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Assessing Willingness for Euthanasia and Assisted Suicide among Dutch General Practitioners: A Comparative Analysis

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Abstract

In 2002, the Netherlands introduced legislation that made euthanasia and assisted suicide (EAS) lawful. Under this law, patients may request EAS for either physical or mental health problems if very strict criteria are fulfilled. Even so, doctors are not required to take part. Because general practitioners (GPs) handle the vast majority of these requests, they play a key role in deciding whether to accept applications from both patient groups. While EAS for people with physical illnesses has become quite common across the country, granting it for mental health problems is still fairly unusual and stirs ongoing debate, even though such requests keep increasing. The current study examines Dutch GPs' willingness to approve and carry out EAS requests for physical versus mental conditions, and contrasts the thinking processes that shape those decisions. Researchers employed a concurrent mixed-methods design combining a quantitative survey and qualitative interviews. A total of 103 GPs answered the survey, which collected details about their background, views on the topic, past involvement with EAS, and responses to six randomly assigned case descriptions. These cases changed according to the type of health issue (cancer compared with depression) and the form of assistance (euthanasia versus assisted suicide), so that willingness to approve requests could be measured. In addition, 13 GPs participated in semi-structured interviews that provided a closer look at their personal reasoning and practical experiences. GPs showed a much lower readiness to approve EAS requests linked to mental health conditions than to physical ones (OR = 0.02, 95% CI [0.009–0.04]). Those who described themselves as religious were less likely to grant any requests (OR = 0.31, 95% CI [0.11–0.85]), and they generally preferred euthanasia to assisted suicide (OR = 2.3, 95% CI [1.31–4.03]). The exact diagnosis and earlier contact with mental health requests did not produce any meaningful difference. Actual readiness to carry out the procedure stood at 95.1% for physical conditions but dropped to 45.6% for mental conditions. GPs who had already performed EAS for someone with a mental health condition were far less likely to limit their involvement to physical cases only (OR = 0.15, 95% CI [0.02–0.73]). The interviews made clear that mental health situations felt considerably more complicated. Doctors pointed to problems with compliance with legal due care rules, struggles to align with the patient's wishes, moral conflicts, much longer assessment times, and lower confidence in their own judgment. In mental health cases, they tended to ask for extra opinions from psychiatric experts and referred the matter to the Expertise Center Euthanasia (ECE) more frequently. Dutch GPs are noticeably less willing to approve or carry out EAS requests that concern mental health conditions than those that concern physical health conditions. This gap seems to arise from obstacles in evaluating the required due care standards, uncertainty in clinical judgment, trouble connecting emotionally with the request, drawn-out procedures, and greater ethical difficulty. The outcomes underline the importance of implementing current guidelines more effectively in everyday GP work, while also providing specific training and better support for doctors. Useful forms of support would include quick access to psychiatric knowledge, SCEN consultations, and tight teamwork with the Expertise Center Euthanasia (ECE).

Keywords: Euthanasia, Assisted suicide, General practitioners, Mental health conditions, Physical health conditions, Decision-making

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Introduction

The Netherlands holds the distinction of being the first country worldwide to permit euthanasia and physician-assisted suicide (EAS) carried out by its own doctors, made possible by the 2002 Termination of Life on Request and Assisted Suicide Act [1]. Under this law, euthanasia occurs when a physician directly injects or supplies a fatal substance to the patient. In contrast,

assisted suicide takes place when the physician only provides the lethal drug for the patient to self-administer [2]. Despite EAS technically remaining a punishable offence in Dutch criminal law, doctors receive legal protection from prosecution when they strictly follow the regulations and satisfy all six due care criteria: (1) the patient's request must be made freely and after thorough reflection, (2) the individual must endure unbearable suffering that offers no prospect of relief, (3) the patient has received complete information regarding their condition and expected course, (4) no other realistic option exists to alleviate the suffering, (5) consultation with a second independent physician is required, and (6) the entire act must be executed with appropriate medical diligence and attention [3].

Doctors in the Netherlands are obliged to file a detailed report with the Regional Euthanasia Review Committees (RTE) after every procedure. These committees then evaluate whether the physician complied with the legal standard of due care [4]. For their reviews, the committees draw on the Euthanasia Code, which provides detailed guidance on interpreting the criteria in actual cases. Among its key points, the Code requires consultation with an independent doctor at all times [5]. Additionally, the Royal Dutch Medical Association (KNMG) published the KNMG Guideline on End-of-Life Decisions, providing medical professionals with a comprehensive framework covering euthanasia, assisted suicide, and palliative support [6]. In daily practice, the mandatory independent consultation is usually performed by a specially trained SCEN physician (Support and Consultation on Euthanasia in the Netherlands). These SCEN doctors — either experienced general practitioners or other specialists — operate within the KNMG system to deliver unbiased advice and assistance in euthanasia matters [7]. When mental suffering forms the basis of the request, the 2022 Euthanasia Code requires mandatory involvement of psychiatric expertise, meaning an independent psychiatrist must be consulted. Apart from official rules and professional guidance, the country also operates a dedicated facility, the Expertise Center Euthanasia (ECE), which was originally called the End-of-Life Clinic and began operating in 2012 [8]. This center provides expert advice and practical support to physicians facing difficult or uncertain requests. Should a doctor prefer not to become involved, they can transfer the patient to the ECE, where a team of skilled physicians re-examines the situation and, provided all due care criteria are met, may proceed with the procedure.

Consequently, patients suffering from either physical illnesses or mental disorders are equally entitled under the law to seek EAS. Nevertheless, cases involving mental health conditions continue to occur infrequently and generate significant controversy. Only a handful of other nations — including Belgium, Luxembourg, Switzerland (restricted to assisted suicide), and, more recently, Spain — have introduced similar provisions [9, 10]. Within the Netherlands itself, the annual count of reported EAS procedures for mental health reasons climbed from 2 cases in 2008 to 219 in 2024, yet these still accounted for only 2.2% of the total reported EAS cases that year [4, 11]. Statistics released by the ECE reveal that merely 10% of all mental health-related requests reaching the center ultimately receive approval, with the large majority rejected for failing to satisfy the due care criteria — most often because treatment options had not been fully exhausted or because the suffering could not be clearly established as unbearable [12].

Over an extended period, Dutch physicians have consistently described requests for EAS linked to mental health conditions as especially intricate and challenging to evaluate. This perception arises in part from the heightened difficulty of applying the statutory due care criteria to psychiatric situations and in part from the relatively limited practical exposure most doctors have to such cases [13, 14]. A crucial point is that no Dutch physician is ever compelled to approve or carry out EAS and may decline involvement for any personal or professional motive [2]. These individual motives can significantly shape how doctors respond to requests stemming from physical health problems compared with those rooted in mental health problems. In general, physicians find it far simpler to judge unbearable suffering, forecast outcomes, and assess decision-making capacity when dealing with physical diseases, given the presence of observable symptoms and more foreseeable disease progression.

In contrast, suffering caused by mental health disorders tends to be more existential, often varies in intensity, and is commonly intertwined with suicidal thoughts or distorted patterns of thinking. Such characteristics make it considerably harder to confirm that the suffering is truly unbearable and offers no realistic hope of improvement. Moreover, the continued existence of various psychiatric treatment possibilities frequently leads to uncertainty about whether the suffering can

genuinely be classified as irremediable [15-18]. In addition to these clinical hurdles, a range of ethical issues, family dynamics, patient perspectives, legal requirements, the quality of the doctor–patient relationship, and external influences have all been shown to affect EAS-related decisions. Even so, relatively little research has clarified how these influences operate differently across physical and mental health contexts [17, 19-22]. Earlier investigations have indicated that doctors generally display greater acceptance of EAS when the underlying issue is a physical condition rather than a mental one [14]. Doctor-related factors such as gender, religious beliefs, and medical specialization have emerged as influential factors. Broadly speaking, physicians who identify as Christian, female doctors, and medical specialists tend to view EAS as less acceptable than their non-religious, male, or general practitioner counterparts. Parallel patterns appear in mental health contexts, where religious doctors, women, specialists, and psychiatrists in particular express notably lower levels of acceptance [16, 18].

Across all medical disciplines, general practitioners (GPs) demonstrate the greatest openness toward these requests, with 47% reporting they would be prepared to perform EAS for a patient experiencing a mental health condition [18]. GPs handle the bulk of all EAS requests throughout the Netherlands and, unlike most specialists, routinely care for patients with both physical and mental health issues [4, 17]. Their prominent position, therefore, makes it especially valuable to investigate how they manage and respond to the two distinct categories of requests. For example, Pronk and colleagues found that 86 of 101 GPs considered EAS feasible for physical health conditions, compared with only 51 of 104 for mental health conditions. When supporting mental health requests, GPs frequently referred to principles such as compassion, justice, and respect for personal autonomy. Yet, they also voiced reservations stemming from concerns about medical boundaries, insufficient hands-on experience, and difficulties in properly applying the due care criteria [14]. That said, those findings date from 2018–2019 and may not accurately capture present-day perspectives, particularly because the volume of mental health-related EAS cases has approximately doubled since that period [4].

The rate of EAS procedures performed for mental health conditions keeps climbing in the Netherlands, intensifying both public discussion and policy-level conversations [4]. With growing international attention on EAS practices, insights from the Dutch context are becoming ever more significant [23, 24]. Although earlier studies have examined physicians' general attitudes and the various factors shaping their choices, most have focused on broad theoretical acceptability rather than concrete willingness to grant or carry out specific requests. Furthermore, while qualitative interview research involving Dutch doctors — especially psychiatrists — has highlighted that mental health-related EAS is widely regarded as more difficult to assess, there remains a limited understanding of how general practitioners specifically evaluate and handle requests originating from physical health conditions versus mental health conditions, and in what ways their decision-making processes diverge between the two. The present study seeks to close this knowledge gap by exploring contemporary attitudes among Dutch GPs and directly comparing their readiness to approve and execute EAS across physical and mental health conditions. It additionally examines the influence of factors such as the precise nature of the mental health condition, the chosen EAS method, the physician's prior experience, and various sociodemographic characteristics on those decisions, while employing qualitative methods to illuminate differences in underlying reasoning and decision-making approaches.

Materials and Methods

Study design

A concurrent embedded mixed-methods strategy was implemented to leverage the strengths of quantitative and qualitative research methods [24, 25]. The quantitative section featured a survey constructed to obtain measurable data and reveal general trends. It recorded sociodemographic details such as age, religious background, length of time in practice, location of practice, gender, and ethnic origin, together with past involvement in EAS and opinions about euthanasia and assisted suicide (including confidence in official guidelines, opinions on eligibility criteria for people with mental or physical health problems, and preference between the two procedures). The survey also presented hypothetical patient scenarios to test how variables such as the presence of a mental health diagnosis and the chosen EAS procedure affected general practitioners' readiness to approve or refuse requests. The collection of survey responses took place in February–March 2025. The qualitative section comprised 13 online semi-

structured interviews with Dutch GPs conducted in March–April 2025, overlapping with the ongoing survey. These interviews were deliberately embedded in the study design to add richer layers of insight, concentrating on the step-by-step reasoning GPs use, the factors shaping their views on EAS for physical versus mental health conditions, and their readiness to approve requests from both types of patients — elements that could not be sufficiently explored through numerical data alone. As a result, the interviews helped provide a more nuanced explanation of the patterns observed in the quantitative results.

Study population and sampling

The study population comprised 103 general practitioners (GPs) who completed the questionnaires. Altogether, 609 GP practices were contacted, yielding 111 individual responses. Eight responses had to be discarded because substantial sections of the questionnaire remained unanswered, leaving a final analytic sample of 103 GPs. Since contact was made with practices rather than individual doctors, an exact response rate could not be determined. Still, the participating GPs represented about 17% of the practices originally approached. Interviewees were selected purposively through survey responses, personal and professional networks, and snowball sampling, to achieve diversity across gender, geographic area, and level of prior experience. Sampling continued until the later interviews no longer produced new meaningful information. The final qualitative sample included 13 GPs (11 female, 2 male), two of whom were SCEN physicians; all were actively working in different regions across the Netherlands. Four of the interviewees had volunteered through the survey itself and therefore participated in both the survey and the interview. The remaining participants were reached through direct outreach or snowball sampling, and it is unknown whether they also filled out the survey.

Data collection

For the quantitative part, the online survey was developed in LimeSurvey and sent electronically to Dutch GP practices throughout February and March 2025. It featured closed-ended items that measured previous experience, attitudes toward euthanasia and assisted suicide (EAS) for patients suffering from physical or mental health conditions, willingness to carry out the procedure, and basic sociodemographic information. Some questions were taken straight from the fourth official evaluation of the Dutch Euthanasia Act. In contrast, others were newly formulated or adapted from that evaluation to better align with the goals of the present research [17]. A complete list of the variables examined through the survey questions is presented in **Table 1**. The cut-off points chosen for age and years of practice followed the same groupings used in earlier investigations of physicians' views on euthanasia [18, 26].

Table 1. Overview of the variables included in the regression analyses, along with their coding schemes

Variable	Description	Coding Scheme	Statistical Model Applied
Dependent variables			
Combined willingness	GP's readiness to personally carry out EAS	0 = Willing to perform EAS for both physical and mental conditions; 1 = Willing to perform only for physical conditions	Binary logistic regression (willingness to perform)
Granting requests	Whether the GP would approve EAS in the presented case scenarios	1 = Yes; 0 = No	Multilevel modelling (case vignette level)
Independent variables			
Age	Respondent's age category	Categorical: < 40 (reference group), 40–54, > 50	Binary logistic and multilevel models
Religion	Presence of religious affiliation	1 = Religious; 0 = Not religious	Binary logistic and multilevel models
Years in practice	Duration of experience as a GP	1 = More than 10 years; 0 = 2–10 years	Binary logistic and multilevel models
Practice setting	Geographic context of the GP's practice	1 = Rural; 0 = Urban	Binary logistic and multilevel models

Experience with EAS requests (mental health only)	Prior experience receiving EAS requests from patients with mental health conditions	1 = Yes; 0 = No	Binary logistic regression
Experience performing EAS (mental health)	Previous experience carrying out EAS for patients with mental health conditions	1 = Yes; 0 = No	Binary logistic regression (restricted to the willingness-to-perform model)
Request category	Indicates whether the request concerns a mental or physical condition	1 = Mental condition; 0 = Physical condition	Multilevel modelling
Type of EAS	Form of EAS requested	1 = Euthanasia; 0 = Assisted suicide	Multilevel modelling
Mental condition category	A specific type of mental health condition in the case	Categorical: Autism (reference group), depression, schizophrenia, PTSD	Binary logistic regression (Models 4 and 5, case vignette analyses)

From: Willingness of Dutch general practitioners to grant euthanasia and assisted suicide requests: a comparative study of physical and mental health conditions

1. Gender was excluded from analysis due to a high rate of missing responses. Ethnicity, experience with EAS requests in physical health conditions, and performing EAS in physical health conditions were excluded from analysis due to insufficient variability in the data. The variable for performing EAS in cases of mental health conditions was excluded from the analysis of the mental health case examples, as the very low number of GPs with such experience led to instability in estimates. All case examples of mental health conditions themselves were included in the analysis. Practice area was assessed as a self-reported variable, which may not fully align with official classifications regarding urban and rural areas in the Netherlands

The survey also used clinical vignettes to gauge GPs' willingness to approve requests. Twelve vignettes were prepared, and each participating GP was randomly assigned six **(Table 2).** These scenarios differed according to the nature of the request (physical versus mental health condition), the specific EAS procedure (euthanasia or assisted suicide), and the particular mental health diagnosis involved (autism, depression, schizophrenia, PTSD). The content of the vignettes was modeled on material from the fourth evaluation of the Dutch Euthanasia Act and was also shaped by the earlier work of Kouwenhoven *et al.* [26].

Table 2. Illustrative set of randomly assigned case examples completed by GPs

Case	Scenario description
1	Mr. Van de Berg is diagnosed with ALS and has lost almost all motor abilities, including walking, speaking, and swallowing without assistance. Despite receiving supportive care, he relies entirely on others for daily functioning. His illness is expected to progress to respiratory failure. He considers both his current condition and future outlook unbearable and submits a request for euthanasia.
2	Ms. De Jong is living with metastatic breast cancer that is no longer treatable despite multiple interventions. She experiences severe, difficult-to-control pain and feels a profound loss of autonomy, which she greatly valued before her illness. She indicates that she cannot continue under these circumstances and requests euthanasia.
3	Ms. De Jong has metastatic breast cancer that has become incurable following several treatments. She suffers from significant pain and a distressing loss of control over her life. She states she is no longer able to endure her situation and asks her GP to provide medication that she can self-administer to end her life.
4	Mr. Jansen has had schizophrenia for many years. Despite ongoing treatment with medication and therapy, he continues to experience persistent hallucinations and delusions that severely diminish his quality of life. These symptoms cause profound suffering, and he sees no prospect of improvement. After careful deliberation, he requests euthanasia from his GP.
5	Ms. Langezaal is physically healthy but experiences chronic, severe depression. Various psychiatric treatments have not alleviated her condition. She has repeatedly expressed a wish to die and has made prior unsuccessful suicide attempts. She asks her GP for euthanasia to relieve her suffering.
6	Ms. Smit has severe autism spectrum disorder (ASD), resulting in lifelong suffering. She experiences constant sensory overload, social isolation, and ongoing emotional distress. Multiple treatment attempts have been ineffective.

She is unable to participate in daily activities or maintain social interactions, and she finds overstimulation intolerable. She requests medication that she can take herself to end her life.

From: Willingness of Dutch general practitioners to grant euthanasia and assisted suicide requests: a comparative study of physical and mental health conditions

Case examples

1. Mr. Van de Berg has ALS and can no longer use almost any of his muscles, making it impossible for him to walk, talk, or swallow without help. Although he receives supportive care, he depends entirely on others for every routine task. His disease will eventually stop his breathing. He views his current life and what is coming as completely unbearable and has asked for euthanasia.
2. Ms. De Jong is dealing with breast cancer that has spread to other parts of her body. She has tried several treatments, but doctors can no longer cure the illness. She lives with very severe pain that is difficult to ease and feels she is gradually losing any sense of control over her days, a feeling she always held dear from her career. She says she cannot keep living this way and wants euthanasia.
3. Ms. De Jong has breast cancer that has metastasized. After different courses of treatment, the cancer is now incurable. She has intense pain and a strong feeling that she no longer controls her own life, which causes her deep upset. She tells her GP she has reached her limit and requests a lethal medicine she can take on her own.
4. Mr. Jansen has had schizophrenia for many years. Even with steady use of medication and therapy, he still suffers from powerful hallucinations and false ideas that badly harm his daily life. These problems cause him enormous distress, and he believes there is no chance of getting better. After thinking it over carefully, he asks his GP to carry out euthanasia.
5. Ms. Langezaal has no physical illness but lives with intense, long-lasting depression. Several psychiatric approaches have not reduced her symptoms at all. She often informs her doctors that she wishes to die and has tried to end her life before without success. She now asks her GP for euthanasia so her suffering can stop.
6. Ms. Smit has severe ASD that has brought her nonstop, unbearable suffering for her entire life. She constantly faces overwhelming sensory stimulation, deep loneliness, and emotional pain that never eases. Many years of different treatments have changed nothing. She cannot join in normal daily activities or connect with others, and the nonstop overload is intolerable. She requests a medicine she can take herself to end her life and her suffering.

To investigate decision-making processes more closely, 13 semi-structured interviews were conducted using a detailed interview guide. The interview guide was prepared by searching the literature on Google Scholar and PubMed and drawing on earlier work on EAS, as well as studies of how Dutch doctors make these decisions. Most interviews were held online via Zoom, though two were conducted by phone due to scheduling issues. The interviewer (first author) recorded every conversation using the Dictaphone app. The talks examined GPs' real experiences, external pressures, and the difficulties they face when evaluating EAS requests tied to physical or mental health conditions. Sessions lasted on average 33 min (ranging from 24 to 43 min) and provided useful qualitative insights into what shapes GPs' choices for the different kinds of requests. All interviews were conducted in Dutch by the first author, who had prior experience discussing sensitive subjects and had taken several courses in qualitative research methods. As someone from the Netherlands, the author approached the topic from an academic and curious perspective. Questions were written and asked in a neutral style. The interviewer remained mindful of her own perspective throughout, ensuring neutrality in both her questioning and her understanding of the answers. In this paper, the exact words participants used in the survey and interview quotes ("psychiatric" and "somatic") have been left unchanged; in the rest of the text, "psychiatric" refers to mental health conditions and "somatic" to physical health conditions.

Data analysis

The survey responses were analyzed using IBM SPSS Statistics 28 and R version 4.4.1. Simple descriptive statistics (frequencies and percentages) helped describe the group's background features, opinions, and past experiences. Responses to the case examples were examined using multilevel and binary logistic regression in R. The main outcome measured whether the GP said they would approve the request shown in each case example (yes or no). Five models in total were created. Because each GP reviewed six randomly selected case examples, the answers were grouped within the same person, potentially leading to clustering. Answers from

one GP were expected to be more alike than answers from different GPs. The intraclass correlation coefficient (ICC = 0.162) indicated that 16.2% of the differences in willingness stemmed from variation between individual GPs, exceeding the usual 10% limit [27]. Multilevel modeling was therefore chosen for Models 1–3.

In all models, the outcome stayed the same: whether the GP would grant the request in the given case example (yes or no). Model 1 looked only at background details (age group, years in practice, practice area, and religion). Model 2 brought in the kind of request (physical or mental health condition), and Model 3 also added the EAS procedure used (euthanasia or assisted suicide). For Model 3, the bobyqa optimizer, run for 15,000 iterations, helped resolve convergence issues. Models 4 and 5 examined only mental health cases and tested the effects of the exact diagnosis and earlier experience with such requests. Because of convergence troubles and unstable estimates for diagnosis and experience with mental health requests, ordinary binary logistic regression was used for Models 4 and 5. Odds ratios (ORs) and confidence intervals (CIs) for the other predictors remained stable across the models, so changing the method did not alter the meaning of the findings. Several variables were dropped because of missing information (gender), almost no variation (ethnicity, experience with EAS requests for physical health conditions), or unstable estimates (experience actually carrying out EAS for mental health conditions). Religion and years of practice were recoded as binary variables due to small cell counts in certain groups. All calculations were done in R using the packages haven (2.5.4), readr (2.1.5), dplyr (1.1.4), stats (4.4.1), tidyr (1.3.1), ggplot2 (3.5.2), nnet (7.3–20), lme4 (1.1–37), broom (1.0.8), boot (1.3–30), and performance (0.13.0).

A separate binary logistic regression was run in R to examine willingness to actually carry out EAS requests. The original three-group outcome (willing to do both physical and mental health condition EAS / willing to do only physical health condition EAS / unwilling for both) was collapsed into a binary outcome by omitting the small ‘unwilling’ group. This created a straight comparison between GPs willing to perform only physical health condition EAS and those willing to perform EAS for both physical and mental health conditions. The same variable exclusions were used as before, except that experience performing EAS for people with a mental health condition was retained in this analysis because it did not cause convergence issues.

For the qualitative part, every interview was transcribed verbatim and analyzed in MAXQDA 24 using a mixed, directed, and conventional content analysis [28]. This mixed coding method provides a well-organized yet flexible way to examine the material, grounded in theory while remaining open to fresh observations [29]. The coding plan was created in several steps. First, deductive codes came from the interview guide itself, which had been shaped by a wide review of studies on EAS decision-making. Second, the transcripts were read many times to become fully familiar with them, and new inductive codes were added for ideas that came directly from the material. Third, larger codes and smaller subcodes were formed, maintaining a clear distinction between physical and mental health conditions so that decision-making could be compared in an orderly way. Fourth, the complete set of interviews was coded using this combined deductive–inductive system. Fifth, English summaries of each interview were generated using MAXQDA’s AI summary tool to support familiarisation, though these summaries did not replace manual coding. In the final step, the first author reviewed and explained the coded sections to identify repeated patterns across all interviews and to highlight the main influences on GPs’ decision-making.

Results and Discussion

Quantitative results

Survey respondents’ characteristics

Table 3 outlines the personal and professional profiles of the GPs who took part in the survey. It is worth noting that several participants did not answer all demographic questions. This means the number of responses shifts slightly from one item to the next, and the overall totals are not identical across all questions. Among those who disclosed their gender, 40 were women, and 25 were men. In the age breakdown, 16 were younger than 40, 58 belonged to the 40–54 age bracket, and 29 were 55 or older. On religious affiliation, 30 GPs described themselves as religious and 72 as non-religious.

Regarding years of experience as a GP, 14 had 2-10 years, whereas 87 had more than 10. As for the setting of their practice, 67 worked in rural locations and 34 in urban areas. Almost the entire group reported Dutch ethnicity (101), with only 2 reporting a non-Dutch background.

Table 3. Demographic and background characteristics of survey respondents

Characteristic	Category	Valid percentage (%)	Count (N)
Gender	Female	61.5	40
	Male	38.5	25
Age group (years)	< 40	15.5	16
	40–54	56.3	58
	> 55	28.2	29
Religious affiliation	Religious	29.1	30
	Not religious	69.9	72
Years in practice	2–10 years	13.9	14
	More than 10 years	86.1	87
Practice location	Urban setting	33.7	34
	Rural setting	66.3	67
Ethnic background	Dutch	98.1	101
	Non-Dutch	1.9	2

From: Willingness of Dutch general practitioners to grant euthanasia and assisted suicide requests: a comparative study of physical and mental health conditions

1. Percentages are calculated based on valid responses for each characteristic. Missing values were excluded from the denominators, leading to varying totals across variables

GPs' experience and attitudes regarding EAS

Nearly all the surveyed GPs had encountered EAS requests originating solely from a physical health condition (101). When asked whether they had ever performed the procedure on a patient with a physical health condition, 97 confirmed they had, and only 5 said they had never done so. In comparison, 72 GPs had received at least one request based purely on a mental health condition, but only 11 reported having actually performed EAS in those circumstances **(Table 4).**

Table 4. Respondents' experience with receiving EAS requests and performing EAS.

Experience type	Category	Valid percentage (%)	Count (N)
Received EAS requests (physical conditions only)	Yes	100	101
	No	–	–
Performed EAS (physical conditions only)	Yes	95	97
	No	5	5
Received EAS requests (mental health conditions only)	Yes	70	72
	No	30	31
Performed EAS (mental health conditions only)	Yes	10.7	11
	No	89.3	92

From: Willingness of Dutch general practitioners to grant euthanasia and assisted suicide requests: a comparative study of physical and mental health conditions

1. "Only" refers to the fact that the EAS request stemmed solely from either a physical health condition or a mental health condition, without influence from a combination of conditions or other contributing factors. Percentages are based on valid responses only; missing values were excluded from the denominator

Views on EAS were explored through a series of statements **(Table 5)** that covered both broad opinions and those specific to patients with physical or mental health conditions. The item that attracted the highest number of strong agreements concerned feeling markedly less confident when evaluating EAS requests linked to mental health conditions, with 70 GPs selecting that option. Support for allowing access to EAS was strongest when the condition was physical (39 strongly agreed and 50 agreed). In contrast, opinions about mental health conditions showed a much wider spread (17 strongly agreed and 52 agreed). Even so, a clear majority backed the idea that people facing mental health conditions should have equal opportunity to request EAS as those facing physical conditions, as 37 agreed and 16 strongly agreed. Statements suggesting it is impossible to judge unbearable and untreatable suffering properly or to decide whether a request is well-considered in mental health cases mostly met with neutral or disagreeing responses (35 neutral and 43 disagreeing on the suffering item; 32 neutral and 47 disagreeing on the well-considered request item). Confidence in the present guidelines was limited, with 35 GPs disagreeing that the guidelines offer enough clarity for mental health-related suffering and 6 strongly disagreeing. Most GPs did not show a preference for assisted suicide over euthanasia for either group. Instead, the dominant trend was a clear leaning toward euthanasia over assisted suicide in both situations, since only a small number indicated they would be more willing to supply assisted suicide.

Table 5. GPs' attitudes toward EAS requests from patients suffering from physical and mental health conditions

Item	Strongly agree (5)	Agree (4)	Neutral (3)	Disagree (2)	Strongly disagree (1)	N	Mean
Compared with somatic cases, I experience greater uncertainty when evaluating EAS requests from patients with psychiatric disorders	70	21	5	2	3	101	4.51
Patients with physical illnesses should be considered eligible for EAS when they explicitly request it	39	50	8	2	3	102	4.18
Patients with mental health disorders should be considered eligible for EAS upon request	17	52	22	7	3	101	3.72
People should have the authority to decide for themselves about life-ending choices	20	39	21	17	4	101	3.53
Access to EAS requests should be equivalent for psychiatric and somatic patients	16	37	28	14	5	100	3.45
It cannot be reliably determined whether a psychiatric patient's wish to die is driven by their mental condition	4	17	39	40	1	101	2.83
Current professional guidelines are sufficiently clear to support the evaluation of EAS requests in psychiatric cases	1	24	29	35	6	95	2.78
It is not feasible to judge whether psychiatric patients are experiencing suffering that is both unbearable and without a prospect of improvement	5	10	35	43	6	99	2.65
It is not possible to establish whether a psychiatric patient's wish to die has been carefully and consistently considered	3	11	32	47	8	101	2.54
I would favor assisted suicide over euthanasia when dealing with psychiatric patients	2	30	11	33	26	102	2.50
I would favor assisted suicide over euthanasia when dealing with patients with somatic illnesses	4	17	17	33	31	101	2.31

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1. The mean scores reflect the average level of agreement with each statement on a 5-point Likert scale. Higher scores indicate stronger agreement. The term "psychiatric" is retained to reflect the original wording of the survey question. In the context of this study, "psychiatric" refers to mental health conditions, and 'somatic' refers to physical conditions.

GPs' willingness to grant EAS requests and influencing factors

Table 6 provides an overview of the findings from the multilevel regression models (Models 1–3) and the binary logistic regression models (Models 4–5). These

were built using the GPs' responses to randomly distributed case examples, along with their earlier experience with mental health-related requests. Model 1 examined only sociodemographic factors and found that religion was the only notable predictor: religious GPs were less likely to approve requests than non-religious GPs. Age, length of professional experience, and practice location had no meaningful impact. Model 2 added the type of request and made clear that requests rooted in mental health conditions had a much lower chance of approval compared with those rooted in physical health conditions, while religion remained important. Model 3 was the most complete version and combined all earlier variables with the specific EAS procedure. In this model three factors stood out as clearly related to the chance of granting a request: (1) requests coming from individuals with a mental health condition were far less likely to be approved than those coming from individuals with a physical health condition (OR = 0.02, 95% CI [0.009–0.04]); (2) euthanasia requests had a higher chance of approval than assisted suicide requests (OR = 2.3, 95% CI [1.31–4.03]); and (3) religious GPs were less likely to grant requests than non-religious GPs (OR = 0.31, 95% CI [0.11–0.85]). Models 4 and 5 focused on mental health-related requests and tested whether the specific diagnosis (Model 4) or prior experience with such requests (Model 5) affected willingness to help. No statistically meaningful effects appeared in either of those models.

Table 6. Overview of the results from the case examples analyses using multilevel and binary logistic regression

Variable	Category	Model 5: Experience with Mental Suffering (Binary) OR (95% CI)	Model 4: Condition Type (Binary) OR (95% CI)	Model 3: Euthanasia vs. Assisted Suicide (Multilevel) OR (95% CI)	Model 2: Physical vs. Mental (Multilevel) OR (95% CI)	Model 1: Demographics (Multilevel) OR (95% CI)
Intercept	—	1.08 [0.38–3.06]	0.88 [0.32–2.30]	23 [5.23–101.3]	32.1 [7.75–132.8]	2.7 [1.27–5.83]
Age group	< 40 (ref.)	1	1	1	1	1
	40–55	0.40 [0.14–1.14]	0.40 [0.14–1.15]	0.84 [0.14–5.03]	0.74 [0.13–4.10]	0.95 [0.35–2.57]
	> 55	0.87 [0.31–2.44]	0.84 [0.30–2.35]	1.28 [0.21–7.90]	1.1 [0.20–6.47]	1.1 [0.41–3.10]
Religious status	Non-religious (ref.)	1	1	1	1	1
	Religious	0.59 [0.39–1.10]	0.62 [0.32–1.14]	0.31* [0.11–0.85]	0.32* [0.12–0.84]	0.46* [0.26–0.80]
Years in practice	2–10 years (ref.)	1	1	1	1	1
	> 10 years	1.15 [0.39–3.44]	1.09 [0.37–3.24]	0.71 [0.11–4.57]	0.78 [0.13–4.58]	0.77 [0.28–2.17]
Practice setting	Rural (ref.)	1	1	1	1	1
	Urban	0.90 [0.48–1.66]	0.88 [0.47–1.61]	0.77 [0.29–2.05]	0.77 [0.30–1.95]	0.87 [0.51–1.50]
Type of request	Physical (ref.)	—	—	1	1	—
	Mental	—	—	0.02* [0.009–0.04]	0.02* [0.01–0.04]	—
Form of EAS	Assisted suicide (ref.)	1	1	1	—	—
	Euthanasia	0.63 [0.36–1.10]	0.62 [0.36–1.09]	2.3* [1.31–4.03]	—	—
Specific condition	Autism (ref.)	1	1	—	—	—
	Depression	0.82 [0.34–1.92]	0.82 [0.34–1.92]	—	—	—

	PTSD	1.74 [0.82–3.76]	1.75 [0.83–3.78]	—	—	—
	Schizophrenia	1.15 [0.54–2.49]	1.19 [0.55–2.56]	—	—	—
Experience with mental-only EAS requests	Yes (ref.)	1	—	—	—	—
	No	0.69 [0.37–1.28]	—	—	—	—

From: Willingness of Dutch general practitioners to grant euthanasia and assisted suicide requests: a comparative study of physical and mental health conditions
1. Multilevel logistic regressions were used for models 1–3 and binary logistic regressions for models 4 and 5
2. *significant results 1 = reference category

Willingness to perform EAS requests: mental versus physical health conditions
When GPs were asked directly in the survey about their readiness to carry out EAS, 98 said they were willing to do so for patients with a physical health condition, and only 5 said they were unwilling **(Figure 1).** For patients with a mental health condition, 41 GPs indicated willingness, while 49 indicated unwillingness.

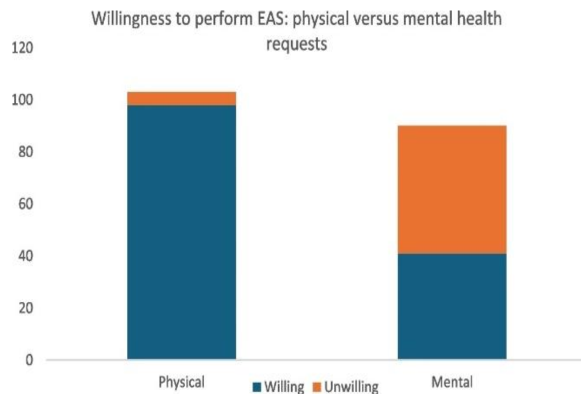

Figure 1. Willingness of Dutch general practitioners to grant euthanasia and assisted suicide requests: a comparative study of physical and mental health conditions

The outcomes of the binary logistic regression that compared GPs willing to perform only physical health condition EAS with those willing to perform both physical and mental health condition EAS are shown in **Table 7.** The only meaningful predictor was prior experience performing EAS for individuals with a mental health condition (OR = 0.15, 95% CI [0.02–0.73]). This suggested that GPs who had performed such procedures before were considerably more open to doing so again. Other variables — age, religion, years of practice, practice location, and experience receiving mental health-related requests — did not reach statistical significance. Variables related to physical health condition, EAS experience, and ethnicity were excluded because there was insufficient variation, and gender was excluded due to a large number of missing responses. However, when the smaller group that provided gender data was examined separately, the results matched those of the main model, indicating no gender-related influence.

Table 7. Results of the binary logistic regression analysis on GPs' willingness to perform

Predictor	Category	95% confidence interval	Odds ratio (OR)
Intercept	—	[0.08, 3.42]	0.53
Age category	< 40 (reference)	1	1
	40–55	[0.24, 10.42]	1.57
	> 55	[0.23, 10.52]	1.54
Religious affiliation	Non-religious (reference)	1	1
	Religious	[0.41, 3.41]	1.17
Professional experience	> 10 years (reference)	1	1
	2–10 years	[0.07, 4.30]	0.56
Practice location	Rural (reference)	1	1
	Urban	[0.23, 1.91]	0.67

Experience receiving EAS requests (mental health only)	No (reference)	1	1
	Yes	[0.85, 7.53]	2.47
Experience performing EAS (mental health only)	No (reference)	1	1
	Yes	[0.02, 0.73]	0.15*

From: Willingness of Dutch general practitioners to grant euthanasia and assisted suicide requests: a comparative study of physical and mental health conditions

Qualitative results

The process of decision-making: Dutch GPs and euthanasia requests

Thirteen Dutch doctors, all trained and experienced as general practitioners, took part in the interviews. At the time of the discussions, eleven were still practicing as GPs, while the other two had moved into SCEN physician roles **(Table 8).** Every one of the 13 GPs reported having dealt with euthanasia requests connected to either physical or mental health conditions, but none had any experience with assisted suicide. For this reason, their described decision-making applies only to euthanasia and not to assisted suicide. Nevertheless, when the topic of assisted suicide came up, many GPs voiced clear hesitation or discomfort with that approach. As two of them explained: "I have to admit that since I never encountered it during my training and have never been involved, if a patient told me they preferred to handle it themselves, I would respect their wish, but I would definitely feel more nervous about it." (P3) and "Up to now I have had no direct involvement with assisted suicide, only with euthanasia. That is partly because a colleague in our practice had a difficult experience with assisted suicide roughly ten years ago, when the dose in the drink was much weaker than it is nowadays. I am also the type of person who prefers to stay in control, and euthanasia gives you far more control than assisted suicide does." (P6).

Table 8. Demographic and professional characteristics of the interview participants

Participant	Practice setting	Sex	Current professional role	Experience with euthanasia (EAS)
1	Urban	Female	Qualified GP, currently working as a SCEN physician	Has both received and carried out EAS requests involving patients with physical and mental health conditions
2	Rural	Female	Practising GP	Has encountered EAS requests from patients with both physical and mental conditions, but has not performed EAS
3	Rural	Female	Practising GP	Has received requests from both groups, but has only carried out EAS in cases involving physical conditions
4	Urban	Male	Practising GP	Has been approached by both patient groups, but has only performed EAS for physical conditions
5	Rural	Female	Practising GP	Has received requests across both groups, but has only carried out EAS for physical conditions
6	Urban	Female	Practising GP	Has experience both receiving and performing EAS for patients with physical and mental health conditions
7	Urban	Female	Practising GP	Has received requests from both groups, but has only performed EAS in physical condition cases
8	Urban	Female	Practicing GP with accredited elderly care specialization	Has encountered requests from both groups, but has only carried out EAS for physical conditions
9	Urban	Female	Practicing GP and locum GP	Has both received and performed EAS for patients with physical and mental health conditions
10	Urban	Female	Practising GP	Has received requests from both patient groups, but has only performed EAS for physical conditions
11	Urban	Female	Practising GP	Has both received and carried out EAS involving patients with physical and mental health conditions
12	Urban	Female	Qualified GP, currently working as a SCEN physician	Has received requests from both groups, but has only performed EAS in physical condition cases

13	Urban	Male	Practising GP	Has been approached by both patient groups, but has only carried out EAS for physical conditions

From: Willingness of Dutch general practitioners to grant euthanasia and assisted suicide requests: a comparative study of physical and mental health conditions

1. Trained as GP refers to the fact that the participant completed formal education and training required to become a GP

All the GPs were comfortable talking about euthanasia with their patients, and twelve indicated a general readiness to carry it out. Their approach to deciding was thoughtful and shaped by several different considerations. Most explained that discussions about euthanasia often begin as broader talks about future care planning, where patients explore possibilities and mention they might consider it later: "So the initial talk is more about leaving the door open rather than a straight request like 'I want this to happen now.'" (P4). These preliminary conversations provide information and help clarify the patient's preferences before the official procedure begins. When patients facing serious, life-limiting illnesses (those that could realistically meet the criteria for euthanasia, as opposed to temporary minor issues) make a clear request, GPs then start weighing what steps to take next.

Importance of the doctor–patient relationship

A common thread throughout the interviews was the value of a long-standing relationship with the patient. Many GPs pointed out that decisions develop gradually throughout the course of an illness rather than in one meeting: "This is not something decided overnight, but something that unfolds over the entire duration of the person's illness." (P7). At the beginning, GPs focus on providing support and information, often discussing options such as palliative sedation. If the patient continues to feel certain about wanting euthanasia, the GPs then examine the legal requirements, particularly the nature of the suffering and whether the request has been carefully considered: "I need to get a clear picture of what the unbearable suffering actually involves, so I encourage the person to describe it in their own words." (P6). Beyond giving support, sharing information, and checking the legal standards, the interviews showed that GPs also wrestle with the ethical weight of ending a human life, even when the patient is in great distress. One GP explained that they could never carry out euthanasia under any circumstances because of their personal convictions: "Even as a child I couldn't bring myself to kill a mosquito, so there is no way I could kill a person. I will do everything possible to ease suffering and provide comfort at the end, but I will not cross that line." (P2). When talking about various situations and their own limits, many GPs said they feel reassured knowing the Expertise Center Euthanasia (ECE) is available, so they can refer patients there if they are unable to perform the procedure themselves.

Ethical considerations in GPs' decision-making

Even among GPs who do carry out euthanasia, the interviews revealed that they engage in deep moral reflection before reaching a final choice. Several described it this way: "You have to be able to defend the decision to yourself." (P1) and "I have to feel that this is the right thing for this particular patient, because I will have to live with the fact that I did it and carry that knowledge with me forever." (P13). Many mentioned that relieving unbearable suffering and enabling a dignified end to life formed the core of their moral reasoning: "When someone is enduring irremediable and unbearable suffering that cannot be eased in any other way, I view euthanasia as the final form of treatment." (P6). Respect for patient autonomy emerged as another key element. GPs emphasized that they strongly honor each person's right to choose the timing and manner of their death: "I am convinced that every individual should have the freedom to decide, and my own beliefs should never stand in the way of that. Everyone deserves the right to determine how they live and how they end their life." (P2). While they place high value on autonomy, GPs also carefully check throughout the process that the request is truly well-considered and made freely, without pressure from family or others: "I always make sure to speak with the patient privately – because family members are often present – to confirm that this is genuinely their own desire and not something suggested or imposed by those around them." (P6). Building trust and showing empathy were repeatedly mentioned as crucial. GPs use the consultations not only to evaluate the legal criteria but also to decide whether they can personally connect with the patient's wishes. This point was expressed by several participants: "For me, I also need to be able to truly understand and relate to the request before I can go through with it. It is not a small

thing." (P7) and "Sometimes the request comes very late, and it is impossible to fully grasp it in only a few days." (P3).

Euthanasia is a complex and demanding process

The GPs made clear that handling a euthanasia request involves a demanding and intricate process that should never be taken lightly. One GP described the full sequence: "You really have to commit to this completely, but I approach it with great care. There are several meetings until you feel ready to involve a second doctor. Then the SCEN physician visits and confirms that the situation truly involves irremediable and unbearable suffering. After that, the official protocol begins – setting the date, ordering the necessary medications from the pharmacy, and preparing all required reports in advance. It is a complete procedure from beginning to end." (P9). Other GPs called the process "intense" and "draining." Apart from the conversations and decision steps, the heavy paperwork was frequently mentioned, especially the reports needed for the RTE (Regional Euthanasia Review Committee). One GP remarked: "I always describe euthanasia as a legal procedure rather than a purely medical one." (P2). In addition to the practical demands, GPs spoke of considerable emotional pressure. One said: "It is difficult for me. The discussions are intense and take a great deal of time." (P6). The emotional load becomes heavier toward the end. GPs described sleepless nights, ongoing tension, and the need for recovery time afterward: "The days leading up to the procedure are tough because it stays on my mind constantly and I sleep badly." (P8) and "I usually need to clear my schedule for the afternoon, then take the evening to unwind. Even so, the thoughts stay with me for about a week after." (P2).

Family influence and professional support

Although the patient's own wish remains the main focus, most GPs also take family perspectives into account. One explained: "The decision centers on the patient, but it certainly makes things easier when the family is on board as well." (P6). When family support is absent or there is disagreement, GPs respond differently. Some feel unsettled by family conflict, while others believe it is the patient's and the family's responsibility to work through it. In any case, a lack of family agreement can complicate the evaluation of the request. A small number of GPs said family views have no bearing on their final decision whatsoever. To manage the emotional and practical demands, GPs regularly look for support. Many emphasized the value of having a colleague or trainee present, with one noting that performing the procedure alone would feel wrong: "I never carry it out by myself – there is always a colleague or my regular partner with me. I have also assisted others, and I would never do it alone if it didn't feel right. It is simply too overwhelming." (P10). GPs also turn to other professionals, such as palliative care nurses and SCEN physicians, for both practical advice and emotional support.

Comparing decision-making processes: mental versus physical health conditions

Interviews with GPs revealed marked differences in how they approach euthanasia requests depending on whether the underlying problem is physical or mental **(Table 9).** A few doctors said the type of condition made little difference to them: "The specific diagnosis does not matter – it could be advanced lung cancer or a persistent untreatable depression." (P13). Others, however, believed such requests involving mental health issues lay beyond the usual responsibilities of a general practitioner: "I do not see this as part of a GP's job." (P4). Responses varied widely: some had prior experience with mental health cases, some were open to considering them, and others ruled them out completely. Despite these differences, every GP agreed that requests tied to mental health conditions tend to be considerably more complicated overall.

Table 9. Comparison of the decision-making process of Dutch GPs for mental versus physical health requests for EAS

Decision-making dimension	Mental health conditions	Physical health conditions
Willingness to assess requests	Views were mixed; some GPs were open to assessment, while others excluded mental health cases entirely	Nearly all GPs (with one exception) indicated willingness to evaluate euthanasia requests

Perception of unbearable suffering	Viewed as more difficult to evaluate due to its subjective nature; patients' descriptions are often harder to interpret	Generally considered more concrete and observable, often associated with clear clinical signs (e.g., pain, dyspnoea) and specialist confirmation
Irreversibility and treatment exhaustion	Considered uncertain, with no uniform treatment pathways and ongoing doubt about whether all interventions had been adequately attempted	Typically seen as clear-cut, supported by specialist evidence confirming that no further treatment options remain
Assessment of voluntariness and decisional capacity	Requests were often seen as fluctuating; concerns were raised about the influence of psychiatric illness on decision-making capacity	Requests were generally regarded as consistent over time and relatively straightforward to verify as voluntary and well-considered
Need for clinical expertise	Strong reliance is expressed on psychiatric input and external specialist consultation	GPs reported feeling relatively competent in evaluation
Referral patterns	Referral to ECE and consultation with specialists were more frequently reported	Referral to the Expertise Center Euthanasia (ECE) was mentioned less often
Ethical considerations	Broader ethical concerns emerged, including societal responsibility (e.g., loneliness, inadequate care), personal moral limits, and religious considerations	Mainly, general ethical reflection was described
Empathic engagement	Some GPs reported difficulty emotionally connecting, even when acknowledging the severity of suffering	GPs generally reported being able to empathize with physical suffering
Duration and complexity of the process	Viewed as more prolonged, requiring additional consultations and extended deliberation	Often described as more efficient and straightforward
Concerns about legal consequences	Occasionally raised but not commonly emphasized	Rarely mentioned; perceived risk of prosecution was low
Knowledge of guidelines and legislation	NVvP guidelines were less familiar and less consistently used among GPs	KNMG guidelines were commonly known and frequently applied
Influence of patient characteristics	Younger patients were more often seen as challenging cases, leading to greater hesitation	Younger age and family context sometimes prompted additional consideration

From: Willingness of Dutch general practitioners to grant euthanasia and assisted suicide requests: a comparative study of physical and mental health conditions

The complexity of assessing unbearable suffering for mental health conditions

A major difficulty when considering euthanasia for mental health conditions is judging whether the patient's suffering truly qualifies as unbearable and impossible to relieve. GPs repeatedly noted during the interviews that it is far harder to establish unreasonableness in these cases. One doctor highlighted the challenge of patients struggling to describe their distress clearly: "Putting the feeling of unbearableness into words can be extremely difficult. Yesterday I saw a psychiatric patient, an uncomplicated man who simply could not articulate how overwhelming his suffering felt." (P1). Another GP observed that unbearable suffering is much easier to evaluate when the condition is physical: "It is obviously simpler when the patient is in severe pain, gasping for breath, or cannot stand being dependent on others. Those are tangible reasons in physical cases so that you can reach a firm conclusion much more quickly than in psychiatric situations."

The complexity of assessing irremediable suffering in mental health conditions

GPs also stressed the difficulty of confirming that suffering linked to mental health conditions cannot be remedied. One commented: "In psychiatry, deciding whether something is truly irremediable feels particularly challenging." (P8), while another added that this judgment is harder to make objectively: "What troubles me is that determining whether a condition can still be treated or is genuinely irremediable is much more difficult to establish clearly in psychiatry." (P13). Uncertainty around irremediability was frequently raised: "Psychiatric suffering is complicated because,

unlike most physical illnesses, it is harder to be sure. At what point can we confidently declare that the condition is irremediable and that no medical options remain?" (P13). Checking whether every reasonable treatment has been tried (treatment exhaustion) is closely connected to this judgment. GPs described this step as more straightforward in physical cases, where it is usually supported by specialist letters: "You receive a clear letter from the oncologist stating the prognosis and confirming that treatment options are exhausted. It is very straightforward and black-and-white." (P3). In mental health situations, the lack of standard protocols and unpredictable results created more doubt. One GP repeated: "What I find hard is that judging whether something is still treatable or truly irremediable is often harder to make objective in psychiatry." (P13).

The combination of unbearable suffering and irremediability

Although unbearableness and irremediability are separate legal standards, GPs often experience them as closely linked. In daily practice, the two criteria tend to reinforce each other, since knowing that suffering cannot be cured can intensify the feeling of unbearable suffering. This connection adds to the overall challenge of assessment in mental health cases. Generally, GPs found suffering from physical conditions easier to define and evaluate because it is usually supported by clear specialist reports that help confirm both elements: "You simply get a letter from the oncologist outlining the prognosis and stating that no further treatments are available. It is very clear-cut." (P3). Another doctor noted: "Patients often return from specialists such as pulmonologists or cardiologists with confirmation that treatment options have run out. Somehow, that feels different from psychiatry. It is not as objective because you cannot measure it the same way. With tumors, you can see and quantify the problem." (P11). GPs also expressed greater doubt when evaluating suffering in mental health conditions, with one asking: "How confident can you really be that these symptoms will never get better in any way?" (P13). Despite acknowledging these difficulties, most GPs accepted that suffering caused by mental health conditions can still be both irremediable and unbearable, although it remains much harder to assess.

Well-considered and voluntary requests in mental health conditions

When dealing with euthanasia requests from patients with mental health conditions, GPs stressed the need to confirm that the request is well-thought-out and made freely: "At one stage he told me that if he ever developed dementia he would want euthanasia. I replied that I would support him, but only if he could clearly demonstrate that it was still his own decision." (P11). However, GPs noted that this is more difficult to verify in mental health cases because requests often fluctuate over time: "For instance, one patient with a personality disorder and depressive symptoms later showed she could change after all, so the wish was not stable." (P9). Furthermore, the mental illness itself can produce symptoms such as delusions, compulsions, or extreme mood swings that directly affect thinking and decision-making. This blurs the line between the illness and the genuine wish. One GP described the problem: "It is hard to separate what comes from the illness and what does not. Does the desire to die arise from the illness itself or from the unbearable suffering?" (P6). This complication is far less common in physical health cases, where patients' wishes tend to be clearer and more consistent.

The challenge of uncertainty and ethics in mental health suffering

Because evaluating suffering and decision-making capacity is more difficult in mental health conditions, many GPs expressed hesitation linked to their limited psychiatric knowledge. Even those open to such requests underlined the importance of specialist input. When asked about handling these cases, one GP said: "No, I cannot manage this alone, so I need much more support from specialists in that field than I do with physical conditions." (P13). The call for psychiatric expertise was repeated often: "In those situations I really need a psychiatrist to help sort out what stems from the illness, what is a true wish to die, and what might still respond to treatment." (P5). In contrast, most GPs felt confident managing the whole process for physical health conditions: "With patients who have physical illnesses, I can handle the entire procedure myself; I feel equipped for it." (P3). The interviews also showed that while every EAS request involves moral reflection, those involving mental health conditions tend to raise extra ethical concerns. Some GPs wondered whether societal or healthcare system gaps were contributing to the patient's distress. One reflected: "Consider older people who are lonely and rarely have visitors. Aren't we, as a care system or as society, failing them? Home care stops by

twice a day, but the rest of the time, they spend alone. The same applies to someone with a psychiatric condition who does not feel accepted by others." (P5). Others spoke of personal discomfort: "When psychiatric disorders or dementia are involved, the ethical side is harder for me to accept. I have to reconcile it with my own conscience. I am religious, and although I support euthanasia, I have definite personal boundaries." (P4).

Difficulties empathizing with requests from patients with mental health conditions

GPs pointed out that, in addition to checking the legal standards, they need to feel a personal emotional connection to the patient's request. The interviews revealed that forming this connection was often more difficult when the request came from someone with a mental health condition. One doctor explained the difference: "If a patient referred for depression only last year now asks for euthanasia, I immediately feel it is happening too quickly. But if I have followed someone for thirty years as they moved from one psychiatric facility to another, knowing how deeply unhappy they are and how isolated they have become, then the request makes much more sense to me. The crucial question for me is whether I can genuinely relate to their situation." (P2). Other GPs underlined that the ability to empathize is essential, yet it frequently creates the biggest obstacle: "The request must be something I can emotionally understand and accept. That is certainly possible with psychiatric patients, but I think that is precisely where the strongest resistance arises." (P3).

Some GPs described a clear divide between accepting that the suffering is genuine and actually feeling it on an emotional level: "I find it hard to connect emotionally with psychiatric problems, even when I fully recognize that the suffering is real and cannot be cured." (P5). In certain situations, the difficulty stemmed from the patient's way of expressing emotions, as one GP observed: "People with autism often do not experience or display emotions in the same way most of us do. With such a person, it becomes very hard for me to build an emotional bond, which makes it difficult for me to feel comfortable approving something as serious as this. I believe this element cannot be written into any formal euthanasia rules, yet it still needs to be something I can personally relate to." (P3). These descriptions show that GPs separate intellectual recognition of the suffering — seeing it as authentic and untreatable — from the emotional capacity to identify with it.

Time, collaboration, and age considerations

Even though the process is more demanding, many GPs believed that mental health-related requests can still be evaluated responsibly, provided more time and teamwork are invested: "There are situations in which we can eventually conclude that every possible option has been exhausted, that everyone involved agrees, and that we can now go ahead with euthanasia. However, it always demands extra time and more extensive discussions." (P13). For some doctors, the additional time and complexity were enough reason to step away from these cases. Others insisted that time pressure must never compromise a thorough assessment. Because of the heightened difficulty, referrals to the Expertise Center Euthanasia (ECE) came up much more frequently for mental health requests than for physical ones: "I have had several patients with mental health problems. I could not or did not want to handle it myself, so I directed them to the Expertise Center Euthanasia." (P7) and "I once had a young woman who asked me directly, but she kept refusing psychiatric treatment and was not clearly suicidal. I sent that kind of case to the Expertise Center Euthanasia." (P4).

Among GPs who were willing to consider or had previously dealt with mental health requests, certain patient traits — especially age — carried considerable influence. Requests from younger individuals are often met with greater hesitation. Some doctors felt uneasy about making such a final decision for someone young. One GP shared: "I have more difficulty with euthanasia for psychological suffering when the patient is young, because I wonder whether their brain has fully matured." (P8). Another recalled: "This came up with two of my own patients who had psychological suffering. One was 43, and the other was 65. I felt the 43-year-old was too young, and I could not personally defend proceeding in that case." (P6).

The role of legal and professional frameworks

Finally, GPs expressed gratitude for the established legal rules and professional guidance that support them when dealing with complicated euthanasia situations. Several noted that Dutch euthanasia legislation has been reliable for many years and provides a strong foundation. One doctor commented: "We have had a solid law in the Netherlands for quite some time, and our training prepares us well for it. As GPs, we therefore understand what is required, and we have clear guidelines to rely on."

(P10). Another added: "I consider the laws and regulations quite clear about what is permitted and what is not." (P11). Most GPs said they primarily followed the KNMG guidelines: "The standards we use come from the KNMG. The Dutch Association for Psychiatry has its own separate guidelines, but as general practitioners we mainly follow the KNMG framework." (P6). However, the majority were not familiar with the psychiatric association's specific guidelines. Those who were SCEN-trained or more experienced knew about them but sometimes viewed them as overly restrictive: "What I find challenging is that the Dutch Association for Psychiatry adds extra conditions. For example, they insist that the SCEN physician must also be a psychiatrist." (P1). A few GPs raised specific legal concerns in mental health cases: "Psychiatry feels more difficult because even if you follow every step correctly, you might still face court proceedings." (P7). Nevertheless, most did not regard the risk of legal consequences as a significant barrier when considering these requests.

Study results in the context of existing evidence

This research offers a fresh understanding of how willing Dutch general practitioners (GPs) are to approve or carry out euthanasia and assisted suicide (EAS) requests, specifically comparing cases involving mental health conditions with those involving physical health conditions. By integrating numerical survey findings with in-depth interview data, the study not only confirms clear differences in willingness but also reveals the underlying thought processes and moral considerations that guide GPs' choices.

Quantitative findings indicated that requests stemming from mental health conditions had a much lower chance of being approved than those from physical health conditions. When asked outright, GPs also showed markedly lower readiness to perform the procedure in mental health cases. These patterns match earlier observations by Bolt *et al*. [16], who found that Dutch doctors considered EAS far more acceptable for physical health conditions (82%) than for mental health conditions (34%). The qualitative interviews provide deeper explanations for this gap by showing why mental health-related suffering feels harder to evaluate. GPs described obstacles such as changing symptoms over time, uncertainty about whether the desire to die arose from the illness itself or from a deliberate choice, problems confirming that the request was truly voluntary, difficulties judging whether all treatment options had been exhausted, and the potential for future improvement. Although these issues are rarely contrasted directly with physical health cases, they appear frequently in existing literature on EAS for patients with mental health conditions [13, 14, 18, 30].

At the same time, the interviews uncovered several additional elements that have received limited attention in previous research. Several GPs reported stronger personal discomfort with requests from younger patients experiencing mental health suffering, indicating that age may carry greater weight in these situations. This observation corresponds with results from a Psychiatry study that highlighted worries about possible future recovery, brain development, and long-term outlook for younger individuals with mental health conditions [31]. Dutch law includes extra protections when minors request euthanasia. A minor must be judged capable of reasonably weighing their own interests. For those aged 12–16 years, parental approval is mandatory; for 16–17-year-olds, parents must be involved in discussions, but their consent is not required. The Euthanasia Code specifically notes that assessing whether a request is voluntary and well-considered can be especially complicated both for minors and for patients with mental health conditions [1, 5]. In general, confirming voluntariness and careful consideration is already more challenging in younger patients because their decision-making maturity and consistency of wishes are harder to determine [5]. The combination of younger age and a mental health condition may therefore account for the heightened reluctance GPs expressed in these situations.

Another notable finding was that many GPs felt emotionally more distant from patients with mental health conditions, making it harder for them to relate to and empathize with the patients. This emotional disconnect, which has often been overlooked in earlier studies, appears to contribute significantly to the reduced willingness observed in mental health cases.

In addition to these hurdles, many GPs openly acknowledged during the interviews that they feel less sure of their own skills when assessing requests from patients with mental health conditions and repeatedly stressed the importance of involving psychiatric specialists. This lack of confidence was also evident in the survey data **(Table 5),** where GPs reported substantially lower certainty when dealing with mental health-related requests, consistent with previous research [16, 18, 32]. Reflecting this uncertainty, several GPs mentioned they were more inclined to refer such cases to

the ECE, where expert teams could conduct a fresh evaluation, which matches national figures reported by the ECE [33]. This dependence on outside specialists highlights both the perceived complexity of mental health conditions and the boundaries of GPs' own confidence in managing these requests.

These observations raise significant ethical questions. The reduced willingness to approve requests from patients with mental health conditions does not necessarily reflect disrespect for patient autonomy; instead, it appears to stem from a careful approach to the uncertainties involved in applying the due care criteria in this setting. Comparable concerns have emerged in earlier qualitative work, in which GPs described the tension between safeguarding vulnerable individuals and honoring their right to self-determination [15, 22]. Ten Cate *et al*. [19] demonstrated that, apart from legal requirements, GPs' decisions are also shaped by their personal moral outlook [19]. The interviews in the present study showed that, while every euthanasia request prompts moral reflection, those involving mental health conditions tended to generate extra ethical dilemmas. These included worries about possible wider societal effects of approving such requests and whether doing so might gradually lower the bar for accessing the option to end life, which may further account for the difference between physical and mental health cases.

Beyond the contrast in willingness between mental and physical health conditions, the study identified religion as another notable influence. Religious GPs were less inclined to approve EAS requests, consistent with earlier research showing that religious convictions can serve as a barrier [15, 17, 34]. Interestingly, religion did not have a significant impact on willingness to actually perform EAS. This suggests that the processes of granting and performing involve somewhat different considerations. Although in everyday Dutch practice, a GP who refuses a request would also refuse to perform it, this study intentionally separated the two to explore distinct layers of willingness. Religion showed a strong link with the decision to grant but not with the decision to perform, indicating that personal beliefs may affect the formal evaluation of requests more strongly than the practical execution of the procedure.

Prior experience emerged as another significant factor. The quantitative data revealed that GPs who had previously carried out EAS for patients with mental health conditions were markedly more willing to do so in the future. This aligns with existing research indicating that hands-on experience helps overcome initial reluctance and strengthens self-assurance [34]. Nevertheless, in contrast to Evenblij *et al*., who reported that merely receiving such requests from patients enhanced physicians' openness to performing EAS [13], the current study found no similar influence. A probable reason for this difference is that Evenblij *et al*. posed more general questions about whether the procedure could be imagined and surveyed a broader mix of doctors. At the same time, this research concentrated exclusively on GPs and assessed their specific willingness to act. Qualitative interviews reinforced these results: although nearly all GPs had received requests from patients with mental health conditions at some stage, many continued to feel unprepared or reluctant to proceed. They stressed that a request alone does not provide the necessary knowledge, confidence, or ethical assurance to move forward. Some highlighted their limited psychiatric expertise and the challenge of separating symptoms of illness from genuine autonomous decisions.

In contrast, others spoke of the intensified emotional load and anxiety about intervening too soon. Notably, even those GPs who had already performed euthanasia for mentally ill patients admitted that these situations continue to be considerably harder than cases involving physical conditions. This suggests that while practical experience may lessen hesitation, it does not eliminate the deep-seated uncertainties and ethical dilemmas inherent in mental health cases.

Another major result was that euthanasia proved more acceptable to GPs than assisted suicide, as detailed in **Table 5**. This finding differs from an earlier study that detected no meaningful distinction between the two methods [35]. The discrepancy may stem from differences in participant groups: the previous research involved elderly care physicians and medical specialists, whereas the present study examined only GPs. Because GPs handle and carry out the vast majority of EAS requests in the Netherlands, they possess substantially greater experience with euthanasia compared with assisted suicide. This heightened familiarity appears to sharpen the perceived difference between the procedures, a theme that also surfaced clearly during the interviews. GPs noted that euthanasia occurs more regularly in their daily work, which diminishes their reluctance, while assisted suicide feels less routine and is therefore handled with extra caution — a pattern consistent with the fourth evaluation report [17]. In addition, participants

underlined that euthanasia enables them to maintain greater control throughout the process, in contrast to assisted suicide, which was viewed as more uncertain and carrying a higher risk. Collectively, these outcomes indicate that both accumulated experience with euthanasia and a professional desire for control contribute to GPs' clear preference for euthanasia over assisted suicide.

Furthermore, although **Table 5** indicated that most GPs agreed or strongly agreed with the idea that "everyone has the right to decide over their own life and death," the interviews made it clear that translating this belief into actual practice is highly challenging. Even when all legal requirements were satisfied, GPs portrayed the decision to proceed with euthanasia as complex, emotionally draining, and ethically burdensome. They repeatedly stressed the value of a solid doctor–patient relationship, careful moral deliberation, and the significant emotional and logistical demands involved, echoing previous research [21, 22, 36]. While earlier studies had focused on understanding patient requests, this research found that GPs placed particular emphasis on empathizing with the patient's wishes—an aspect seldom addressed in the existing literature [22]. Moreover, although some studies have suggested that family views can exert considerable influence or even create pressure on doctors, the majority of GPs in this study appreciated input from relatives without experiencing it as coercive. This observation corresponds with recent evidence showing that Dutch physicians frequently consult family members, yet only 35% ultimately factor their opinions into the final decision [20, 21, 37].

Finally, although most GPs indicated that they consult the KNMG guidance, the interviews revealed only modest familiarity with the NVvP guideline specifically addressing EAS for mental health conditions. **Table 5** revealed widespread dissatisfaction with the existing guidelines for evaluating mental-health-related cases. When viewed together, these results suggest that such dissatisfaction arises largely from insufficient awareness and limited use of available resources. Even though the NVvP guideline is not formally mandated by the RTE, improved implementation — for instance, by simplifying its application in everyday GP settings and offering targeted training — could raise awareness and lessen dissatisfaction. This, in turn, could promote greater consistency in decision-making and decrease variability in the assessment of requests from patients with mental health conditions.

Strengths and limitations

This research adopted a concurrent mixed-methods design that merged quantitative survey data with qualitative interview findings to bolster the overall validity of the conclusions. The questionnaire revealed widespread trends in how GPs view EAS. In contrast, the in-depth conversations uncovered the underlying motivations and thought processes behind their choices, thereby adding considerable interpretive richness and completeness to the project. The timing of the study is especially pertinent amid the steady increase in EAS procedures across the Netherlands and the expanding worldwide discussion on these sensitive practices. Observations from the Dutch setting could offer helpful guidance to other nations grappling with parallel legal and moral issues [4, 24].

Despite these strengths, several limitations should be acknowledged. With a relatively modest participant group (n = 103), the ability to generalize the outcomes broadly may be constrained, although the majority of patterns observed here align closely with earlier investigations. Several GPs commented that the survey's response choices failed to capture the full nuance of their opinions, notably the absence of an option to refer a patient's request to another practitioner. Moreover, technical difficulties with convergence in the technical model meant that multilevel modeling could not be applied to Models 4 and 5; binary logistic regression without hierarchical layering was used as an alternative. Importantly, the odds ratios (ORs) and confidence intervals (CIs) for nearly all predictors were highly consistent with the results from the hierarchical models, confirming that the chosen modeling method had no meaningful effect on the interpretation of the findings. The dataset also contained occasional missing responses, which could introduce bias if ignored. To address this, any variables with substantial missing data (e.g., gender) were omitted from the final models. At the same time, those with minimal missingness (e.g., practice area) were retained and handled using case-wise deletion. These steps helped maintain an adequate and effective sample size and safeguard the integrity of the overall results.

The qualitative portion carries its own constraints. All interviews were performed and subsequently analyzed by the first author alone. This arrangement might heighten concerns about researcher bias; however, it was counterbalanced by the first author's thorough preparation in qualitative techniques, proven background

in discussing delicate subjects, and reliance on a carefully prepared interview protocol that received input from the second author. Additionally, some conversations occurred via online platforms or by telephone rather than in person, primarily because of the distance between the researcher and the participants. Encouragingly, those involved generally felt at ease voicing their perspectives in these remote formats. Another drawback involves the reliance on hypothetical patient scenarios within the survey. Although GPs might find it harder to connect emotionally with fictional cases than with genuine situations from their own caseload, the vignettes were deliberately crafted, drawing on established tools from the fourth evaluation and prior work, including Kouwenhoven *et al*. [26, 35], which lend them solid credibility and allow meaningful comparisons. Lastly, a few respondents may have shared the same GP practice. No identifiers for individual practices were gathered to protect participant confidentiality, so any potential clustering could not be statistically adjusted for. Still, given how GPs are typically spread across practices nationwide, it is improbable that any significant number came from identical settings. Consequently, this issue is unlikely to have exerted any substantial influence on the study outcomes.

Recommendations for future research

Given the continuing upward trend in EAS requests involving mental health conditions in the Netherlands, continued scholarly attention in this domain is vital. The current project underscores the value of delving more deeply into the role of empathy and how it shapes doctors' readiness to consider requests from patients experiencing mental illness. Subsequent qualitative inquiries could profitably investigate the impact of specific patient features — above all, younger age — on GPs' decision processes, since younger patients tend to evoke particularly intense ethical reservations. Beyond that, expanded quantitative investigations on a larger scale would be beneficial to clarify the effects of various physician characteristics, including level of experience, religious outlook, and frequency of contact with mental health-related EAS requests, on actual clinical judgments. It would also be instructive to explore how GPs understand and implement the Euthanasia Code, along with the additional stipulations for mental health situations outlined by the RTE. This area remained largely unaddressed in our conversations, yet is likely to exert considerable influence on day-to-day practice. Future work should also pay closer attention to the way physical comorbidities interact with mental health conditions in shaping GPs' preparedness to approve such requests, as these overlapping presentations are commonplace and can markedly sway medical assessments. Ultimately, such knowledge is expected to guide the creation of more precise educational programs, support mechanisms, and policy measures to better prepare GPs to manage these demanding EAS situations.

Conclusion

Dutch GPs display noticeably lower readiness both to approve and to carry out euthanasia or assisted suicide when the requests come from patients with mental health conditions rather than physical ones. This reluctance arises from the inherent challenges in determining unbearable and irremediable suffering, lingering clinical doubts, uncertainty about whether the request truly reflects a well-considered choice or is shaped by the illness, and difficulties in fully connecting with the patient's lived reality. Requests of this nature usually prove lengthier, more ethically complex, and more dependent on specialist psychiatric involvement, with factors such as younger patient age and the doctor's personal sense of comfort intensifying hesitation. A substantial number of GPs further acknowledged only limited familiarity with the available guidelines specifically addressing mental health-related cases. Taken together, these observations emphasize the urgency of improving how guidance is put into practice in everyday GP settings, securing swift access to psychiatric assessment and SCEN consultations, reinforcing partnerships with the ECE, and delivering specialized training alongside practical resources that promote the uniform and reliable application of the due care criteria.

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Ethics Statement: This study was conducted in compliance with the Declaration of Helsinki. Ethical approval for this study was obtained from the Ethics Committee of the Management Center Innsbruck (MCI). All participants received information about the study's aims. Written informed consent was obtained before participation in both the survey and the interviews. Interviews were recorded with permission, and all data were securely stored and accessible only to the researcher. Anonymity and confidentiality were strictly maintained throughout the research process. Given the sensitivity of the topic, special attention was paid to participants' comfort and the voluntary nature of their involvement.

References

1. Termination of Life on Request and Assisted Suicide (Review Procedures) Act. Act of April 1, 2001. Bull Acts Decrees. 2001;194.
2. Government of the Netherlands. Is euthanasia allowed? 2025 Jan 21. Available from: https://www.government.nl/topics/euthanasia/is-euthanasia-allowed
3. Netherlands Penal Code. Wetboek van Strafrecht, Article 293. 2025. Available from: https://wetten.overheid.nl/BWBR0001854/2025-01-01
4. Regionale Toetsingscommissies Euthanasie. Jaarverslag 2024. 2025. Available from: https://www.euthanasiecommissie.nl/
5. Regional Euthanasia Review Committees. Euthanasia Code 2022. 2022. Available from: https://english.euthanasiecommissie.nl/the-committees/euthanasia-code-2022
6. Royal Dutch Medical Association (KNMG). KNMG guideline on end-of-life decisions. 2021. Available from: https://www.knmg.nl/download/knmg-guideline-end-of-life-decisions
7. Royal Dutch Medical Association (KNMG). Over SCEN [About SCEN]. Available from: https://www.knmg.nl/ik-ben-arts/scen/over-scen
8. Euthanasia Expertise Center. Expertisecentrum Euthanasie. Available from: https://expertisecentrumeuthanasie.nl/
9. Nicolini ME, Kim SY, Churchill ME, Gastmans C. Should euthanasia and assisted suicide for psychiatric disorders be permitted? Psychol Med. 2020;50(8):1241-56.
10. Albarracin P, Mayor F, Aparicio M, Herrero E. Euthanasia and psychiatric patients: a Spanish glance to the Dutch experience. Eur Psychiatry. 2023;66(S1):S874.
11. Regional Euthanasia Review Committees. Annual report 2008. 2009. Available from: https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2008/nl-en-du-fr/nl-en-du-fr/jaarverslag-2008/jaarverslag-2008-52.pdf
12. Expertise Centre Euthanasia. Research report on psychiatric patients. 2020. Available from: https://expertisecentrumeuthanasie.nl/app/uploads/2020/02/Onderzoeksrapportage-Psychiatrische-Pati%C3%ABnten-Expertisecentrum-Euthanasie.pdf
13. Evenblij K, Pasman HRW, Pronk R, Onwuteaka-Philipsen BD. Euthanasia and physician-assisted suicide in patients suffering from psychiatric disorders: a cross-sectional study exploring the experiences of Dutch psychiatrists. BMC Psychiatry. 2019;19:1-10.
14. Pronk R, Sindram NP, van de Vathorst S, Willems DL. Experiences and views of Dutch general practitioners regarding physician-assisted death for patients suffering from severe mental illness: a mixed methods approach. Scand J Prim Health Care. 2021;39(2):166-73.
15. Pronk R, Evenblij K, Willems DL, van de Vathorst S. Considerations by Dutch psychiatrists regarding euthanasia and physician-assisted suicide in psychiatry: a qualitative study. J Clin Psychiatry. 2019;80(6):19m12736.
16. Bolt EE, Snijdewind MC, Willems DL, van der Heide A, Onwuteaka-Philipsen BD. Can physicians conceive of performing euthanasia in case of psychiatric disease, dementia, or being tired of living? J Med Ethics. 2015;41(8):592-8.
17. van der Heide A, Legemaate J, Onwuteaka-Philipsen B, Bosma F, van Delden H, Mevis P, et al. Vierde evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding. The Hague: ZonMw; 2023. Available from: https://www.zonmw.nl/sites/zonmw/files/2023-05/Wtl-IV-online.pdf
18. Evenblij K, Pasman HRW, van der Heide A, van Delden JJ, Onwuteaka-Philipsen BD. Public and physicians' support for euthanasia in people suffering from psychiatric disorders: a cross-sectional survey study. BMC Med Ethics. 2019;20:1-10.

19. 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(6):723-9.
20. Roest B, Trappenburg M, Leget C. The involvement of family in the Dutch practice of euthanasia and physician-assisted suicide: a systematic mixed studies review. BMC Med Ethics. 2019;20:1-21.
21. De Boer ME, Depla MF, den Breejen M, Slottje P, Onwuteaka-Philipsen BD, Hertogh CM. Pressure in dealing with requests for euthanasia or assisted suicide: experiences of general practitioners. J Med Ethics. 2019;45(7):425-9.
22. van Zwol M, de Boer F, Evans N, Widdershoven G. Moral values of Dutch physicians in relation to requests for euthanasia: a qualitative study. BMC Med Ethics. 2022;23(1):94.
23. Creswell JW. Research design: qualitative, quantitative, and mixed methods approaches. 3rd ed. Thousand Oaks (CA): SAGE Publications; 2009. p.3-21.
24. van Veen SMP, Widdershoven GAM, Beekman ATF, Evans N. Physician assisted death for psychiatric suffering: experiences in the Netherlands. Front Psychiatry. 2022;13:895387.
25. Plano Clark VL, Huddleston-Casas CA, Churchill SL, O'Neil Green D, Garrett AL. Mixed methods approaches in family science research. J Fam Issues. 2008;29(11):1543-66. doi:10.1177/0192513X08318251
26. Kouwenhoven PS, Raijmakers NJ, van Delden JJ, Rietjens JA, Schermer MH, van Thiel GJ, 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(3):273-80.
27. Hox JJ. Multilevel analysis: techniques and applications. Mahwah (NJ): Lawrence Erlbaum Associates; 2002. p.5-7.
28. Hsieh H-F, Shannon SE. Three approaches to qualitative content analysis. Qual Health Res. 2005;15(9):1277-88. doi:10.1177/1049732305276687
29. Linneberg MS, Korsgaard S. Coding qualitative data: a synthesis guiding the novice. Qual Res J. 2019;19(3):259-70. doi:10.1108/QRJ-12-2018-0012
30. Van den Ende C, Bunge EM, Eeuwijk J, van de Vathorst S. Exploring doctors' reasons for not granting a request for euthanasia: a mixed-methods study. BJGP Open. 2022;6(3):BJGPO.2022.0015.
31. Schweren LJ, Rasing SP, Kammeraat M, Middelkoop LA, Werner R, Mérelle SYM, et al. Requests for medical assistance in dying by young Dutch people with psychiatric disorders. JAMA Psychiatr. 2025;82(3):246-52.
32. Verhofstadt M, Moureau L, Pardon K, Liégeois A. Ethical perspectives regarding euthanasia, including in the context of adult psychiatry: a qualitative interview study among healthcare workers in Belgium. BMC Med Ethics. 2024;25(1):19.
33. Expertisecentrum Euthanasie. Feiten en cijfers over 2024. 2025. Available from: https://expertisecentrumeuthanasie.nl/app/uploads/2025/04/EE-Feiten-en-Cijfers-over-2024_web.pdf
34. Onwuteaka-Philipsen BD, Muller MT, van der Wal G, van Eijk J, Ribbe MW. Attitudes of Dutch general practitioners and nursing home physicians to active voluntary euthanasia and physician-assisted suicide. Arch Fam Med. 1995;4(11):951.
35. Kouwenhoven PS, van Thiel GJ, Raijmakers NJ, Rietjens JA, van der Heide A, van Delden JJ. Euthanasia or physician-assisted suicide? A survey from the Netherlands. Eur J Gen Pract. 2014;20(1):25-31.
36. Georges JJ, Onwuteaka-Philipsen BD, van der Wal G. Dealing with requests for euthanasia: a qualitative study investigating the experience of general practitioners. J Med Ethics. 2008;34(3):150-5.
37. Renckens SC, Onwuteaka-Philipsen BD, van der Heide A, Pasman HR. Physicians' views on the role of relatives in euthanasia and physician-assisted suicide decision-making: a mixed-methods study among physicians in the Netherlands. BMC Med Ethics. 2024;25(1):43.