On assisted suicide

Thesis by : Hafez Ismaili m'Hamdi

University of Utrecht Applied Ethics Department 2013

Table of Content

Introduction

On 19 October 1991 the NRC Handelsblad published an essay by Huib Drion, the ex-vice president of the Dutch Supreme Court, titled; 'Het zelfgewilde einde van oude mensen.' In this essay he reflected on the desirability of providing lethal drugs to the elderly so they might end their lives if they wish to on a moment and in a place they see best fit[1]. Drion touched on a delicate matter concerning life and death and his article generated a lot of public response. This was to be expected since the question, should we aid elderly in their wish to die, was and still is a notoriously difficult one to answer and has a major impact on many lives.

In the Netherlands there is a broad support for the current euthanasia and assisted suicide policy but there continue to be different views about the justification of this policy[2]. The requirements that are stated in the law can serve as a guideline to understand the legal justification for euthanasia. There are two requirements in the euthanasia law that play a pivotal role in the discussion of euthanasia. First of all there is the notion of autonomy. The autonomy of the patient is safeguarded by making sure that the request for euthanasia is voluntary and well considered[3]. Second of all there is the notion of offering help to those who are suffering, also known as compassion. Compassion can only lead to euthanasia if the doctor has certainty that the patient is suffering unbearably and hopelessly.

But how does the second criterion of unbearable and hopeless suffering, relate to the question whether it should be possible to assist the elderly in the termination of life where the desire to die does not stem from a clear medical disease or condition[4]? What to do when

[1] H. Drion, Het zelfgewilde einde van oude mensen. Balans, Amsterdam 1992, page 11
[2] Handboek gezondheidsrecht H.J.J. Leenen, J.K.M Gevers, J. Legemaate, Bohn Stafleu van Loghum 2007, Page 338
[3] Handboek gezondheidsrecht H.J.J. Leenen, J.K.M Gevers, J. Legemaate, Bohn Stafleu van Loghum 2007, Page 348
[4] KNMG position paper the role of the physician in the voluntary termination of life, Utrecht June 2011, page 10

the suffering of these elderly consists of physical and social deterioration, loneliness of existence, a severe reduction of autonomy, the general dependency on others and a perception that life has become pointless? The doctor has to assess within the medical domain whether the patient is suffering unbearably and hopelessly. Therefore the doctor has to make sure that the above mentioned examples of suffering have a medical base. But can a doctor be expected to be able to evaluate whether the above mentioned subjective notions of suffering have a medical base? This is to say, is it within the possibilities of a doctor to translate and ground these subjective notions of suffering into the requirements of unbearable and hopeless suffering? To be able to answer these questions I will present a short description of the existing euthanasia law and present a couple of leading points of view on the capability or incapability of this law to deal with requests of assisted suicide of the elderly whose request to die does not stem from an evident medical condition. Furthermore I will explore the notion of subjectivity and try to ascertain if subjectivity is as transparent and impenetrable as one might believe. The accessibility of subjective suffering by doctors is of great importance in answering the question whether the subjective notion of suffering can have a medical base.

A group that is pessimistic about the euthanasia law's ability to deal with these requests is the civil initiative Uit Vrije Wil. They hold the opinion that the suffering felt by the elderly, which they call existential suffering, is of another order than the medically based unbearable and hopeless suffering that is required by law to decriminalize the act of euthanasia. They have written a proposition law that would be, according to them, far more effective in dealing with requests for assisted suicide from the elderly, because it respects the subjective constitution of this suffering and gives the notion of autonomy, that is to say the choice to freely decide when one wants to end life, the proper weight. I will be aiming at exploring the soundness of Uit Vrije Wil's claim about the existing euthanasia law and its proposed inability to deal with what they call existential suffering. Furthermore it will be interesting to subject their proposition law to critical scrutiny. They claim that the elderly's right to autonomy should be respected. But does the elderly's right to autonomy really generate a duty towards doctors to aid them in their request for assisted suicide?

Questions concerning life and death deserve all our consideration especially because these types of requests for assistance are more likely to increase than decrease.[5] The gravity and complexity of assisted suicide cannot and should not be reduced to a legal tug of demarcation[6] but should also encompass ideas about the possible scope of the medical domain, the area of expertise of a doctor, the vulnerable position of elderly and the compassion they deserve. These questions and notions converge towards the following question; '*Is Uit Vrije Wil's proposal as described in their manifest and in their proposition law ethically desirable?*'

The Dutch euthanasia law

In 2002 the legal framework was introduced in the Netherlands that regulates under which particular terms a doctor is allowed to terminate the life of a patient.[7] This law is necessary because euthanasia, that is to say, the practice of intentionally ending a life in order to relieve unbearable and hopeless suffering even if it is a doctor who is assisting in suicide, is in conflict with the one of the most elementary rights, namely the right to life. This right is articulated in the 'ECHR' (European Convention on Human Rights.) and therefore it has a supreme legislative authority. This article stipulates that *"Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law"*[8] To accomplish the successful implementation of a law governing euthanasia, the rights described in article 2 of the ECHR have to be respected. Actually, by law euthanasia is still forbidden[9] because it violates article 293 of the Dutch penal law, but a penal exclusion to article 293 has been added to decriminalize the act of euthanasia in a specific set of conditions. This exclusion states that euthanasia is only allowed when a set of requirements are met. The set of requirements that have to be met by a physician is stipulated in 'Wet

[5] KNMG position paper the role of the physician in the voluntary termination of life, Utrecht June 2011, page 11
[6] Idem
[7] Handboek gezondheidsrecht H.J.J. Leenen, J.K.M Gevers, J. Legemaate, Bohn Stafleu van Loghum 2007, Page 338
[8] ECHR Protocol no 11, article 2, Rome 1950
[9] Wetboek Strafrecht , Artikel 293, 294

toetsing levensbeëindiging op verzoek en hulp bij zelfdoding[10].' The criteria that have to be met by the doctor in the case of a euthanasia request are the following:

Artikel 2[11]

1. The prudential requirements, meant in article 293, second lid, Penal law, are such that the doctor:

a. has had the conviction that the request from the patient was voluntary and well considered,

b. has had the conviction that the patient was suffering unbearably and hopelessly,

c. has informed the patient about his or her situation and about his or her prospects,

d. came together with the patient to the conviction that there was no other reasonable solution.

e. has consulted at least one independent doctor, who did see the patient and gave a written judgment about the prudential requirements, meant in parts a until d , and,

f. Has terminated the life or aided in the self-termination the patient's life with medical prudency.

Worth noticing is that the predominant principle of the 'Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding, from here on WTL' is not an articulation of the right to autonomy of patients but is based on the compassion of a doctor for the bleak and desperate situation of the patient[12]. This is to say, this law is intended for the physician not for the patient. The patient doesn't have a right to demand euthanasia from his physician. A patient can merely request euthanasia; it is the physician who ultimately decides what to do with this request. The WTL serves as a guideline to show which criteria have to be met by a physician to not be prosecuted when honoring the euthanasia request of the patient. This claim is supported by the first chapter in the WTL. This chapter serves to clarify descriptions that are formulated in further chapters. When examined, these clarifications are directed to

[10] Toetsing levensbeëindiging op verzoek en hulp bij zelfdoding. Artikel 2
[11] Idem available at http://wetten.overheid.nl/BWBR0012410/geldigheidsdatum_25-05-2013
[12] Keuzewegen naar de dood, Tijdschrift voor Humanistiek 11 ,Ton Vink, 2010, 105-115.

physicians, consultants, counselors and commissions, but the notion of patients and their autonomy is gloriously absent[13]. The autonomy of the patient is introduced in the second chapter under subsection A '*De zorgvuldigheidseisen, bedoeld in artikel 293, tweede lid, Wetboek van Strafrecht, houden in dat de arts: a. de overtuiging heeft gekregen dat er sprake was van een vrijwillig en weloverwogen verzoek van de patiënt,*[14] This subsection states that the request for euthanasia by the patient has to be made voluntarily and be well considered. These requirements are of course in place to safeguard the autonomy of the patient, but the addressee of this law remains the doctor and not the patient. The 'WTL' is a law that unambiguously serves as a judicial justification for the doctor not for the patient in the case of euthanasia. A possible strong intuition that euthanasia is justified by means of autonomy of the patient is one that does not reflect the judicial justification of euthanasia in the Netherlands.

Although a lot more can be said about the euthanasia law now a slight shift will be made to address the main question of this thesis. The euthanasia law seems to be appropriate in dealing with the requests from patients that are suffering from an ailment that is obviously medically classifiable such as cancer. In these cases it can be shown that the suffering is unbearable and without hope because there are proper medical data to back this up. But what about the cases where this is not so obvious? What to do when the suffering of these elderly consists of physical and social deterioration, loneliness of existence, a severe reduction of autonomy, the general dependency on others and a perception that life has become pointless and is only a source of suffering? How about the case of elderly people that feel they have outlived their life and wish to die? Is suffering from life itself enough of a justification to claim that one is suffering unbearably and hopelessly and use the existing euthanasia law to honor the request to die? Between 1998 and 2002 there was a famous case that made it to the Supreme Court that dealt with exactly these questions. It is known as the Brongersma case. Mr. Brongersma turned to his physician dr. Sutorius to help him die because he felt that the condition in which he was living became unbearable for him. The problem was that it wasn't all together clear that the suffering he felt could be medically based and would fit the criteria that are set in the Euthanasia law. Does a doctor have legal

[13] Wet Toetsing levensbeëindiging op verzoek en hulp bij zelfdoding. Artikel 1
[14] Wet Toetsing levensbeëindiging op verzoek en hulp bij zelfdoding. Artikel 2

justification to aid in the suicide in cases where the medical condition of the patient is such that it isn't clear whether the suffering is medically based?

The Brongersma case

On April 1998 the former PvdA- senator E. Brongersma ended his life by taking medicines that were subscribed to him by his physician Dr. Sutorius. Brongersma wasn't in severe physical pain and had no psychiatric ailments, but because of physical and social deterioration, loneliness and his general condition of dependency, life itself became unbearable to him.[15] Was Sutorius acting within the law when he aided Brongersma in his suicide by giving him the lethal pills? And is suffering from life itself, as described above, reason enough to expect aid from a doctor? As to be expected Dr. Sutorius had to justify himself in court.

In 2000 this case came before the Court of Haarlem. The crucial point during the court session was to establish whether Brongersma was suffering hopelessly and unbearably because these were the two criterions that had to be met to claim necessity or force majeure (exclusion from punitive measures because of conflicting duties of the doctor),[16]. Worth noticing is that the current euthanasia law wasn't in force until 2001 but there was jurisprudence that described cases where force majeure was used to exclude the accused from punitive measures. Force majeure was used as a penal exclusion for doctors who assisted in the suicide of patients who were suffering unbearably and hopelessly. The Court ruling was that, first of all, unbearable suffering isn't an unequivocal notion and that the description of the suffering felt by Brongersma could be classified as unbearable. Furthermore there was no indication that Brongersma's situation would improve and therefor it could be assumed that his suffering hopeless. Because, according to the Court, both criteria were met Sutorius was free from all charges. But the Public Prosecution appealed against the Court's ruling because they questioned the Court's conclusion that it was proven that Brongersma was indeed suffering unbearably and hopelessly. The Public

[15] Website NvvE available at http://www.nvve.nl/nvve2/pagina.asp?pagkey=7189
[16] KNMG position paper the role of the physician in the voluntary termination of life, Utrecht June 2011, , page 10

Prosecution claimed that Brongersma was weary of life, a mental state that is outside the domain of medicine to judge. Jurisprudence and the euthanasia law demand that the suffering can be assessable by a doctor and the doctor can only make assessments within the medical domain. Being weary of life is not a medical condition that can be judged by a doctor within the medical domain and therefore neither force majeure nor the current euthanasia law apply.

The Amsterdam Court appointed two experts to judge whether the situation of Brongersma was indeed as claimed by the previous ruling unbearable and hopeless. Both experts reported that the Brongersma's suffering couldn't be properly assessed by a doctor within the medical domain and therefore the Amsterdam Court ruled that neither the force majeure nor the euthanasia law were applicable for this case and Sutorius was found guilty. But although he was found guilty he wasn't penalized because according to the Court *"The deliberation on assisted suicide in case of non- medical suffering is at a premature stage."*[17] In 2001 the Court of Appeal reaffirmed the ruling of the Amsterdam Court.

The 'Commissie Dijkhuis' and the KNMG

The Court's ruling in the Brongersma case raised many questions within and outside the medical world about what the role of the physician should be in the request of assisted suicide of elderly whose wish to die does not stem from a medical condition. Their suffering is not of a somatic nature but it is so to say existential (a notion I will explain in more detail later on). They are suffering from life itself, and the only way to relieve this suffering is to stop living. But it isn't unconceivable that this existential suffering is the result of symptoms associated with old age. Growing older comes with certain symptoms of frailty. It might be possible that these symptoms play a role in the request for assisted suicide. So what is a doctor to do when faced with such a request? The Dijkhuis commission was asked by the KNMG, The Royal Dutch Medical Association, to labor on this question and to formulate their findings in a report that is known as the 'Commissie Dijkhuis rapport[18].'

[17] Website Openbare Ministerie, toelichting hoofdadvocaat-generaal Egbert Myer, available at http://www.om.nl/actueel/de_officier_van/@123530/de_zaak_brongersma/

[18] Commissie Dijkhuis rapport, Utrecht december 2004, page 3,

The report first of all concludes that although the requests for euthanasia by the elderly that are suffering existentially aren't substantial, it is to be expected that these requests will increase greatly within coming years[19]. Physicians claim that a part of these requests are indeed classifiable as suffering that is unbearable and without hope.

The exact border between the medical and non-medical is very hard to establish according to the report. Pain and suffering do not acknowledge the barrier between medical and non-medical. Nor do patients. Physicians have to deal with a great number of patients in their practice, who don't necessarily suffer from a medical ailment or where the medical ailment isn't necessarily the source of suffering.

The Brongersma case demonstrates that requests for euthanasia that are made by elderly who are suffering existentially, needs to be medically based in order to justify the euthanasia. This is to say, the medical domain as purely empirical and scientific lacks the apparatus to understand and process the claim of suffering existentially. Although this approach is fairly unequivocal it remains questionable whether this approach does justice to the presented problem of requests for assisted suicide in the medical practice. Is the medical domain, that is to say the doctors, really that impotent in dealing with these requests? It would be unfair to depict a doctor's consult as a mere classification of pathology of the patient without empathizing with the patient's situation. Of course pathology is very important but it isn't uncommon that doctors also make certain normative claims based on their knowledge and experience. This is why the report questions whether the description of the medical domain that was used by the Supreme Court to reach their verdict is a fair representation of the 'real' medical domain.

The Commissie Dijkhuis proposes that the medical domain should be understood as a domain that isn't without boundaries but includes more than mere empirical and scientific claims about pathology[20]. The medical domain isn't static but dynamic. Added to the physician's formal training the experience gained in daily life work is also valuable. This broader notion of the medical domain also creates the space to address the question of euthanasia in cases of existential suffering. The Commissie Dijkhuis justifies their proposal

[19] Commissie Dijkhuis rapport, Utrecht december 2004, page 37
[20] Commissie Dijkhuis rapport, Utrecht december 2004, page 41

to widen the notion of the medical domain by pointing out that the source of suffering isn't necessarily determining for the amount of suffering felt by the patient.

The Commissie Dijkhuis continues by arguing that the current narrow demarcation of the medical domain given by the legislator does not deal with the given problem[21]. The request for assisted suicide from elderly that suffer existentially is a real one and needs to be dealt with seriously and diligently. The claim that the medical domain isn't able to deal with these requests is an oversimplification of the medical domain all together and it evokes the feeling that the elderly that suffer existentially are not taken seriously. The request for assisted suicide is a real one and closing the legal space to address this problem will not make these requests magically disappear. Especially because it is to be expected that the frequency of these requests is most likely to increase in the years to come. The Commissie Dijkhuis is aware that these requests bring new responsibilities. They acknowledge that the medical domain is not static nor should it be. They claim that, it should develop to deal with new challenges offered by society. These new requests for assisted suicide offer such a challenge. Existential suffering isn't a notion that is alien to doctors. With present experience and possible training the medical domain should be capable of dealing with cases of existential suffering.

For these reasons the Commissie Dijkhuis adviced that the existing conceptual legal framework could suffice in dealing with requests for assisted suicide from elderly that suffer existentially. Although the legislator demands that the two criteria of suffering are met in a request for euthanasia, he does not define how these two criteria are to be determined. It is up to the medical world to define what the medical domain is and to make palpable that the request for euthanasia on grounds of existential suffering can be addressed within this domain. Of course the question will remain whether the legislator and the courts will adopt this wider interpretation of the medical domain in. But if they do not adopt the broader notion of the medical domain, the medical profession could always insist on reevaluating the existing legal framework[22].

[21] Commissie Dijkhuis rapport, Utrecht december 2004 , page 41
[22] Commissie Dijkhuis rapport, Utrecht december 2004, page 44

Also the KNMG, the federation that represents Dutch physicians, has taken position within the debate on existential suffering. They have presented their point of view in their position paper 'the role of the physician in voluntary termination of life.' They ascribe to the role of the physician the care taking of a patient's overall well-being. This encompasses providing guidance to patients who have existential questions arising from their illness, demonstrating empathy and offering palliative care, terminal guidance and emotional comfort[23]. This view of the doctor taking care of the patient's overall well-being does indicate that doctors should always take into consideration the subjective and emotional component that comes with suffering. "*The physician is always responsible for determining the burden of suffering on the patient and what the components of that suffering are, regardless of its source or the way in which the patient characterizes the suffering, and even if the patient's desire to die stems from a sense that his life is 'completed'. The judgment that life is completed – assuming that completion as such exists – is one that a person can only make for himself. Physicians have no role or task to fulfill when it comes to judging if a life is completed. When physicians assess suffering within the framework of ending life, there must always also be a medical basis, meaning a condition that can be defined as a disease or combination of diseases/ailments. A medical classification can aid in assessing the nature of suffering. Distinguishing between the various dimensions of suffering that patients experience is difficult in practice, and these dimensions together can furthermore have a mutually reinforcing effect*[24]". The position paper also demonstrates that an accumulation of geriatric afflictions, including loss of function, that result in progressive deterioration may also qualify as unbearable and hopeless suffering.[25] It seems that the KNMG has approached the conclusions that are made in the Dijkhuis report. The existing euthanasia law offers enough space to deal with requests of assisted suicide from the elderly. But this space isn't unlimited, there has to be a link between the suffering and a medical ailment or a medically classifiable condition. This does not necessarily imply that the medical ailment itself is responsible for the unbearable and hopeless suffering. Medical ailments, such as age related complications, can result in a devaluation of life so that life itself becomes unbearable and

[23] KNMG position paper the role of the physician in the voluntary termination of life, Utrecht June 2011, page 39
[24] Idem
[25] KNMG position paper the role of the physician in the voluntary termination of life, Utrecht June 2011, page 7

results in a request for assisted suicide. The existing euthanasia law is, according to KNMG, sufficient to allow the assistance of suicide in these cases.

Not everybody is optimistic about the ability of the euthanasia law to deal with requests for assisted suicide. The civil initiative 'Uit Vrije Wil' has a different reading on what the euthanasia law can and cannot include. In the question of assisted suicide Uit Vrije Wil claims that the euthanasia law is not sufficient to respect the wishes of the elderly who are suffering existentially and have a concluded life. So why are they less optimistic about the existing euthanasia law?

Uit vrije wil

The well- known voice that pleas for a legally based help for the elderly who wish to die because they are done living and suffer existentially is the civil initiative 'Uit Vrije Wil' that was founded by Yvonne van Baarle and has its current form since 2009[26]. They adopt the point of view that assisting in the suicide of the elderly is forbidden within the current euthanasia law.[27] So why do they adopt this position? The name 'Uit vrije wil' strongly depicts one of the initiative's core values which is autonomy (Uit Vrije Wil meaning out of free will). It is for every free human to decide about the way they want to live and the way they want to die. Therefore when the elderly come to the conclusion that life is not worth living anymore they deserve to be taken serious. When they ask for professional help in the form of assisted suicide this request should be honored while taking into consideration certain requirements of prudency. Specially trained care givers would be designated to deal with these requests of assisted suicide. These caregivers can be psychologists, mental care givers, and physicians but physicians aren't necessarily included nor excluded. These care givers have the task to make sure the request for assisted suicide meets a set of requirements. The requirements that have to be met are that the request should be voluntary, well-considered, enduring, competent, authentic and the elder who requests the assistance has to be a Dutch citizen and 70 years or older.[28] UVW feels that the elderly

[26] Uit Vrije Wil waardig sterven op hoge leeftijd, Yvonne van Baarle, pagina 9, Boom 2011
[27] Idem
[28] Proeve van wet, Jit Peters Eugene Sutorius, Uit Vrije wil, pagina 46, Boom 2011

should receive aid in the request for assisted suicide. It is the elderly's own decision to determine whether life is worth living or not. And if they decide living life is reduced to a source of suffering they deserve help because the way to a humane and respectful end is not available for them. They need compassion from society to open the way to the drugs they need so they don't need to take their life in a horrific manner such as jumping in front of a train, death by suffocation, or any other inhumane way of suicide. So the two pillars, if you will, of UVW are the respect for the autonomy of the elderly on the one hand and compassion from society on the other.

When euthanasia is requested by law there is a requirement of proof required that the suffering is based on a medically classifiable disease or condition. But reaching the conclusion of life and suffering existentially is not a medical condition according to the civil initiative[29]. A concluded life and suffering existentially are complex phenomenon that cannot be fully understood within the language of the medical domain. The NRC handelsblad, a prominent Dutch paper, published a small piece by Huib Drion that elaborates on the complexity of this phenomenon. *The problem concerning the wish to die from the elderly is not a medical problem. Dignity, the need for independence and the willingness to burden next of kin with their elderly years are determining factors in their judgment*[30].

So far UVW tries to make palpable that existential suffering and having a concluded life are distinct from suffering that is caused by a medical condition. But are these notions really as distinct as UVW wants us to believe? The fact that existential suffering cannot be completely reduced into a medical condition does not sound unreasonable. But is there no relation to be found between existential suffering and a medically based condition?

Reaching older age can bring specific age related burdens. It would be rather naïve not to acknowledge that existential suffering is at least often accompanied by certain physical disabilities and limitations that impact the way life is lived. From a certain age, growing older is accompanied with a certain increasing frailty. Loss of eye sight is an example of such frailty. Normally the increase of this loss, strictly somatically spoken, isn't cause for suffering. A patient doesn't suffer from the physical process of losing eye sight induced by older age.

[29] Uit Vrije Wil waardig sterven op hoge leeftijd, Yvonne van Baarle, pagina 10, Boom 2011
[30] Op weg naar het einde, Eugene Sutorius, Wouter Beekman, Uit Vrije Wil pagina 23, Boom 2011

But the implications for an elder can be severe on an existential level. Loss of eye sight can lead from the feeling of the loss of independence up to a feeling of complete dependence. Next to loss of eye sight, the loss of hearing, incontinence, low body weight and a compromised lung functioning are also well known symptoms of frailty and can all lead to the feeling that one is not in control of life anymore[31]. One has to take into account that the elderly often suffer a variety of these symptoms of frailty rendering them unwillingly dependent on the care of others. The thing to notice here again is, that from a narrow medical point of view, these symptoms of frailty themselves do not necessarily lead to unbearable suffering. It is the impact they have on an elder's life that can lead to existential suffering.

So, According to UVW the euthanasia law asks for medical proof, existential suffering cannot be determined within current regulation. But once we start probing and questioning the notion of existential suffering it should be noticed that existential suffering is mostly accompanied by symptoms of frailty. An elder that is suffering existentially will often have corporeal or mental disabilities that force him or her to adapt and live life in a manner which they can find objectionable and not worth living. This leads to the question whether the existing euthanasia law is really as insensitive to existential suffering as UVW wants us to believe.

Play by the rules

I have given a description of a couple of leading points of view in the debate on assisted suicide. Now it will be interesting to find out whether Uit Vrije Wil is correct when they claim that the existing euthanasia law doesn't include requests for assistance in suicide by the elderly. The current euthanasia law consists of a set of requirements that have to be met by a doctor in the case of a request for assisted suicide. These requirements are formulated in article 2 of the WTL.[32] Whether these requirements are met by a doctor is judged by so called 'RTE's (Regionale Toetsingscommisie Euthanasie), regional testing commissions for

[31] A.H.J. van de Rijdt-van de Ven in opdracht van Landelijke Vereniging voor Huisartsen, Complexe ouderenzorg in verzorgingshuis en thuis, pagina 7, 2009
[32] Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding, artikel 2.

euthanasia. The WTL formulates six requirements that have to be met. UVW focuses on the second requirement and claims that the doctor cannot ascertain whether the suffering in unbearable and hopeless in the case of existential suffering.

The second requirement states that the doctor has had the conviction that the suffering was unbearable and hopeless. UVW claims that in the case of assisted suicide requests from the elderly it isn't up to the doctor to make this assessment to begin with. It is the elder who can assess whether life is worth living or not. This point of view could possibly be supported by the verdict from the Supreme Court in the Brongersma arrest.

The verdict from the Supreme Court in the Brongersma case introduced an addition to this second requirement. The unbearable and hopeless suffering of the patient has to be medically based[33]. This addition is an important reason why UWV wants to amend the existing euthanasia law. They argue that one may suffer from having outlived one's self but outliving one's life is not a medical condition as is described in the verdict of the Supreme Court. A concluded life is not a medical ailment. Therefore reaching a concluded life and the wish to end it cannot be understood in the same way as euthanasia to relieve the suffering of a patient based on a medical condition. A patient who has a cancer can be in absolute agony. If the patient has no hope of improvement, euthanasia can be the most humane thing to do to relief this patient's pain and suffering. In this case the fruits of life do not outweigh the pain and suffering felt by the patient. But what about the case when life itself does not produce any fruits anymore? This is the situation, according to UVW, the elderly that feel they have outlived their life and wish to die, are caught in. To defend the interests of this group of people the current law does not suffice. That's why UVW has written a proposition law to address this issue. This proposition law will be addressed later on in this thesis.

UVW describes four cases of elderly with concluded lives and following their logic these elderly would not be eligible for euthanasia. The first case is that of an 85 year old independent and proud lady[34] who has become more and more dependent on the help of others. Although this is not explicated in this case one may assume that this loss of

[33] Als de dood een vriend wordt, Govert den Hartogh, Uit Vrije Wil, pagina 92, Boom 2011
[34] Website Uit Vrije Wil available at, http://sparta.projectie.com/~uitvrije/index.php?id=1002

independence is because of an increasing frailty like loss of eye sight, immobility, loss of memory, dementia and so on. Because of this loss of independence she developed a lasting wish to die.(the reason to assume these symptoms of frailty is because in all the other examples used by UVW symptoms like the above mentioned play a role) She turned to her doctor for help but his reply was that she did not meet the euthanasia requirements because here suffering did not have a medical cause.

The case of the 85 year old woman is an example of existential suffering which is different from medical suffering according to the UVW. But one cannot help but to insist on the fact that there is a medical dimension here. The principal reason to ask for help is the fact that the lady is losing her independence. And of course this is a major loss to suffer in life. But what is in fact causing this loss of independence is her increasing frailty, that is to say loss of eye sight, loss of hearing immobility and so on. As Govert den Hartogh rightfully points out; "*the elderly do get help for cataract, deafness, arthritis, angina, incontinence, impotence and symptoms of depression, even if the cause is no other but the cause of normal aging. These conditions are without a doubt within the medical domain. They don't even need a Latin classification*[35]." This begs the question whether the 85 year old lady still does not meet the requirements to be eligible for euthanasia. The requirements are that she is suffering unbearably and without the hope of improvement and that the suffering is caused by a medically classifiable ailment. The loss of dependency is causing her to suffer unbearably. There is no reason to assume her condition will get any better so there is no hope for improvement. Furthermore, the loss of independence is caused by her frailty which is a condition that is medically classifiable. The criteria for euthanasia are met. So the question ought to be, which reasons does the doctor have to not assist in this lady's request for suicide? Perhaps the doctor made an error in judgment

Does UVW make a convincing case by portraying the situation of this woman and the decision of the doctor? It is highly debatable especially when one reads actual euthanasia requests that are reported in the RTE reports. The following case is derived from the RTE 2011 report.

[35] Als de dood een vriend wordt, Govert den Hartogh, Uit Vrije Wil, pagina 94, Boom 2011

A short resume of case 5; a 70 year old woman developed cognitive problems. Medical diagnoses revealed she had a dementia syndrome, possible Alzheimer and vascular white tissue damage. There were no treatment options available. After hip surgery the woman also suffered a delirium. The suffering of the patient was caused by her loss of autonomy the irreversible deterioration of cognition and the loss of control over her mind. She was losing her personality and her grip on reality. She did not want to experience the completely loss of autonomy, personality and grip on reality. This resulted in a request for euthanasia while she was still able to think and act coherently and rationally. The doctors confirmed that this lady was suffering unbearably and hopelessly and the RTE did approve of this confirmation[36].

The lady mentioned in the above case was suffering not only from her ailments but also from the prospect of these ailments taking over her life rendering her without personality and autonomy. Although she had medically classifiable ailments the ailments themselves weren't the source of suffering at the time of her request. The suffering was caused by the impact these ailments had on her life and her bleak prospect of life. Wouldn't this case classify as a good example of UVW's coined notion of existential suffering? Suffering from the fact that life itself is not worth living anymore because nothing lays in the future except a never ending loss of her human abilities and faculties. This case, in my view, strongly resembles the example UVW uses on their website to explain what existential suffering is and why the existing euthanasia law isn't sufficient to relieve the elderly lady from her suffering. But although the objective medical description is more or less similar, this case demonstrates exactly the opposite of UVW's point of view. It demonstrates that existential suffering, that is the result of medically classifiable ailments, can indeed be a valid reason to request euthanasia. Doctors and RTE's are aware of and sensitive to the existential dimension of suffering. Unbearable and hopeless suffering can be justified in terms of existential suffering. Based on the RTE report, there is no reason to read the second requirement of the WTL in such a manner that this requirement always excludes requests for assisted suicide based on existential suffering.

Based on current euthanasia practice it is fairly safe to assume that the current euthanasia law is at least sensitive to cases of existential suffering. As shown in the example above the

[36] Regionale Toetsings Commisies Jaarverslag 2012, pagina 19.

RTE approves cases of euthanasia that do fit the description of existential suffering made by UVW. But the fact that the euthanasia law includes some requests for assisted suicide doesn't necessarily imply that it can include all cases of existential suffering. Perhaps, as UVW wants us to believe, the subjective character of existential suffering is the reason why cases of existential suffering are excluded. Therefore a conceptual analysis of subjectivity might be helpful.

Respect my subjectivity

UVW wants to point out that having a concluded life or suffering existentially are actually subjective notions that are based on the loss of quality of life. A concluded life and the loss of quality of life aren't objectively measurable notions but subjective personal insights. On their website they present their point of view;

"De euthanasiewet geeft geen mogelijkheden omdat deze slechts ziet op ondraaglijk en uitzichtloos lijden met als grondslag een medisch classificeerbare ziekte of aandoening. Voor de stervenshulp aan ouderen met een voltooid leven, gebaseerd op verlies van kwaliteit van leven, introduceert Uit Vrije Wil daarom o.a. een nieuwe groep hulpverleners (stervenshulpverleners) die niet alleen uit artsen bestaat. Het gaat immers ook en misschien wel juist om existentiële problematiek.[37]"

"2.Voltooid leven is een subjectief begrip. Lijden aan het leven is wat de oudere daar zelf onder verstaat. Een definitie valt derhalve niet te geven; voltooid leven krijgt zijn eigen betekenis in ieder individueel geval.[38]"

According to UVW the existing euthanasia law doesn't offer the possibility to help the elderly with a concluded life because the law asks for the suffering to be objectified and translated into unbearable and hopeless suffering. But a concluded life is a subjective notion. A concluded life derives its own meaning from every individual case. The argument gains its power through the division of the objective necessity in describing unbearable and hopeless suffering in the euthanasia law and the subjective notion of a concluded life. This subjective

[37] Website Uit Vrije Wil, available at http://sparta.projectie.com/~uitvrije/index.php?id=1
[38] Idem

notion cannot be reduced into objective data, and therefore the euthanasia law isn't sufficient to deal with elderly that request euthanasia based on a concluded life. Intuitively, this argument doesn't sound unreasonable. The subjective realm is personal. I am my own ultimate judge when it comes to matters of religion, love, happiness and suffering. No one else but me can fully read my mind; I think all can agree on the latter fact. But none the less does this imply that a third person has no access to my mind? And although the subjective realm is personal, is it necessarily the case that I am in fact infallible in my subjective perception of my suffering? Because the notion of subjectivity plays a key role within the debate about existential suffering and concluded life it would be of great value to subject this notion to some critical scrutiny. Henri Wijsbek offers a conceptual analysis of this notion in his article 'knowing me knowing you[39].' On a more personal note, I think that it is a major lack in UVW's argument that they strongly depend on a notion such as subjectivity but to my knowledge do not make a serious attempt to explain what they exactly mean with this notion.

In his article, Wijsbek isolates two main assumptions that are generally made when we think about the notion subjectivity. First of all there is the assumption of first person transparency. That is to say that everybody knows his or her own mind. Second of all there is the assumption of third person inaccessibility. That is to say, experiences aren't accessible to anybody except the person who holds these experiences[40]. If it is indeed true that experiences are inaccessible for anyone except the subject self than it wouldn't be unreasonable to claim that subjectivity wouldn't be a good measure for doctors to base life and death decisions on. A strong case can be made for UVW's point of view if we adopt these two assumptions. But how accurate are these two assumptions really?

Wijsbek starts by asking the question what it is to have an experience. Having an experience is having a mental state. This is to say, to have a representation, to be about something, to carry information, to have content. But not all representations are the same. Wijsbek refers to Goodman's example to explain this distinction[41]. Suppose I see an animal from a great distance and I take it to be a horse. I would have a horse representation. But if this animal is

[39] Artikel Henri Wijsbek 'Knowing me knowing you'
[40] Artikel Henri Wijsbek 'Knowing me knowing you' pagina 3
[41] Article Henri Wijsbek 'Knowing me knowing you' pagina 4

in fact a cow then my horse representation is in fact the representation of a cow. The *object* of my representation is a *cow* but it is *represented* as a *horse*. So I can have a particular experience, but what it is an experience of is not necessarily what I experience it to be. The representation of a horse does not necessarily have to correspond with the horse representation.

Even more, there is no necessity for the actual object of experience to be present for me to experience it. Imagine a father tells his son he has cancer. The son doesn't have to have had the experience cancer to understand his father's experience and the emotional gravity of this horrible news. The son can evoke the representation of having cancer even in the absence of actually having cancer. Actually, everyone with an appropriate command of language, some imagination, and a tolerable amount of common sense and experience can be given enough clues to be able to understand in a rich and deep way what it is like for someone else to have cancer[42]

The first point made by Wijsbek is that first person transparency isn't infallible at all. Introspection does not always offer a flawless access to one's own ideas. I might be absolutely certain that I see a horse but if what I was looking at was in fact a cow I would have to admit that what I took to be the representation of a horse was in fact the a cow representation. I would like to emphasize here that the mistake Wijsbek is pointing out is not merely that I can be wrong about the object itself in the world which is in this case a cow instead of a horse. The crucial point is that I can be wrong about the belief I have about the representation of that object. I made a wrong verdict about the experience I had when I believed the object I was observing was a horse instead of a cow. Surely horses and cows are different from suffering but this doesn't mean that the same critique of the infallibility of first person transparency doesn't hold. A person might be suffering. He can believe that the suffering is caused by the conclusion of life. Without doubting the fact that this person is suffering, the question whether the belief he holds about the source of this suffering is correct, is justified. Even if we assume that having a concluded life can lead to suffering, and this person has the belief that his experience of suffering is caused by him having a concluded life, there is no reason to assume that his belief accurately represents and

[42] Article Henri Wijsbek 'Knowing me knowing you' pagina 7 (Wijsbek uses the example of a car crash instead of cancer)

describes his experience of suffering. He can have the experience of suffering, but this experience alone does not guarantee that his belief about the source of his suffering is correct.

The second point Wijsbek makes has to do with the assumed inaccessibility of a third person to my experiences. Going back to the previous example, I held the belief has the experience of seeing a horse when in fact I had the experience of seeing a cow. A profound introspection about the belief I hold of my experience will not lead me to correct myself and recognize a cow instead of a horse. But my error might be pointed out by someone else who is looking in the same direction but who rightly identifies the object as being a cow. He knew all along that I had the experience of a cow whereas I believed it was the experience of a horse. The role of the other is interesting for at least two reasons.

First of all, just like the son in a previous example was able to identify and empathize with his father's predicament, another person could understand why I held the belief that the object I was looking at was a cow instead of a horse. Identification and empathy do offer us an entrance to understand another person's predicament in a meaningful way. All that is needed is a certain similarity with the person we empathize with. A doctor shares some similarities with his patients and his medical expertise accompanied with his knowledge of what makes life worth living make it possible that he can understand the predicament of his patient in a meaningful way[43].

Second of all, it is actually the case that sometimes we need the other to point out the mistakes we can make in the interpretation of our experiences. In the horse example it is not me but the other person who makes me aware of my error of judgment. So the assumption that third persons do not have any access my personal experiences does not reflect the human ability to identify and empathize with fellow man and given the proper situation actually correct the subjective views he holds to be true.

With Wijsbek's analysis in mind let us go back to UVW's argument of why the current euthanasia law is insufficient to deal with elderly people that have a concluded life. They claim that the notion of a concluded life derives its substantive meaning through a fully

[43] Article; Knowing me Knowing you, Henri Wijsbek, page 18

subjective process. Because of this subjectivity, the doctor isn't able to ascertain whether the concluded life of an elder leads to unbearable and hopeless suffering. Therefor the request for euthanasia cannot pass the criteria of unbearable and hopeless suffering that are posted in the euthanasia law. But is there really reason to be so pessimistic about the ability of a doctor to understand what a concluded life is and whether it might lead to unbearable and hopeless suffering? I think not. UVW uses exactly the two assumptions that Wijsbek criticizes namely, the first person transparency and the third person inaccessibility. UVW assumption of first person transparency is articulated in their definition of a concluded life. As we have seen before, they claim that the meaning of a concluded life is individually and subjectively constituted[44]. But as Wijsbek made clear, even if we assume that a concluded life can lead to suffering, the subjective belief that the experience of suffering is caused by having a concluded life isn't proof enough that this belief accurately represents the felt experience. This is to say, the experience of having a concluded life isn't necessarily caused by having a concluded life. UVW's claim that the subjectivity of the elderly's suffering would be a barrier in assessing whether this suffering is unbearable and hopeless doesn't seem to hold.

Furthermore, Wijsbek's reflection on third person inaccessibility shows that it isn't by any means impossible to understand and identify with another person's predicament in a meaningful way. A doctor is able to understand the suffering of his patient without having the patient's same ailments just like I am able to empathize with the victim of a car accident without being in the accident myself. I need only to be human with somewhat normally functioning faculties and emotions to do this. To add to this point, sometimes a person can be mistaken in the beliefs he holds. I might have a headache and hold the belief that it has to do with the stress that accompanies the writing of my thesis. But the ophthalmologist might correct this belief and show me that I actually need glasses and that the headache is the result of staring too long at a computer screen without proper glasses. Because we all are at risk of making judgment errors about our own experiences and there is always a chance that other persons can point out these errors, I think in decisions concerning life and death we should at least do all within our power to make sure an error in judgment does not lead to a person's death. Although UVW has a too pessimistic view on the notion of subjectivity, and

[44] Website Uit Vrije Wil available at, http://sparta.projectie.com/~uitvrije/index.php?id=1

they should try to overcome the challenge of Wijsbek's refutation of this pessimistic interpretation, they still do not claim that the process of assisted suicide should be done without any guidance. As mentioned in the chapter 'Uit vrije wil' they introduce a new caregiver called the death councilor who overlooks and facilitates the whole process of assisted suicide.

As Wijsbek points out it is reasonable to expect a minimum of empathy and identification for the situation of other people. Keeping this in mind I would like to raise the question if we really would benefit from a care giver and if the plain old conventional doctor wouldn't do just fine.

Good doctor bad doctor

UVW claims that the assessment of suffering of the elderly is not a task that can be properly performed by a doctor. The required skills to assess existential suffering aren't medical so why should we ask the doctor to perform this assessment in the first place? This isn't an unreasonable question. The answer to this question depends greatly on what concept we have of a doctor. What can we expect from our doctor? Is he merely a skillful master of pathology or is there more to be said?

The elderly deserve to be taken seriously when they express a wish to die. They should not merely be reduced to and judged by their pathology. This isn't an unfair claim that captures UVW's position on existential suffering. But how fair is the depiction of doctors as pathology detectives and drug administrators? Of course UVW does not portray the work of a doctor in such a blunt way, but this somewhat ridiculous depiction of doctors is inviting to ask a very naïve question. What is a good doctor? Surely someone who understands his métier, this is to say someone who has the appropriate knowledge of the human body. But would this be the complete picture of a good doctor? One would think that there is more to be expected from a good doctor. Actually a doctor who only performs his analytic duty could arguably get the qualification bad because he lacks something. Patients expect more from their doctor. They expect a degree of empathy, someone who can relate to the problems of the patient

on a pragmatic medical level but also and especially on a more humane level. 'Like things can only be known by like things' the well-known quote from Empedocles can be insightful here. A physician can only encompass the full meaning of his patient's ailment by virtue of their shared human nature. This shared human nature makes it possible for the physician to identify with a patient's problems. And in this act of identification, which only requires empathy and strictly spoken no medical training, a patient will feel that he or she is being taken seriously. So a good doctor is more than a skillful healer. The doctor should also have a certain level of empathy and the ability to identify with his patient's situation. These extra requirements are especially clear in the care for the elderly.

According to the report 'Complexe ouderenzorg in verzorgingshuis en thuis' written by A.H.J. van de Rijdt-van de Ven, commisioned by the 'Landelijke Huisartsen Vereniging' ,the National Physicians Association, in the care for the elderly the doctor has the role of a (stage) director[45]. As a director the doctor has a good view of the availability of care for the elderly, and he can direct caretakers into the right direction. He understands what kind of care is needed and where this care is best found. He understands priorities and can intervene where necessary. So his activities are both logistical and authoritive. The authority in this process is only justified by the trust a patient has in his doctor[46]. The patient trusts the doctor to inform and treat him as good as possible. And the notion of 'treating as good as possible' isn't necessarily a narrow medical treatment. A doctor might advise one of his elderly patient's to move to a house for elderly people. His advice can be based on medical reasons but also on more broad humane reasons. If his patient among other things also suffers from social isolation, perhaps a home for the elderly can offer a solution. This is of course not a medical advice, but none the less it is advice that is not uncommonly given by doctors. So in the existing medical practice we expect from doctors to act and doctors indeed act beyond the realm of pathology. A doctor should be able to identify with a patient's situation and aid him as best possible. This help isn't always contained within the boundaries of medical science. The medical domain seems to encompass more than medical science. This shouldn't come as a surprise. This description of what a doctor ought to do is not a mere speculation. The KNMG, the organization that represents physicians in the

[45] A.H.J. van de Rijdt-van de Ven in opdracht van Landelijke Vereniging voor Huisartsen, Complexe ouderenzorg in verzorgingshuis en thuis, pagina 11, 2009
[46] Idem

Netherlands, clearly states that within the medical domain existential concepts such as loneliness and loss of autonomy have to be taken into account when assessing a euthanasia request. "*When viewed against the backdrop of these developments, and of the response to these developments within the medical profession, it is wholly justifiable that vulnerability – extending to such dimensions as loss of function, loneliness and loss of autonomy – should be part of the equation physicians use to assess requests for euthanasia*[47]*."*

As various other ailments and complications such as disorders affecting vision, hearing and mobility, falls, confinement to bed, fatigue, exhaustion and loss of fitness take hold, so too does their degree of dependence. The patient perceives the suffering as interminable, his existence as meaningless and – though not directly in danger of dying from these complaints – neither wishes to experience them nor, insofar as his history and own values permit, to derive meaning from them. In the KNMG's view, such cases are sufficiently linked to the medical domain to permit a physician to act within the confines of the Euthanasia Law. This view further reflects the second option cited by the Dijkhuis Committee[48]*.*

This is exactly what one would expect from a good doctor. The doctor isn't merely concerned with pathology, that is to say signs of frailty such as loss of vision, hearing, mobility, and so on, but also how these ailments do affect a person's life on an existential level. The medical domain isn't blind to the connection between the bodily and the existential. On the contrary, the openness and regard of the impact of frailty on a human life is exactly a feature which makes a doctor a good doctor. This description of the good doctor is in line with Wijsbek's analysis of subjectivity. Wijsbek demonstrates that an individual isn't infallible in his personal judgments and that it is possible for a third person, by virtue of identification and empathy, to have a meaningful understanding about an individual's predicament. A good doctor, as described above, is exactly aware of these two features. Patients aren't infallible in their judgments about their suffering; that is human nature as Wijsbek points out. The doctor's ability to identify and empathize with his patient offers him the opportunity to understand his predicament in a meaningful way and because of his expertise he can also correct judgment errors of his patient. This identification, empathy and

[47] KNMG position paper the role of the physician in the voluntary termination of life, page 22, Utrecht June 2011
[48] Idem

the ability to analyze and correct judgments are qualities we look for in a doctor. These qualities make that we feel we are being taken seriously as patients and not only reduced to objects with ailments. We feel human when we are treated as humans, and to treat someone as a fellow human is to take the time and make the effort to understand and even if possible enhance his situation.

So my claim is that when we think about a good doctor we think about a doctor who is sensitive and aware of his patient's situation and tries to improve it. Apart from having a deep insight in pathology he also understands the impact ailments can have on a patient's life. With UVW I agree that existential suffering should be taken very seriously. The way to do this would be to make sure that patients that are suffering existentially are being helped by those people who have the best possible set of skills and qualities to assess and understand this subjective notion. This is to say someone who is aware that the patient's beliefs about the sources of his suffering aren't necessarily correct without disqualifying the suffering itself. Someone who is capable of identifying and empathizing with his patients because of his expertize on the human body but also because of his innate shared human nature. These qualities are imperative to understand and assess existential suffering, and lead me to believe that if we want to take existential suffering seriously we need a good doctor.

A good doctor plays an important role in the request for assisted suicide. But although a doctor can understand the situation of an elder in a meaningful way he also has the euthanasia law to take into consideration. The euthanasia law also demands a certain degree of objectification of a patient's subjective suffering. This demand for objectification is made unambiguously clear in the Brongersma arrest. "*De ondraaglijkheid van het lijden dient voor de vraag of euthanasie mag worden toegepast evenzeer te worden vastgesteld, maar is, in tegenstelling tot de uitzichtloosheid van het lijden, een in hoge mate subjectieve, en moeilijk te objectiveren factor. Niettemin zal de arts, indien het lijden niet ook voor hemzelf, naasten en hulpverleners evident is, het lijden moeten kunnen invoelen en - afgaande op zijn ervaringen als arts met de gevolgen van een bepaalde gezondheidstoestand in verschillende vormen en gradaties - tot op zekere hoogte moeten kunnen objectiveren*[49]*."*

[49] Idem

In the arrest from the Supreme Court the demand for objectivity is added to the existing requirements of unbearable and hopeless suffering of the patient. This demand for objectivity would only be a problem if we assume that these two are antagonistic notions. This is to say, a fully subjective notion would be impossible to grasp from an objective point of view and vice versa. But is this actually the case? Is a subjective notion such as existential suffering inaccessible from an objective point of view?

Subjectivity vs. Objectivity

According to UVW, existential suffering, suffering that takes place in the subjective realm, is supposed to be something that is inaccessible for technological medicine, acting in the realm of the bodily. They claim on their website that '*voltooid leven is een subjectief begrip. Lijden aan het leven is wat de oudere daar zelf onder verstaat. Een definitie valt derhalve niet te geven; voltooid leven krijgt zijn eigen betekenis in ieder individueel geval*[50]' 'The notion of a concluded life is a subjective one. Suffering from life is that what the elderly perceives it to be. Therefore a single definition cannot be given; a concluded life derives meaning from each individual case.' The point made here is that the notion of a concluded life is a subjective existential notion. It is subjective because the notion gets its meaning through personal ideas which can perhaps be described but not reduced to a set of objective scientific data and it is existential because it deals with the perception of one's life. Existential suffering is in this sense a manifestation from the subjective realm. A question one might ask when thinking about a notion such as existential suffering is, "why would we accept this distinction to begin with?" Why would we assume that there is a separate subjective and objective dimension?

What would be useful is to subject the notions of a concluded life and existential suffering and its relation to a subjective realm to critical scrutiny. To elaborate on what existential suffering or suffering from life is, UVW gives the following definition; "*Lijden aan het leven is wat de oudere daar zelf onder verstaat*[51]*"* Suffering from life is whatever an elder perceives it to be. This is to say, a doctor cannot objectively verify if the patient's subjective notion of

[50] Website Uit Vrije Wil available at, http://sparta.projectie.com/~uitvrije/
[51] Idem

existential suffering is unbearable and hopeless, because existential suffering cannot be understood as a reduction into scientific knowledge. There is a translation problem; existential suffering has to be translated into unbearable and existential suffering. In the verdict of the Brongersma arrest the Supreme Court explicated what unbearable and hopeless suffering entails and adds the criterion that it should have a standard of objectivity."*Uitzichtloos en ondraaglijk lijden is aan de orde in situaties waarin de arts als genezer machteloos staat. (...) Voor de uitzichtloosheid van het lijden is - uiteindelijk - het medisch oordeel bepalend. Naar medisch vakkundig oordeel moet vaststaan dat de situatie van de patiënt niet te verbeteren is. Aldus wordt de uitzichtloosheid geobjectiveerd*.[52]" Suffering is unbearable and hopeless in situations where the doctor as a healer is powerless. To verify whether the situation is hopeless, medical judgment is defining. The fact that the patient's situation cannot be improved must be determined medically. So the hopelessness is being objectified." This criterion is also required in determining whether the patient is suffering unbearably. "*De ondraaglijkheid van het lijden dient voor de vraag of euthanasie mag worden toegepast evenzeer te worden vastgesteld, maar is, in tegenstelling tot de uitzichtloosheid van het lijden, een in hoge mate subjectieve, en moeilijk te objectiveren factor. Niettemin zal de arts, indien het lijden niet ook voor hemzelf, naasten en hulpverleners evident is, het lijden moeten kunnen invoelen en - afgaande op zijn ervaringen als arts met de gevolgen van een bepaalde gezondheidstoestand in verschillende vormen en gradaties - tot op zekere hoogte moeten kunnen objectiveren*[53]*."* Whether the suffering is unbearable is unlike the hopelessness a difficult factor to objectify. None the less the doctor needs to, to a certain extent, objectify using his experience as a doctor. So for suffering to be considered unbearable and hopeless the doctor has to be able to translate the situation of the patient into certain medical scientific data, this is to say to objectify the situation. These objective facts can lead to the approval or rejection of a euthanasia request. The problem here of course is that the notion of existential suffering, as put forward by UVW, is fully subjective. "Existential suffering is whatever and elder perceives it to be". It is as if the notion of existential suffering does not only gain its identity by the affirmation of its subjectivity but also by its negation of objectivity.

[52] Brongersma Arrest LJN: AE8772, 184 ad 1, http://zoeken.rechtspraak.nl/detailpage.aspx?ljn=AE8772
[53] Idem

But why can't the notion of existential suffering be objectified and still be a subjective perception? Doesn't this objectification actually play a key role in delivering the subjective message? If one analyzes the very way UVW tries to demonstrate cases of elderly with a concluded life that suffer existentially they are in fact objectifying the situation to deliver the message.

No subjectivity without objectivity

UVW did put on their website a couple of cases to explain how they interpret the notion of a concluded life. "*There is the case of a 74 year old man who has always been working with his hands. But because of his general physical weakening his loss of coordination and stiffening of the body he cannot perform the activities anymore that are meaningful to him. He lost all his interests and developed a strong desire to die. He started to have discussions with his physician where he revealed his wish to die. The physician however didn't want to aid his patient in his wish to die because according to him the patient's state of grief and his ailments do not lead to unbearable and hopeless suffering as formulated in the euthanasia law. The man feels deeply denied and after a period of pain and loneliness he dies at the age of 82*[54]". So in this case the man's suffering is caused by the fact that could not perform the activities anymore that were meaningful to him. In this sense this suffering is understood as existential suffering. To help the patient in his request the doctor has the euthanasia law at his disposal that requires unbearable and hopeless suffering which is caused by a medically classifiable ailment. His patient's suffering cannot be described as a medically classifiable ailment because the cause is existential and not a disease or condition

So what is in fact used by UVW to portrait this man's situation as existential suffering? Well, he is suffering existentially because he cannot perform the activities anymore that gave meaning to his life. His physical weakening, loss of coordination and stiffness denied him to do the meaningful activities in life he used to do. But isn't this exactly an objective description? Isn't it exactly the case that we are able to understand the situation of this man because we can relate to his specific constellation of objective features? One might say; "If it

[54]Website Uit Vrije Wil available at, http://sparta.projectie.com/~uitvrije/index.php?id=1002

was me in this man's situation and if this man's specific activities gave meaning to my life and I wouldn't be able to do them anymore, I also might come to the same conclusion." It is possible to empathize in this way with this man because one understands the objective facts about this man's life. These objective facts are used to create the subjective picture that represents this man's situation. It are objective messengers such as physical weakening, loss of coordination and stiffness that deliver the subjective message of a man losing the will to live. The subjective message is being mediated by its objective counterpart. So even UVW with its fully subjectivized notion of existential suffering and concluded life is forced to mediate this subjectivity of suffering through a description of objective facts. One might go as far as to say that the genuine authenticity of a subjective notion only gains strength through the very fact it can be objectified. There is no subjectivity without objectivity.

Imagine a lack of the objective counterpart. So, in this case, there are no physical ailments at all. This would imply that the man is still able to do all the activities that are meaningful to him. None the less his wish to die is enduring and persistent. How would one react to this situation? Does the mere request to die without any objective situation like frailty, an ailment, the loss of a close one and so on, offer enough ground to honor the request to die? An appropriate question is here at place; what possible reason to end his life can this man have if it isn't some kind of ailment or any other given relevant reason? Again, this would be a request for objective data to be able to imagine oneself in this man's subjective situation which explain why he requested assistance in suicide. Surely we understand this request if he is suffering from an ailment that interferes with the way he lives his life, but such an ailment or cause of interference is missing. This is to say the objective data are missing to construct the given subjective picture. Without the relevant objective data the request seems to be confused. And we shouldn't want to aid in the suicide of a confused person. These requests deserve another type of attention, perhaps psychiatric or medical attention, but certainly not a free pass to death. So if existential suffering and concluded life are notions that can only be made palpable by understanding the underlying objective facts why would we introduce these notions to begin with?

The introduction of these notions doesn't seem to add anything that isn't already clear in the notions unbearable and hopeless suffering. This is actually already clear when we would engage in a common sense analysis. What does it mean to suffer unbearably and hopelessly?

It means that the suffering is so severe and intense and without any prospect of relief that one cannot take this suffering anymore, that is to say, one cannot live anymore with this suffering. But isn't this exactly what existential suffering entails? What kind of suffering could be unbearable but not existential, or vice versa?

There is no existential suffering, no concluded life without unbearable and hopeless suffering. The existing requirement within the euthanasia law is that the doctor has to have the conviction that the patient is suffering unbearably and hopelessly so the existential suffering is actually already inscribed within this criterion. The objectification of unbearable and hopeless suffering does not defeat the subjectivity of existential suffering. It explains and fortifies it. To put it in another way, To make sure someone is suffering existentially you actually have to make sure that the suffering is unbearable and hopeless. This opposition that is introduced by UVW is not correct since existential suffering and unbearable and hopeless suffering are two sides of the same coin.

To summarize, according to UVW existential suffering is a subjective notion. There are no objective measures to ascertain the un-bearableness and hopelessness of existential suffering. The only measure is the person self who is suffering. He or she alone knows whether life has reached its conclusion. These general notions of existential suffering and a concluded life are on the surface interesting and seem to hint at a profound wisdom namely that not all suffering can be caught in the cobweb of the medical technical domain. But when UVW tries to demonstrate cases of the elderly that are suffering existential they themselves use objective data to make palpable what it is to suffer in this way. They use examples of elderly that are suffering from ailments that are common for people of old age, that is to say ailments that are medically classifiable. In their examples they use patients that are suffering from all kinds of symptoms of frailty such as dementia, loss of eye sight, loss of hearing and so on. My claim is that you need these medical objective data to make the subjectivity of the existential suffering palpable. This claim is enforced by looking at a subjective suffering claim without any relevant objective data. Imagine a patient who wants assistance in his suicide but he has no somatic or psycho-somatic ailment at all. The proper response to his request would not be to right away aid in his suicide but to look for the reasons why this man wants to die. Before deciding whether to aid this person in his request it has to be made clear where the request stems from. This search for the source of the request is exactly a search

for objective data to back up a subjective notion of suffering. Subjective suffering without any objective data seems to be somewhat confused, and we shouldn't aid people in their suicide when they make a confused request.

A little recap

Up to this point I have focused on whether the UVW's critique of the existing euthanasia law holds. A reading of the euthanasia law and an analysis of RTE reports makes clear that the euthanasia law is not incapable in dealing with requests from the elderly that suffer existentially. But is this capability sufficient to deal with all requests for assisted suicide based on existential suffering? When asking this question especially the assumed inaccessible subjectivity of existential suffering plays a major role. This argument has been brought to the public's attention by UVW. Subjectivity would encompass a first person transparency and a third person inaccessibility that result in the inability of the current euthanasia law to deal with requests for assisted suicide. Using Wijsbek's article I made an attempt to show that these assumptions don't hold and that individuals can be mistaken in their beliefs about the cause of their suffering. In fact, third persons, in the form of doctors, are capable of identifying and empathizing with their patient's predicament and should be able to judge and where necessary correct their beliefs about their suffering without doubting the gravity of their suffering. These empathetic and analytic skills are actually the features we ascribe to a good doctor. Finally I have considered the request of objectivity that has been added by the Supreme Court to the formulated requirements of un-bearableness and hopelessness in the euthanasia law. According to UVW existential suffering is a subjective notion that cannot be captured by and reduced to an objective set of data. But subjectivity and objectivity aren't opposite antagonistic notions but they supplement each other. To understand a subjective position it is necessary to provide the objective context. And you need a personal subjective narrative to be able to understand the objective data. Therefore I claimed that subjectivity and objectivity aren't antagonists but complementary. Two sides of the same coin.

Of course claiming that the current law isn't incapable of dealing with requests for assisted suicide doesn't imply that the introduction of another law would deal with these requests in

a better way. UVW made a specific proposition law that is tailored for requests of assisted suicide from the elderly. Would this law in fact improve the policy on assisted suicide?

The proposition law

As described before, UVW claims that the existing euthanasia law isn't sufficient to deal with requests for assisted suicide from the elderly whose request does not stem from a medical condition or disease. The existing law only adopts a medical perspective whereas the problems of a concluded life and existential suffering are existential problems. The elderly should be able to decide for themselves when the value of life has decreased so much that death is preferable over life[55]. This is an articulation of the elderly's right to self-determination. The voluntary and well considered decision to request assistance in euthanasia therefore deserves our attention, respect and solidarity.

In their plea for a better judicial base for assisted suicide Uit Vrije Wil appeals first of all to the principle of respect for autonomy. They say that the question whether someone is suffering unbearably can only be answered by the person himself. And if the answer is that life isn't worth living anymore there should be a legal base for respecting this act of self-determination and provide to proper assistance in terminating the elder's life. This is the second principle UVW appeals to. Solidarity and compassion are needed from society to provide the proper aid in the assistance of suicide. Without this solidarity and compassion, the elderly will have to apply suicide methods that are without any question inhumane and degrading. These two principles form the base of the amendments made to the existing euthanasia law to result in UVW's proposition law. Autonomy results in the self-determination of the quality of life and the assessment of suffering. Solidarity and compassion are needed to affirm the autonomous decision of suicide by providing the drugs to end life in a humane and respectful way.

The proposition law "*Wet toetsing stervenshulp bij ouderen*[56]*"*,as Henri Wijsbeek points out, strongly resembles the existing euthanasia law but lacks the second and fourth (b and d)

[55] Memorie van toelichting, Jit Peters Eugene Sutorius, Uit Vrije Wil, pagina 55, Boom 2011
[56] Proeve van wet, Jit Peters Eugene Sutorius, Uit Vrije Wil, pagina 45, Boom 2011

requirement[57]. So the doctor does not need to have the conviction that the patient is suffering unbearably and hopelessly and the doctor and the patient are not required to make sure there are no alternatives. As pointed out before, these changes are based on the principle of autonomy. The only one to decide whether the suffering has become unbearable and hopeless is the person himself, so the doctor as the assessor of suffering and provider of alternatives has become obsolete. Wijsbeek raises a fair question apropos the proposition law and its lack of criterion b and d. "*Voordat je die laatste vraag kunt beantwoorden, moet je wel eerst ervan vergewissen of ouderen met een voltooid leven echt behoefte hebben aan stervenshulp. Is hun roep om zelfbeschikking niet in feite een schreeuw om aandacht, waardering en respect, een aanklacht tegen een maatschappij die ouderen marginaliseert en laat vereenzamen?*" Isn't there a duty to at least be sure that the request for euthanasia from an elder isn't in fact a desperate cry for attention, appreciation and respect, an accusation against society that marginalizes the elderly and condemns them to solitary life? The question Wijsbeek raises here is a fair one. It is definitely imaginable that an elder's request for euthanasia is a desperate cry for help. It is part of the human condition to make mistakes about views they have concerning their own well-being. As we have seen in the chapter on subjectivity, a person can feel suffering and hold the belief that the assistance in his suicide will be the only way to relieve this suffering. But especially in cases of life and death we should take into considerations that the ideas a person can have about his suffering aren't a priori indisputable. So isn't there a duty to protect these people even if it's from their selves? Perhaps the notion of a duty to save the elderly from themselves is far too paternalistic. But does the rejection of this form of paternalism necessarily result in the hegemony of autonomy and self-determination? To answer this question it will be useful to understand what the right to autonomy and self-determination exactly entails in the case of euthanasia.

Autonomy

[57] Samen op weg naar het einde, dr. Henri Wijsbeek, TGE jaargang 21 – nr2 -2011, pagina 33

Autonomy and the right to self-determination are often heard arguments in the discussion on euthanasia[58]. Although they play an important part in the current euthanasia law these notions aren't used to justify the act of euthanasia or the assistance of suicide. As is demonstrated in the chapter on the euthanasia law, the person's autonomy is respected by making sure the request for euthanasia is voluntary and well-considered. But this respect for autonomy is in no way a justification to claim a right to euthanasia. There is no right to die or a right to euthanasia to begin with[59]. But why isn't the right to self-determination a sufficient ground to justify euthanasia? Why doesn't the notion of autonomy lead to a doctor's duty to assist in a request for suicide?

Like everybody the doctor has the duty to respect another person's autonomy. But what does it exactly mean to have the duty to respect another person's autonomy? The right to autonomy is a right that guarantees an individual the freedom to make his own decisions (within the legal domain) without being interfered[60]. Within the medical domain this means that a patient (who is capable) always has to agree with the proposed medical treatment from a doctor. It is therefore also within the patient's right to self-determination to refuse treatment even if this would seem to be an irrational thing to do[61]. So based on the right to self-determination, a patient can accept or refuse treatment without the necessity of justifying himself to anyone. But this guarantee to personal freedom of choice in the acceptance of treatment isn't enough ground to demand treatment. The patient's consent to treatment isn't sufficient to start treatment. The restrictive character of the right to self-determination does not lead to a duty to help[62]. To put it more bluntly, by doing absolutely nothing a doctor is in fact respecting the patient's right to self-determination. So in terms of euthanasia, a person cannot claim that merely on the base of the right to self-determination he has the right to euthanasia. First if all there is no right to euthanasia. Second of all from the right to self-determination no duty to aid arises.

---

[58] G. den Hartogh, Het Nederlandse euthanasierecht: is barmhartigheid genoeg? Tijdschrift voor Gezondheidsrecht (2007) 31:137–148, page 3

[59] Handboek gezondheidsrecht H.J.J. Leenen, J.K.M Gevers, J. Legemaate, Vijfde geheel herziende druk Bohn Stafleu van Loghum 2007, page 340

[60] idem

[61] There are medical exceptions where a patient can be forced to be treated such as patients who are a clear danger to themselves or to society. The terms that have to be met to force treatment upon a person are articulated in 'de wet BOPZ'

[62] G. den Hartogh, Het Nederlandse euthanasierecht: is barmhartigheid genoeg? Tijdschrift voor Gezondheidsrecht (2007) 31:137–148, page 3

Govert den Hartogh points out that indeed more is needed than the right to self-determination to generate a duty to help. "*De meeste mensen die in termen van zelfbeschikking denken ontgaat het dat uit het zelfbeschikkingsrecht zelf niets volgt betreffende de toelaatbaarheid van actieve hulp door anderen. Wat je daar aanvullend voor nodig hebt is het Volenti-beginsel: Volenti non fit iniuria, wie ingestemd heeft kan niet klagen dat zijn recht is geschonden*[63]*."* Most people who think in terms of self-determination aren't aware of the fact that from the right to self-determination nothing follows concerning the admissibility of active help by others. What is needed is the so called Volenti non fit iniuria principle; [64]"*the consenting person cannot be wronged, the fact of a person's consent exculpates you from causing a setback to his interests.*" For example if I would decide to be adventuresome and bungee jump from a high bridge I know I'm putting myself in a dangerous position. But if I sign a contract stating that I am aware of the hazards of jumping and I unfortunately get harmed but the let's call him jump overseer did not make any intentional mistakes, the jump overseer is exculpated from my setbacks caused by the harm of the jump.

But this principle is widely rejected in traditional medical ethics because a doctor is only supposed to act if it is in the interest of a patient. This professional ethical consideration is backed up by using John Locke's claim that we have certain rights that are inalienable. The rights to life, liberty and bodily integrity are inalienable, that is to say that it isn't possible for me to transfer the goods protected by these rights to another person even if I voluntary request to do so. I cannot make a legally binding contract where I give up all my rights to liberty making me someone else's slave even if I explicitly wish to do so. Nor can I transfer my right to life to another person and allow him to take my life. Even though the Volenti principle would hypothetically state that a doctor is exculpated from any harm he may cause to a consenting patient this patient cannot transfer the rights to his life to begin with. Life is an inalienable right and therefore the elder cannot transfer this right to a doctor even if he consents. In the case of assisted suicide the Volenti principle cannot serve as a justification for the doctor to assist an elder in suicide. Respecting an elder's autonomy does not imply

[63] Idem

[64] G. den Hartogh, Euthanasia Reflections on the Dutch Discussion, Article first published online: 25 JAN 2006 Annals of the New York Academy of Sciences Volume 913, pages 174-187.

that he can transfer his right to life. From the respect for the elder's autonomy does not follow a duty from the doctor to assist in the elder's suicide.

But perhaps the restriction of the Volenti principle and the acceptance of inalienability of the right to life can be considered to be paternalistic. But what is paternalism and why is paternalism considered to be unjust?

Paternalism

A well-known argument against paternalism has been formulated by Joel Feinberg in his article 'A harm to self.'[65] He argues that someone who interferes with the decisions you make in life claiming it is in your best interest implicitly presupposes a moral asymmetry between him and you. By not treating you as an equal moral agent he insults you. So respect for autonomy isn't an interest you have among other interests. Respect for autonomy presides over these interests because it is needed to be acknowledged as a full member of moral society giving you equal duties and rights within a community. This acknowledgement of being an equal moral agent has to be established before you can start weighing interests of well-being. Paternalism precisely undermines this acknowledgement of being an equal moral agent.

Although den Hartogh does not necessarily disagree with this analysis he points out that some forms of paternalism are more insulting than others and that the analysis might not apply in cases he calls 'indirect paternalism'. So what is indirect paternalism? Den Hartogh makes this clear by arguing that for example my interference with your autonomy by refusing to help you, because I think it is in your best interest, isn't insulting at all. It isn't a denial of your autonomy, you can still do as you wish, but you cannot make me do what I don't wish to do. Just like you, I also have a right to self- determination. Now imagine that I do want to help you but a third party prevents me from doing so. Is this insulting in the same way as interfering with someone's autonomy is? Does the interference of the third person insult you? It doesn't because it still leaves you to do as you please; you are still master of

[65] Joel Feinberg, Harm to Self (New York: Oxford University Press, 1986), p. 27

your own actions. Of course it might be insulting to me, but that is not the question that is addressed here.

In the case of the presence of a valid existing contract you can have legitimate expectations arising from a consented agreement. If a third party interferes with the execution of my part of the contract this can be insulting to you because we have a valid contract. But this situation can only arise is the case of a valid contract, that is to say the case when my consent is sufficient to validate the contract. In the absence of such a valid contract this argument doesn't hold. When dealing with the question whether a doctor has a duty to aid in the request for euthanasia out of respect for the autonomy of the patient there is no such valid contract. Of course the doctor might consent but not merely because he has to do so out of respect the autonomy of the patient. This would be a transgression of his own autonomy to choose whether he feels that euthanasia is the best possible solution or not. I cannot demand from a doctor to give me an unnecessary treatment and justify my demand by claiming that he has to respect my autonomous decision. The doctor himself has to have the conviction that it is medically beneficial for me to undergo this treatment. The mere respect for autonomy of his patient does not compel the doctor to act in anyway and therefore there is no valid contract based on merely a duty to act out of respect for autonomy. The autonomy of the doctor also deserves to be respected and his conviction that treatment is needed is necessary to validate the contract. Without a valid contract a transgression of the Volenti principle isn't paternalistic but according to den Hartogh merely indirectly paternalistic. So a doctor who doesn't want to aid a patient in the request for euthanasia, because he believes that more justification is needed than merely the respect of the autonomy of that patient, is acting in an indirect paternalistic way. It is indirect because unlike paternalism there is no moral asymmetry between the doctor and the patient. The doctor and the patient both have to bear the consequences their actions have on the other. A doctor isn't an instrument in the hands of the patient, but he tries to take care of the patient's well-being as good as possible as he sees fit.

The proposition law from UVW differs from the euthanasia existing law by not requiring the suffering to be unbearable and hopeless and not requiring the doctor and patient to look for an alternative option. Autonomy and self-determination are used to justify the abandonment of these requirements. Therefore I have questioned whether autonomy and

self-determination can serve as justification for euthanasia and assistance of suicide. Using Wijsbek I have argued that the request for euthanasia from patients isn't necessarily well-considered and because it is wrong to kill people it is necessary to determine whether the request for euthanasia is indeed well-considered and follows from unbearable and hopeless suffering.

UVW claims that the assessment of unbearable suffering can only be done by the person himself. Making anyone else except the person himself the judge of the unbearableness and hopelessness of suffering would not respect the autonomy of the elder and is paternalistic. But I have argued that the respect for autonomy doesn't generate a duty to aid in the request for euthanasia. Using den Hartogh I have shown that the Volenti principle is needed to generate the right to act. But this principle is widely rejected in the medical domain because professional ethics stipulate that a doctor shouldn't harm his patient and this is backed up by so called inalienable rights such as the right to life and the right to bodily integrity. This rejection of the Volenti principle can be criticized as being too paternalistic. Using den Hartogh I have shown that it is only paternalistic if two parties (e.g. the doctor and the patient) have an agreement where their mutual consent is sufficient to validate the agreement. So within the space of which is already valid the Volenti principle guarantees that the person who is acting out his part of the agreement in good faith isn't liable for the possible harm that is the result of his acting. But the Volenti principle is not a means to validate of justify the space itself that is to say to justify the claim that a doctor has a duty to aid in the request for euthanasia out of respect for the autonomy of his patient. Therefore den Hartogh claims that the transgression of the Volenti principle isn't paternalistic in the Feinberg sense but only paternalistic in an indirect way. It is indirect because the patient and the doctor are both equal moral agents who both have to bear the consequences their actions have on the other person.

For these reasons I would be very skeptical about UVW's proposition law. The removal of the requirement for the establishment of unbearable and hopeless suffering because this requirement would undermine the autonomy of the elderly doesn't seem to be very strong. In fact, the doctor's autonomy should also be considered. It isn't unreasonable to make sure that the person who has the difficult task to assist in the suicide of a patient can at least identify with this task and is convinced he is doing the right thing. But why would the debate

on assisted suicide be centered on the question of autonomy? What if the very way the problem is perceived is part of the problem itself, as it mystifies the problem? In my opinion the strongest case that has been made to aid the elderly in their wish to die is exactly the man whose contribution had an immense impact and put the topic on the public agenda. His essay that was published in the NRC and many responses to that essay have been bundled in a book named after the title of his essay 'Het zelfgewilde einde van oude mensen[66]. 'The book begins with an in introduction by the publisher which exactly shows the problem I would like to address.

Drion revisited

In the introduction the publisher of the book quite rightfully praises Drion's contribution to the public debate on assisted suicide for the elderly. The publisher values Drion's contribution in the discussion on the growing influence of medical technology on people's lives and the discussion on the moral, psychological and judicial aspects of assisted suicide. The publisher especially values Drion's contribution on self -determination when he writes "*Op het specifieke punt van 'zelfbeschikkingsrecht' voor oude mensen is Drion met zijn publikatie echter bij uitstek voorloper en verkenner*[67]*."* With his publication Drion is a frontrunner and an explorer especially concerning the right to self-determination of the elderly. But is this the case? Is Drion a frontrunner and explorer in the debate on assisted suicide because of his insights concerning self-determination and autonomy? In the actual article the word self-determination is absent and the word autonomy is used only once. This is pretty bleak for a proposed champion of self-determination and autonomy. These are strong signals that show that Drion wasn't thinking about the right to self-determination of the elderly as a means of justifying the assistance of suicide at all. So what was Drion thinking about?

Drion is also mentioned in the UVW's book. They also value him as the man who put the discussion on assisted suicide for elderly on the public agenda. Again this is true, but what is overlooked is the justification Drion gives for being in favor of the assistance of suicide for

[66] H.Drion, Het zelfgewilde einde van oude mensen, Balans, 1992
[67] Idem

elderly. His justification is not the well-known one of the elderly's right to self-determination as proposed by the prior mentioned publisher. I believe that Drion was actually sensitive enough for the fact that a right to self-determination can only get you so far, which is not far enough to fully justify assisted suicide for the elderly. He approaches the matter from the opposite direction.

Before I continue in arguing why I think Drion is a valuable asset in the assisted suicide debate I would like to point out that he published only one article on this matter. This article was published in a Dutch newspaper and was not intended for an academic audience. In his article he does not argue in the scholarly way which results in some unjustified assumptions. I would like to ask the reader to bear with me especially because I will not use any conceptual analysis from Drion. For me Drion is interesting because he approaches the question from an interesting point of view.

Huib Drion's proposition is to legalize the access to lethal drugs for everybody who reaches a certain age. (Drion proposes 75 but adds that this age isn't written in stone) He starts the justification of this proposition by stating that society already provides for a lot of ways to end one's life. There are bridges to jump from, trains to jump in front of, canals to drown in and ropes you can buy to hang oneself[68]. Of course these means aren't very attractive for the person who wants to commit suicide and for this person's family and friends. There are people who have access to more humane means to suicide like pharmacists and doctors but they are but a small exception. Drion asks why this is the current situation? (A propos the current situation, this article is from 1991 and the existing euthanasia law is from 2001) Why don't we, as a society (when using the word society Drion also includes the political and judicial constellation. I will also use society in this manner in this chapter) grant people the possibility to terminate their lives by not prohibiting the distribution of existing legal drugs. Of course the question whether providing legal drugs would be the same as providing bridges, trains and rivers is at place here. Unfortunately Drion's writing on this matter does not cover this question. But if we replace trains, bridges and rivers with books and websites that present in great detail ways to commit suicide the distinction between allowed and blocked methods for suicide can be reintroduced. Where the answer to the question, is

[68] H. Drion, Het zelfgewilde einde van oude mensen, Balans, 1992, pagina 4

providing bridges, trains and rivers the same as providing lethal drugs based on common sense is no. (We make trains with the goal to transport people not to run them over.) The answer to whether providing a book describing in great detail how to commit suicide and providing a lethal pill are the same is in my opinion not so obvious. Especially when focused on the question what the moral difference is between a suicide book and a suicide pill.

Drion continues, lethal drugs are available but they have been made illegal to distribute freely. Drion claims that we do so out of solidarity with the future 'me', as Drion calls it, of the person who wants to commit suicide. If I would want to commit suicide I wouldn't be solidary with my future me. Therefore society has to take upon itself this task. Again a claim by Drion that needs more justification but sadly no justification was provided by Drion. Why would society have to take upon itself this task?

But this task is performed by prohibiting measures that could lead to a humane way of committing suicide leaving only open the more inhumane options.[69] Now Drion asks if the prohibition of the free distribution of lethal drugs and only leaving open the horrific methods for suicide is justifiable in the case of the elderly who feel they have lived long enough[70]. Again a lack of explanation from Drion but I assume he is arguing that society has a task to be solidary with young people's future in cases of suicide and therefore it blocks the free access to lethal drugs. But in the case of the elderly the interests of this future 'me' might not outweigh the interests of the present 'me' who is suffering and wishes to die.

The argument works in the exact opposite direction of the more popular autonomy argument that we have already seen. In the autonomy argument the right to autonomy or self-determination is used to justify a duty to assist in the request for suicide. Drion's argument is that suicide is legal. There are humane and inhumane ways to commit suicide. Why does society allow the inhumane ways, such as jumping on front of a train, and not allow the humane ways such as a lethal pill. Drion understands that allowing lethal pills for everybody would be unjust, because society has to be solidary with the future of persons

[69] Idem

[70] "Waar het mij nu om gaat is, of deze rechtvaardiging van een politiek, waarbij de daad van de zelfdoding zo weerzinwekkend mogelijk wordt gemaakt, met evenveel recht kan worden ingeroepen als het gaat om de oude mens, die vindt dat hij lang genoeg heeft geleefd en die met afschuw denkt aan een voortzetting ervan in aftakeling die hij zelf als onwaardig voelt." H. Drion, Het zelfgewilde einde van oude mensen, Balans, 1992, pagina 4

who want to commit suicide, that is to say, the non-elderly have a future that might be worth protecting and society takes upon itself this task. (Again, this claim really needs justification from Drion) But why would this justification also hold for the elderly who feel they don't have a meaningful future anymore? What is society's justification to block access to lethal drugs in the case of the elderly?

We have seen that this interference from society in the access to lethal drugs is a form of indirect paternalism. And indirect paternalism does not harm the autonomy or the moral value of the engaged parties. But Drion's argument isn't centered on the notion of autonomy or moral value of the elderly. Drion argues that suicide is legal and asks for a justification as why the access to certain humane ways of committing suicide is denied. What right does society have to block this access? So does den Hartogh's argument of indirect paternalism still hold?

Indirect paternalism revisited

In order to answer this question I will revisit den Hartogh's argument of indirect paternalism. I will do so, to be able to argue whether this argument would defeat Drion's proposition to legalize lethal drugs for people who reach the age of 75 or not. In his article den Hartogh uses the example of wearing a seatbelt while driving to explain the so called balancing view[71]. He starts by pointing out that the principle of autonomy safeguards our interests in freedom. Although this is one of the most important interests we can have it remains one interest among others and therefore occasionally it has to be weighed against these other interests. In the case of the question whether we should wear a seatbelt our interest in freedom or autonomy may result in not wearing a seatbelt. But the justification of these interests is not very convincing, if someone is too lazy to wear the seatbelt or is too weak willed. Furthermore the act if not wearing a seatbelt does not or hardly compromises our life's plans. On the other hand the interest in public well-being and safety is greatly influenced by the decision to wear a seatbelt. So when weighing the interests of freedom against the interests of public well-being in this specific case it would be justified by pure

[71] G. den Hartogh, Euthanasia Reflections on the Dutch Discussion, Article first published online: 25 JAN 2006 Annals of the New York Academy of Sciences Volume 913, pages 174-187.

common sense that the interests of well public well-being would outweigh the interests of freedom.[72] This weighing of interests is called the balancing view and indirect paternalism is a logic extension of this view. It weighs the interests of freedom against the interests of the possible harms that may result from the exercise of this freedom. A justified question here would be whether the interest of autonomy is commensurable with other interests. As we have seen before Feinberg claims that autonomy has a special position because we first need to establish a moral symmetry or a moral equality between persons before we can start weighing interests. But in favor of not digressing too much I will focus on den Hartogh's balancing principle and indirect paternalism.

In the case of a request from an elder for assistance in committing suicide with the justification that the duty of the doctor to aid results from the elder's autonomy, this balancing principle does work. The harm coming from reducing a doctor into an instrument in the hands of an elder is grave and outweighs a possible duty of a doctor that is generated by respecting an elder's autonomy (if there's a duty at all to begin with). But Drion proposes the idea that the elderly who reaches a certain age becomes legally entitled to get free access to lethal drugs (This is commonly known as Drion's pill.)So there is no doctor who can be harmed in the process of weighing interests. But surely someone has to subscribe these drugs? Even though this is true, this obviously does not have to be done by a doctor or for that matter by anyone. I can imagine that when you reach the age of 75 you would only need your passport or another form of identification to go to a pharmacy and pick up the lethal drugs. No subscription needed. But how about the pharmacist's interests? Well, it could be arranged that only pharmacists who have no objections against distributing legal drugs to elderly will take upon themselves the task of distributing these drugs. (So basically the argument for the doctor also goes for the pharmacist) Of course the biggest question would be how about society?

Society works as a third party in blocking the access to these legal drugs. So we may ask, how about society's legislation that blocks the access to these lethal drugs to begin with? Society's interests should be taken into consideration as well. I do agree but I believe that

[72] Den Hartogh doesn't actually claim that common sense is the means of justification in his article. But because of the lack of justification in his article and the obviousness that he relies on the justificatory power of common sense I will infer that he depends on common sense as a means of justification.

with this question we have penetrated the heart of Drion's argument. It isn't the question whether society has interests that have to be weighed in the discussion on assisted suicide but the focus should be on what these interests are? That is to say, which interests does society have in blocking the access to lethal drugs for the elderly? When using the balancing principle common sense is enough to understand that a neither a doctor nor a pharmacist can be reduced to an instrument of will in the hands of the elderly, subscribing lethal drugs just because an elder asks to, without taking the interests of the doctor into consideration. But is common sense enough in helping us to balance the weight of the interests of the elderly against the weight of the interests of society? So important questions that have to be answered are, what are the exact interests society has in blocking the access of lethal drugs for the elderly and how should we weigh these interests? I will articulate these considerations in three questions.

We are left with a couple of questions at the address of society. Why does society block the access to legal drugs for the elderly? Drion argued that it is understandable to block the access for the non-elderly. They have a future life in front of them where there is a real possibility that life will make a change for the better. But does this argument suffice to justify blocking the access to legal drugs for the elderly whose lives are most probably not going to make this change for the better? If these interests of the elderly don't need to be protected than whose interests is society protecting? So my first question is; 'whose interests are taken into consideration when blocking the access to legal drugs for the elderly?'

When question number one is answered and we have determined the group whose interests are taken into consideration the next question will be ; 'What are the interests that are being considered when blocking the access to lethal drugs for the elderly?'

When question number two is answered and we have determined what interests are being considered when blocking the access to lethal drugs the last question I would like to ask is; 'How should we weigh these interests against the interests of the elderly?' In the balancing principle common sense is used to weigh interests. I do agree that common sense can in fact be a great asset in weighing interests. But it is also possible that common sense will not be

enough to produce an equivocal weighing result. And if this is the case, how should we then weigh competing interests?

I think these are important questions especially because they restate relatively common questions in the euthanasia debate but approaches them not from the position of the duties autonomy can generate but from the position that society has to justify its policy on blocking the access to lethal drugs for the elderly. I think this is Drion's great insight in the debate on assisted suicide that is somewhat overlooked.

Conclusion

The main question I have set out to answer in this thesis is; 'Is Uit Vrije Wil's proposal as described in their manifest and in their proposition law ethically desirable?' To answer this question I have isolated three arguments that, according to UVW, are reason to believe that their proposition law that is elaborated in their manifest is desirable to aid the elderly who are suffering existentially and require assistance in suicide. The three arguments are, that unbearable and hopeless suffering does not suit the kind of suffering that is felt by the elderly. Subjectivity makes it impossible for a doctor to assess the elderly's suffering. And the elderly's autonomy entails that we have a certain duty to aid the elderly who come to the conclusion that they want to end their life.

To begin with the two requirements, based on results presented by RTE's we can see that the existing euthanasia law can already deal with some requests for euthanasia that stem from the kind of suffering that approaches UVW's description of existential suffering. And the RTE reports also demonstrate that in these cases this suffering can be linked to a medically based condition such as symptoms of frailty. So in these cases the requirement of unbearable and hopeless suffering does not hinder requests for assisted suicide based on existential suffering. But perhaps this isn't enough.

The fact that the euthanasia law can help some elderly with their request for assisted suicide does not entail that the scope of the law is enough to deal with all the requests for assisted suicide. UVW very pessimistic about the ability of the existing euthanasia law to deal with requests for assisted suicide. They claim that not doctors but the elderly are the ones who

can decide whether their suffering is grave enough to lead to assistance in suicide. Therefore the requirement of unbearable and hopeless suffering should not apply for the elderly. But I don't agree with UVW's interpretation of the notion of subjectivity. Using Wijsbek I have argued that subjectivity does not entail some first person transparency and a third person inaccessibility. A doctor can be empathetic and identify with his patient's situation and sometimes even correct the patient's beliefs he may have concerning his situation. And these qualities are actually qualities we look for in a good doctor. Furthermore I have argued that subjectivity can only be mediated through its objective counterpart. This is to say, a subjective feeling like suffering has to be accompanied by certain objective data such as symptoms of frailty, loss if independence, depression and so on. If it is not, we do have reason to believe that the request for assisted suicide might be confused and arises from other possible problems. The requirement for objectivity in the assessment of unbearable and hopeless suffering does not necessarily compromise the elder's subjectivity. The fact that subjectivity isn't as narrow as UVW would like us to believe makes the requirement of unbearable and hopeless suffering less problematic in dealing with requests for assisted suicide from the elderly. The subjectivity of the elder doesn't seem to be reason enough to claim that the existing euthanasia law needs to be amended in order to respect this subjectivity. To put it in another way, UVW has to make a better effort in showing that the current euthanasia law does not respect the elderly's autonomy.

But how about removing the requirement for unbearable and hopeless suffering from the law because it is in conflict with the elderly's right to autonomy and self-determination. UVW wrote a proposition law that is in fact very similar to the existing euthanasia law but lacks this requirement. Is it in fact the case that the requirement of unbearable and hopeless suffering is in conflict with autonomy? Using den Hartogh I have argued that the problem we have with the transgression of autonomy is paternalism. He who interferes with my decisions claiming he is doing so out of my best interest is implying a certain moral asymmetry. And not respecting me as a moral equal is insulting. So when we are interfering with the elderly's decision to end their lives we are being paternalistic. But when analyzed more carefully we have to come to the conclusion that the elderly are not being interfered in their wish to die. Although it might sound harsh but when an elder wants to commit suicide there is no interference, that is to say, committing suicide is perfectly legal in the

Netherlands. But the problem arises when the elderly require assistance in their suicide. Autonomy alone does not generate a duty to assist in the elderly's suicide. So in fact the interference starts when the elderly requests from the doctor assistance in suicide. Because a doctor is an equal moral agent and not merely an instrument in the hand of an elder he cannot be forced or, there is no duty based on the autonomy of the elder, to assist in the request for suicide. The harm of reducing a doctor to an instrument of will in the hands of an elder is greater than the benefit of respecting an elder's autonomy. Therefore interference is allowed to protect the interests of the doctor. This is what den Hartogh refers to as indirect paternalism.

The three key arguments, as put forward by UVW, are not very convincing and do not lead me to believe that their proposal that is described in their manifest and their proposition law is ethically desirable.

So are we out of the woods? I think that one consideration might have been overlooked in the assisted suicide debate. The consideration that was put forward by one of the fathers of the assisted suicide debate, Huib Dion. He claims that suicide is allowed by society. There are inhumane ways such as buildings we can jump off or rivers we can drown in but also humane ways such as legal drugs. So what is the justification from society to allow for the inhumane methods but to block access for the elderly for the humane methods? I have argued that den Hartogh's notion of indirect paternalism isn't sufficient to justify the interference from society. My three questions were; who has an interest in blocking the access of lethal drugs? What are these interests? And how should we weigh these interests against the interests of the elderly?

I think the questions that are posed are relevant because, with due respect, they put emphasis where emphasis is needed. What do I mean with this claim? While examining literature about the debate on assisted suicide notions such as autonomy, subjectivity, the medical domain, unbearable and hopeless suffering and many more are used to explicate the judicial tug of war between on the one hand people who believe that a close reading of the existing euthanasia law is sufficient to deal with these requests and the other hand people (e.g. UVW) who believe that the existing law needs to be amended. Who should ultimately have the last word in the actual decision to assist in the suicide, doctors or the

elderly? I am fully aware that this is an oversimplification of a debate that has been going on for several decades, but what I want to point out is that although the debate is and has been an elaborate one the emphasis remains, in my point of view, on the judicial tug of war.

But asking in whose interest it is to block the access to lethal drugs from the elderly, what these interests are and how they should be weighed shifts this emphasis. These aren't questions that can be answered by judicial facts but by moral values we hold as a society.

I would like to end the thesis by posing a question that demonstrates my latter claim. For now it is true that the access to legal drugs is blocked. But as many people engaged in the euthanasia debate have pointed out, there are other ways. One way 'out' for the elderly could be the so called helium method. In a nutshell, the elder puts over his head a plastic bag and connects this bag via a hose to a helium tank. The plastic bag prevents the inflow of oxygen and outflow of carbon gas which results in the loss of consciousness, suffocation and eventually death. The helium prevents the panic sense of suffocation.

So why do we on the one hand allow books where this method and others are describes to end one's life but on the other hand block access to lethal drugs for the elderly? Whose interests are we serving by blocking access and why are their interests suddenly not worth protecting when they use the helium method? Are these two methods morally unequal? I wouldn't mind a debate that addresses these questions.

Literature

- *Het zelfgewilde einde van oude mensen,* H. Drion, Balans, Amsterdam 1992
- *Handboek* gezondheidsrecht H.J.J. Leenen, J.K.M Gevers, J. Legemaate, Bohn Stafleu van Loghum 2007
- *KNMG position paper the role of the physician in the voluntary termination of life,* Utrecht June 2011
- *ECHR Protocol no 11, article 2,* Rome 1950
- *Wetboek Strafrecht , Artikel 293, 294*
- *Toetsing levensbeëindiging op verzoek en hulp bij zelfdoding*. Artikel 2 available at http://wetten.overheid.nl/BWBR0012410/geldigheidsdatum_25-05-2013
- *Keuzewegen naar de dood,* Tijdschrift voor Humanistiek 11 ,Ton Vink, 2010
- *Wet Toetsing levensbeëindiging op verzoek en hulp bij zelfdoding.* Artikel 1
- *Wet Toetsing levensbeëindiging op verzoek en hulp bij zelfdoding.* Artikel 2
- *Website NvvE* available at http://www.nvve.nl/nvve2/pagina.asp?pagkey=7189
- *Website Openbare Ministerie,* toelichting hoofdadvocaat-generaal Egbert Myer, available at http://www.om.nl/actueel/de_officier_van/@123530/de_zaak_brongersma/
- *Commissie Dijkhuis rapport,* Utrecht december 2004
- *Uit Vrije Wil waardig sterven op hoge leeftijd,* Jit Peters Eugene Sutorius, Yvonne van Baarle, Wouter Beekman, Samantha Daniels, Loes de Fauwe, Govert den Hartogh, pagina 9, Boom 2011
- *Complexe ouderenzorg in verzorgingshuis en thuis,* 2009 A.H.J. van de Rijdt-van de Ven in opdracht van Landelijke Vereniging voor Huisartsen
- *Website Uit Vrije Wil* available at, http://sparta.projectie.com/~uitvrije/index.php?id=1002
- *Knowing me knowing you* Article by Henri Wijsbek
- *Brongersma Arrest* LJN: AE8772, 184 ad http://zoeken.rechtspraak.nl/detailpage.aspx?ljn=AE8772
- *Samen op weg naar het einde,* dr. Henri Wijsbeek, TGE jaargang 21 – nr2 -2011
- *Het Nederlandse euthanasierecht: is barmhartigheid genoeg?* G. den Hartogh, Tijdschrift voor Gezondheidsrecht (2007) 31:137–148
- *Euthanasia Reflections on the Dutch Discussion,* G. den Hartogh, Article first published online: 25 JAN 2006 Annals of the New York Academy of Sciences Volume 913, pages 174-187.
- *Harm to Self ,* Joel Feinberg, New York: Oxford University Press, 1986