Supplementary Material. Three case descriptions[#]
Case 2014-78: A woman in her 30s with post-traumatic stress disorder, borderline personality disorder and recurrent depressive episodes, had endured several voluntary and involuntary hospitalizations related to multiple suicide attempts. She underwent "various forms of drug treatments and electroconvulsive therapy, all with mediocre results". The patient's suffering consisted of very low self-esteem, "continuous negative thoughts and negative judgments about herself" and omnipresent "thoughts that she was not worthy to live, could not handle life, and wanted to die". She "experienced nightmares and relived her childhood traumas". A year before her death, after she had made a euthanasia request to her previous therapist, the EAS physician[1] (psychiatrist) took over the treatment with regard to the euthanasia process. A second opinion psychiatrist was consulted, and concluded that the patient was mentally competent. Other therapeutic options were discussed, including mentalization based therapy (MBT), but the patient refused further treatment. The physician "agreed with her as her personality structure was deemed not strong enough to endure such a drastic treatment (MBT) without her suicidal tendencies or depression getting out of control". The physician then consulted an independent (primary care) SCEN-consultant[2], who visited the patient twice within a month prior to her death. The consultant found that the alternatives mentioned were no longer realistic and concluded that due care criteria were met.
Case 2014-82: A woman in her 50s with serious psychiatric pathology for the past 35 years (post-traumatic stress disorder, dissociative disorder, borderline or multiple personality disorder, and extended periods of depression and psychosis), had been hospitalized many times for suicide attempts. She also had chronic migraines and chronic neurological pain after back surgery. She had been treated extensively with psychotropic medication, including opiates and weekly intramuscular antipsychotics. The many drug and psychotherapeutic treatments did not help. The patient's suffering consisted of "continuous intrusions, extreme dissociative symptoms in which 'alters' emerged, compulsive behavior, obsessive thoughts, chronic anxiety, loneliness and conflicts with her relatives". The patient made a euthanasia request to her treating primary care physician and psychiatrist, both of whom could not honor her request. The patient then registered at the End-of-Life Clinic, four months prior to death, where the EAS physician (non-psychiatrist), asked for a second opinion psychiatrist. The psychiatrist advised other pharmacotherapies and electroconvulsive therapy, but these were not tried. The EAS physician then consulted two independent psychiatrists. The first found the patient competent and advised to consult a second psychiatrist. The second psychiatrist stated that "the focus was on psychotherapeutic treatment, which the patient had had exhaustively", concluding that there was no reasonable alternative. The first psychiatric consultant then visited the patient again, five days prior to death, and concluded, based on his two visits, that due care criteria had been met.

Case 2016-78: A man in his 30s with chronic and increasing schizoaffective disorder, personality disorder (mixed cluster B and C) and prominent obsessive-compulsive traits, had had almost the entire protocol for the treatment of schizoaffective depression. He had been "hospitalized multiple types, had tried many types of medication and undergone ECT". Despite being treated by a psychiatrist and a FACT[3] team, this did not reduce the patient's suffering, which consisted of "an empty feeling in his head" and "not being able to think". The patient, who had been an intelligent, sociable man and suffered from his loss of abilities, described "a feeling of painful emptiness and intense pain in the soul, which he couldn't bear and which was overwhelming". The patient had talked about euthanasia previously with his treating physicians, who were not willing to endorse his request. The patient requested euthanasia to the EAS physician (non-psychiatrist) 3.5 months prior to death. This physician consulted an independent psychiatrist, who found that there were remaining pharmacological and psychotherapeutic options. The EAS physician "acknowledged that these were possible in theory, but that with the patient's lack of motivation these couldn't be forced on the patient" and that "psychotherapeutic treatments would have little chance of success because of the patient's low coping capacity". The EAS physician then consulted an independent SCEN-consultant (non-psychiatrist), who visited the patient two weeks prior to death, and concluded that due care criteria were met.

[#]The full case reports can be found on the following link: https://www.euthanasiecommissie.nl/uitspraken-en-uitleg. We have summarized three cases that illustrate some of the key themes from the report. These have been added in response to an anonymous reviewer's suggestion and for the purpose of illustration only. Therefore, these 3 cases cannot be considered a representative sample of the 74 cases included in our study.

Abbreviations:
[1] EAS physician: The physician who was in charge of providing EAS
[2] SCEN: Consultants trained by the Support and Consultation on Euthanasia in the Netherlands (SCEN) organization
[3] FACT: Flexible Assertive Community Treatment