



# The social–political challenges behind the wish to die in older people who consider their lives to be completed and no longer worth living

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## Abstract

In the Netherlands, physician-assisted dying has been legalized since 2002. Currently, an increasing number of Dutch citizens are in favour of a more relaxed interpretation of the law. Based on an ethos of self-determination and autonomy, there is a strong political lobby for the legal right to assisted dying when life is considered to be completed and no longer worth living. Building on previous empirical research, this article provides a critical ethical reflection upon this social issue. In the first part, we discuss the following question: what is the lived experience of older people who consider their lives to be completed and no longer worth living? We describe the reported loss of a sense of autonomy, dignity and independence in the lives of these older people. In the second part, from an ethics of care stance, we analyse the emerging social and political challenges behind the wish to die. Empirically grounded, the authors argue that the debate on ‘completed life in old age’ should primarily focus not on the question of whether or not to legitimize a self-directed death but on how to build an inclusive society where people may feel less unneeded, useless and marginalized.

## Keywords

Ageing, assisted dying, attitudes towards ageing, completed life, old age

## Introduction

The North-Atlantic world is in the midst of some major demographical transitions. Declining fertility rates and increased life expectancy are important determinants of an ageing society (World Health Organization (WHO), 2015). In order to attain successful ageing, emphasis is put on minimizing physical and mental deterioration and disability; on life

satisfaction, social participation and functioning and on psychological resources (Bowling and Dieppe,

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2005). Despite all efforts, old age is often increasingly accompanied by physical and mental age-related problems. These problems have an influence on the perceived well-being, threatening meaning and purpose (Kellehear, 2007). Older people may experience a shift from the benefit of living longer towards the suffering of living too long (Van Rein, 2013). Being excluded from participation in daily social life, they may consider themselves to be ‘socially dead’ before they are biologically dead (Seale, 2000). It is argued that longevity and accompanied age-related problems – among other things – have constituted the awareness of determining the time and manner of death and dying in the whole western world (Chabot and Goedhart, 2009; Kellehear, 2007; Pool, 2004; Seale, 2000; Van Rein, 2013). Indeed, in the Netherlands, an increasing number of citizens can imagine appreciating physician-assisted dying (PAD) in case they would suffer from old age, even if they lacked any classified medical condition (Buiting et al., 2012; Raijmakers et al., 2013; Ross, 2015).

Since 2002, PAD has been legalized in the Netherlands under strict requirements laid down in the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* (2002) (see Online Annex 1 for the legal requirements). Notably, the Dutch law does not distinguish between physical and psychological suffering: the suffering does not need to have a diagnosable origin. Euthanasia can be an option for people ‘who suffer unbearably and without any prospect of improvement’. However, in 2002, the Dutch Supreme Court ruled that a doctor who helped an 86-year-old man who was ‘tired of living’ to die was found guilty of assisted suicide, without punishing the physician because he was argued to have acted out of great concern for his patient. This ruling – which became known as *The Brongersma case* (Hoge Raad, 2002, NJ2013, 167) – is seen as upholding guidelines for PAD in the Netherlands: it is only permitted in cases of unbearable and hopeless suffering stemming from a medical condition (De Vries, 2004; Huxtable and Möller, 2007; Sheldon, 2003). In most cases of tiredness of life, it is very difficult to prove whether the suffering is irremediable and, thus, hopeless from a medical perspective (Raus and Sterckx, 2015; Rurup et al.,

2005). Indeed, recent research has shown that most Dutch physicians find it inconceivable that they would grant a request for euthanasia from a patient who is tired of living (Bolt et al., 2015).

The Dutch end-of-life debate continues progressively, however, and the public opinion is shifting. In 2010, the Dutch initiative group ‘Of Free Will’ started an influential campaign and placed the discussion about ‘older people and a self-directed death’ high on social and political agendas (Van Rein, 2013). They argue that people aged 70+ who have come to the well-considered conclusion that the quality of their lives has deteriorated to such an extent that they prefer death over life should have legal options for PAD or a non-medically assisted suicide, even if they do not suffer unbearably from a classified medical condition. They, thus, made a plea for further relaxation of the legal requirements, advocating that people’s personal judgement should be decisive, rather than the professional judgement of the physician.

In 2014, in response to this civil initiative, the Dutch government established a multidisciplinary committee of acknowledged experts to explore the legal possibilities and the societal dilemmas with regard to PAD and non-medically assisted suicides in cases of ‘completed life in old age’ (for an overview of definitions of completed life, see Online Annex 2). This committee was called *The Committee of Wise People on Assisted Suicide to People Who Consider Their Lives to Be Completed*. In February 2016 – after 2 years of intensive research and consulting national and international stakeholders and experts – the committee presented its report in which the committee members unanimously gave the advice not to change the current law because of the risks of undermining the current euthanasia practice, the potential enforcement of feelings of insecurity in old age, social pressure on the elderly and reinforcing the stigma of old age (Schnabel et al., 2016).

In contrast to the advisory report, in October 2016 the Dutch Minister of Health, Welfare and Sports unexpectedly put forward a proposal to legalize assisted dying for older people who are generally healthy but feel that they have led a so-called ‘completed life’ (2016). In her explanatory statement, the minister underlined that the older people concerned

do not fall under the current law as most of them do not meet the required criteria. Therefore, in order to take the wish to die of these individuals seriously, the Dutch government proposed to draft a new assisted dying law, with broader criteria. This proposed expeditious policy has again led to a fierce debate as to whether or not to further extend the freedom of choice in end-of-life issues.

Shortly afterwards, in December 2016, the Dutch liberal party ‘Democrats 66’ went one step further and launched a detailed bill, which was already in preparation, named *Review Procedures End of Life Counselling of Elderly People on Request Act* (2016). With this bill, they want to legalize assisted dying for older people who have no medical complaints. The main assumption underlying this D66 bill is that the current euthanasia law is based on a strictly medical perspective. Besides, with this new law, autonomy should be paramount rather than mercy. There should be a shift from a focus on the role of the doctor and his or her conflict of duties to a focus on the right of citizens, namely, the right of self-determination and the right to die if one so wishes. Indeed, they not only want to acknowledge the right to die but also want to enable older citizens to exercise this right.

As a matter of course, in order to develop a careful and morally responsible policy, it is a prerequisite to build on a thorough understanding of the phenomenon of ‘completed life in old age’. Remarkably though, very little empirical research has yet been done into this specific phenomenon. Indeed, we performed the first study worldwide into the lived experiences of older people who consider their lives to be completed and want to terminate their lives at a self-directed moment, without being severely physically or mentally ill. This study – consisting of several subprojects – has already been published (Van Wijngaarden et al., 2015a, 2015b, 2016, 2017).

Subsequent to our empirical work, this current article provides an ethical analysis of the issue of older people and the self-directed death. With this reflection, we aim to nuance and critically reflect on the current public debate and exert some influence on recent developments in politics by providing clues for the humanization of society and policy. This article is divided into two main parts. By using

the Dutch situation as our case study, in the first part, we discuss the following questions: what is the lived experience of older people who consider their lives to be completed and no longer worth living? And what are the needs and concerns underlying the wish to die? We describe how autonomy, dignity and independence are put at risk in the lives of the people concerned. In the second part, we analyse the emerging social and political challenges behind the wish to die from an ethics of care stance. We point out the need to rethink the dominant social imaginaries on dependence and vulnerability dominant in the North-Atlantic world. Besides, we defend the primacy of investing in the reduction of situational vulnerabilities, rather than broadening the criteria of assisted suicide. We will conclude by critically examining the question as to whether the opted regulation of assisted dying can be seen as a morally appropriate societal answer to the issue of ‘completed life in old age’.

## Completed life in old age

This part of the article concerns a description of the phenomenon ‘completed life in old age’ and the people concerned. For this purpose, we draw heavily upon our own empirical work that serves to provide evidence and constitutes a ground for the ensuing normative reflection further on in this article (see Online Annex 3, for an overview of the context of our empirical study, participants’ backgrounds and our analytical approach).

Our research has shown that the essential meaning of the phenomenon ‘completed life in old age’ should be understood as ‘a tangle of inability and unwillingness to connect to one’s actual life’. Daily experiences have become increasingly incompatible with older people’s self-esteem. The people involved attempt to resist an inevitably growing dependence and try to preserve their remaining independence. Always having perceived themselves as proactive, independent people, their resistance is strengthened by their beliefs and their character. Even though everyday life continues, these people feel as if their life story has already ended. While feeling more and more disconnected to life, a yearning desire to end life is strengthened. The experience of disconnectedness is further explicated in five

constituents: (1) a sense of aching loneliness, (2) the pain of not mattering, (3) the inability to express oneself, (4) physical tiredness and/or existential boredom and (5) a sense of aversion towards feared dependence (Van Wijngaarden et al., 2015a, 2015b).

As mentioned, the wish to die was driven by the high value that the older people concerned place on autonomy and independence during their lives. Below, we will clarify how – in the perception of these people – old age puts autonomy, dignity and independence at risk.

### *Autonomy at risk*

In general, people's self-understanding is deeply influenced by what Taylor (2004) calls 'modern social imaginaries', defined as 'the way people imagine their social existence, how they fit together with others, the expectations that are normally met, and deeper normative notions and images that underlie these expectations'. A powerful 'social imaginary' of most older people under research – as with many western citizens – is that they perceive the self-disciplined, independent, entrepreneurial agent as the cornerstone of society, and economic productivity as the cornerstone of a new ethic. Independence and agency are not just seen as personal ideals. They are social ideals as well, contributing to national well-being and harmonious coexistence, hence something to strive for (Taylor, 2004).

One of the main interests of the people under research is, thus, to maintain autonomy and independence. During their lives, most have attached great value to the ability to run their own affairs as much as possible without interference from others. They often highly valued work and personal projects: one's public contribution to society is viewed as one of the most important goals in life. Consequently, ageing, the increasing deterioration of health and other age-related vulnerabilities threaten their sense of agency. They resist the idea of being vulnerable and fragile, as this is conceived to be incompatible with full autonomy. Vulnerability in old age is strongly associated with qualities such as weakness, helplessness, victimhood and humiliation (De Lange, 2015; Van Wijngaarden et al., 2017). In their view, it puts their autonomy at risk.

### *Dignity at risk*

Ageing, the increasing deterioration of health and other age-related losses not only threaten their sense of autonomy. For the majority of the people under research, their sense of dignity also seems affronted. This is due to a life view in which dignity is closely related to one's capacities, behaviour and ability to act competently (Van Wijngaarden et al., 2015a). For them, dignity is – to a significant extent – about autonomy, independence and competence. In this view, humanity is fully realized only when you are able to govern your own actions and to behave reasonably. A side effect of this self-understanding is that when people become increasingly dependent, needy and economically unproductive, they feel judged by society *and* by themselves. They view – and may experience – dependency as a reprehensible, undignified and character-destroying condition, a breach of humanity (Van Wijngaarden et al., 2015a). It contradicts their values or commitments, their ideas of who they are and who they ought to be. This has a profound impact on people's identities. People might view themselves below their personal standard or even as subhuman (Van Wijngaarden et al., 2017).

Regarding the people under research, the loss of dignity is, thus, closely associated with the loss of agency and competence. In addition, they associate a sense of indignity with the loss of belonging and recognition. Our empirical accounts are full of the strong human desire of being visible, recognized, wanted, needed, valued, missed, depended upon or attended to by others (Van Wijngaarden et al., 2015a). However, in everyday life, most older people under research completely lack the feeling of mattering and being needed within a community.

### *Independence at risk*

During our empirical research, an interesting paradox emerged, namely, that the older people concerned *think* of themselves as being autonomous, independent and self-determined agents who run their own affairs and are capable of making rational choices (i.e. when and how to terminate life). Simultaneously though, they *experience* themselves as highly dependent, vulnerable and needy as well (Van Wijngaarden

et al., 2015a). Faced with considerable existential challenges, their experiences reflect the ambiguity of everyday realities: on one hand, the wish to die is driven by the great value they attach to independence and autonomy. On the other hand, it is also strongly influenced by anxieties, fears and unfulfilled needs. While they want to run their own affairs without interference from others as much as possible, paradoxically they simultaneously present themselves as being highly dependent on others when it comes to their well-being and their need for care. However, they have difficulties accepting this ambiguity as part of life; rather, they strongly tend to resist this.

The group of older people studied not only resists facing dependency upon others due to their life view. They also do not dare to face dependency upon others because they are concerned about the quality and the sufficiency of care and care arrangements. There seems to be a certain absence of relations of trust and a presence of negative perceptions and experiences. These concerns are highly sensitive towards the fact that care is often not an activity between equal agents. Professional and informal caregivers might have their own ideas of what is necessary to meet the needs of these older people. The older people themselves sense (or expect) this care relation to be distinctly negative; since it could compromise their agency, they fear to be paternalized or even infantilized. This concern shows that to be dependent on others, to accept others caring for you, requires a certain degree of trust that others will not impose their beliefs on you. If people do not trust other people, they do not want to be dependent on them. Most older people under research seem to lack trust that their autonomy can be fostered through (informal or professional) relationships of respect and recognition. The loss of control and the lack of confidence in tailored assistance and care strengthened the wish to safeguard themselves, trying to make themselves unapproachable to potential patronizing (Van Wijngaarden et al., 2015b, 2016).

### **The emerging social challenges behind the wish to die**

From the above description, it follows that people's self-evaluations and their death wishes prove to have

several distinct social dimensions: first, it appears that the wish to die is partly rooted in feelings of societal exclusion and marginalization. The accounts are full of experiences of loneliness, the lack of reciprocity, and the sense of not mattering and of being ignored (Van Wijngaarden et al., 2015a).

Second, the older people consider their lives to be unworthy, not only in their own eyes, but also in the eyes of others and society (Van Wijngaarden et al., 2015a, 2017). It seems that the idea that life is no longer worth living is partly constituted by a societal idea that old-age dependencies seriously compromise one's autonomy and dignity (Van Wijngaarden et al., 2015a, 2015b). Besides, they seem to have internalized negative stereotypical cultural images and integrate them into their self-evaluations, thinking and talking about old age in terms of victimhood, imprisonment, void, stagnation, redundancy, subhumanization and infantilization (Van Wijngaarden et al., 2017).

Third, they also seem to lack the assurance that others would take care of them properly when they became utterly dependent. Some explicitly doubt that others would take care of their wishes and respect their physical integrity (Van Wijngaarden et al., 2016). Indeed, they fear that others might take over control of their lives 'by deciding what is best' for them 'without taking into account' their wishes; there is 'no absolute assurance' that their family would safeguard their interests; a physician 'might probably force' them to undergo (life-prolonging) treatment against their will; their requests to hasten death 'might not be respected' (Van Wijngaarden et al., 2016). Some explicitly say that the self-directed death is a way to 'safeguard themselves'.

Fourth, our empirical work has disclosed a sense of mistrust due to feared (and/or experienced) scarcity of material goods, money, time, skills and other resources. Concerns and anxieties are expressed about the adequacy of professional care in our society, the devaluation of care arrangements and the worsening state of the nursing homes and home care due to budget cuts (Van Wijngaarden, 2016). How does one trust a society that mentions protecting and valuing older people's lives and cutbacks in health care in the same breath? Some elderly people think that it is absolutely paradoxical if, on one hand,

insufficient resources are available to maintain a high quality of life in later life, but on the other hand, no medical assistance is made available to terminate life when this quality is no longer considered to be sufficient (Van Wijngaarden et al., 2016).

### **A care-ethical analysis of the emerging social challenges**

Clearly, it follows that we should not approach a self-directed death as a merely individual issue. The wish for a self-directed death reveals a desperate attempt to escape a perceived undignified life, at least partly driven by unmet (societal) needs and negative social imaginaries of old age. This raises a highly important question: how to deal with these societal influences on this wish to die when making careful and responsible policy?

In search of answers, we make use of the ethics of care. This political ethic – which draws upon feminist sensibilities – may provide a fruitful framework to analyse the emerging challenges of the self-directed death in old age, as it criticizes the dominant conception of autonomy as the capacity of an individual to make and effect rational, self-determined choices. Rather, it proposes a shift from the dilemma of autonomy or dependency to a more sophisticated notion of human interdependence (Tronto, 1993). Besides, care ethicists point out the primacy of addressing human needs, by which they mean ‘the things we cannot do without, things without which our life is seriously harmed or vitally impaired’ (Mackenzie et al., 2014; Reader, 2005; Wiggins, 2005). Needs are seen as a matter of social concern, pointing out the political-ethical dimension of an underlying problem that should be acknowledged and addressed. Indeed, addressing needs is a prerequisite of human agency and therefore foundational in responsible social policies (Mackenzie et al., 2014; Reader, 2005; Tronto, 1993; Wiggins, 2005).

### ***Dependence and vulnerability as intrinsic human conditions***

We have stated before that the social imaginary of the self-disciplined, independent, successful, entrepreneurial agent as the cornerstone of society is clearly

deeply rooted in the minds of the people under research. If we collectively think that autonomous agency is one of the defining characteristics of personhood, then what ultimately follows from this is that to be exceptionally vulnerable is to lack the traits of full personhood (Scully, 2014; Tronto, 1993, 2013). Rather than providing vulnerable and dependent people with a proper self-understanding, this social imaginary leaves them behind, questioning their dignity.

Care ethicists have criticized the representation of the human being as a unified, autonomous self (Gilligan, 1982; Tronto, 1993, 2011; Walker, 2007). Autonomy should not be thought of in terms of self-determination or self-sufficiency, but rather as a process of self-realization in which others play a crucial role (De Lange, 2014). Indeed, care ethicists challenge the idea that vulnerabilities and dependencies are necessarily incompatible with autonomy (Mackenzie et al., 2014). In line with Ricoeur and Taylor (Ricoeur, 1994; Taylor, 1989), among others, care ethicists argue that humans are intrinsically dependent; they are born in the condition of dependence and remain dependent upon others – to a greater or lesser degree – throughout their lives. Certainly, care ethicists underline that autonomy should be recognized as an important normative idea for our social order, providing the necessary conditions for self-respect and self-agency and to protect people from paternalism (Dodds, 2014; Tronto, 1993; Verkerk, 2001). Yet they understand autonomy in a relational sense, acknowledging the networks of interdependencies within which people are embedded not as compromising choice and action but as providing the conditions of the possibility for them. Indeed, the self can only be developed in interaction with others, being dependent on reciprocity and recognition, and constituted through and mediated by intersubjectivity (Van Nistelrooij, 2015).

Applied to old age, care ethicists get support from many other authors who have acknowledged the responsibility of societies to actively resist and counteract the negative power of this social imaginary of the self-disciplined, independent, successful human agent through putting an emphasis on connectedness, commonality and interdependency (Behuniak, 2011; Gilleard and Higgs, 2011; Laceulle and Baars, 2014; Schnabel et al., 2016).

### *Intrinsic and situational vulnerabilities*

Obviously, care ethicists also dispute the dichotomy between vulnerable groups and alleged non-vulnerable groups. Rather than restricting vulnerability to some specific lives or circumstances, vulnerability is primarily seen as the capacity to suffer inherent to all human beings due to our embodied, social and affective nature (Dodds, 2014; Mackenzie et al., 2014; Scully, 2014). While it does not obscure that some people are more vulnerable than others, the ethics of care starts from the empirically substantiated notion of shared vulnerability.

It also, however, points out the moral need to make a distinction between inherent and situational vulnerabilities (Dodds, 2014; Mackenzie et al., 2014; Scully, 2014). This means that some vulnerabilities are recognized as inherent to (i.e. old-age) impairment (such as degenerative processes, pain, fatigue and age-related losses), directly affecting health and well-being. Other vulnerabilities, though, are situational vulnerabilities, which means that they are context-specific (such as some forms of loneliness, marginalization, social exclusion, lack of good care, insufficient care resources and forced relocations). These situational vulnerabilities depend, for a great deal, on policies and institutions that could be changed or organized differently, if prioritized. Among others, Scully (2014) argues that although the presence of inherent vulnerabilities undeniably has a significant impact on people's lives, the major impact on people's lives is probably mediated through situational vulnerability. Different social, positional and institutional aspects might at least decrease the negative impact of these (situational) vulnerabilities on people's lives. From the standpoint of an ethic of care, we pose that, as a society, we have a moral duty to put in considerable efforts to at least reduce these situational vulnerabilities in old age (e.g. by building trust in care and care resources) rather than offering an exit by legalizing assisted suicide.

### *The distinction between normal and stigmatized dependence*

Another clarifying distinction is the difference between 'permitted dependencies' (referring to the

network of 'normalized' dependencies of food, light, heat, housing, education, rubbish disposal and health care, among innumerable other things) and 'non-permitted dependencies' (referring to stigmatized forms of dependence). Scully (2014) states that permitted dependencies refer to 'needs that are so ubiquitous and so much a part of contemporary life, that they are not even seen as dependencies'. These dependencies are 'supported without question, while the vocabulary of vulnerability is never used' (Scully, 2014).

In order to live a good life, everyone needs relationships of care to meet these (permitted) dependencies. While these 'ecologies of interdependencies' are not at all 'a matter of rational contract or balanced exchange of services between equals' – but inevitably asymmetric – there is still a kind of mutual (and often voluntary) cooperation (Kittay, 1999). A core problem in the lives of the people under research is that they increasingly lack any sense of mutuality and reciprocity. Dependency has become a one-way dependency: they feel that they cannot do anything meaningful in return, which is experienced as a humiliation, but it also enhances feelings of senselessness. It is precisely this one-way dependence that is strongly rejected and stigmatized, not only in the minds of these older people but also in the negative deficit-oriented societal discourse on ageing (Behuniak, 2011; Featherstone and Wernick, 1995; Hockey and James, 1993; Van Wijngaarden et al., 2017). Again, in line with Scully, we think that it depends, a great deal, on societal responses to impairment whether these accompanied vulnerabilities and dependencies are experienced as relatively normal or profoundly stigmatized (Scully, 2014). Accordingly, there might be a risk that conceptualizing the dependencies associated with old age as 'undignified' will lead to a vicious circle of negative stigmas. In the Netherlands, there is a growing societal acceptance that 'undignified' suffering from age-related dependencies in some cases can be 'well addressed' by assisted dying, of course, only if people themselves prefer so (Schnabel et al., 2016; Van Delden et al., 2011; Van der Heide et al., 2014). However, it is not inconceivable that such an approval might enforce feelings of indignity and social marginalization in people of old age (Schnabel et al., 2016).

### *The interdependence of inherent, subjective and social dignity*

Above, we have already noted that there is an association between the experience of dependence and vulnerability and the experienced threat of one's dignity. In contemporary ethical discussions, mainly three versions of dignity play a role (Leget, 2013). First, there is the notion of inherent dignity, which emphasizes the fundamental human dignity of all persons based on the unique fact that they are human. Dignity is an ontological given. While this abstract notion of dignity is independent of experience, it does uphold a fundamental equality of humans, making a moral claim on society to provide the basic freedoms and goods that are needed for the fulfilment of one's dignity (Kirchhoffer, 2013; Leget, 2013). Second, there is the notion of subjective dignity, which refers to the experience of one's own dignity. In other words, it refers to a self-interpretation of one's dignity associated with self-worth and self-respect. In experiencing a sense of one's own value, worth, ability and meaning, one 'acquires' this dignity (Kirchhoffer, 2013; Leget, 2013). Third, the notion of social dignity refers to the experience that one feels respected by other persons and by socio-cultural practices and institutions. Attitudes, certain practices or institutions can both affirm and undermine the experience of the value of a human being (Galvin and Todres, 2014; Kirchhoffer, 2013; Leget, 2013; Van Heijst, 2011).

None of these notions of dignity alone can provide a balanced moral view on dignity. We need an integrated view in which the various dimensions of dignity are intertwined and interrelated (Galvin and Todres, 2014; Leget, 2013). Besides, it should be emphasized that dignity is not only about agency and competence (to have) but also about belonging and connection (to be) and recognition (to be recognized). In other words, dignity is not only a dignity of 'I can' but, at a deeper existential level, it is also a dignity of 'I am' (Galvin and Todres, 2014) and a dignity of 'I am being seen' (Van Heijst, 2011; Van Heijst and Leget, 2011). By putting too much emphasis on dignity in terms of agency and competence, what remains underexposed – and maybe even disregarded – are the social-relational needs such as

belonging, connection and recognition that are also essential for dignity.

If we now look at the issue at stake, we see that not only the subjective dignity of the older people is ruptured. The social dignity – which refers to the recognition by others and society – is threatened as well (Leget, 2013). Not only do they lack a sense of self-respect but also a sense of reciprocity and mutual respect, which is of vital importance to the experience of life quality and self-esteem. People's dignity is, thus, painfully threatened at several levels. This raises the urgent question: what is a morally good societal response to this painful experience of indignity resulting in a wish to die? Could the loss of experienced dignity be seen as a sufficient ground for legalizing a so-called 'dignified' assisted death? (Beekman, 2011; Kirchhoffer, 2013). We rather think that the state should prioritize counteracting the feelings of indignity by ensuring that people feel more respected by (care) practices and institutions.

### *The shortcoming of prevailing social imaginaries*

Looking through an ethics of care lens, it shows that the one-sided focus on independency and individuality falls short in appropriately recognizing the full humanity of every human being, leaving people in grave doubt as to whether others would agree that their life is (still) worthwhile. Thinking of vulnerability and dependency as a threat to human status and value does not seem to serve a 'good life' and 'good ageing'. Rather than implicitly affirming or disregarding these ideas, we should probably counter them actively by collectively rethinking existing social imaginaries on dependency and vulnerability within culture. What if it were widely acknowledged that a shared inability to be in total control of our lives is common ground for people (Van Heijst and Leget, 2011)? And what if we would be prepared to acknowledge that dependency does not automatically exclude autonomy but can arise and be strengthened within a context of social relations capable of bringing about the feeling of one's ability and legitimacy to act (Ferrarese, 2011)? How can we create new forms of (intergenerational) solidarity and community, rooted in the realization that each person

should take responsibility for the other because all have an interest in the integrity of their shared life context (Ferrarese, 2011)? Reformulating the ontology of the individual might positively influence the way older people are viewed and how people view themselves. Like the advisory committee, we presume that the Dutch state should actively develop inclusive policies (Schnabel et al., 2016).

## Conclusion

With this analysis, we aim to nuance and critically reflect on the current public debate and exert some influence on recent developments in politics by providing clues for the humanization of society and policy. Based on the needs and concerns of the older people involved, we are of the opinion that the Dutch state should not regulate assisted dying in cases of completed life in old age. The recent proposal to legalize assisted dying for older people who are generally healthy but feel that they have led a so-called ‘completed life’ departs from a neo-liberal paradigm that strongly focuses on self-determination, autonomy and a drive to satisfy individual choices and interests. In contrast, we make a plea for a more communitarian and relational political paradigm that can enrich the current dominant political thinking. The government should primarily protect the lives and safety of its citizens, in particular of its vulnerable citizens, and complying with positive obligations build an inclusive society where people might feel less unneeded, useless and marginalized. In line with the advisory committee (Schnabel et al., 2016), we think that the public debate on alternative moral views on ageing and the place and role of older people in society should be encouraged. Besides, we think that societies and states have a moral responsibility to do whatever can be reasonably done to reduce the level of distrust in care, medicine and society and to minimize the impact of inherent vulnerabilities and situational dependencies on the lives of older people (Dodds, 2014; Scully, 2014).

Although our reflections are primarily based on developments in Dutch society, in which the end-of-life debate continues progressively, in Belgium there is also a public debate as to whether the accumulation of old-age complaints – in Belgium referred to

as poly-pathology – has justly become the second highest indication for euthanasia (Raus et al., 2016). Raus and colleagues pose that euthanasia should not be seen as an appropriate alternative for social problems such as loneliness. Rather, they have made a plea for being heedful not to medicalize old age and for the prioritization of good care and solidarity.

Besides, we presume that our current reflections can contribute more broadly to the moral deliberation on the issue of completed life in old age and to the wider political discussion on ageing in other European societies. Analysing the modern social imaginaries on autonomy, independence and dignity throws a light on how we deal with an ageing population and society’s ‘new forms of malaise’, such as alienation, meaninglessness, feelings of social exclusion and existential loneliness (Taylor, 2004).

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