

ARTICLE

Old age rational suicide

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Abstract

In the societal debate surrounding voluntary euthanasia or physician-assisted suicide, there is a concern that older people will be left exposed to any legislation, subject to either faint suggestion or outright coercion from familial or professional carers. Whilst it is critical to take account of older people's potential vulnerability to any current or proposed assisted suicide legislation, there is a parallel strand of research exploring another relationship which older people can have with this debate: one of activism. Sociological research has shown that older people make up the "rank and file" of those active within the right-to-die movement. One of the stated motivations of some older people requesting hastened death has been that, in spite of an absence of life-threatening disease, they feel "tired of life" or that they have lived a "completed life" and feel ready to die. The notion of suicide for reasons of longevity and being tired of life are becoming increasingly significant given the fact of global ageing. This article brings together empirical and theoretical research on the phenomenon of old age rational suicide in order to develop an underexplored area in both the sociology of death and the sociology of ageing.

1 | INTRODUCTION

As societal debates about assisted suicide or the so-called "right-to-die" gather pace around the world, they have generally focused on whether or not people living with terminal or life-limiting disease have a right to request help to die from their physician as a way to relieve intractable suffering (McInerney, 2000; Lewis, 2007; World Federation of Right to Die Societies, n.d.). For such persons, assisted suicide, where a doctor prescribes a lethal drug to a patient, or voluntary euthanasia, where a doctor administers a lethal drug to a patient, is now a legal option in the Netherlands, Belgium, Luxembourg, Switzerland, a number of US states, and in Canada. However, even in these jurisdictions, for older people who do not have a diagnosable life-limiting illness but who may wish to die because of accumulated age-related losses, it is much more difficult to receive lawful assistance to die.¹ Although older people are free to take their own life without legal sanction,² if they are assisted in the act or the planning of the act by either a medical professional or a lay person, then their assistor may face a criminal prosecution.

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Globally, statistics consistently show that suicide rates are higher amongst people over 70 than any other age group and that those planning suicide often give no warning of their intention or request help (WHO, 2014). There is little agreement about the reasons why older people are at the highest risk of completed suicide (Kellehear, 2007, p. 229). Clearly, some of the most common drivers of suicide—chronic illness, functional disability, and social isolation—can become more acute in later life. Although some older people who contemplate suicide will have a clinically diagnosable and potentially treatable psychiatric illness such as depression, other people will arrive at the decision to take their own life following a long process of deliberation and a holistic assessment of their current and/or future circumstances and quality of life. Nonimpulsive suicide driven by what is perceived to be an irremediable poor quality of life and not prompted by an underlying psychiatric illness is what is known in the right-to-die movement as “rational suicide” (Werth, 1999). When the reasons for rational suicide are related specifically to the experiences of old age, the phenomenon has been termed “old age rational suicide” (c.f., McCue & Balasubramaniam, 2017; Society for Old Age Rational Suicide, n.d.).

Within the worldwide right-to-die movement, the primary goal of which is to legalise a form of medical assistance with suicide, discussion of and support for old age rational suicide occupies only the fringes of the debate (Richards, 2012). This is because people with a terminal or life-limiting disease are seen as having a more legitimate and ethically valid claim to accessing help to die than those people whose suffering stems from the more diffuse experiences of old age. The main reason for this is the idea that if a person is already deemed to be dying,³ then it is less ethically problematic to hasten their death. Severe physical suffering is also deemed a more justifiable reason for helping to end someone's life than psychological or existential suffering, because it is deemed harder to objectively verify, potentially remediable, and therefore overall less hopeless (Ost, 2010; Raus & Sterckx, 2015).

There are also concerns in many of the societies where the issue of assisted suicide is debated that older people are potentially more vulnerable than other groups to any proposed legislation because they commonly have care needs that place them in a relationship of dependency with familial and/or professional carers. There is a fear that a small number of carers, motivated by the prospect of financial gain or in order to be relieved of the burden of caring, might be in a position to encourage (however subtly) the older person to make use of the legislation. Given all of these factors, it has arguably been more politically expedient for the proassisted suicide lobbies in Europe and America to restrict their demands for legalisation to those who are already diagnosed as dying.⁴ Repeated opinion polls also suggest that restricting assistance to those suffering from a life-limiting illness wins the broadest based support across the general population (Adetunji, 2011; Park & Clery, 2008). Even in countries that have legalised assisted suicide, such as the Netherlands, physicians have been reluctant to help older people who want to die for reasons of nonphysical suffering. The main reason for this is physicians' doubts over the unbearable and hopeless nature of nonphysical suffering (Bolt, Snijdwind, Willems, van der Heide, & Onwuteaka-Philipsen, 2015; Rurup et al., 2005).

However, keeping all of these different rights claims separate in the public imagination has not proved a simple task. In the UK, a number of older celebrities, such as TV cook Mary Berry, actress Joan Collins, and entertainers Cilla Black and Bruce Forsythe, have all called publicly for the legalisation of assisted suicide in order to avoid age-related decline (Methven, 2014; Moodie, 2015; Pleasance, 2015; Plunket, 2014). Mary Berry, for example, was quoted as saying that she had “no desire to be a centenarian” and would rather her children helped her to die if she became too much of a burden for them (Plunket, 2014). There have also been a number of well publicised cases of Britons travelling to Switzerland for an assisted suicide for reasons relating to old age rather than terminal illness (Allen & Wilson, 2015; Donnelly, 2015; Doughty, 2011). So although right-to-die campaigners might want to keep separate the requests of older people who have a specific age-related wish to die from the requests of those who wish to die because they are suffering from a life-limiting disease, in reality, the two issues remain firmly intertwined, both in terms of the public debate and, arguably, the underpinning philosophical principles of compassion (through relief of suffering in all its forms) and autonomy (Ost & Mullock, 2011).

In this article, I aim to elucidate the central issues in the debate about old age rational suicide by bringing together a selection of empirical and theoretical works in what is an underexplored area in both the sociology of death and the sociology of ageing. In light of the unprecedented ageing of the world's population and a significant increase in longevity, it is essential that we think about the processes of ageing and dying together rather than supporting an

artificial separation designed to support a mantra of “successful” ageing (Gott & Ingleton, 2011). Only if we acknowledge that ageing and dying are a continuum can we start to imagine how the struggles of those in the “fourth” age might influence their thoughts about their future dying. There are many cultural influences on older people who have an age-related desire to die, not least ingrained ageist attitudes, and it is my intention in this article to emphasise that nobody makes the decision to hasten their own death in a cultural vacuum. Yet, these attitudes necessarily interact with and are informed by the physical realities of bodily ageing and decline, as well as an unavoidable position in the life course (that is, nearing the end). All of these factors must be taken into account when determining how to respond to individuals with an age-related wish to die.

The main goal of this work is to synthesise knowledge from different fields in a way that has not been done before. First, I will outline the concept of rational suicide and briefly summarise some of the key philosophical arguments which support the concept and those which oppose it. I will then give some consideration to the underlying reasons why someone in advanced old age might want to hasten their own death by building up a picture of the lifeworlds of the oldest old. There is (sadly) a dearth of ethnographically rich accounts of these fragile lifeworlds, but I analyse the few useful accounts that currently exist. This will lead to a discussion of how advanced old age—the so-called fourth age of life—is perceived by other ages in the lifecourse, specifically those in the “third” age, and the influence of ageist cultural attitudes on such perceptions. Subsequently, I move into a discussion about the end of life care context for frail older people, dubbed the “disadvantaged dying” because of a lack of access to palliative care services. Although there is a medical impetus to extend life wherever the medical technologies and procedures exist to do so (Kaufman, 2015), there has been little societal consideration of the profound effects (both practical and existential) of doing so. Finally, I move back into philosophical territory, and consider the concept of the “completed life” and the loss of meaning and purpose, which can afflict very frail, very elderly people and the significance of this as a motivation for suicide.

2 | OLDER PEOPLE AND RATIONAL SUICIDE—WHAT MAKES IT RATIONAL?

Adults aged 70 and older have the highest rates of death by suicide in most regions of the world (WHO, 2014). Suicide attempts amongst older people also have more lethality, that is, there are fewer attempted suicides and more completed suicides than amongst younger cohorts. Research suggests that rather than being a “cry for help,” older people who attempt suicide show a determination to die (Conwell et al., 1998). Reasons for suicide amongst older cohorts can be the same as for younger cohorts—psychiatric illness, lack of social connectedness, physical illness, and poor subjective sleep quality and insomnia (Stanley, Hom, Rogers, Hagan, & Joiner, 2016). The incidences of chronic illness, social isolation, and insomnia are all known to increase as a person ages thereby increasing the motivation for suicide. Psychiatric illness, particularly depression, represents the biggest risk factor. However, as Stanley et al. (2016) highlight, the vast majority of older adults who are depressed neither think about suicide nor attempt suicide. This points to the fact that in the vast majority of the scientific and psychological literature on suicide in later life, the act and the reasons motivating the act tend to be seen as abnormal and thus pathologised (c.f., Sachs-Ericsson, Van, & Zarit, 2016). In other words, there is a presumption underlying much of this literature that suicide and thoughts of suicide (what is known as “suicide ideation”) are bad for the individual and for society and that every effort should be made to identify risk factors and develop appropriate preventative strategies.

Clearly, all efforts should be made by the health and social care system to identify and treat depression, regardless of a person's age. But we should not assume that all expressed age-related wishes to die stem from an underlying pathology.⁵ Indeed, there is some evidence to suggest that many older adults with suicidal thoughts do not meet the criteria for clinical depression or anxiety (Corna, Cairney, & Streiner, 2010). The rationality of the decision to take one's own life for reasons relating to advanced old age is a topic which is openly debated in British right-to-die groups where the majority of activists are themselves older (Judd & Seale, 2011; Richards, 2012). Many right-to-die supporters hold the view that we must all die at some point, the vast majority of us will die in old age,⁶ some people would

like to exercise control over when and under what circumstances their death occurs, and such a wish is reasonable and should not be pathologised.

Accepting that, under certain limited circumstances, suicide could be considered rational, what would be the defining theoretical criteria? Werth (1999, p. 5) delineates the following criteria, which I advise readers not to treat as a crude checklist but rather a list of issues for consideration. How far an individual fulfils these criteria will no doubt be considered by doctors in jurisdictions where euthanasia or physician-assisted suicide is lawful, either explicitly in order to comply with the law, or implicitly in order to satisfy their own conscience.

1. The person considering suicide has an unremitting “hopeless” condition. Hopeless conditions include, but are not necessarily limited to, terminal illnesses, severe physical or psychological pain, physically or mentally debilitating or deteriorating conditions, or *a quality of life no longer acceptable to the individual* (emphasis added).
2. The person makes the decision as a free choice (i.e., is not pressured by others to choose suicide).
3. The person has engaged in a sound decision-making process. This process should include the following:
 - a. Consultation with a mental health professional who can make an assessment of mental competence (which would include the absence of treatable major depression);
 - b. Nonimpulsive consideration of all alternatives;
 - c. Consideration of the congruence of the act with one’s personal values;
 - d. Consideration of the impact on significant others;
 - e. Consultation with objective others (e.g., medical and religious professionals) and with significant others.

Many of Werth’s (1999) criteria are consistent with the statutory requirements in many of the countries which have legalised euthanasia or physician-assisted suicide. They have been refined and reiterated over years of debate in the right-to-die movement such that some commentators have tried to develop a formal test which could be applied to assess and provide clinical assurance as to the rationality of someone’s decision to die (Stewart, Peisah, & Draper, 2011).

The issue of whether or not a person’s suicide is deemed a reasonable or rational response to the situation in which they find themselves in old age is a matter of perspective and relates to the prevalent social attitudes and historical traditions of the society in question (MacIntyre, 1988, p. 6). The idea of what constitutes a hopeless situation, the first of Werth’s (1999) criteria, is often a matter of perspective depending on cultural expectations about the good life. Some philosophers have argued that although a suicide may be considered rational in that there is a fit between the person’s underlying values and their proposed course of action, this does not mean that it can ever be considered reasonable for a society to accept those underlying values. For some, suicide will always be counter to the interests of society as a whole and do “harm to those of us who remain” (Callahan, 1999:26). Other philosophers hold a different view that if an individual is precluded by their pain from experiencing and enjoying anything else in their life; if the act of suicide will prevent the person from experiencing any further harm; and if the act is in accordance with their “deepest personal, moral, or aesthetic convictions,” then it can be considered both a rational and a reasonable act (Battin, 1999).

Van Wijngaarden and colleagues (2016, p. 6) question the rationality underpinning the decision making of the 25 older people (70+) they interviewed in the Netherlands who all expressed a wish to die. They argue that these individuals’ thoughts of suicide were just as often driven by “bodily or emotional compulsions” as “rational, deductive calculation.” My own view is that we should not fall prey to a false binary distinction between rationality on the one hand and emotions on the other. For a long time, researchers viewed decision making as a purely cognitive process. But it has since been extensively argued that emotions actually serve an essential function in coordinating people’s behaviour and influencing their decision making and cannot be extracted from that process (Loewenstein & Lerner, 2003). People decide what to do and how to act based on the likely emotional impact of their actions as much as anything else. This might be the emotional impact for themselves as well as the emotional impact on others. Van Wijngaarden and colleagues (2016) touch on this when they discuss the emotional yo-yoing of their participants as they worked

through their fears and anxieties. For me, the assessment of whether or not a suicide can be considered rational is not to prove that the decision was arrived at without any emotional ambivalences, but rather whether, all things considered, there might be an “overlapping consensus” (Rawls, 1993) as to the “reasonableness” of the decision.

These are complicated and long-standing philosophical debates that will not be resolved here. Suffice to say that it is a contentious issue, not least because to label a decision as rational, it appears that one is morally endorsing that decision. In the next section, I turn to issues of motivation, which are key to understanding these phenomena. I also look at what the research evidence shows about the day-to-day life of some of the “oldest old.”

3 | THE LIFEWORLDS OF THE OLDEST OLD

In their review of the existing literature on the subject, Van Wijngaarden and colleagues (2014) identify a number of experiences and motivations common amongst older people without a psychiatric illness who have expressed a wish to die. Accumulated and irreversible age-related losses—physical, social, and mental—play a crucial role. But the personality and coping strategies of individuals and the social support available to them are also significant in mediating these age-related losses. The researchers argue that the older respondents in many of the studies they reviewed seemed to be undergoing a “natural mourning process,” which made their wish to die understandable and justifiable rather than the result of a pathology such as clinical depression (2014). In their own empirical study carried out in the Netherlands, Van Wijngaarden and colleagues (2015) describe their research participants as being, in the main, “outspoken, proactive⁷ people who highly value their independence ... and who want to maintain control over their own life” (2015, p. 260). The researchers found that all of their interviewees felt disconnected from their present day-to-day existence. Some or all felt a deep sense of loneliness, of “not mattering,” of being unable to express their individuality through engaging in activities which were important to them, of a multidimensional tiredness, and of an aversion towards dependence. In the researchers’ small purposive sample of 25, only three interviewees were found to have depression, as measured using a standardised screening tool.

A number of ethnographic studies have tried to depict the lifeworlds of the oldest old in western societies, where frailty and thoughts of death often loom large (c.f., Hazan, 1980; Myerhoff, 1980). More recent phenomenological accounts provide some insight into the incremental losses and daily struggles of frail older people in the UK. Nicholson, Meyer, Flatley, Holman, and Lowton (2012), for example, interviewed 17 people aged 86–102, who were still living independently. For the individuals interviewed, the challenges of decreased physical and social mobility made social connections increasingly hard to sustain. People were concerned about the security of their home environment given their frail state, they spoke of their dislike of the professionalised care they received, and of the sadness they felt at the many other losses experienced—bereavement, loss of abilities, etc. They also experienced a heightened feeling of uncertainty as to how they would cope with further decline, loss of independence, and separation from society.

A similar qualitative research study with the oldest old (42 people, aged 95–101) also found that participants were living day-to-day (Fleming, Farquhar, Cambridge City over-75s Cohort (CC75C) study collaboration, Brayne, & Barclay, 2016). These participants were asked explicitly about their thoughts on death and some said that they felt their quality of life was so poor that they felt ready to die: “I’m ready to go,” “I wish I could snuff it,” and “I wish I wasn’t here.” As this type of in-depth qualitative research reveals, the accumulated vulnerabilities of the oldest old can make day-to-day living a constant struggle. Although it is important to stress that not all thoughts of death translate into suicidal impulses or actions, it is clearly the case that for some, the unavoidable dependencies experienced in the fourth age of life evoke strong feelings of aversion and can contribute to a desire to hasten death (Van Wijngaarden, Leget, & Goossens, 2015). Although this aversion can be felt by those already dependent on others in their day-to-day living, it can also be felt prospectively by those contemplating (probable) future dependency. To this extent, cultural beliefs and attitudes about the fourth age of life are equally important as lived experiences for understanding why an older person might want to bring about their own death.

4 | CULTURAL FEARS ABOUT THE FOURTH AGE

The views of British TV celebrities, such as cook Mary Berry and entertainer Bruce Forsythe who have publicly called for the option of assisted suicide for older people with dementia, or for older people who feel they have become a burden to family, can be seen as indicative of more widely held cultural views (and fears) about "old" old age. For some, to accept that it might be rational or reasonable for an older person to want to die for reasons related solely to their age would be to endorse dangerous ageist attitudes (c.f., O'Connell, Chin, Cunningham, & Lawlor, 2004). To even acknowledge that the wishes of such individuals might be justifiable, let alone endorse actively assisting them with their suicide, would be to cast judgment on the quality of life of older people and would be to deem their lives potentially not worth living. Further still, if any assisted suicide legislation were passed, it would leave older people, who are often in a position of dependency vis-à-vis familial or professional carers, vulnerable to either faint suggestion or outright coercion (c.f. Mumford, 2015). The alternative view, however, is that not to acknowledge the multifactorial suffering that is specific to people in the fourth age of life and not to offer the same assistance with suicide as you would someone with a diagnosable terminal illness is in itself an ageist response (Van der Geest & Niekamp, 2003). Existential suffering resulting from accumulated age-related losses and from a feeling that one has "lived too long" can be just as unbearable⁸ as physical suffering stemming from a diagnosable terminal illness, so the argument goes. To interrogate further the influence of ageist values on this debate, I turn now to sociological discussions about the fourth age of life.

The baby boomers (those born in the immediate post-war period) who have already entered what is termed the third age of life (Laslett, 1996) are starting to contemplate what life in the fourth age might be like. The third age is defined as that period in the lifecourse when the responsibilities of work and family are shed and new opportunities for leisure and self-actualisation present themselves (Laslett, 1996). It has come to be represented as a period of active, healthy, and successful ageing (WHO, 2002). But many in this post-war baby-boomer generation have now begun to witness family and friends of earlier generations ageing and dying, and this has had an influence on their views about their own old age, and their death in old age (Judd & Seale, 2011). Specifically, many have developed an acute fear of cognitive decline because of the loss of personhood this is perceived to entail (Cantegreil-Kallen & Pin, 2012; Suhr & Kinkela, 2007). In the UK, a national poll showed that people (of all ages) fear developing dementia more than any other disease, including cancer (Alzheimer's Research Trust, 2008). So whilst this post-war generation pioneered the active ageing movement and has been at the forefront of challenging the marginalisation of older people in Euro-American societies, it has done so by rejecting an earlier cultural narrative about bodily decline and senility and by "refusing to wear the death mask of old age" (Hazan 2011, p. 1,130). In a sense, the success of the active ageing movement has meant that those older people who are increasingly impaired by chronic illness and functional decline continue to be marginalised or "othered" by younger cohorts, including those in the third age:

... the fourth age emerges as a re-imagined old age where all the undesirable elements of later life cluster together to create a symbolic other on the margins of everyday life (Higgs & Gilleard, 2015:viii).

In Van Wijngaarden and colleagues' study of the death wishes of older people, fear of dependence featured prominently. Interviewees regarded involuntary dependence as an "unacceptable, abhorrent condition devoid of any dignity" and "utterly incongruous with their idea of who they are" (2015, p. 262). As one interviewee commented "gaunt and half dead, pointlessly driven around in a wheelchair ... it is a stage of life I simply don't want to go through" (Van Wijngaarden et al., 2015, p. 262). The "stage of life" identified by this man is the imagined fourth age where frailty, vulnerability, and lack of personhood are seen to coalesce (Higgs & Gilleard, 2015). In a case reported in the British media in 2015, two Scottish cousins chose to travel to Switzerland for assistance with their (double) suicide in order to avoid a move into a care home (Templeton, 2015). To many, institutionalisation signifies loss of independence more acutely than any other life transition and is a key concern for many older people nearing the end of their life (Kendall et al., 2015).

Hearing such stories prompts the question of whether such people's death decisions are prompted by present suffering or fears of future suffering. Clearly, uncertainty about future living arrangements and future quality of death play a part in people's decision to end their own life or to opt for an assisted suicide (Richards & Rotter, 2013). In this sense, the baby boomer generation who have "never had it so good"⁹ and who are accustomed to having control over many aspects of their lives are perhaps more resistant than previous generations to the dependence and vulnerability characteristic of "old" old age, whether that be a real or simply imagined condition.

Undoubtedly, ageist sentiments and assumptions are part of the cultural backdrop influencing debates about old age rational suicide. For some, Euro-American attitudes towards dependency and bodily decline are the main driving force behind the right-to-die movement more generally. However, what must be remembered in this debate is that (a) older people are not a homogenous group and are likely to have different life circumstances, personalities, and biographies, which can coalesce to give rise to a desire to die, and (b) the reasons behind people's wishes to die are multifactorial. In other words, a person's own holistic assessment of their past life and likely future existence will be the most likely basis of a "rational" decision to die.

5 | THE DISADVANTAGED DYING

Equally important in the debate about old age rational suicide is the end of life care context in which older people find themselves, the topic to which I now turn.

There is clearly a continuum between "living with" and "dying of" frailty and old age. Dying in old age often follows a trajectory which does not conform to the "dominant myth of dying," that is, that dying is a short, discrete period of time where the dying neatly wrap life up and then go (Lynn, 2005). As the study by Nicholson and colleagues (2012) showed, many elderly people will instead experience an incremental process of deterioration over many months or years leading up to death. According to Lynn (2005), in America, approximately 40% of people are likely to die in this way, needing years of personal care in the preceding period. And with a proliferation of life-extending medical procedures offered at ever older ages, this trend of pushing death further and further forward into advanced old age is set to continue (Kaufman, 2015). Although older people have the freedom to decline life-extending procedures¹⁰ (and indeed the oncologist and bioethicist Emanuel (2014) suggests that those over 75 should decline them), to do so is to swim against a cultural tide that promises hope (through medical technology), an open ended future, and a chance to delay death ad infinitum. There is a compulsion to "add time" without serious reflection on what that might mean in terms of how that time will be spent (Kaufman, 2010). Equally, if a person survives cancer or heart disease, then it is not unlikely that he or she will die of or with dementia, the incidence of which increases with age, and which will inevitably limit the individual's control over all aspects of ageing and dying.

So although life expectancy for those living in western societies is higher than ever before in human history—a fact which should be celebrated—this has had the effect of making it difficult for medical professionals to admit when someone is dying and to know where to draw the line in terms of offering more treatment (Gwande, 2014; Kaufman, 2015). The medical profession's (and wider society's) failure to recognise the continuum between living with and dying of frailty in old age has negatively affected the way in which end-of-life care is mobilised for older people who are dying with multiple conditions but without a diagnosable terminal illness.

It is known that older people are increasingly likely to have unplanned hospital admissions as their health deteriorates in the last year of life. In the UK, research suggests that at any one time, nearly 30% of hospital inpatients are likely to die within the next year (Clark et al., 2014; Gott et al., 2013) and that for inpatients who are over 85 years old, this proportion increases to 45% (Clark et al., 2014). Research also shows that, despite being in the last year of life, older people tend not to be referred to specialist palliative care services (Burt & Raine, 2006) or to receive care at home that would enable them to die at home (Gomes & Higginson, 2008). Instead, they are often transferred to hospital at the last minute or experience a "revolving door" scenario with repeated hospital

admissions in the last months of life (Gill, Gahbauer, Han, & Allore, 2015). Despite all of this research, frail older people very often do not receive the palliative care that they need and do not die in their preferred place of care leading researchers to label them the “disadvantaged dying” (Gott & Ingleton, 2011; Seymour et al., 2005; Harris, 1990).

So, on the one hand, the “naturalness” or “timeliness” of death in old age is no longer taken for granted given the procedures and interventions which are on offer to prolong life. Yet, on the other hand, when older people are at the end of their life, there appears to be age discrimination at play in terms of their access to adequate palliative care and being enabled to die at home. Perhaps both these phenomenon are part of the same picture: society’s reluctance to acknowledge when a person of advanced age is dying of old age. This is nowhere more stark than in the reporting of deaths on death certificates in the UK. Doctors are advised by state procedures not to report old age as the sole cause of death except in very limited circumstances and only when the individual is over 80 years old. This also comes with the warning “to be aware that the patient’s family may not regard old age as an adequate explanation for their relative’s death and may request further investigation” (The General Register Office for England and Wales, 2010).

On a final note, could it be argued that older people are also the “disadvantaged dying” when it comes to access to physician-assisted suicide or euthanasia? There are only a handful of jurisdictions where gaining assistance with suicide without a diagnosable life-limiting disease is possible. There are privately run right-to-die organisations in Switzerland, which offer assistance to foreign nationals without a diagnosable life-limiting disease, but there are many barriers to access, not least the financial cost. On a practical level, options for taking one’s own life when old and frail are also limited. One option is the voluntary refusal of food and fluid, but the jury is still out on how painful this option is with much of the evidence suggesting that it is a course of action that needs to be “palliated” by someone (e.g., comfort measures such as regular mouth care; Quill & Byock, 2000; Richards, 2015). In other words, an individual taking this course of action needs to secure the support of someone else who is both willing and able to care for them in their dying days.

In the final section of my article, I move away from the difficulties of saying “no” to life-prolonging measures or to ensuring that one has a good death when one is old and frail. Instead, I turn to the existential questions raised by this issue of old age rational suicide, encapsulated in the terms “tired of life” or “completed life.”

6 | A COMPLETED LIFE

In the Netherlands, where euthanasia and physician-assisted suicide have been legalised since 2002, a “Completed Life” campaign was initiated in 2010 by the country’s largest right-to-die organisation, the NVVE. The aim behind this campaign was to open up a debate about extending access to physician-assisted suicide and euthanasia for elderly people “suffering from the prospect of having to continue to live in such a way that there is little or no more quality of life ... without the main cause for this being a somatic (physical) or mental condition” (Doctors’ organisation KNMG quoted in NVVE, 2016). The campaign led the way for a Citizen’s Initiative called “Out of Free Will,” which ultimately collected 116,871 signatures from supporters. Research suggests that a growing minority of the Dutch population supports extending assistance with suicide to people over 70 who do not have a medically diagnosable disease (Buiting, 2012).

It is useful to consider the list of factors given by the NVVE (2016: p. 25-26), which might lead to a person becoming weary with life:

- non-life-threatening conditions such as physical deterioration (trouble walking, seeing, hearing, tiredness, feeling listless, and incontinence) resulting in an inability to perform activities that make life worthwhile;
- loss of independence and personal dignity;
- dependant on professional care and/or care from family and loved ones;

- loss of status and control over one's own life;
- loss of one's social network as a result of the death of a partner and/or children, friends, and neighbours;
- loss of meaning and purpose;
- detachment from society (connection with people, material matters, and "today's world" no longer exists);
- afraid of the future; and
- no prospects for the future.

Some of these factors are the same or similar to the motivating factors I discussed earlier in this article. However, I suggest that feeling a "loss of meaning and purpose" and that one has "no prospects for the future" are existential factors, which are worth considering separately in more depth.

The Danish philosopher Kierkegaard once wrote that "given a possibility, the desperate man breathes once more, he revives again, for without possibility a man cannot, as it were, draw breath" (2013[1843]:311). The sentiment expressed here is that to feel a sense of satisfaction with life a person needs to feel meaning and purpose, and that they have some future possibility. Some of the older people interviewed by Van Wijngaarden and colleagues (2015) felt they were no longer able to express their individuality because they had lost the ability to undertake worthwhile projects or there was a lack of sharing and gaining new ideas to enrich their life. "Worthwhile projects" extended to a continuing ability to care for others, rather than just being the "cared for."

In Emanuel's (2014) provocative call for everyone over the age of 75 to consider rejecting life-prolonging treatment and medication, part of his argument is based on the idea that by 75, "creativity, originality, and productivity are pretty much gone for the vast, vast majority of us" and that this leads to a loss of meaning in life. Although our ambitions and expectations are bound to be constricted as we age, writes Emanuel, there may come a time when they become so constricted that one might wonder what was the point of continued existence? Into this mix of existential reasons for wanting to decide on the timing of one's own death, we should add consideration of one's legacy. Emanuel (2014) writes that he wants to leave his progeny with memories of his vitality and vivacity, not of his frailty and decline. Similarly, Gill Pharaoh, who made headlines in the UK when she travelled to Switzerland for an assisted suicide, wanted people to "remember me as I am now – a bit worn around the edges and not quite at my peak, but still recognizably me!" (Donnelly, 2015). Curating our legacy—trying to control how we are remembered—is important to many people and is linked to this notion of "completeness." A person may feel that the story of their life has come to an end and may long for their biographical life to coincide neatly with their biological life, to avoid a sense of living too long or experiencing a social death (Lawton, 2000). Ultimately, the mode of our death becomes important for our dying aesthetic. For some people, the way they die is a reflection of their identity: how they see themselves and how they want others to remember them (Richards, 2016).

In reality, it is likely that the incidence of feeling one has lived a completed life is far higher than the incidence of old age rational suicide. In other words, it takes a certain type of personality, arguably a rather extreme personality, to convert a commonly held sentiment into a rare form of action. But the issue of wanting to control the narrative arc of one's life, although important throughout life, can become amplified at the end when one has more time to reassess one's biography (Johnson, 2009).

7 | CONCLUSION

The desire to end one's own life for reasons relating to advanced age arises from an amalgamation of complex and intersecting factors. These factors can include, but are not limited to, psychological issues (most notably depression); physiological and cognitive decline; loss of independence; loneliness; loss of purpose and meaning; and a feeling that one's life is complete and should rightly be at an end. Many of these issues are potentially remediable, for example, through screening for and treatment of depression or through increasing social support to lonely older people

(O'Connell et al., 2004). However, not all motivating factors are open to being remedied. For some, a feeling that their biography is complete can be the central motivation in their decision to end their own life. For others, the loss (or feared loss) of independence resulting from declining physical and cognitive health is also something which cannot be remedied and is considered sufficient reason by some for wanting to end their own life.

In this article, I have argued that not all suicide ideation or planning for suicide should be unquestioningly pathologised. Rather I suggest that we should acknowledge that wishing for death in later life is a normative response to nearing the end of life and to coping with the extensive challenges of "old" old age (to answer a question posed by Van Orden & Conwell, 2016). I also argue that we should accept that death is not a tragedy in every situation. Rather, it is the manner of our death—perhaps in hospital with extraordinary and invasive measures taken to try to extend our (already long) life (Cardona-Morrell et al., 2016) or in a care home without the requisite pain relief (Smalbrugge, Jongenelis, Pot, Beekman, & Eefsting, 2007)—which can be the real tragedy. For many of us, it is important that the manner in which we die corresponds to the embodied values by which we have lived our lives. Although the success of active ageing campaigns in the third age of life has undoubtedly had the side effect of othering life in the fourth age (Higgs & Gilleard, 2015), this does not necessarily mean that the phenomenon of old age rational suicide can be taken as evidence of how such othering has become internalised to deadly effect. Instead, planning for suicide in the fourth age of life might be about honestly facing up to a different other—death. The philosopher Mary Warnock (2009), a long-time supporter of old age rational suicide, once wrote that what many older people truly fear is not frailty and dependence per se but "a life bereft of any of the pleasures they value." There is a middle ground between, on the one hand, pathologising and, on the other, facilitating older people's plans for hastening their death. And that is to acknowledge that older people's values matter, in all their diversity, and that it is understandable that someone might want to celebrate a good life followed by a good death and reject a life lived without pleasure in the specter of a future "bad death."

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NOTES

- ¹ This is a possibility in Switzerland, the Netherlands, and Belgium—jurisdictions where access to assistance is based on unbearable suffering rather than prognosis from a specific disease.
- ² In the UK, for example, the Suicide Act 1961 decriminalised suicide.
- ³ Some "life-limiting" illnesses in fact do not significantly limit one's life span. Multiple Sclerosis, for example, may only shorten life expectancy by a few months (Rolak, 2003). For many people in their 80s and 90s, life could be considered to be "limited" by virtue of the human lifespan.
- ⁴ In recent legislative proposals put before the English Parliament, a person had to have been given a prognosis of less than 6 months to live in order to qualify for medicalised assistance with their suicide (House of Commons, 2015). Similarly, in all the American states, which have legalised physician-assisted suicide, the person requesting assistance must have a prognosis of less than 6 months.
- ⁵ Indeed, we should perhaps not assume an underlying pathology for any expressed wish to die, regardless of age.
- ⁶ Average life expectancy at birth in England in 2013 is 81 years, but there is some regional disparity across the UK with life expectancy in Scotland dropping to 79 (Newton et al., 2015)
- ⁷ These characteristics might be attributable to the fact that the sample was self selecting.
- ⁸ "Unbearable suffering" is the term used in the due care criteria laid down in the Dutch *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* (2002).
- ⁹ British Prime Minister Harold MacMillan in 1957
- ¹⁰ Such as angioplasty, stents, implantable cardioverter defibrillators, kidney dialysis, transplants etc.

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