 (from 1,765 to 5,826). This enormous difference may be indicative of patients’ reluctance to end their own lives. In percentages, euthanasia went up from 93.3% of all assisted deaths in 2005 to 96.2% in 2016 (table 2).

Table 2. Euthanasia and assisted suicide 2005-2016²

² In this table, I have combined the patients who died through assisted suicide and cases where assisted suicide was initiated, but in which the physician failed and decided to perform euthanasia. Source: RRC (2006-2017).
The shift from assisted suicide to euthanasia is all the more significant in light of three other circumstances. First, there is the increasing importance of patient autonomy (Beauchamp & Childress, 1978), together with the fact that assisted suicide can take place safely and effectively today. These combined would justify a shift towards a more active role of the patient in bringing about his own death. Secondly (specific for the Dutch situation, in which euthanasia is still in the criminal code), there is a difference in the sentence for doctors who do not meet the legal criteria. Doctors who administer euthanasia in an improper manner can be punished much more severely (with a maximum of 12 years imprisonment) than those who assist a patient to kill himself (a maximum of 3 years). Thus, one would expect physicians to prefer assisted suicide. In an interview published in 1995, professor of criminal law and euthanasia advocate Eugene Sutorius predicted and recommended a shift from euthanasia to assisted suicide:

“There are patients who leave the actual execution of their death wish to their doctor, because they fear doing this themselves. But in the voluntary act of killing oneself lies the ultimate proof of self-determination”. (Ten Haaft & Schipper 1995)

Finally, an important shift in the pathology underlying a euthanasia request has taken place: from terminal illnesses to chronic conditions, including psychiatry, dementia, and accumulated age related complaints. Physically, these ‘new’ patients are relatively better capable of taking their own lives than the more ‘traditional’ patients who are in a final stage of cancer, many of whom can no longer swallow.³

³ Of a random sample of 41 patients with a psychiatric condition who received aid in dying, 24 (or 58%) had euthanasia and 17 (or 42%) assisted suicide.

The reluctance of patients to bring about their own deaths is likely to mean that an unknown but considerable number of patients with a psychiatric condition who have received euthanasia would not have taken their own lives without euthanasia being an option.

(3) Euthanasia may discourage patients from cooperating in therapy
A clinical depression, almost by definition, includes despair about the possibilities of effective treatment and a preference for dying soon. Thus, if this most effective and ‘wanted’ of all options is within reach, why go through burdensome therapy without having any hard guarantee of success? No doubt, the option of euthanasia may be a comfort and a stimulus to go on living for some, but this same option may also have a discouraging effect.

(4) The political signal and the societal climate
No doubt, those who advocate the option of euthanasia for psychiatric patients are motivated by compassion and by respect for a suffering patient’s autonomy. On the other hand, making this a legal possibility is a political decision with potential implications for a society’s credibility and resolve to protect life and prevent premature deaths. Making euthanasia available to people with a psychiatric condition sends a paradoxical societal signal: ‘If our citizens want to end their lives, we will try to keep them from doing so. However, when they insist we will actively help them.’ Patients with a depression, many of whom by definition want to die, will tend to hear only the latter part.

Seen more broadly, the option of euthanasia for psychiatric patients may contribute to a societal climate in which death is increasingly seen as a remedy for all forms of severe suffering. The Dutch documentary film ‘Het beste voor Kees’ (‘Best for Kees’) is a case in point. Kees is a 45-year-old man with severe autism. After attempts by his parents to find appropriate housing for their son in case they can no longer care for him have failed, Kees’ mother comments, “Euthanasia” is a sacred word for us. When we have passed away, for whom would Kees stay alive? His deepest wish is to go to sleep, he will be totally satisfied. Euthanasia is a wonderful option.’ Kees himself remarks, ‘Euthanasia is the only way to be relieved of all misery’ (Nolte 2014). Many studies have reflected on the effects of a suicide on others to do the same (‘copycat suicide’, the ‘Werther effect’, etc.).

(5) Is euthanasia always less traumatizing?
The most convincing argument for euthanasia is that it may be a much less traumatizing alternative for relatives. However, not always, and for two reasons. To some, the fact that a death wish of a loved one is being effectuated by a professional caregiver may to some extent be traumatizing as well, as the story of the Belgian teacher Tom Mortier illustrates (Aviv 2015). Mr. Mortier’s mother suffered from a psychiatric illness and received euthanasia on the basis of her suffering. His mother’s euthanasia left her son deeply troubled: previously, his father had committed suicide. The fact that his mother was not only allowed to give up, but was also facilitated in doing so, had a traumatizing effect on her son. Furthermore, euthanasia may be traumatizing in the sense that relatives may have serious doubts about whether a euthanasia was really ‘necessary’ and unavoidable. Could their loved one not have regained his balance and wellbeing? Could additional treatments not have been found that might have been beneficial to this patient?
3. Suicide and Euthanasia: the Numbers

The assumption that euthanasia will lead to lower suicide rates is not supported by the numbers. In the Netherlands, the percentage of euthanasia of the total mortality rate tripled from 1.3% in 2002 to 4.08% in 2016.\(^5\) During that same period, the suicide numbers did not go down. From 1,567 in 2002, they went up to 1,894 in 2016, a rise of 20.8%. Suicide rates reached a relative low of 1,353 in 2007, compared to which the 2016 numbers did not only constitute a rise of 40%, but also reached the highest level ever. This is even more significant given the fact that euthanasia from 2007 on started becoming available to people with chronic and psychiatric illnesses, dementia, and others (see section below). In terms of the percentage of the overall mortality, suicide numbers went up from 1.01% in 2007 to 1.27% of overall mortality in 2016 (figs. 3a and 3b).

Tables 4a and 4b. Euthanasia and suicides in absolute numbers and as percentages of total mortality in the Netherlands

For the sake of comparison, we also looked at suicide rates in some countries close to the Netherlands in terms of ethnicity, age, religion, and language but which, with the exception of Belgium, lack the option of euthanasia. If suicide numbers in the Netherlands have gone up, one would expect at least a similar increase in suicide numbers in countries that do not have the option of euthanasia. However, as can be seen from Table 5, the Netherlands of all countries shows the

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The largest increase in suicide numbers. The increase of the numbers from 2008 on cannot be explained in terms of economic malaise only, as some have suggested, since neighboring countries were similarly affected by the 2007 crisis. Suicide figures in Europe are coming closer and closer together (the Netherlands traditionally had a relatively low number of suicides), despite the availability of euthanasia in the Netherlands:

![Suicide rates per 100,000 persons, 2001-2014](image)

**Table 5. Suicides in the Netherlands, compared to suicides in some of its neighboring countries, per 100,000 inhabitants.**

In June, 2017, the Dutch Central Bureau of Statistics (CBS) published numbers which show an ongoing increase in suicide numbers. Some have suggested that the reason for this lies in the fact that elderly persons have insufficient access to euthanasia. CBS spokesperson Jan Latten suggested a different explanation: the numbers have not gone up in the absence of sufficient access to euthanasia, but because of the many discussions about euthanasia and a right to assisted suicide: ‘There is [much] public discussion about ending your life,’ Latten said, ‘and people will tend to act accordingly’. Likewise, euthanasia pioneer and psychiatrist Boudewijn Chabot wrote: ‘What happens to doctors for whom a deadly injection becomes monthly routine? There is no doubt about their good intentions, but do they realize that the fire they cause can become a blaze because they stir death wishes in vulnerable people who are trying their best to live with their handicap?’

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6 Francis (2017).
8 Wetering (2017).
9 Chabot (2017).
4. Conclusion

In public opinion, there is the widespread opinion that the option of euthanasia for patients with a psychiatric condition will have a dampening effect on suicide rates. Despite its strong moral and emotional appeal (taking into consideration the enormous tragic consequences of violent suicides for the next of kin), this argument is not convincing. Evidence from the Netherlands suggests that the option of euthanasia for people with psychiatric conditions does not reduce the number of non-assisted suicides and rather contributes to a rise in their numbers.

References

- All websites last visited Nov. 11, 2017

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