2008

Weighing the balance: An examination of and possible justification for euthanasia

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Weighing the Balance: An Examination of and Possible Justification for Euthanasia

by

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A Thesis
Submitted to the Faculty of Graduate Studies
through the Department of Philosophy
in partial fulfillment of the requirements for
the degree of Master of Arts at the
University of Windsor

Windsor, Ontario, Canada
2008

Your file Votre référence
ISBN: 978-0-494-47042-8
Our file Notre référence
ISBN: 978-0-494-47042-8

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Abstract

The purpose of this thesis is to explore the concept of euthanasia as well as the situations in which it could possibly be justified. This thesis posits that euthanasia can be justified where a liberal conception of personal autonomy is given significant importance and where there exists suffering of a level which an autonomous individual is either unable or unwilling to bear. Following this the various distinctions within the concept of euthanasia are drawn out before the extant euthanasia legislation is discussed in order to illuminate what a justified form of euthanasia might look like. The bulk of this thesis is then given over to a detailed discussion of representative arguments against euthanasia and the possible responses thereto. Through the course of this discussion it becomes clear that a belief in the sanctity of life is foundational for almost all the arguments against euthanasia. Rather than attempting to refute this belief this thesis argues that, when taken as a whole, the arguments in favour of euthanasia are more persuasive than the arguments against, and that therefore there are circumstances in which euthanasia should be seen as a justifiable and rational choice made by an autonomous individual.

Dedication

In the late 19th century the body of an unknown woman was pulled from the River Seine, an apparent suicide. The Paris morgue attendant was struck by the beauty of the woman's face. Having drowned she showed no signs of struggle, and her face retained the look of serene composure. Known as "L'Inconnue de la Seine" the death mask of this woman became a popular fixture on the walls of artist's homes in the early 20th century. When, in 1958, Asmund Laerdal needed a face for what was to be the world's first CPR training dummy he chose the well known face of L'Inconnue as a tribute to her death. This doll, Resusci Anne, would go on to become an exceptionally popular CPR training tool. Because of this history it has been said that L'Inconnue de la Seine has the most kissed face of all time.

I dedicate this paper, then, to L'Inconnue de la Seine.
A tragic death and the most kissed face.

Acknowledgements

I would like to acknowledge the help and support that I received from my entire family throughout the course of my writing: My parents, Colin and Julie, for putting up with a ghost in their basement; my Grandparents, Ken and Dorothy, for always being proud of me; my Granny, Margaret, who, sadly, died less than a month before the completion of this work, I'm sorry that she never got to see this finished; and my friends who were able to get me out of the basement for more pints than medically advisable.

I would also like to acknowledge the contribution of my advisor Dr. Philip Rose, without whose help this would not have been the work that I am so proud of. And to the rest of the Philosophy department at the University of Windsor, who over the last 6 years have all helped me in their way. And, finally, thanks to Dr. Mark Letteri, the professor who initially fostered in me a love of philosophy, and who has since become a valued friend.

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Philosophy ought to imitate the successful sciences in its methods, so far as to proceed only from tangible premises which can be subjected to careful scrutiny, and to trust rather to the multitude and variety of its arguments than to the conclusiveness of any one. Its reasoning should not form a chain which is no stronger than its weakest link, but a cable whose fibres may be ever so slender, provided they are sufficiently numerous and intimately connected.

- C.S. Peirce, *Some Consequences of Four Incapacities*

The Elimination of Taboo: Towards the Prevention of Suicide

This work was originally motivated by a purely intellectual interest in suicide and euthanasia, specifically regarding their possible justifications. As an intellectual exercise this was where it ended. I have never been suicidal, but I know all too well what the suicidal mind must be like. In conducting research for this paper I found myself reading more and more about particular instances of suicide. Unknown at the time, I was becoming increasingly affected by these stories to the point where I had no desire to do any writing whatsoever for the period of about a month. That month was devoted to research into possible justifications for suicide. This was the worst thing that I could possibly have done. Despite not being suicidal I found thoughts of suicide constantly in my head[1]. Locked away in my basement apartment I was often working well into the early hours of the morning. This was a very lonely time for me.

At some point, I do not remember when, I decided that I needed to get some help and I talked with my family and friends about contacting a therapist, if only to help me give context to the thoughts that I was having. I found, though, that this was ultimately not necessary. Once I spoke about the issues I was having they became easier to deal with, but it was a hard subject to bring up. This is what is so dangerous about suicidal thoughts and ideation: they change the way you think about things and you begin to feel as if nobody could possibly understand what you are going through. Suicidal thoughts close you off from the world. Alvarez's The Savage God discusses suicide as a closed world with its own irresistible logic (143):

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[1] I suppose that I would have thought about nothing but the Will to Power had Nietzsche been my research interest.

> The logic of [this closed world] is different. It is like the unanswered logic of a nightmare, or like the science fiction fantasy of being projected into another dimension: everything makes sense and follows its own strict rules; yet, at the same time, everything is also different, perverted, upside-down. Once a man decides to take his own life he enters a shut-off, impregnable but wholly convincing world where every detail fits and every incident reinforces his decision. An argument with a stranger in a bar, an expected letter that doesn't arrive, the wrong voice on the telephone, the wrong knock on the door, even a change in the weather – all seem charged with special meaning; they all contribute. The world of the suicide is superstitious, full of omens.
>
> (Alvarez, 144)

It is as if the suicidal individual loses all parts of himself except for those parts that reinforce his suicidal ideation. Suicidal thoughts often strip the individual of their individuality reducing them to an object that is (the "is" of identity) suicidal. I hope, then, that the current work will only ever serve to open up the discussion, to get suicide out of the shadows and into a place where people can talk about it without feeling like their loved ones would not understand. I hope that it would help to reintroduce suicidal individuals to their individuality, as it were, in such a way that they could overcome their problems without having to resort to drastic measures. Unfortunately, however, this help is often very difficult to find because of the taboo just mentioned. This can lead to tragedy, not unlike the events that have been occurring in Bridgend, Wales, where, since 5 January 2007, twenty three young people have taken their own lives[2].

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[2] I found this case to be particularly eerie as the suicides have been occurring for exactly as long as I have been writing this paper. In a way, my understanding of suicide has developed as these young people have been taking their lives.

Bridgend, Wales and the Werther Effect

The closed world of suicide persists precisely because it is closed. For the suicide it often seems as if nobody talks about suicide and as such there is nowhere for them to turn. This is typically compounded by the recognition that there is a very strong social taboo surrounding suicide that is often very difficult to break. This is something that not many suicidal people have the strength to do[3]. The closed world of suicide allows the problem to be compounded and even promotes further suicides. Nowhere is this more evident than in the historical case of Goethe's Young Werther, and the modern example Bridgend, Wales. These cases illustrate how the logic of suicide can begin to infect others, steadily increasing the number of suicides. In 1774 Johann Wolfgang von Goethe published The Sorrows of Young Werther in which a young man, the eponymous Werther, commits suicide after realizing that his long-loved Charlotte will continue to refuse his advances in favour of another. Following the release of the book a number of young men killed themselves after a similar fashion to Werther, many going so far as to dress themselves in a style like Werther's prior to their suicide. The similarities of the suicides and the seemingly motivational nature of Goethe's book led to 'The Werther Effect' becoming the accepted term for cluster suicides that share, or appear to share, more than passing similarity to each other.

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[3] It is this fact which suicide hotlines such as 1-800-SUICIDE (US) and The Samaritans (UK and Ireland) recognize and try to combat. By providing an anonymous non-judgemental outlet for the suicidal these organizations and others like them are trying to offer an alternative to the idea that the suicide has nowhere to turn. The Samaritans in particular are so convinced of the importance of an outlet that they do not try to convince the individual not to kill themselves; they just let the individual talk, leading the conversation where they want to take it without fear of being judged. Often this is enough.

The county of Bridgend, Wales has had a number of youths commit suicide – mostly by hanging – since January 2007. The latest victim[4], the 23rd, died on 9 August 2008. There have been many theories as to why these individuals have killed themselves. Some people insist that a suicide cult is working in southern Wales. Others, perhaps as a reaction to the sheer number of deaths, suggest that this is the work of a serial killer though no evidence exists to support this. The theory that is gaining the most traction is that the media is at least in part to blame for their coverage of the deaths. The parents of the dead have come out against the media coverage of the suicides claiming that the coverage of the deaths is only used to sell papers. There is no simple answer to this problem. Many of these individuals knew at least one of the other people to commit suicide, and many of them tried to find an outlet for their pain on social networking websites. But these forms of communication are fundamentally lacking an element of personal interaction, and so, finding nowhere to turn to express themselves they are forced back into the closed world where a memorial page for a previous suicide is seen as presenting a viable solution to the problems that they are facing. Finding no one willing or able to talk, and being unable to break through the social taboo, these young people have taken what they see as being the only option available to them.

[4] As of this writing.

Introduction

Why the Question?

Why does it matter that we die? There are myriad possible ways to address this question, the variations of which depend mostly on the beliefs held by the person attempting the answer. The religious and the otherwise spiritual may believe in the possibility of another life after death. For those who hold religious beliefs[5] the end of this life means the end of your opportunity to live according to whichever sacred writings you hold important, and it also means that the question of whether you have lived a sufficiently virtuous, brave, or pious life will be answered once and for all. This cannot hold, though, for the non-religious people in the world. But surely death still matters to those who do not subscribe to any otherworldly beliefs. For those with no belief in an afterlife, death matters because of its finality. Without life after death these people are bounded by the years between their birth and the day that they will assuredly die. On this day they will see the last of their family, their friends, and everything else that they have known, and that will be the end of that. What is important for these sorts of lives is the multitude of actions taken while still alive and how they will be remembered by those who survive them. This understanding of death as finality, unlike the religious belief in an afterlife, can have a more widely extended importance for the religious and the spiritual alike. The finality of death is important regardless of belief because having a

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[5] I must immediately point out my biases in order to prevent them from undermining the overall course of this work. I am writing from within a Judeo-Christian, Western society during the first decade of the twenty-first century. I am aware of the differences between various religions or cultures existing today as well as the differences that exist within individual societies over time. I would like to think that the following work could extend to other cultures and societies but my ignorance prevents me from making these claims. My work must then be situated within my culture and I invite anyone from other cultures or beliefs that do not coincide with my biases to take what they can out of this work.

belief does not change the fact that their current life and all of its particularities will come to an end. So it is quite clear that, regardless of religious or spiritual belief, or the complete lack of belief, *that* we die is of crucial importance.

Why, then, does it matter how we die? I take it as a truism that people would prefer to live a life free of torture howsoever minimally torture might be conceived for that individual. Also, I cannot think that it would be too presumptuous to assume that most people would prefer to die a natural death[6,7] free from any debilitating diseases, many happy and healthy years in the future. Given these reasonable assumptions it would seem that there can be better and worse deaths depending on the values of a particular person.

Finally, why does it matter when we die? This is a more complex question, one that cannot be answered with an assumption of preference. Any attempt to do so would be to neglect the intricacies of the issue. The question is so intricately bound to the question of how we die that, at times, they are apparently the same question. There are those who would argue that what is most important is how we live our lives rather than how and when we die. However noble the spirit of this mindset may be, it neglects the issue that our death is fundamentally meaningful to us as the end of our particular existence, and as such we cannot ignore the fact that our lives will end nor can we overlook the consequences, both psychological and social, of our understanding of our mortality. Others would argue that the plain fact that we die cannot be changed and so

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[6] For the remainder of this paper the term "natural death" will be meant to refer to the unavoidable reality of multi-system organ failure under the conditions of advanced age. The human body, as it is stands, is not capable of living beyond 125 or so years before the general wear and tear of advanced age brings about death.

[7] I recognize that some might prefer to die an honourable death (Samurai come to mind) or a memorable death, etc... but I maintain that these are not the majority.

there is little reason in questioning the when of it. But this argument functions as a stopgap that must not be allowed to halt a potentially profitable examination, for the more we know about the limits of our lives, the more we are able to say about our lives themselves.

Answering the questions of whether or not it matters how and when we die will require a detailed analysis of many difficult issues such as the importance and limits of personal autonomy, and the right to self-determination. In cases of a natural death this question need not be addressed if only for the fact that deaths of this sort are beyond our control. What control we do have, medically, over our lives tends to become less and less effective as age increases. When we factor in illness and disease our ability to control our health is restricted even further. Despite the best efforts of science and the advancements of health technology there are still terminal conditions that severely limit the life horizons of particular individuals. For every Polio and Measles vaccine invented there are still diseases like Huntington's and Alzheimer's which cannot presently be cured. The unfortunate reality is that there are people whose lives will be forever changed by the diagnosis of a disease who will then be forced to watch their lives degrade before their eyes. Here we turn to an example in order to illustrate some of the struggles that a person with a terminal illness must endure. This example will also serve as the lead in to the main project of this paper which will attempt to offer a justification for suicide in particular situations.

The Case of Sue Rodriguez – Euthanasia in Canada[8]

Sue Rodriguez, a Victoria, British Columbia woman, was 41 when she was diagnosed with amyotrophic lateral sclerosis (ALS). Her doctors told her that she would have three to five years, on average, before the disease killed her. She was also told that the last days would be particularly gruesome as the disease progressed into its final stages. ALS is a degenerative disease that affects the nervous system without impairing cognitive function. The disease progressed with such rapidity that Rodriguez would be faced with new physical limitations on a daily basis, and because there was no cognitive impairment she was able to understand exactly what was happening to her. Within two and a half years she could no longer bathe, dress, or feed herself without assistance. A few months later she got to the point where she was so weak that she could no longer operate the television remote control on her own; thus she required assistance for even the most passive of undertakings. At this point the morphine that she was prescribed for pain management was of a sufficiently high dose that she became unable to control her own eyelids.

At some point during these years Sue Rodriguez decided that there would come a time when she would not want to continue the daily struggle, and at this point she would end her life. But ALS once again made that impossible; swallowing any pills required muscular control that she no longer had. It was clear then that here too she would need help. In an effort to secure for herself the help that she needed at the end of her life she would have to try to change Canadian law.

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[8] All information related to the case of Sue Rodriguez contained in this section was collected from the CBC Digital Archives: "Sue Rodriguez and the Right-to-Die Debate".

Prior to 1972, suicide was illegal in Canada[9] but the decriminalization of suicide left certain holes in the law that Sue Rodriguez was poised to fall into. Even though suicide had not been illegal in Canada for over twenty years at the time of her legal challenge, laws were still in place that prevented her from obtaining assistance with her death. Rodriguez argued that this prohibition on assisted suicide[10] violated her fundamental right to liberty and security[11] as well as her right to be free from cruel and unusual treatment[12] given her supposedly equal status under the law[13]. Stripped of the obfuscating legal language Rodriguez was arguing that by not allowing her to obtain the needed assistance with her suicide she was being treated unfairly on the basis of her physical disability because without her illness, if she wished, she could easily kill herself. The British Columbia Supreme Court ultimately rejected her appeal on the grounds that liberty and security cannot be divorced from the sanctity of life which is another Charter value protected by Section 7. All life is valuable, the courts said, and this particular deprivation of Rodriguez's security, if that was what was occurring, was not contrary to the principles of fundamental justice and it was, therefore, still in line with Section 7 (Rodriguez *v.* British Columbia p. 79). Despite losing her court cases Rodriguez, with the help of an anonymous physician, ended her life on 12 February 1994 by drinking a liquid laced with morphine and a powerful barbiturate.

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[9] A legal fact mirrored in many countries around the world. France decriminalized suicide after the 1789 revolution. In the United States suicide has never been punished as a crime even though it was still considered a felony in six states in the 1960's. England decriminalized suicide with the Suicide Act of 1961, previous to which the suicide was met with the forfeiture of property and the desecration of the body. Ireland finally decriminalized suicide in 1993.

[10] Section 241(b) of the Criminal Code of Canada

[11] Section 7 of the Canadian Charter of Rights and Freedoms

[12] Section 12 of the Canadian Charter of Rights and Freedoms

[13] Section 15(1) of the Canadian Charter of Rights and Freedoms "Every individual... has the right to the equal protection and equal benefit of the law without discrimination... based on... physical disability...".

To many observers (though by no means all) it would seem that Sue Rodriguez was acting rationally and that she should have been able to have help ending her life without having to participate in a criminal act. Emotionally, at least, one can see reasons for accepting her desire to die which should, at the very least, serve as an indication that there is some important factor of her case that might contribute to a justification of suicide. But 'many' is not all, and emotional justifications are fraught with problems. There is an oft-quoted legal phrase that 'hard cases make bad law' which can be read to say that emotionally difficult cases should not be allowed to sway opinions towards a change in the law because such emotional justifications can very easily violate the spirit and scope of the original statute, possibly changing it beyond recognition. While this does speak to the issues surrounding emotional justification such an adage cannot and should not be allowed to put an end to any investigation into possible rational justifications that can eventually take the place of prima facie emotional justifications.

This, then, is how the present work will proceed: the justification of euthanasia begins with a justification of suicide. If a justification of suicide can be found to such an extent that the rational termination of one's life could be an acceptable option, it would go a long way to justifying the further case of euthanasia or assisted suicide. The key to justifying the contentious issue of suicide (and also, then, euthanasia) is to focus on the importance of personal autonomy which, following the liberal tradition, I take to mean self-governance. Rather than simply assume the importance of personal autonomy this paper begins by presenting an argument in favour of autonomy by developing a synthesis of classical and modern liberal positions. The biomedical literature typically presents Kantian notions of autonomy in order to contrast with the liberal conception, but Secker

(1999) provides an important refutation of the too common use of Kantian autonomy which she argues has a negative influence on both patient rights and welfare. In arguing against the appropriateness of using the Kantian notion of autonomy, the liberal notion is retained as being the preferable conception of autonomy in that it does not devalue patients in the way that Kantian notions of autonomy might.

After this is completed the paper shifts focus slightly to deal with the myriad distinctions that run throughout the entire ethical considerations of suicide and euthanasia. These distinctions begin with a discussion of suffering both physical and 'existential' followed by a differentiation between Rational and Emotive suicide. Importantly for this paper it is the former sort of suicide that should be considered as being argued for throughout as the latter will be shown to be intensely problematic in various situations. As such, rational suicide will be put forward as the ideal type of suicide – if there can be an ideal form of suicide – though this paper will admit that, as an ideal, rational suicide is not always attainable in practice.

In order to ensure, as much as is possible, that rational suicide is being attained, or, more precisely, that emotive suicide is being avoided, various checks on the practice are discussed. Euthanasia legislations in Australia, The Netherlands, and Belgium are compared to find areas of overlapping import which provide the starting point for the discussion of euthanasia criteria. A discussion regarding multiple autonomies – which is included to ward off a particular criticism of euthanasia – the majority of the paper will turn to the various arguments against euthanasia as well as the various responses that could be made to each. It is in the course of this discussion that the argument for the sanctity of life is first identified. This argument will be held as the main influence behind

the majority of arguments against euthanasia and as such it will be discussed in detail. Ultimately this will be found wanting on the balance of the arguments presented throughout, and this – the balance of the argument – will serve as the strongest reason to support the idea of justified euthanasia. What follows is the discussion of autonomy as it relates to suicide.

The Question of Autonomy

The entirety of this current work is underwritten by a strong and abiding respect for autonomy. This is a common occurrence within biomedical ethics, but it is by no means a unifying one, for there are many divergent conceptions of autonomy that are used seemingly interchangeably. Gedge, Giacomini, and Cook (2007) use a definition of autonomy that insists that "people have a right to self- governance, to act freely in accordance with a self-chosen plan" (1, quoting Beauchamp and Childress (2001)). Kantian approaches, on the other hand, understand autonomy as the freely and rationally adopted moral policy of moral agents. As such I will take some time here to get clear on just what is meant by "autonomy". The most expedient place to begin is by admitting of my attachment to the more liberal conception of autonomy of John Stuart Mill and those writers that trace a connection back to Mill. Briefly put, Millean autonomy holds that individuals should be left to determine for themselves just what and how their lives will be lived. Mill favours limiting all restrictions to this freedom to act save for a restriction on those actions that harm another individual. What follows here is an attempted justification of suicide throughout which the Millean conception of autonomy will be made clearer. This is intended to fulfill two roles. First, it is meant to introduce Millean

autonomy while simultaneously illustrating how such a concept can be applied in ethics today. Secondly, the focus on suicide is meant to serve as a starting ground for the argument in favour of euthanasia to which this paper is given.

As mine is a rather liberal discussion I will often use the terms 'Freedom' and 'Autonomy' interchangeably[14]. In this way I use freedom to mean a general ability to self-determine without paternalistic imposition. This should not be seen as eliminating the possibility of intervention in specific circumstances as we will see later in the distinction between rational and emotive suicide.

Further, my conception of autonomy should not be read as solipsistic or isolationist. I recognize the existence of other individuals as it is not possible to consider people as living completely independent from others. The social situation and biological nature of human life requires that no human being could possibly exist in isolation. Even in the most extreme cases of hermitage it is not possible (at least in this day and age) to completely separate oneself from every other human being. Also, the existence of others with expert knowledge on a subject would pose an interesting problem for a notion of autonomy committed to solipsism as any decision reached via this form of autonomy would be fundamentally ignorant of far too much. My notion of autonomy requires the final decision be made by the individual. This decision making will typically involve weighing various pieces of information and the thoughts or opinions of others (thus integrating the social situation). In this way we can also allow for a sort of external evaluation of an individual's decision which will become important after the introduction and discussion of the distinction between emotive and rational actions.

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[14] As Seay does (2005, p. 521)

Personal Autonomy and the Proper Application of Liberty

If we take suicide to be an action which can, at least in part, be justified by an appeal to personal autonomy we must first illustrate just why people should be granted any personal autonomy at all. For if a society is interested in securing the public welfare, or some other such publicly minded good, then it would seem that they could be justified in imposing the will of a benevolent dictator that would ensure that all are treated equally and fairly while simultaneously restricting the actions of individuals that do not reflect the standards of the society. No matter how justified such a community may appear we cannot call that society free, and if the society is fundamentally unfree we cannot say that it properly recognizes the equal worth of its citizens. This argument in favour of the respect of autonomy is seen throughout the works of David Beetham, Benjamin Constant, Isaiah Berlin, and John Stuart Mill. In the following section I should like to draw the connections between these thinkers into a more complete argument in favour of personal autonomy and liberty.

David Beetham discusses the underlying conditions of modern democracy which he sees as the idea of equal human worth and dignity, which has as its core value human self-determination and autonomy (Beetham, p. 7). Beetham prefers a conception of society that allows for the greatest multiplicity of opinions[15] as such a society would also allow for the development of individual opinions to such a degree that it could benefit

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[15] This use should be read in the common sense of the word. Beetham maintains that a society that allows for a multitude of opinions has a much greater intellectual resource to draw from than a society which strictly limits the expression of opinions, in that the former society would benefit from the development of opinions into ideas to an extent not possible in the latter, more restrictive society. It is important to note, however, that this should not be taken to mean that this position would be in favour of the development of all opinions as those that foster hatred and violence can hardly be called beneficial to society. The difficulty is in distinguishing when a society could be seen to be legitimately restricting opinion. I would hold that this is precisely what Mill does in On Liberty.

society as a whole. An increase in the number of opinions, Beetham argues, also increases the number of developed ideas as individuals would be allowed to persist in their opinions in order to develop ideas based on their opinions. I am aware that this seems a problematic means of justifying suicide as there is nothing that the suicide[16] would be able to actively contribute to society after their death. I would still maintain that having a society that allows the option of suicide, or assisted suicide, would ease the fears of some members of the population. I meant this in that it would give them the knowledge that the option was open to them if (and only if) the time came when they no longer wished to live their lives. In the wake of the Sue Rodriguez case, Erwin Krickhahn, who also suffered from ALS, insisted that without legal recourse to assisted suicide he would be forced to kill himself months before he was ready if only to ensure that he could die before his life became unbearable (CBC Digital Archives, "Reaction from the ALS Community").

Beetham ultimately sees democracy to be the realization of this ideal situation as it properly recognizes the necessity of mutual accommodation and compromise required of any life in a society (Beetham, p. 17). That the multiplicity of opinion protects security relies fundamentally on a certain level of existing security at the macro level. This modern conception of liberty or personal autonomy would not have been possible in ancient times, as we shall see in the works of Benjamin Constant.

To outline the benefits of modern liberty Benjamin Constant contrasts it to the model of ancient liberty. Constant saw ancient liberty as a communal order under which

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[16] In the literature "the individual who has committed suicide" or "the suicidal individual" is often referred to as "the suicide" for the sake of efficiency. I must admit of my distaste for the tendency of this practice to reduce the individual to one final action. Keeping the multi-faceted nature of all people, suicides included, in mind while discussing the act of suicide will help to eliminate this restrictive habit.

the individual was subjugated to the rules of the state in order to insure the necessary security from invasion. The security of ancient liberty relied on a perfectly unified citizenry – such as was seen in Sparta – that could be turned towards defence rather simply. Modern liberty, on the other hand, was unencumbered by this pressing need for territorial security and so developed a form of liberty which sought to protect the security of private pleasures. Modern liberty allowed the individual to practice their own beliefs provided that this form of liberty was not maintained by sacrificing the political rights of the population. Keeping the security of private pleasures and opinions in tandem with the political powers granted to citizens in a modern society had the benefit of protecting the population from tyranny because they were able to utilize their political power to ensure their beliefs and, ideally, the beliefs of others from being abused by the governing powers.

The concept of liberty that Constant makes use of is not a singular entity, which Isaiah Berlin points out in his essays, "The Two Concepts of Liberty". Berlin distinguishes between the concepts of Negative Freedom (or Liberty, Berlin uses these terms interchangeably) and Positive Freedom. Negative Freedom can be read as a freedom 'from' whereas Positive Freedom is a freedom 'to'. The freedom from of negative freedom posits the degree to which the person should be left alone by powers other than his own. This places constraints on a given society by defining the limits to which a society may justly interfere with the life of an individual member. Positive freedom, alternatively, deals with the degree to which individuals have the freedom to determine for themselves what their life is going to be. Berlin favours an area of personal freedom which at least allows for a minimum area of self-determination. Failing to allow

for this minimum level risks constraining the individual to such a degree that it would become impossible for the individual to have "that minimum development of his natural faculties which alone makes it possible to pursue, and even conceive, the various ends which men hold good, or right, or sacred" (Berlin, p. 124). Berlin draws this limit, in a way similar to Mill, between private life and public authority. In support of this limitation Berlin offers an argument in favour of a sort of collective benefit. The argument maintains that while a uniform agreement amongst all peoples in a society may provide said society with a level of tranquility it will nevertheless be harmful to that society, which will be "crushed by the weight of collective mediocrity" (Berlin, p. 127). This has already been seen in the above discussion of Beetham and the multiplicity of opinions, and it will be seen again in the work of J.S. Mill.

In On Liberty Mill seeks to offer the individual person protection from both excessive government intervention as well as the tyranny of the prevailing opinion and authority. Mill favours a conception of society that does not interfere with the individual except where the actions of the individual endanger the liberty of others. Self-protection is the only legitimate aim that individuals can claim in favour of actions directed against another individual (Mill, p.80). Earlier Mill made explicit his refusal to allow society to interfere with the individual on the grounds that it was for the good – either physical or moral – of the individual (Mill, p. 80). Mill maintains this based on his belief, and it is a belief that I share, that any particular person is generally in the best position to determine for themselves how they will live their life. Any thinking to the contrary seems to assume a level of privileged knowledge which is impossible to maintain in practice. Mill's position is not above allowing society to attempt to convince the individual as this

assumes the individual's rationality and able mindedness, and as such is perfectly amenable to Mill's argument. What Mill does not allow is the intentional compulsion of the individual by society. "The only part of the conduct of anyone, for which he is amenable to society, is that which concerns others. In the part which concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign" (Mill, pp. 80f). Mill's is a liberal philosophy because autonomy must apply to all peoples equally, claiming your own autonomy requires recognizing the autonomy of others. Refusing one refuses the other.

We can see here, finally, the connection between suicide and personal autonomy. We said at the outset that suicide is an intensely personal action. We can go further to say that it is an action for which the individual concerned is ultimately the only one who can make the decision. Given this we can say that the only rationally coherent option is to respect the autonomous decision making capabilities of individuals, and we can begin to see how personal autonomy and/or liberty plays a role of crucial importance to any justification of suicide. Before we continue to examine the other aspects that might contribute to suicide we must first account for an apparent problem in applying Mill's argument to the discussion of suicide.

The Apparent Contradiction in Using Mill to Justify Suicide

In the fifth section of On Liberty, Mill introduces the only other limit to liberty that he allows. He maintains that the only time a person's liberty can be limited is if their actions threaten their liberty. In Mill's example he insists that the only thing that someone is not allowed to do with their liberty is sell themselves into slavery. For Mill, "the

principle of freedom cannot require that he should be free not to be free" (Mill, p.164). Mill opposes anything that would eliminate the continued realization of an individual's freedom. This apparently also eliminates the person's ability to end their lives as such an action would completely eliminate the individual and, afterwards, they would no longer be free in that after a suicide the individual no longer exists at all.

This apparent contradiction can be dealt with by pointing out the important differences between slavery and death. When I sell myself into slavery, for whatever reason, I remain a 'free' man who must at all times recognize and suffer this lack of freedom. Slavery is the continued refusal to recognize the inherent human freedom that Mill insists we have. While every instance where our freedom is not recognized is an injury done to us, slavery is an injury compounded by our knowledge that we are unlikely ever to be free of it again.

Death on the other hand, when taken in the base physical sense[17], is a singular action after which the individual cannot be aware of anything, let alone the rejection of their freedom. Also, and equally as important, death in the case of suicide[18] is an action brought about as the result of suffering which overwhelms an individual's coping mechanisms to the point that they think they have no choice but to end their lives. Briefly using the Utilitarian principle of greatest happiness, in order to be consistent with Mill, we can see that a life of constant suffering is not preferable to no life at all. This is most readily apparent in relation to those individuals whose suffering is medically identifiable. Insisting that someone with terminal bone cancer must not end their lives because it is

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[17] That is without any reference to any religion or spiritual belief that would have some idea of an afterlife.
[18] In the traditional sense, ignoring what will later be called rational suicide. We should note though that suffering plays a role in almost all suicides.

better to be alive than to be dead does not take adequate account of the intractable suffering that is often – but not always – the daily life of the cancer patient. Once this is recognized the connection between slavery and suicide, and the apparent prohibition against ending one's life from a Millean point of view, can be seen as not quite as necessary as it might have seemed at first glance.

Having seen how suicide might possibly be justified on Millean grounds we should take time to address possibly the most frequently used conception of autonomy in biomedical literature: that of Immanuel Kant. Kant insists that the moral imperative – that is, what someone ought to do – is found by the agent's own freely and rationally chosen moral policy. Rationality is important to Kantian autonomy because it is free from the problems found in inclinations. As Guyer says in his 2006 book on Kant "The only way for your will to be free or autonomous is for it to be governed by a law that gives itself rather than to allow itself to act on whatever mere inclination happens to be alluring at the moment" (204). It would seem then that Kantian autonomy gives primacy to the rational mind of the individual as the deciding factor in moral issues in light of the rigorous nature of rationality that does not fall victim to the ephemeral whims of inclinations. Those actions which are prompted by factors not rational are termed heteronomous in Kant. As heteronomous actions are generally considered to be promoted by external factors they are to be avoided because they, in a way, compel the individual towards problematically irrational actions. The ability to define our own actions; that we should be allowed to "choose what we do according to the dictates of our own soul, without being compelled" (Bunnin, 271) is freedom of the will and we can see here the close connection that exists between autonomy and freedom.

The importance of rationality in the Kantian conception of autonomy is not without its problems. The most interesting concerns were brought against Kantian autonomy by Barbara Secker who makes a distinction between what she calls Kantian autonomy and Kant's original concept of autonomy (44) saying that the former has little in common with the latter (48). The easiest way to characterize the distinction is to realize that the concept of Kantian autonomy has come to apply to individuals while Kant only ever meant for autonomy to be applied universally (Ibid). When Kantian autonomy (in the modern sense) is taken as applicable to biomedical ethics, Secker recognizes three difficulties which "make [the] concept unfit for practical use in bioethics" (49). These concerns surround the rational requirement of Kantian autonomy in relation to the situation of the patient.

First, Kantian autonomy is impractical given the nature of patients and health contexts (Ibid). The notion of autonomy here demands too much of patients who rarely resemble the exclusively rational individual found in the idea of autonomy. There are various constraints, both internal and external, that "may impede capacity for reasoned deliberation and choice and, therefore, [eliminate or reduce the possibility to the individual meeting the requirements of] Kantian autonomy" (50).

The second concern is that Kantian autonomy "appears to place a moral premium on autonomy" (Ibid) which could contribute to the devaluing of those patients who might themselves be dependent. This is particularly worrying when it is remembered that the nature of patienthood is at least partially characterized by dependence of one sort or another (Ibid). If the notion of Kantian autonomy fundamentally devalues – or even so much as seemingly devalues – a patient by virtue of their being a patient (and I think

Secker has provided enough to at least think this possible) we can see how the author might be correct in labelling the concept unfit for use in bioethics.

The third concern comes out of the previous two and questions whether or not the concept of autonomy, if it is as 'rationality centric' as it appears, would promote paternalism better than it would patient autonomy (51). For if this concept remains the standard interpretation of autonomy some patients might not be able to measure up to the standards that it sets, and the concern is that "some health care professionals and institutions may attempt to justify wholesale paternalism" (Ibid). Secker warns that adopting a model of autonomy that patients cannot reasonably hope to live up to may work in the favour of those who would attempt to deny patient autonomy. If the patients are not autonomous individuals according to the standard interpretation of autonomy what reason is there to extend to them the choice or responsibility that an autonomous individual would be entitled to? Allowing for autonomy of this sort is merely a formal declaration; it pays nothing more than lip service to the *idea* of autonomy while the incredibly high standards of rationality and independence serve as a substantive block to *actual* autonomy. The most succinct statement of this problem comes from Beauchamp and Childress's book Principles of Biomedical Ethics:

> [The principle of respect for autonomy] does not apply to persons who are not in a position to act in a sufficiently autonomous manner – perhaps because they are immature, incapacitated, ignorant, coerced, or in a position in which they can be exploited by others... The behaviour of non-autonomous persons may be validly controlled on grounds of beneficence in order to protect them from harms that might result from their behaviour. (qtd. in Secker, 51)

One such example of a concern for autonomy leading to what could be described as paternalism can be seen in a paper by Jukka Varelius entitled "Autonomy, Wellbeing, and the Case of the Refusing Patient". In this work Varelius maintains that a patient should not be allowed to refuse treatment that would save his life which means – more troublingly – that there are certain cases where a physician should be allowed to treat a patient *against their will.* Against this position I would insist, along the traditionally liberal lines mentioned earlier, that a patient is in the best position to determine for themselves what they wish, and as such I would support their right – in particular circumstances[19] – to refuse treatment even if that treatment had the potential to save their lives. Interestingly both of these positions are justified on the basis of autonomy. The position (mine) that a patient should be allowed to refuse treatment is based on a respect for their autonomy and their ability to determine their own lives based on their desires and choices. The later position (Varelius) is based on a respect and concern for the patient's *future* autonomy. Varelius presents the argument in terms of prudential value (118) saying that the respect for autonomy in the first instance is based on a subjective sort of well being that is itself based on individualistic attitudes of favour or disfavour (Ibid) which Varelius views as being problematic.

In contrast to a subjective sort of well being Varelius supports a more objective conception of well being where an appeal can be made to objective conditions that show "whether a thing or an activity satisfies human needs" (Ibid). Varelius's preference for the objective determination of well being strikes me as overly paternalistic especially

[19] A person who wishes to refuse treatment should be found to be reasonably free from depression or other similar emotional stresses. The requirement of being completely rational here is not possible (as was seen in Secker's article) but the idea of mitigating depression needs to be address. This will be addressed later in the paper.

because it allows for an individual to have their autonomy ignored on the basis of their future autonomy. This is in direct contrast to the generally acceptable statement of Beauchamp and Childress that states that the behaviour of *non-autonomous* persons could be controlled on the grounds of beneficence whereas Varelius is willing to violate an individual's autonomy at one point in order to protect their autonomy at another time. The issue here is that this undermines autonomy itself. If an individual is to be considered autonomous their decisions regarding their lives should be respected on the basis of this autonomy. A refusal to recognize autonomy in respect to current decisions for the sake of some future autonomy calls into question every instance of autonomy for there is no reason to suppose that the next autonomous decision would not be ignored as well for the sake of some still future autonomy, and so on ad infinitum. This issue is insurmountable as long as present autonomy is ignored.

Later in this work the issue of emotive suicide becomes important and I insist that under particular circumstances an external individual could be justified in interfering with an individual's attempted suicide. I make this case on the grounds that the overly emotional state of mind of the suicide might result in an action that the individual would regret at a later time (if such thing as after-suicide-regret were possible). This does, in fact, give import to the individual's future autonomy which seems to contradict my above disagreement with Varelius. However, in Varelius' case the respect for future autonomy is granted to some *always*-future autonomy that the individual can never reach. On the other hand, the future autonomy that I give preference to is the autonomy of a person who is not then at the mercy of excessive emotion. The future autonomy that I wish to preserve by allowing an external individual to interfere with a suicide is not one that will

continually be posited as some future point. At some point (which I hold requires a specific level of rationality) an individual's choice to end their lives could be a perfectly justified alternative. This is something that Varelius' objective future autonomy could never allow.

Autonomy alone, however, does not typically serve as an appropriate means of justifying suicide. If autonomy alone could serve as a justification of suicide then no instance of suicide could possibly be considered problematic as it was a perfectly acceptable autonomous action, like eating a peach. This is not the case, and there are, unfortunately, thousands of suicides a year that simply have no precipitating factors. Too often do we hear a grieving family asking why their son, daughter, wife, or husband took their own lives. In order to justify suicide or euthanasia personal autonomy must be taken into consideration along with at least one other influencing condition. The most recognizable condition that could meet this criterion is the existence of suffering.

The Consideration of Suffering

Physical and/or Medical Suffering

The final consideration for this analysis of suicide is the existence of suffering. In patients with a terminal disease it is incorrect to think of pain as being a series of painful experiences. Pain itself is defined by the International Association for the Study of Pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" (Merskey, S74). Others point out that chronic pain is more than just the physical manifestation of pain and refer to chronic pain as being the culmination of the progression of pain through from acute to persistent

pain (Perkins and Keller qtd. in Shipton and Tait, 406). Robert Twycross defines chronic pain as a situation rather than an event in which the emotional and psychological response to pain is considered as important as the physical experience itself. The situation of pain is one that is often impossible to precisely predict, which usually gets worse rather than better, which appears to be meaningless and which frequently expands to occupy the whole attention of the person suffering (Twycross, p. 89). The important thing to note about chronic pain is that the elements combine to isolate the sufferer from the world. Whereas acute pain has a specific locality (i.e. the lower back) chronic pain is often experienced as a more generalized pain, though no less severe. This lack of a concrete pain centre is precisely what makes chronic pain so difficult to treat effectively. Those suffering from acute pain have available to them a series of steps that can be taken to combat the pain (such as taking an analgesic for a headache; utilizing orthotics to correct musculoskeletal issues; or surgery to remove an appendix). Chronic pain sufferers, as already mentioned, have progressed through acute pain and have found themselves in another place entirely. They are made to exist in a world that they cannot understand or explain to anyone else[20]. When understood in this way we can see how physical suffering can be a major factor that needs to be considered seriously in terms of the justification of suicide. When coupled with the right to self determination, unremitting physical suffering forms the most persuasive argument in favour of justifying suicide.

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[20] There are often successful pain management regimes put in place by physicians that do work to eliminate the pain to a degree that the individual can manage on their own, but just as often the pain medication can make no appreciable difference in the level of pain.

These are the rational aspects that were meant to replace the prima facie justification of suicide that was given in relation to Sue Rodriguez. The question surrounding the fact 'that we die' is important, and we have seen that the importance of how we die is only increased in relation to the discussion of suffering as an all encompassing situation. As it stands we can safely say that, in light of the existence of medical suffering, it does matter 'when we die' as the progression of a disease can fundamentally change the experience of our lives. When faced with suffering of the sort described above as well as the right to self-determination we can legitimately state that there are better and worse times to die and that the individual is in the best position to judge for themselves when a better time to die would be. Maintaining an interest in self-determination we should insist that there be little or no interference from society into the life (and death) of a person who has rationally decided to end their lives on the basis of physical suffering.

Existential Suffering

What might be more philosophically interesting is the possibility of a suicide prompted by suffering that manifests within the individual psychologically rather than physically. Without getting into the complex notions of knowledge of brain states and the existence of other minds, what remains now is the examination of whether or not suicide can be justified on the basis of personal autonomy alone. Prior to 1998, former Dutch Senator Edward Brongersma approached his doctor on numerous occasions asking for help ending his life. Medically there was nothing wrong with Brongersma. Aside from the usual physical failings expected in a man of his age, Brongersma was in perfect

health. In support of his desire to die Brongersma argued that, at his age, his life was all but over as he had already achieved everything that he was going to in his life and now all he had to do was endure the slow ravages of time as his friends and loved ones died around him. This argument convinced his doctor, Philip Sutorius, who helped Brongersma to end his life. These arguments came to be called 'tired of life' arguments, and while these are significantly more difficult questions, in terms of their implications, I would propose that such arguments in favour of suicide could, possibly, serve a justificatory function. If such arguments were to serve as justification it would require that the respect for personal autonomy be taken in a more extreme sense as a possible means of justifying any action. I would, provisionally, like to agree that it can be. However, for the scope of this work we must leave this discussion for another time. Having just distinguished between the types of suffering the paper will now turn to a distinction between what I see as two distinct types of suicide before then continuing on to the primary discussion of euthanasia.

Two Types of Suicide: Rational and Emotive

Treating suicide as a specific action without taking account of the different possible motivations will invariably lead us down the wrong path. Here we should introduce an important distinction between two different types of actions (which would necessarily include suicide): the rational and the emotive[21]. This distinction is introduced here in order to avoid complications from any juxtaposition of this discussion and the

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[21] I do not mean to imply that reason and emotion are contraries. I would hold, as Nietzsche's Zarathustra does, that there is "always some reason in madness" but also some madness in reason. By using the terms rational and emotive I merely mean to point to the controlling factor of the action.

discussion of suffering. One issue in particular that I would like to avoid – for the time being as it will become important later – is the fact that excessive amounts of pain can have a serious affect on a person's rationality.

The emotive action is characterized by an excess of emotion that often bursts forth when people do not expect it. Raised voices, tears out of nowhere, and fists through drywall are just some of the more recognizable results of unchecked emotion. Typically (though not always) these outbursts are followed by regret or confusion. Once emotion takes over people act in ways that they would not have had calmer heads prevailed. The rational action would weigh the options and possibilities before deciding on the best course of action to take. The rational suicide, for instance, will take time to put their affairs into order while the emotive suicide leaves things in a shambles. The distinction rests on the relative levels of emotion behind the suicide and while it is not likely to have a suicide be completely devoid of emotion – as suicide is so inherently emotionally charged – it is possible to have a particular suicide be of a more considered sort than another.

Alvarez, in his book The Savage God, points to an interesting example of this distinction. Members of London's Metropolitan Police Service are apparently able to informally determine the state of mind of the suicides that they pull out of the river Thames. Those who have decided to end their lives after a great deal of consideration are usually pulled from the water without too much extraneous physical damage, whereas those who have killed themselves out of an excess of emotion usually have fingers torn and bloody from trying to grab hold of various bridge pilings once the reality of their situation becomes apparent (Alvarez, p.102). The distinction between a rational action

and an emotive one is recognized in modern courts of law where crimes such as murder[22] are classified as being either premeditated or a crime of passion. That crimes of passion are treated (relatively) more leniently illustrates the judicial system's willingness to recognize the extenuating circumstances of an excess of emotion.

Emotive and Rational Actions: Implications for Autonomy

The concept of autonomy discussed earlier specifically insisted that it was not to be considered solipsistic or isolationist. Autonomy, that is the ability to self-determine, typically requires a degree of rationality that can be expected of any individual seeking to make a decision[23]. As such the importance of other individuals in both a social and an educational sense becomes important as a form of checks and balances for the individual's decision making process. It is especially important when the individual is confronted with the excess amounts of pain and suffering that are often associated with end of life issues. Excessive pain of this sort could reasonably be expected to overcome an individual's coping mechanism hampering their ability to carefully weigh options and measure their relative merits. How then could anyone be sure that a person suffering sufficiently to justify suicide had made the decision to end their lives after a careful consideration of the options? The existence of suffering seems to conflict directly with the idea of autonomy. The apparent conflict between suffering and autonomy is saved by the very existence of other individuals. The question of justified suicide is a question that

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[22] I'll use murder here as the most familiar example without wanting to draw and comparison between murder and suicide or euthanasia.

[23] The precise degree of rationality that this might require is both very important and very difficult to adequately address here. I must admit that the detailing of this position is well beyond the scope and aim of the current work which seeks to set the various groundwork(s) for a justified euthanasia. The specific details must be left to a later work.

does not concern the suicidal individual, for if they are in a sufficient amount of pain that their ability to rationally judge is compromised then the idea of justification goes out the window. The other individuals, those external to the suicidal person, are the ones who would be concerned with justifications. If we take the aggregate of the opinions of an individual's family, friends, coworkers, etc., we might be able to gather together an idea of their motivations that does not suffer from the mitigating effects of severe suffering. In this way the external individual(s) would be able to judge for themselves whether their friend or loved one was acting rationally when taken in comparison with other, previously rational actions. The external individuals would be able to tell, ideally, if the action – the suicide attempt – was the product of excess emotion, something that might possibly be regretted later. In cases such as these, where rational action is compromised by an excess of emotion, those external would be justified, in their way, of directly confronting the suicidal individual. A police officer who happens to witness a man running towards a cliff face would be perfectly justified in tackling the man in order to prevent him from going over the edge. The friend who walks in on his friend about to hang themselves would be justified in holding them up and cutting the rope. The justification for these external interferences comes from the fact that overly emotional decisions are typically regretted after the fact. The external individual could be justified in interfering based on the assumption that the person attempting suicide might be about to do something that they would – if this were possible – later, in a future, more rational state, regret. While this may appear to be inconsistent with the overall idea that suicide (and, in turn, euthanasia) should be justified I would maintain that it is not. The purpose of this paper has never been to justify suicide or euthanasia in any or every instance, but

rather to point out circumstances in which these acts could be justified. The most important consideration – when taken in tandem with the existence of suffering – is the level of rationality with which the suicide is carried out. In these cases (the cliff-runner or the hanging) external individuals could be justified in interfering with them because these suicides have all the hallmarks of an overly emotional response, the interference is justified due to the severity of the suicidal action. If the person were yelling or punching holes in drywall the external individual would be able to wait for the excess of emotion to run its course. With the suicide the action carries with it more finality. It is a more serious action, and the external individual should be seen as acting properly if they interfere on grounds that the emotional individual might not completely understand what they are doing. The ideal suicide that this work is attempting to justify is one that is devoid of *excessive* emotion. End of life decisions are filled with emotion and it would be naïve to require the decision to commit suicide (or request euthanasia) be completely rational. Just what level of rationality would be required of a suicide is an issue that we have already seen to be too difficult to obtain here, but I might venture a suggestion.

The implication for autonomy is that there should be a sort of objective system of checks meant to ensure that a person does not kill themselves while in the grip of excess emotions. As hard as it might be to accept, I should like to maintain that there could possibly be a suicide motivated by such rationality that an external individual would have no business interfering with the suicide. This would be characterized as a suicide whose motivations meet the objective checks on rationality required by a more completely delineated concept of suicide. Just what these checks against problematic suicide and euthanasia might be is discussed in the forthcoming treatment of the various arguments

against euthanasia. Though this discussion can only be the beginning of the answer, and the grey areas surrounding 'justified suicide/euthanasia' will at first be rather wide. Much work will remain to be done in order to finally arrive at a more complete conception of an appropriate level of rationality.

Euthanasia

Definitions of Euthanasia

The standard dictionary will see euthanasia defined rather loosely, either in etymological terms such as the OED's "A gentle and easy death" or in terms of the barest procedure such as Miriam-Webster's "the act or practice of killing or permitting the death of hopelessly sick or injured individuals (as persons or domestic animals) in a relatively painless way for reasons of mercy". These definitions are both correct, in their respective ways, but they are also almost completely useless because of the paucity of information they include. Despite the intentions of this paper, which are to justify, in some sense(s), the prospect of euthanasia, these definitions come across as far too favourable to a concept which often has many very real problems with it. So, as a place to begin, these definitions will do just fine, but they will not serve this paper well at all. Instead we should look to the more detailed, more in-depth definitions of euthanasia, taking account of the varying forms of the practice in order to get a clearer understanding of what euthanasia is as well as what it can be.

Distinctions Within

Within the concept of euthanasia there are contained several important distinctions that must be made. These distinctions are of the utmost importance and one

should be wary of ever confusing the discussion of euthanasia by conflating the various senses. What follows is a breakdown and discussion of the various definitions of euthanasia that are in use today. Euthanasia always involves the intentional taking of someone's life in the interest of that someone[24]. This condition contains both the dictionary definitions contained above, but there is more to the story. The main distinctions will be between Active & Passive, and Voluntary & Involuntary.

1. Passive Euthanasia – consists of the withdrawing or withholding of life-prolonging treatment with the main (or one of the main) purpose(s) being to hasten death for the patient's best interest (Garrard & Wilkinson, 65).

   1a. *Voluntary Passive Euthanasia* – consists of passive euthanasia with the patient's explicit consent. This typically takes the form of the patient refusing treatment with the use of a Do Not Resuscitate (DNR) order, or a patient requesting to be taken off life-prolonging treatment.

   1b. *Involuntary Passive Euthanasia* – consists of passive euthanasia without the patient's explicit consent. This typically involves the use of a proxy, or medical power of attorney, who acts on their beliefs as to what the patient would want if they were able to give consent.

2. Active Euthanasia – consists of directly acting, that is 'doing something', with one of the main purposes being to hasten death for the patient's best interest (Bishop, 220).

   2a. *Voluntary Active Euthanasia* – consists of active euthanasia with the patient's explicit request. Typically involves a physician injecting a lethal dose of some

[24] This definition of euthanasia could also be extended to animals, in cases where they are put down in order to end their suffering, but this is beyond the concerns of this paper.

medication into the patient in order to hasten death. This is one of the two concepts of euthanasia that is usually encountered during ethical discussions.

2b. *Involuntary Active Euthanasia* – consists of active euthanasia without the patient's explicit consent. Involuntary Active Euthanasia is typically, but not always, directly against the patient's wishes. This is the most problematic definition of euthanasia, as it meets all the criteria for murder. This is, categorically, *not* the idea of euthanasia that is being discussed throughout this paper.

3. Non-Voluntary Euthanasia – This idea of euthanasia arises in especially unique cases where euthanasia "is administered to a patient who has irrevocably lost (or never had) the capacity for competence, so that questions of consent—either given or withheld—cannot arise" (Seay, 524). Such situations could involve infants born with profound mental and physical deformities, or adults after a massive ischemic stroke. In such cases the decision often rests with a proxy, usually next of kin.

4. Physician Assisted Suicide (PAS) – While similar to euthanasia, PAS is not a form of euthanasia because it does not involve the action, or inaction, of another individual. In these cases the patient is the instigator of death (Dieterle, 127), typically acting with the help of a physician. What constitutes help varies according to the circumstances. It could involve the physician prescribing a lethal quantity of medication, or it could involve providing the patient with information on lethal combinations of drugs. In the latter case the physician avoids any direct connection with the death; telling a patient, for instance, that taking

chlorpheniramine in conjunction with dextromethorphan will result in a fast and painless death[25] would be a sort of physician assisted suicide.

Despite the importance of the above distinctions, this paper will often refer only to 'euthanasia', which, for the sake of brevity, should be taken to include all the above distinctions[26], including physician assisted suicide. Occasionally and where necessary, more specific references will be used.

Euthanasia Legislation Around the World

There have been several jurisdictions around the modern world where euthanasia has been either fully legal, or decriminalized to a certain extent. For instance, in Japan voluntary euthanasia was approved by a high court in 1962 (Humphrey), but it remains rare in the country due to the strong notions of hierarchy within the country. Interestingly, Humphrey points out that 80 percent of Japanese die in hospitals (compared to 35 percent in the United States) which might also account for the lower rate of euthanasia because, as Humphrey points out, euthanasia is essentially a process which takes place outside of hospitals. This corresponds with the idea of euthanasia which would see individuals dying in their own time, in familiar surroundings, and with family nearby.

Most recently, in February 2008, a bill legalizing euthanasia passed first reading in Luxembourg ("Euthanasia bill passes first test"; "Luxembourg"). The bill is expected

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[25] It won't. These two medications are the key ingredients in Children's Nyquil, and are quite harmless together.

[26] This does not include Involuntary Active Euthanasia, which we dismissed as bordering on outright murder. Also, the euthanasia being discussed throughout has nothing except the name in common with the conception of euthanasia explored by the Nazi party's Action T4 in the early 1940s.

to come to its second reading before year's end 2008. If passed, it would come to force 1 January 2009 ("Euthanasia bill gets second reading"). Several other, smaller, countries and regions appear to have euthanasia legislation either in the law books, or tacitly approved. However, there is little information available in regards to many of these, and the remainder of this section will discuss the history of euthanasia legislation in the three areas where such legislation has, at one point, been adopted: Australia, The Netherlands, and Belgium.

Australia[27]

On 22 September 1996, Bob Dent became the first person to legally end his life with the help of doctors in Australia's Northern Territory. Dent had suffered from prostate cancer for five years before he finally had help from his physician Dr. Philip Nitschke. Nitschke connected Dent to a machine controlled by a computer. The computer displayed several messages to Dent, requiring him to answer either yes or no at each stage. The final screen displayed the question: "In 15 seconds, you will receive a lethal injection and die. Do you wish to proceed? YES/NO" (Alcorn). Dent pushed yes, and two drugs were administered to put him to sleep. After this a powerful muscle relaxant was delivered which impeded his breathing, and Dent died within minutes. This was made possible because of the unique situation of the Northern Territory of Australia. The government of Australia passed the Northern Territory (Self-Government) Act of 1978 which gave the legislative assembly of the Northern Territory the power to pass and uphold its own laws. In 1995 the Northern Territory passed The Rights of the Terminally Ill Act 1995 which allowed terminally ill individuals to commit medically assisted suicide. This included both the direct involvement of the physician (voluntary active euthanasia) as well PAS. The act was nullified in 1997 when the government of Australia used the Euthanasia Laws Act to amend the Self-Government Act to eliminate the possibility of such acts occurring again. The amendment read that: "the power of the Legislative Assembly... in relation to the making of laws does not extend to the making of laws which permit or have the effect of permitting (whether subject to conditions or not) the form of

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[27] Unless otherwise cited the information in this section comes from the articles "Euthanasia and Assisted Suicide in Australia", "Lessons from Down Under".

intentional killing of another called euthanasia (which includes mercy killing) or the assisting of a person to terminate his or her life". Before The Rights of the Terminally Ill Act 1995 was nullified, the Act made it legal for "A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, [to] request the patient's medical practitioner to assist the patient to terminate the patient's life"(§4). The medical practitioner could only assist with the suicide as long as the following conditions were met.

Suffering from a terminal illness (§7.1b.i) with no other medically acceptable solution (§7.1b.ii) and any available treatment would only be palliative in nature (§7.1b.iii).

Two other medical practitioners, previously uninvolved with the case, one being a specialist in the area (§7.1c.i), the other being a psychiatrist (§7.1c.ii) have examined the patient and agreed with the original medical practitioner's opinion (§7.1c.iii.A,B,C), or, in the case of the psychiatrist, have concluded that the request was not brought about by clinical depression (§7.1c.iv).

That the patient has been fully informed of the prognosis and the expected course (§7.1e) and still wishes to die (§7.1f); that the medical practitioner believes that the patient has considered the possible implications to their family (§7.1g); that the patient is of sound mind and body, and that the decision was made "freely, voluntarily, and after due consideration" (§7.1h).

The patient has to wait seven days after making the request to sign the official request (§7.1i); and that 48 hours have not passed since the signing of the request (§7.1n).

At no time does the patient indicate, in any way, that they no longer wish to die (§7.1o).

That the medical practitioner provides the assistance, or remains present while the assistance is given and the patient is dead (§7.1p).

In the nine months where euthanasia was legal in Australia four people took their lives.

The Netherlands

On 28 November 2000, by a senate vote of 104 to 40 the Netherlands became the first country to legalize euthanasia. The legalization of euthanasia in the Northern Territory of Australia, passed five years earlier, was a territorial concern which was, as mentioned, overruled by the Australian government not a year after it was passed. Being the first nation to legalize euthanasia, the Netherlands would play an important role in the future of euthanasia legislation the world over. Belgium, as we will see, based much of its euthanasia legislation on that of the Netherlands, and so it would seem to be of paramount importance to understand what the Dutch perspective on euthanasia was, and is, in order to come to a more complete understanding of worldwide euthanasia legislation. In the Netherlands, euthanasia is taken to mean "the termination of life by a doctor at the patient's request, with the aim of putting an end to unbearable suffering with no prospect of improvement. It includes suicide with the assistance of a doctor" (VWS[28], §1). It is important to note that deaths caused by the removal of life sustaining equipment, usually considered passive euthanasia, and deaths caused by a foreseen but unintended side effect of aggressive pain medication, usually justified by appeal to the doctrine of double effect, are *not* considered euthanasia under this definition (Ibid.). The doctrine of double effect justifies the foreseen, but unintended negative effect (most usually death) on the grounds that some other positive effect (like pain relief) was intended (McIntyre, 2004). The most important element of this definition, for the purpose of the discussion to follow, is the idea of unbearable suffering with no prospect of improvement. It is the

[28] Ministerie van Volksgezondheid Welzijn en Sport – The Dutch Ministry of Health, Wellbeing and Sport

existence of such suffering in the patient that allows the physician to proceed with the euthanasia.

The Termination of Life on Request and Assisted Suicide (Review Procedures) Act[29], passed the 75 seat Dutch Senate – 46 in favour, 28 opposed, 1 absent – on 10 April 2001. Termination of Life on Request and Assisted Suicide[30] remains illegal under the Dutch Criminal Code (VWS, §8), but the Dutch Act introduces certain conditions which, if met, protect the physician from being charged with a crime. Chief among these conditions is the physician meeting the various due care criteria as defined at II.2.1 of the Dutch Act. These criteria require that the physician must:

a. [Hold] the conviction that the request by the patient was voluntary and well considered,
b. [Hold] the conviction that the patient's suffering was lasting and unbearable,
c. [Has] informed the patient about the situation he was in and about his Prospects,
d. [Ensure that the patient hold] the conviction that there was no other reasonable solution for the situation he was in
e. [Consult] at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts a - d, and
f. [Be the individual who] has terminated a life or assisted in a suicide with due care.

These criteria apply to patients who have reached the age of majority but, unique to the Dutch Act, a physician may be permitted to assist with a younger patient under certain circumstances. If the patient is 16-17 the doctor may comply with the request once the parents have been consulted. A patient aged 12-16, who has been "deemed to have a reasonable understanding of his interests" (II.2.4) may be euthanized at the consent of their parents or guardians. In *all* cases of requests for euthanasia the physician cannot be

[29] Hereafter "Dutch Act"

[30] This is what is meant by any further use of the term 'Euthanasia' in connection with The Netherlands.

required to participate in the action if they believe the consent to "compromise their personal principles" (VWS, §3), but, in these circumstances the doctor is required to pass the patient's medical file on to another physician that might be willing to comply with the request. The due care criteria could be considered the substantive requirements of the euthanasia legislation, with the formal requirements being the procedural element of the legislation which follows the patient's death. Once a patient dies by euthanasia the physician is required to alert the pathologist while simultaneously making a report available to a regional review committee as outlined in Chapter III of The Termination of Life on Request and Assisted Suicide Act. The pathologist undertakes an independent investigation into the death and makes a subsequent report to the same review committee. Once both reports are in the hands of the committee a decision regarding the due care criteria is made. If the doctor is determined to have met the criteria the investigation is complete. If, however, the review board believes that the physician has not adequately ensured that the procedures were followed they would forward their findings to the licensing board who decide whether or not to press charges against the physician.

The Dutch Act further limits those situations under which euthanasia might be justified by insisting that dementia itself cannot serve to justify euthanasia unless the physician comes to believe that the patient's suffering is unbearable and without prospect of improvement. It is here that some people object to the amount of interpretation required of the Dutch Act. One area where the Dutch process of euthanasia is safe from objection, where other countries and territories might suffer, is that Dutch law explicitly states that foreigners cannot end their lives in the Netherlands because the physician who determines whether or not a patient is suitable for euthanasia must have a long-standing

relationship with the patient in order to properly diagnose unbearable suffering (VWS, §11), such a doctor-patient relationship would not be possible if the patient were to come from another country.

Further, unlike other areas where euthanasia has been legislated, the Act is such that it codifies existing practices which, it is thought, will allow for a more open review of each instance. Previous to the legalization of euthanasia, the practice was rather widespread across the Netherlands, which allowed for far more frequent abuses of the medical system. The expectation of the Dutch Act is that the reporting requirement of the act will eliminate the possibility of some deaths going unreported by physicians (VWS, §8), an expectation which some, such as Cohen-Almagor, say has not been met.

Cohen-Almagor's article "The Guidelines for Euthanasia in the Netherlands: Reflections on the Dutch Perspective", brings out the shocking admission that many doctors – up to 30% of general practitioners in 1990 – had "performed a life-terminating act at some time without explicit request" (3). Such admissions point to an important problem that should be taken seriously until such time that they are shown to be either false, or no longer the case. Refusal to admit of the shortcomings of the euthanasia legislation, which Cohen-Almagor sees as being rife within the Dutch medical community (12), pose a significant problem to the country as a whole. Cohen-Almagor clarifies the issue, saying, along with James Kennedy, that, for the most part, the Dutch community is ignorant of the shortfalls of the legislation (10) preferring to leave the discussion to the specialists who are often inordinately in favour of the law. The trouble with this is that scientists who unquestioningly accept euthanasia legislation could be seen as merely submitting to the 'voice of the state' to such a degree that the objectivity desired and required of science would be lost (5f).

It must be asked, then, where this unquestioning attitude originated. For it is a problem that needs to be dealt with if the Dutch euthanasia situation is ever to be improved to the degree that its detractors desire. Cohen-Almagor rather offhandedly writes off the under-reporting of euthanasia as a product of laziness (7), which, I think, entirely overlooks an important element of euthanasia in the Netherlands that does not exist in other countries. I would maintain that this attitude came from the very history of euthanasia within the country. As the VWS report says, the legislation of euthanasia found in the Dutch Act is responsible for codifying existing practices regarding euthanasia (§8). The importance of the existing practices cannot be overlooked as they, more so, probably, than the legislation itself, will inform the practices of the physicians. The imposition of legislation over and above accepted practice is not usually met favourably, and this instance shows little change. One thing that does need to change if the Dutch euthanasia legislation is to be made safer regards the burden of proof in relation to the due care criteria. Previously it was the responsibility of the physician to show that they had followed the guidelines and procedures set out in the Dutch Act, but over time this has shifted and the current practice is to require the regional review committees to show that a particular physician has not met the requirements (Cohen-Almagor). The original situation should be reinstated to wit the physician should be made to show that they have met the due care criteria.

Belgium

The Belgian Act on Euthanasia (hereafter Belgian Act) was established on 28 May 2002, and came into effect several months later on 23 September 2002. Having

suffered from multiple sclerosis for years, Mario Verstraete became the first person to legally end his life, via euthanasia, in Belgium on 30 September 2002. This case has been mentioned numerous times by those who wish to argue against euthanasia, citing a requirement of the Belgian Act for at least one month to pass between the patient's written request to end their life and the act of euthanasia. Being that only a week had passed between the law coming into force and Verstraete's death it would seem that these objections would have something important to say. However, the problem with this being used to argue against euthanasia is that Verstraete made his intentions know to his physician *after* the law was established in May 2002, but *before* it came into effect in September, so his death occurred over four months after the request even though it was only a week after the law came into effect. This will be discussed again after the particulars of the Belgian Act are introduced below.

The Belgian Act contains several sections which each deal with a particular point of clarification that would be necessary for any proper legal discussion of euthanasia. Sections 1 and 2 deal with general provisions of the act in its relation to the law of Belgium, while Section 3 is where the particulars relating to "conditions and procedure" are introduced. §3.1 requires that the patient be of the age of majority (that being over 18 in Belgium), or an emancipated minor, which results either from marriage, or from the more legally exceptional case of a judge granting the minor power over their own affairs (Nys, 5). The patient must have regularly and voluntarily repeated their request to die without the presence of external pressures, while in a "medically futile condition of constant and unbearable physical or mental suffering..." (Kidd, 282).

Before agreeing to assist the physician must, pursuant to §3.2, inform the patient of their condition and prognosis, and discuss possible palliation (Bernheim et al., 865). As a result of this discussion both the patient and the physician must come to the conclusion that there is *no reasonable alternative* to euthanasia available to the patient. To be sure of the patient's condition and suffering the Physician must have several conversations with the patient over time to ensure the durable nature of the request. After which the Physician must consult with another physician – who is independent from both the patient and the original physician – who then reports back to the physician. This is followed by the original physician discussing the prognosis and the decision with the patient's family if this is something that the patient requests, and finally the physician must ensure that the patient has had the opportunity to discuss his decision with anyone who they wish to see (this assumes some form of spiritual advisor, or trusted friend).

§3.3 makes conditions available if the patient is not expected to die in the near future, that is, if they are not currently in the terminal phase. These conditions require the physician to consult with another independent doctor who is either a psychiatrist – who ensures that the request for euthanasia was not brought about by depression or other sort of mental issue – or a specialist who has advanced knowledge of the patient's condition – which allows the specialist to speak to the probable progression of the condition. §3.3(2) concerns the one month waiting period required for patients not in the terminal phase of their illness, such as the aforementioned Mario Verstraete. This requirement is meant to ensure that individuals are not making the request for euthanasia in the heat of the moment of diagnosis, or that it is not the product of any depression. In the Verstraete case his illness had long preceded his request to die, and it would be incorrect to insist that

anything untoward had occurred given the length and severity of his suffering, not to mention the fact that he had actually waited a full four months between requesting and receiving euthanasia. The majority of the remaining conditions (§3.4, 3.5, 4.1, 4.2, and 5-13) concern the particulars regarding the reporting procedure, such as the requirement that the request be made in writing (§3.4), and that such a request would only have the force of law for a period of five years (§4.1). The remaining sections put in place the special provisions of the Act which insist that no physician can be made to conduct an instance of euthanasia that they do not have confidence in (§14), and that, from a legal point of view, anyone who dies of euthanasia is to be considered having died from natural causes (§15). This last condition has important implications for contract law, and insurance policies.

Herremas points to a rather important interpretation of the Belgian Act. She argues against those who insist that legalizing euthanasia will turn Belgium into a destination for foreigners who wish to die but are unable to do so in their home country. Herremas insists, and I agree with her, that the Belgian Act's requirement of a long and sustained doctor-patient relationship, which can be read into §3.1, prevents against patients coming to Belgium to die. This is an important reading of the Belgian Act, and it is one that should not be taken lightly as any openness to foreign patients traveling to Belgium for their deaths would place an enormous strain on the Belgian healthcare system which should be guarded against.

Meulenbergs & Schotsmans highlight the definition of euthanasia that the Belgian Act operates on as being "intentionally terminating life by another person than the person concerned, at the person's request" (87). An important outcome of this definition is that

the Belgian Act does not consider the possibility of including involuntary euthanasia or Physician Assisted Suicide. It could be argued that the former was meant never to be included in the discussion of euthanasia given the Act's focus on autonomy, while the latter could be read as an extension of the idea of euthanasia with the difference being that euthanasia is the more active procedure on the part of the physician. Meulenbergs & Schotsmans also note that Euthanasia was *kept* on the Belgian Penal Code (90) which, they say, highlights the importance of following the procedures outlined in the Act. Had euthanasia been removed from the penal code, Belgium would have been in the rather unique – and troublesome – situation of having an act which explicitly discusses the conditions for a procedure that is not illegal; essentially, the Belgian Act would have been redundant from the outset. Having euthanasia still illegal also gives the Belgian Act the weight of law, as there is a specific punishment available to them for anyone who fails to meet the standards set forth by the act.

Various problems regarding the implementation of The Belgian Act on Euthanasia have been noted by commentators. The majority of these issues have to do with the speed of which the Act was passed through to Belgian Law, and the relative lack of writings on the practical elements of the act in comparison to the Dutch Termination of Life on Request and Assisted Suicide Act.

Comparison of the Netherlands and Belgium

Given the proximity, in time, of the Belgian Act on Euthanasia and The Netherlands Termination of Life on Request and Assisted Suicide Act it would seem fair to assume that both legal documents originated around the same time. This would be correct as far as the legal elements of the discussion are concerned, but looking only at

the legal discussion of the two countries overlooks the important history that the Netherlands has in regards to euthanasia. Importantly this is a history which Belgium lacks, and this lack shows more than a few problems that could be read into the Belgian discussion on euthanasia.

Herman Nys produced a rather useful comparative analysis of euthanasia legislation in the neighboring countries which could illuminate some of the issues that the Belgian Act might suffer from, while at the same time showing where and how euthanasia originated in the Dutch context. The Dutch Act did not introduce euthanasia to the Netherlands. Rather the practice existed in medical circles for almost thirty years before the legislation came into effect (Nys, 1). This is integral to an understanding of euthanasia in the two countries because, for Belgium, the law on euthanasia is fundamentally limited, indeed, it could be argued that it consists of little more than the Belgian Act on Euthanasia itself. The differences between the two countries – one where euthanasia is a recently codified, previously practiced act, and the other, where euthanasia is coming into practice as the legal precedent being developed – is useful in its ability to uncover limitations in the legislation that might have remained hidden had the comparison been made. These limitations are important in relation to the possible criticisms that might be leveled against other euthanasia justification and/or legislation.

Justification of Euthanasia

The Problem of Multiple Autonomies

If euthanasia is to be justified it is to be done along the same lines as suicide which is itself justified, above, by appeals to choice and autonomy in light of the

existence of real suffering. The situations of suicide and euthanasia are more similar than they are different, and one can expect that any justification of the latter will not differ to any great extent from a justification of the former. In fact, the only difference between suicide and euthanasia is the inclusion of the other agents including assisting physicians or patient proxies. Suicide itself is a fundamentally, some might say definitionally, individual action characterized by an intense desire to end one's life and the will and ability to do so. There are cases, though, where the individual who wishes to die lacks either the will or the ability to commit suicide. In these circumstances, it may be possible for the individual to request the assistance of some other willing individual.

Euthanasia, then, is a fundamentally interactive process. If we take suicide to be made of three unique requirements – first, the desire to die; second, the will to end one's life; and third, the ability to act to affect that desire – contained within one individual we can see how autonomy can be an effective means of justifying the action. If, however, as is the case with euthanasia, the three requirements are spread between two or more individuals – with the patient having the desire and will to die and the physician having the ability – we are confronted with a situation where autonomy alone can no longer be an effective means of justification as it is not possible to share autonomy. In light of this the question of justifying euthanasia shifts to a discussion of interaction.

Suicide was previously justified on the basis of autonomy in the face of the existence of suffering. There was also introduced the mitigating factor of emotive and rational suicide in relation to other individuals. While suicide requires the action of only one individual, euthanasia is a different situation because it requires the direct interaction

of at least two agents (the individual who wishes to die and the agent[31] who intends to help) and it is this very interaction which makes the act of euthanasia apparently unjustifiable[32]. How then could euthanasia be justified? It is not a question of finding another means of justification as this does not solve the question of interaction; rather it is a question of finding a situation where the interaction of two autonomous agents, as mentioned above, could be justified. It is not enough to say that the two autonomous individuals desire the same end as such congruence of autonomy could be used to justify certain cases of cannibalism[33]. If such interaction is to be justified we must find a solution which will address the various issues that could emerge from the interaction involved in euthanasia. The most damning issue is that there is the possibility that the individual physician assisting with the euthanasia might not be acting out of a concern for the patient's best interest.

There are myriad situations in which a physician could be willing to help a patient to end their lives for ulterior motives – several of these will be discussed in the section dealing with arguments against euthanasia – and these issues must be dealt with before a

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[31] At this point in the history of euthanasia legislation the assisting agent should be limited to a physician or other health care professional. The already contentious issue would not benefit from any individual, regardless of medical knowledge, being able to assist with a suicide. This will be discussed again later (at p. 78).

[32] There is another wrinkle introduced into the discussion when it is remarked upon that a physician works at a hospital which is usually supported in some way by taxes or other monies. Does this not make euthanasia a more institutional situation that the above allows for, fundamentally changing the nature of the interaction? I would maintain that it does not, at least not in any significant way. While the government does have a stake in the operations of the hospital this should not extend – at least not ideally – to the doctor patient relationship. Provided that the relationship maintains the bounds of legality this is the end of the governmental role. If, however, the government does insist on interfering with the relationship to any greater extent this is an issue that needs to be dealt with, but one that is also beyond the scope of this paper.

[33] Such is the case of Bernd Brandes, who *volunteered* to be killed and eaten by German cannibal Armin Meiwes, after responding to an internet advertisement posted by Meiwes. Interestingly, after being sent to prison, Meiwes became a vegetarian because the thought of factory-farmed meat sickened him.

justification of euthanasia could be arrived at. In order to mitigate the issues associated with the interaction of autonomous agents we must look for ways in which the goals, the desires, or the ends of one individual could be taken up by another. If we could show that it is possible for an individual to act out of the best interest of another we would be able to use this to shore up the issue surrounding autonomy which would then allow the justification of euthanasia to proceed in the same way as the justification of suicide. One such way is the concept of sympathy introduced by the Scottish philosopher David Hume.

Hume and the Concept of Sympathy

For Hume, sympathy exists as a special relation between individuals, and he "consistently affirms that sympathy is a psychological mechanism that causes benevolent motivation" (Vitz, 275). Humean sympathy might best be described using a sound-wave analogy in order to explain how one comes to feel concerned for another individual's plight. All living things are similarly constituted in that they have feelings and desires, etc.... Like strings of a similar gauge, what happens to one will reverberate across to the other causing a similar feeling in the second. This quasi-transcendental interaction accounts for often radically different individuals feeling for each other. In more detail, Hume says that my idea of myself is always "present and lively" (Hume, 317), and that objects related to myself be conceived of with similar "vivacity of conception" (Ibid.). Given that other individuals closely resemble my understanding of my self[34] – indeed Hume says that "every human creature resembles ourselves and by that means has an

[34] Hume mentions human beings explicitly, but it is not a far stretch to extend the idea of sympathy to all living things.

advantage over every other object in operating on the imagination" (359) – I am able to understand a connection between their concerns and my own (318). This understanding is not, properly, the same thing as imagining a connection, for Hume sees that the relations of contiguity and causation convey the impression or consciousness of one person to the idea of the sentiments or passions of others (318ff). That is, given the closeness of other human beings to myself I am able to understand the concerns of others as if they were my own concern. Hume, however, takes this one step further, insisting that since "all ideas are borrowed from impressions" I am able to take the impression of the other's passion as my own (319). The sentiments of another individual are transferred, via sympathy, to become my own sentiments as "all the affections readily pass from one person to another, as motion between strings equally wound up" (576). And thus I undergo what can be termed 'sympathetic conversion'. So, to summarize, through sympathy I encounter another individual and, recognizing their similarity to myself, I take up their concerns – I enter into their sentiments (Vitz, 264) – to such an extent that they become my own. When acting out of sympathy I do not act as the proxy of the other, rather I act for myself as well as the other individual because their concern has become my concern as well.

Turned towards euthanasia we could discuss sympathy as follows. The physician encounters the patient who has requested euthanasia. In that both are human the physician is readily able to identify the specific sentiments (or desires, or ends) of the patient. Seeing the patient in pain, and deciding that this pain is unbearable – which the physician must do in all cases of euthanasia – the physician recognizes the concern of the patient, and, sympathetically, takes up the patient's desire to have life ended as her own. In this way, then, when the physician decides to assist with the patient's death, it is possible that

they are doing so because it is both the patient's desire and her own wish as well. As such, the physician can act out of beneficence; she can help the patient end their life not because it suits her particular machinations, but rather because she is able to understand the desires of a person much like herself to have life ended before it becomes an unbearable burden. Thus, on Humean grounds, it is reasonable to assume that a person can become so sympathetically attuned to another as to act sincerely and genuinely for the other's interests. The question then becomes one of discerning the capacity of the assistant to sympathize with the other as a matter of degrees and intensity though this is a particularly detail-intensive process that must only be mentioned here and carried out in another work.

Arguments Against Euthanasia, and Some Responses Thereto

The following section deals with common arguments provided by opponents of euthanasia. The arguments typically address the morality, or moral permissibility, of euthanasia per se, but questions of its legalization have become increasingly important as euthanasia legislation gains ground in countries such as the Netherlands, Belgium, and Oregon in the United States. In what follows various arguments will be put forward in what I hope will be their most persuasive formulations followed by what might be put forward by a defender of euthanasia as a response to the argument. Unless noted in the text, each of these arguments should be seen to be representative of arguments against euthanasia rather than being espoused by a particular individual or specific group. Other arguments that have not been addressed here will likely be answerable along the lines of the representative arguments included below. By following this objection/response

organization I hope to point out that the arguments against euthanasia all fall for rather similar reasons. The arguments are, for the sake of organization, discussed in sections relating to the underlying object of concern. The first section, for example, deals with the individual who is considering, or who has requested, euthanasia for themselves. The second section addresses the individual who would be involved in any act of euthanasia in an assisting capacity. Most commonly this 'assisting agent', as I term them, refers to a medical professional and this will continue throughout what follows. However, I should note that, provisionally, I do not think that it need always be a medical professional who assists with a suicide. I could envision a situation in which a sufficiently motivated relative or friend could act in this capacity. But the issues that this raises are far too intricate to be considered here. It should also be noted that many of the following objections will be phrased in terms of an individual request for euthanasia, but that each of these objections could easily be modified to regard the justification or legalization of euthanasia per se. All that this requires is changing the final line to read "*and as such euthanasia should not be allowed*" rather than "*and as such the request for euthanasia should not be honoured*".

Concerning the Primary Agent

1. *The request for euthanasia was brought about not by a concrete and well considered desire to have life ended, but rather it was a product of depression (or some other such temporary condition) and as such the request for euthanasia should not be honoured.*

It says much about the issue as a whole that this first argument against euthanasia would be so difficult. There is not one way to address this issue because it contains so

many implicit assumptions. One could argue that underneath the objection itself is the idea that euthanasia is fundamentally wrong and that any request for euthanasia must have come from an individual with some form of psychological disturbance. Addressing such an assumption here would miss the content of the objection, so it will have to be sufficient, for now, to leave this assumption for a later time.

Returning to the objection itself, Clark (1998, p.251) mentions this objection as a standard example of the slippery slope style of argument, which maintains that allowing any form of 'justified' euthanasia will, eventually, result in people requesting euthanasia when they have no real wish to die, either because of severe depression, or some other form of external pressure. Slippery slope arguments will be dealt with in detail later in the paper (p. 74), but this objection can still be addressed here because there are those who would claim that depressed people would request euthanasia from the moment of its legalization. The risk, this argument maintains, is not that we will slide down the slippery slope ending at this form of euthanasia, but that we would begin there. From such a perspective the objection does have much weight, and depression is indeed a very real concern for anyone involved in the debate. However, the fact that it is a concern also means that it is not a very large risk. The possibility that patients are requesting euthanasia only because of severe depression is well known, and provisions have been placed in the existent legislation to protect against this possibility. Most usually these provisions require a secondary examination by a psychiatrist with the intent of detecting and treating mitigating depression.

Perhaps paradoxically I should like to recognize the very real existence of depression in patients approaching the end of their lives. To ignore that depression

brought on by the prospect of death can be a factor in decisions to request euthanasia is to miss much of the complexities of the decision. Those charged with the care of the patient should always be conscious that depression will inevitably be a factor in the decision; the difficulty will come in deciding whether that depression is the sole cause of the request, or, if it is caused by a realistic evaluation of the circumstances and the prognosis. If the individual's depression can be treated such that the desire to die is extinguished that should be done. But as was just pointed out not all requests for euthanasia can be dealt with in this way. Some requests, while influenced, in part, by depression, can nevertheless be a real decision. And, in keeping with the important respect for individual autonomy, that person's autonomous request should be honoured. This rests on the idea that depression, to some extent, could be one of the proper responses to end of life issues, as I believe it can.

2. *Similar to the above, where depression is taken to be an internal pressure to request euthanasia, external pressures could be forced upon the patient (i.e. familial, monetary, etc...) such that their request for euthanasia would not reflect their own desires, and as such it should not be honoured.*

Clark (1998) again mentions this possibility as another standard example of an argument against euthanasia, one that weighs the risk of the potential abuse against forcing individuals to have to live in pain with no hope of turning to euthanasia. Clark maintains that this choice is illusory because it requires that the two alternatives be equally weighted. The argument assumes that it is "rational to be equally averse to protracted suffering at the end of our life as to abusive euthanasia" (255), which cannot

be done without giving preference to one 'choice' over the other. To put this another way, the argument will only be persuasive to those who already hold the risk of abuse to be the worst possible outcome of legalized euthanasia, while those who hold suffering at the end of life to be worse will find the argument to be less than persuasive. That being said, there is still the risk that patients could indeed be subjected to outside pressures to request euthanasia, and in much the same way that depression is something to be wary of, so too is the possibility of external pressure. What is required here is an understanding that outside pressures do not necessarily negate the patient's request for euthanasia. As the above discussion of depression requires recognizing depression as a (possibly) adequate response to end of life issues, J.M. Dieterle maintains that the influence of the family on the patient could indeed be a contributing factor, but that such a case does not show that the family put pressure on the patient to die (131). A patient who requests euthanasia could legitimately care for their family's financial welfare but this does not show that such pressure is responsible for their choosing to request euthanasia. Insisting that financial pressures on the family could contribute to an individual's desire to request euthanasia is interesting in that it does not necessarily function as a reason to reject euthanasia. Such an argument could also be seen as being in favour of universal health care as such a system would eliminate the financial difficulties that an extended health care crisis could impose on a family, though this is by far the only argument in favour of universal health care.

Dworkin et al. (1997) discuss the difficulties that will inevitably factor into decisions concerning euthanasia and their paper suggests that this argument against euthanasia entails further difficulties that many would not accept. Presumably the

argument is against euthanasia because it is an active process which terminates a life that would otherwise have continued. Those that object to euthanasia on these grounds are often in favour of granting medical power of attorney to a loved one to act in the stead of the individual who, through the course of a disease or due to advanced age, is no longer capable of making decisions regarding their health care. In these cases, which are generally accepted as proper procedure, there is the increased risk, as Dworkin et al. explicitly mention, that "the patient might have changed his mind before he became incompetent, though he did not [inform his proxy that he no longer wished to die], or his proxy may make a decision that the patient would not have made himself if still competent" (The Brief of the Amici Curiae, ¶22). Later in The Brief, Dworkin et al. explicitly come out against imposing legal restrictions on euthanasia in order to protect individuals from any possible undue interference from family members. For them the legal restrictions are far too strict to be imposed in this case, because the "possibility [of familial pressures and/or abuse] could hardly justify the most serious pressure of all – the criminal law which tells them that they may not decide for death if they need the help of a doctor in dying, no matter how firmly they may wish it" (Ibid, ¶28). In both cases (familial pressure and/or legislative prohibitions) the autonomy of the patient is being violated. In the former case because the family "knows" that the individual should die, regardless of the individual's actual desires, they feel justified in pressuring the individual to request euthanasia. In the latter case, the government, wary of external pressures, legislates against euthanasia for the benefit of the patient, again, regardless of the patient's actual desires in regards to death. Like the possibility of mitigating depression,

the possibility of abuse does not necessitate the outright rejection of euthanasia as much as it points to another area that people involved in euthanasia must carefully observe.

3. *The patient does not/cannot have all the facts regarding their condition, and as such they cannot make a proper decision in favour of euthanasia, and as such the request for euthanasia should not be honoured.*

This argument against euthanasia is problematic precisely because it demands far too much of the patient while simultaneously denying the individual's ability to accurately weigh data in order to make an autonomous decision. The burden of proof is placed on the individual who wants to justify euthanasia to prove that there could be no other information that could possibly alter the patient's desire to make the request to die. There are several issues with such a requirement. Firstly, this argument against euthanasia seems to suggest, at least in principle, that the patient has not informed themselves to the best of their ability to understand the relevant information. Just what might be required of the patient who seeks to inform themselves is open to discussion, but it might include talking to relevant specialists, getting several opinions, doing some independent research into the situation, and so on. The assumption that people would not be properly informed is not one that can be effectively made without first showing that people are likely not to inform themselves as much as they can. Not only does this assumption completely violate the respect for personal autonomy, such willful ignorance, on the part of the patient, while possible, does not seem to be likely given the severity of the decision. Secondly, it is quite often the case that a patient who has undergone intensive treatment will reach a point where they no longer wish to continue the fight,

they take stock of their condition and they make the decision that they have gone as far as they will in its treatment. In cases such as these any requirement to undergo further treatment could be considered to run directly contrary to the individual's wishes. Thirdly, and most importantly, is that this argument benefits from the fact that it is all but impossible to overcome the burden of proof that the objection places upon those who wish to request euthanasia. The argument could be restated to read "*The individual has not shown that there is no further pertinent information, and so it is reasonable to assume that there is – or could be – further information which would fundamentally alter the request for euthanasia, and as such the request should be denied*". Seen in this way this particular argument against euthanasia suffers from the negative proof fallacy, which states that the proposition is true because it has not been proven false. Given the requirement that all knowledge possibly relevant to the situation be considered there is no possible way to continue as there is no practical way to decide when all the information has been considered. This is not to say that a higher standard of proof should not be considered when dealing with questions of euthanasia and the end of life, but rather that the requirement of perfect information is impossibly strong. The aforementioned higher standard of proof is precisely what euthanasia allows for. By consulting a physician – and getting multiple opinions – the patient is seeking the best knowledge available at the time. If, on the other hand, the individual had decided to take his own life on the opinion of any random person we could justifiably claim that he was not being rigorous enough in regards to his decision, but that would rarely be the case and any claim that it was would surely be a straw-person.

4. *If the individual is determined enough to end their lives, why not choose suicide rather than euthanasia?*

This argument against euthanasia differs from the above because it is not dealing with a reason not to accept a particular request for euthanasia; rather it is dealing with a much more practical issue. As discussed in the introduction (p. 10), suicide has been legal in Canada since 1972, the above argument against euthanasia asks why people who wish to die need go through all the trouble of securing help to end their lives – which would entail meeting the various legal conditions and securing the help of a willing participant, among other things – when it is perfectly legal to end it yourself without having to cut through the red tape. Also in the introduction, the case of Sue Rodriguez was discussed. When her ALS advanced to a certain degree she found that she no longer had the muscle control necessary to either swallow pills or inject herself. For her suicide was no longer an option. As with Erwin Krickhahn, if Sue Rodriguez were to have relied on her ability to effectively end her life, she would possibly have had to kill herself months earlier than she would have wanted to die, if only to ensure that she was physically able to do it on her own. Besides the issues with the above discussion, there are several practical reasons why an individual might prefer euthanasia (or specifically physician assisted suicide) to suicide. The first of these is that few people have the knowledge or the means of procuring medication guaranteed to end their lives quickly and (relatively) painlessly. One could expect a profound fear of waking up after the suicide attempt having only aggravated the underlying condition. That mistakes are entirely possible, and in some cases probable, with non-assisted suicide is one reason why an individual might prefer to be able to request euthanasia rather than take the risk of suicide.

Secondly, there remains a rather strong taboo against suicide in the modern western (read: Judeo-Christian) world. While the Ancient Romans may have seen suicide as a virtue in certain circumstances, the view has not persisted into modern times. As seen above, early Christian scholars such as St. Augustine and Thomas Aquinas were among the first to directly oppose suicide, going so far as to consider suicide as the greatest sin because it is the only sin that prevents any form of repentance. This idea of suicide as the greatest sin was maintained through the centuries, and even informed British common law, where the body of the suicide would not be buried in a cemetery. The suicide, instead, would have his body desecrated and buried at a crossroads to signal the extreme stance against suicide (Alvarez, 68). To this day there still remains an unspoken fear of suicides such that suicides are rarely reported in newspaper obituaries. There exists a debate surrounding the reporting of suicides in newspapers. Generally the consensus is that reporting a suicide could provide those close to such actions, who, it standard argument assumes, are already suffering from the psychological issues of the closed world of suicide, with the impetus to attempt suicide. Because of this many of the articles on the subject (such as Ziesenis, or O'Carroll and Potter) provide newspapers that choose to report suicides recommendations to include in the article in order to prevent or limit copycat suicides (Ziesenis, p. 241). These articles tend to recommend not sensationalizing or romanticizing the details of the suicide, as well as interviewing a mental health professional as a source to illustrate that help is available to those who need it.

Because of the lasting Christian influence, suicide was usually looked down upon by society, and the stigma of suicide was often carried by the family for some time after

the death. Suicide is typically a lonely act, carried out in isolation, either alone in a bedroom or in an outbuilding. It could be that the stigma associated with suicide remains so strong that suicidal individuals, for all their emotional and psychological distress, still manage to distance themselves from their family as much as possible. These reasons: the fear of making a mistake, the stigma of suicide, and the isolation that suicide prompts from family, are some of the more forceful reasons why one could possibly prefer to turn to euthanasia rather than choosing suicide as their means of dying. Finally, I should like to point out that euthanasia offers the dying individual several unique opportunities that is all but unavailable to the suicide. First, while the suicide is typically isolated, the individual choosing euthanasia is able to be surrounded by their friends and family. Second, euthanasia is a rather lengthy process characterized by repeated interviews and evaluations; these open lines of communication allow the individual deciding to die the opportunity to explain themselves to their family before they die. The typical suicide leaves a note that more often than not provides more questions than answers, which does not provide the family with much needed closure. These questions are only compounded in cases where there is no suicide note. Lastly, the medicalized nature of euthanasia gives the procedure an air of legitimacy that could go a long way to eliminating the stigma of suicide that has attached itself to the action throughout the centuries.

Concerning the Secondary Agent

1. *Determining the time and manner of an individual's death is not something that a physician should do; it is, in effect, "playing God". Any physician who wilfully assists with euthanasia is taking power for themselves beyond that which should be reasonably expected of them.*

This argument against euthanasia centres on the idea that any physician who participates in euthanasia could, theoretically, be acting on a desire to "play god" or to take for themselves the power over life and death. While this may sound like a rather strange argument to make, given the strong religious overtones, there is still an important consideration to be made regarding the risk posed to individuals by physicians or nursing staff with less than well meaning intentions. In March 2008, Colin Norris, a British nurse, was convicted of the murder of four elderly patients under his care and sentenced to at least 30 years in prison. Norris injected each woman, whom he described as 'frail and helpless', with lethal doses of insulin, going so far as to 'predict' the patient's time of death to other staff members ("Nurse Predicted Patient's Death"). Years earlier, in 2000, Dr. Harold Shipman had been found guilty of murdering 15 patients with lethal injections. After the trial it was revealed that there was sufficient evidence to connect Shipman with a further 200+ deaths, which would make Dr. Shipman Britain's most prolific serial killer ("Harold Shipman found dead in cell"). Given these examples it would seem that there is a very real risk that some physicians would wilfully murder their patients under the guise of providing them with euthanasia.

The above examples, however, should be seen as extreme cases that would never become normal procedure. Norris and Shipman, both health care professionals, were

nevertheless not operating in such a capacity when they committed their murders. This is not to say that a doctor, by definition, cannot murder, but rather that the above mentioned cases dealt with serial killers who happened to be employed in a field that made it easier to find their victims. The argument against euthanasia could be reworked to say that while the above cases can be excused as not directly relevant to the issue at hand – serial killing and murder can never be justified – the idea that some doctors could welcome the idea of being in control of life and death that they may be only too willing to assist individuals who have asked for assistance in dying and that this willingness might overshadow the necessary due care required in cases of euthanasia. A doctor who enjoys the feeling of being in power might be more inclined to assist rather than refuse cases of euthanasia which would result in individuals dying in cases that might not be considered justifiable (such as the above mentioned depression, etc...). Ignoring the fact that it is insulting to the medical profession as a whole to assume that a physician could be interested in whatever 'power' might be associated with dying this is yet another instance of the issue being sorted out through appropriate standards and practices. Any euthanasia legislation would require the assisting doctor to obtain several independent verifications to ensure that their decision to help with the death could be considered in the patient's best interest. All the legislation in place today (discussed above at pp. 40, 43, and 48) contains this requirement, and the Nevada Supreme Court insisted on outside confirmation of competency and beneficence before a patient could discontinue medical treatment (Dworkin et al. ¶21). This requirement would serve to sufficiently mitigate against the possibility of one doctor acting unilaterally for the sake of some morbid fascination with death.

Finally the argument is often made that euthanasia should be rejected because it allows the physician to determine the time and nature of death, and that this allows the doctor to change a life from its natural course. This argument maintains that life should not be extinguished before its time, and that death should be allowed to happen naturally. This fails, of course, when we recognize that any advanced life saving techniques – CPR, or the use of a defibrillator – constitute acting against nature to prolong life. Modern medicine's ability to provide patients with artificial breathing apparatus, or kidney dialysis also constitutes acting against nature, and should, according to the argument, be avoided. That it is unlikely that anyone objecting to euthanasia would also insist upon a moratorium on chemotherapy shows that the argument is motivated by a desire to suspend euthanasia rather than a desire to see medicine act "according to nature".

2. *Euthanasia is against the "Do No Harm" criteria of the Hippocratic Oath, and is, as such, fundamentally against the scope of medicine and health care.*

This argument against euthanasia relies completely on a definition of 'harm' that allows death to be seen as a harm regardless of context. There are several reasons why an appeal to the Hippocratic Oath cannot serve as an adequate argument against euthanasia: the first deals with the historical foundations of the Oath, the second with the interpretation of the Oath, and the third with the scope of the Oath. Historically, as Amundsen points out, the Hippocratic Oath came out of a time where there was not a particularly identifiable medical profession such that we would find today; rather doctors in antiquity were individuals who had, over time, independently acquired various pieces of medical knowledge. There was no accreditation to speak of and no governing body

such as the Royal College of Surgeons today. The idea of "Do No Harm", which is today seen as one of the cornerstones of the Hippocratic Oath, was contained within the Oath as a means of reminding physicians not to attempt a procedure that they knew to be beyond their abilities. Amundsen further points out that the idea of medicine being aimed at the prolonging of life does not share its origin with the Hippocratic Oath. In other words, the Hippocratic Oath does not contain within it the idea that life should be preserved at all costs. Medicine aimed at prolonging life was first mentioned in Francis Bacon's The Advancement of Learning, where Bacon himself called the idea a new (in 1605, when Bacon first published *De Augmentis Scientiarum*) element of medicine (Bacon, quoted in Amundsen, p. 27). That the idea was considered new in 1605 should allow the Hippocratic Oath to shed the idea that "Do No Harm" also means "Do everything to keep the patient alive as long as possible".

But, some might argue, this does not mean that the Oath did not evolve over time to encompass the idea that life should be prolonged wherever possible. If this is the case, the argument could be made that euthanasia, now, is something that the Hippocratic Oath has come to show as wrong. The issue with this, as Dieterle point out, is that euthanasia cannot be called wrong because it conflicts with the Hippocratic Oath; the Oath has to disagree with euthanasia because it is wrong (138). Appealing to the Oath as the arbiter of right or wrong medical procedure is incorrect, and as such the argument fails.

3. *If the physician is to be allowed to proceed with euthanasia then it must be shown that the diagnosis is correct, that is, that the physician is not mistaken. The impossibility of this requirement means that euthanasia should be avoided.*

Not much time will be spent with this objection to euthanasia as it is of the same structure as the objection requiring perfect knowledge of the individual requesting euthanasia. For much the same reason this argument requires far too much of the physician and as such it cannot serve as an adequate argument against euthanasia. As Dworkin et al. point out "the Constitution does not allow a state to deny patients a great variety of important choices, for which informed consent is properly deemed necessary, just because the information on which the consent is given may, in spite of the most strenuous efforts to avoid mistake, be wrong" (¶27). Outside of limited cases in game theory we cannot often act on perfect knowledge, and as such this argument against euthanasia should be rejected as being unreasonably demanding.

4. *Mistakes do happen in medicine, and while we cannot demand perfect knowledge before undertaking an action, we can and should, reject the use and justification of euthanasia due, precisely, to its severity.*

This is but one way of proceeding in the wake of the above discussion. The idea that euthanasia should be avoided because the decision is difficult and the results severe is not an argument that can be allowed to continue. There are other individuals who would take the risk associated with euthanasia as acceptable in light of the severity of end of life issues. Those who would argue against euthanasia in this way are, quite simply, begging the question.

Concerning Society

1. *Euthanasia fundamentally harms the family members of the individual who seeks to die, and as such should be avoided.*

For the most part, any death will fundamentally harm members of a family. The means of death, however, can fundamentally change the degree of harm caused. Personally, my Grandfather's death in 2000 followed a long decline and illness and I was able to make my peace with his eventual death before he died. That is not to say that his death did not hurt, it did, but rather that I knew he was dying for several months prior and I said my goodbyes. On the other hand, had he been a healthy individual who died in a traffic accident, the stress of his death would have been magnified by the shock of the circumstances. The sudden nature of the death removes the possibility of coming to terms with the event beforehand. In either case there is harm, I miss my Granddad, and I imagine that I would miss him just as much had he died suddenly rather than after a long illness. In fact, because I would not have had the chance to say goodbye, I would conceivably miss him more. It is true that euthanasia, in that it is a death, would harm a family, but it is not clear euthanasia in and of itself would not harm a family any more so than any other sort of death (unless that family was strongly opposed to the practice on moral or religious grounds, in which case it is unlikely that the euthanasia would ever have been explored as an option). Also, because euthanasia is a rather long process the patient would be able to make their peace with their family, thus allowing for more closure than would be allowed by an accidental death. Purely on the basis of harm to the

family[35], then, euthanasia itself would seem to harm the family members to no greater extent and, might, in fact, be less harmful than other manners of death.

2. *Allowing euthanasia promotes a culture of death, which can corrupt medicine and eliminate the possible future work in palliative care.*

Clark cites David Lamb making this objection to euthanasia which can be read in various ways of which the above is a composite of the more frequent examples. What all the formulations have in common is the insistence that any justification of euthanasia would correspond with a decrease in the respect for life. The indirect proportion claimed in the argument, however, is not borne out by empirical research. Dieterle cites statistics that palliative care in Oregon *improved* in the wake of euthanasia being decriminalized in 1994. This makes sense when one considers the obvious link between euthanasia and palliative care. Those individuals who most readily seek euthanasia are those suffering from some (usually) terminal illness which would see them undergoing hospital care – including palliative care – prior to their request for euthanasia being honoured. One of the requirements of euthanasia legislation has almost universally been the insistence that euthanasia be the last alternative in severe cases. What this would require is documented proof that various forms of palliative care had been previously attempted. Also, Dieterle goes further by highlighting that this objection to euthanasia assumes that all individuals would choose euthanasia which would, eventually, make palliative care an outmoded concept (134f), but this is not the case, and it is unlikely ever to be. Even in the

[35] It must be admitted that the family must be willing to accept euthanasia as at least a possible choice for the individual in order for this argument to work. If a member of a particularly religious family were to choose euthanasia this could harm the family. However, if the individual were religious as well, they would be unlikely to choose euthanasia.

Netherlands, which is often seen as the hotbed of euthanasia activity, only about 3-15% of deaths are the result of euthanasia. This means that there is another 85-97% of deaths that have nothing at all to do with euthanasia, and one can only assume that a number of these deaths were of patients who had previously been involved in some sort of palliative care. Palliative care, then, will only suffer because of euthanasia if the majority of persons choose euthanasia over palliation at the end of their lives. The statistics do not bear this out, and so this argument against euthanasia seems to be fundamentally flawed.

3. *Accepting one form of euthanasia will eventually lead to other, unacceptable, forms.*

This argument is the standard formulation of the slippery slope argument, which was dealt with briefly earlier in the paper (p. 58). Clark notes that those who oppose euthanasia often accuse those in favour of euthanasia of being "crude consequentialists" who give too much value over to social utility without realizing that they, the opposition, are themselves offering a consequentialists argument by posing the slippery slope (252). Slippery slope arguments all function in the same way: they insist that implementing X will cause unwanted consequence Y to follow, either directly or eventually. The variables can stand for any number of options, and in the case of euthanasia there are many different formulations of the slippery slope argument. One of the more repeated arguments maintains that allowing euthanasia of any sort will lead directly to involuntary active euthanasia; some might take the objection further insisting that it will lead to the outright murder of the old and the infirm. This tactic is taken by those who would argue that euthanasia is wrong because it was undertaken by the Nazis, which fails to recognize

the drastic differences between the euthanasia being discussed in this paper and the practices of the Nazi party.

Nielson notes an often overlooked feature of the slippery slope argument saying that "It is... used only by the side which is in the ascendancy at any given time, for it is an argument for the *status quo*, claiming, as it does, that if even a small change in the *status quo* is undertaken it will lead to more of the same until finally a tragedy results" (Nielson, 13, emphasis in original). Seen in this way it is fair to characterize the slippery slope argument as one that is firmly against change. Any use of arguments of this style then, should be an indication that change is anathema to the arguer. This should not be thought to be a wholesale rejection of the slippery slope argument, but merely a warning that the argument is typically used within certain circumstances. Virtuous uses of the slippery slope argument require, above all else, that the argument clearly explicates the connection between the original situation and the resulting, unwelcomed, consequence. If one were able to show that the precedent set by allowing the first situation, whatever it may be, directly and explicitly led to an undesirable consequence, the argument by slippery slope would have succeeded. The issue with most slippery slope arguments is that the connection between the two situations is *assumed to exist* rather than being explicable. All slippery slope arguments rely on empirical claims that link the original situation to the consequence, and their strength depends on the likelihood that the predicted empirical connection will occur (Dieterle, 127).

This alone, however, is not sufficient to save the slippery slope argument, for even if there is a direct connection between the original situation and the unwanted consequences, the moral problem is not with the original condition, it is with the

individual or group that perpetrate the unwanted consequence. Despite the appeal of the slippery slope argument, those that participate in the "bottom of the slope" situation are at fault in the same way that anyone else would be at fault for their actions. That the unwanted action was a consequence of the slippery slope does not mean that those who performed the unwanted action are blameless. Clark insists that the "novus casus interveniens", or new intervening cause, is blameworthy (253). If the unwanted consequence is indeed wrong it will not be due to the original position, or at least not only due to it, rather the "fault will lie with those who perpetrate the wrongs" (Clark, 252).

Perhaps the most useful argument against using slippery slope arguments against euthanasia is that it assumes that people will willingly continue down the slope without pause. Allowing voluntary active euthanasia does not automatically lead to a situation akin to the Nazi Aktion T4. It is plausible that arguments would occur at every stage of the 'decline' that would serve to end the slippery slope before it got to the undesirable conclusion that the slope argument warns us against. Allowing one form of euthanasia does not condemn society to accepting all forms of euthanasia (Clark, 252) in the same way that incarcerating a car thief does not lead to prisons being populated by gangs of six year olds guilty of stealing candy from the corner store.

Finally, the issue with the slippery slope argument can be seen by appealing to similar cases. We can see that it would be immoral to refuse asylum to a refugee that we knew beyond doubt would be tortured and killed purely on the grounds that it would set a precedent that would allow other refugees to claim refugee status for purely economic pursuits (Clark, 255f.). Just as the immorality of the final situation (the unwanted

consequence) must be based on that action itself, so too must the morality of the original situation be judged on its own merits without appealing only to future concerns that may never materialize[36]. A more damning question to be put to opponents of euthanasia regards the problems associated with countries where euthanasia is illegal, and yet practiced in secret. The tacit approval of euthanasia in these cases is far more damaging precisely because it lacks the sort of controls that would be imposed on euthanasia by legislation. This will be discussed later in the paper (p. 86, below).

4. *Accepting euthanasia endangers those at risk members of society that do not have adequate means to defend themselves against unwanted euthanasia.*

The above argument against euthanasia holds that there are some members of society that are thought, by society, to be less worthy of concern, and that these individuals are at a greater risk to be either pressured into euthanasia, or euthanized

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[36] It was brought to my attention that my treatment of the slippery slope style arguments might have been limited in its scope. The real thrust of the argument is not, so the objection goes, with the particular actions, but rather with the shift in social values that the particular action represents. I agree that the slippery slope argument could be read as being concerned with changing social values, but in the reviewed literature the argument specifically dealt with the resultant actions without any mention of the change in values. I am prepared, however, to recognize that these arguments might have been dealing with an implicit understanding of the transition of values. However, I believe that my argument still stands for two reasons. First, the idea that a change in values – for the worse – will occur if a particular action is permitted is problematic for the same reason as the above discussion indicates. The idea that one particular value out of many will obtain as the result of falling down the slippery slope, and that this value shift can be predicted in advance is problematic. Social values are fluid, and as stated in the paper, slippery slope arguments function to preserve the status quo. The idea that refusing one particular action will prevent a shift in values does not fully understand the transient reality of social values. I remain sensitive to the idea that negative consequences (or shifts in values) could obtain as a direct result of present actions, but I am not prepared to throw the baby out with the bath water. As it stands one should never accept anything (euthanasia or otherwise) unquestioningly as this is where the real problem starts. Secondly, and perhaps more contentiously, I would maintain that if accepting euthanasia requires a shift in social values, then that shift in values is necessary in order to ensure for people like Sue Rodriguez to end their lives on their own terms. Far from maintaining the status quo, I would insist that accepting euthanasia would produce a *beneficial* change in social values rather than the negative 'culture of death' that the critics of euthanasia fear.

against their will. While each of these has been dealt with above there is the further assumption that these members, because they are deemed to be worth less (not worthless) to society than other, more productive members, will freely be killed off by euthanasia without anyone advocating their right not to be killed against their will. These vulnerable groups, the argument maintains, must be protected from unwanted euthanasia. In this formulation I must agree with the argument: if a group exists that would be particularly vulnerable to euthanasia pressures they, as a group, should be protected from these pressures to the extent that their decision to request euthanasia, should they make one, could be seen as legitimately autonomous. The problem, of course, is that it is unlikely that such a group exists. Usually the argument maintains that the elderly, the poor, and the uneducated are at an increased risk to be abused by euthanasia, but this assumption does not bear out given the statistics. Chin et al. point to the data found after a year of legalized euthanasia in Oregon which shoes the median age of those requesting euthanasia is 69 years old – which can be termed the young-old in light of people living to 100+ years – over 97 percent were Caucasian, visible minorities are not at an increased risk to be abused, and the majority (61%) have at least some university education ("Legalized Physician-Assisted Suicide in Oregon"). These facts seem to show against the argument that uneducated minorities are at an increased risk of abuse.

It might be the case, however, that Oregon is an atypical case and that these statistics might not stand in other instances of legalized euthanasia. The problem here is that there are so few places in the world where euthanasia is or has been legal that the statistics simply do not exist to the extent required to make a strong conclusion either way. In the same way that mitigating depression is acknowledged as being a problem,

and therefore guarded against, the abuse of at risk groups of the population is also (or should likely be) a concern that must be take into account before any euthanasia is justified. If the possibility of abuse is continually held as a concern, throughout all stages of legalization and implementation, it is likely that the concern would not have the strength that this argument would see it have.

5. *It seems likely that women would be at an increased risk of requesting euthanasia because they have been socialized to be self-sacrificing.*

This permutation of the above argument against euthanasia featured in Wolf's feminist account of physician assisted suicide[37]. In it she argued that women, traditionally, have been socialized to be self-sacrificing and that this would cause women to request euthanasia with more frequency than men, and that this socialization therefore constituted an unequal pressure on women that should be avoided (Dieterle, 137). This is an especially confounding objection because, as I have argued elsewhere in this chapter, it may be an unwarranted assumption given the impossibility of finding empirical support. However, given my feminist leanings, I am inclined to believe that it might be true, or, if not true, at least sufficiently plausible. That being said, I do not think that this could prove to be adequate objection to the legalization of euthanasia for as true (or plausible) as the objection may be I cannot see that it constitutes a reason for the wholesale rejection of euthanasia. As has been the position throughout this chapter the objection should be seen to be a warning against possible abuses. Once made aware of the issues surrounding gendered euthanasia there could be adequate procedures put in

[37] My discussion of Wolf was informed by J.M. Dieterle's article *Physician Assisted Suicide: A New Look At The Arguments*

place in order to prevent against possible abuses. It should be noted, however, that not every instance of a woman requesting euthanasia will be a result of gendered socialization, and this constitutes another reason *not* to reject euthanasia. By not legalizing euthanasia – or by banning it outright – the medical community is telling women that they have to be protected from themselves, a possibility that does not sit well with me, nor, I believe, will it with other feminists. As Dieterle succinctly puts it: "[If] we were to ban PAS because of these considerations, what we would, in effect, be paternalistically saying to women is, 'We won't let you make the choice to end your life as you see fit because we think that cultural conceptions of gender have unduly influenced your decision making process. Were it not for these cultural conceptions, you would not want to die.'" (137). Stripped of the well meaning sentiment we can see just how sexist this rejection of female autonomy is. From a more strictly feminist point of view I hesitate to think that many women would be grateful for this so-called protection, as it constitutes yet another area where the typically androcentric powers (both in society and especially in medicine) are attempting to strip women of their autonomous decision making capacity in order to dictate just how women should behave.

6. *Accepting euthanasia promotes the idea that some lives are less valuable than others.*

While on the surface this may appear to be a fair objection, it can only stand if there is ever an official requirement for those of a certain life to submit to euthanasia. Such a requirement would be responsible for sending the message that a particular life (or lives) were worth less than another. This would send a message to a society that there is a particular condition of life that is 'objectively' viewed as being so corrupted as to be

worthy only of death. The reason that such a position should not be promoted (besides the fact that it is obscene) is that it could stand as an external pressure on individuals to end their lives if and once they find themselves in such a condition. Taken in this way there should never be an official declaration that some lives are more valuable than others, but this is not what the legalization of euthanasia would present. As it stands, the euthanasia being advocated in this paper is such that individuals request it based on their own evaluation of their lives and the prospects open to them in the future, not on an external suggestion that their lives are not worth living. One can well imagine a film editor who spends most of their day sitting behind the controls of an editing bay becoming paralyzed in a car accident and being able to adjust to life in a wheelchair. By the same token a contractor who walks around job sites, driving tractors, and demolishing buildings could, conceivably, have a more difficult time adjusting to a life where most of these activities are denied to them by a degenerative nerve disease. What constitutes a life worth living, at least in the context of this paper, depends on how the individual sees their own lives progressing. If the editor is able to adjust to life in a wheelchair while the contractor is not able to adjust to the loss of his abilities the latter could be justified in requesting euthanasia. The justification of euthanasia, as far as concerns the individual, does not depend on an objective determination of value, rather it requires that individuals decide for themselves at what point their life is no longer worth living. In light of this it would seem that the objective checks introduced throughout this paper are directly contradictory to this stated concern for subjective valuation, but this is not the case. The subjective determination of value discussed above is of importance to the individual while the objective checks are important to the society in which the euthanasia is allowed to go

forward. The objective checks on the suicide's request are in place to ensure that a number of conditions are met – that the patient is not being unduly pressured to request euthanasia, that the physician has the best interest of the patient in mind, or that some mitigating and otherwise treatable depression is not present – not that the patient has correctly evaluated their lives. In other words, the objective checks are not meant to be considered more important than the individual's subjective determination of value, they are meant only to ensure that external forces are not interfering with the individual's free choice. Because the objective considerations are intended to prevent external abuse, and not to indicate which members of society should be euthanized the objection does not apply.

Concerning Practical Issues

1. *Proper palliative care makes euthanasia unnecessary.*

Many of the previous arguments against euthanasia have insisted that allowing euthanasia will prevent further advances in palliative medicine from being made. These arguments, however, have fallen short of debasing euthanasia due, almost entirely, to their faulty assumptions that all patients would opt for euthanasia over palliation. This argument, then, is the inverse of these previous attempts to argue against euthanasia. This argument works by maintaining that advances in palliative care have progressed to such an extent so as to make euthanasia no longer necessary to treat patients at the end of life. The problem with this argument is that it grossly overestimates the effectiveness of current palliative procedures[38]. Even the best palliation will occasionally fail, and "even if palliation could be effective 100 percent of the time, that still would not guarantee a solution to the moral problem—for what of the dying patient who *does not want* to approach death drugged into insensibility?" (Seay, 526). Seay's rhetorical question introduces a rather important element into the argument. Even if palliative care could be completely effective in all cases, and there are, of course, cases where that does not happen, the patient could still wish *not* to be drugged into a stupor before their death. The idea that palliative care can be a solution to end of life problems for every individual does not work. For many patients the idea of being drugged into semi-consciousness in the

[38] Zimmerman et al. conducted a detailed study of the available data on the effectiveness of palliative care. In terms of quality of life, patient satisfaction, caregiver satisfaction, and economic considerations, the only evidence that consistently pointed to the effectiveness of palliative care was in regards to caregiver satisfaction (1706). Zimmerman et al. concludes that this points to a lack of data, and it does, but I maintain that it also points to a shortcoming of palliative care: palliation that is only consistently effective in assuaging the concerns of caregivers does not address the real heart of the matter, which is the quality of life and the concerns of the patient. This may be proven false by future evidence, but I think that it is a safe (provisional) conclusion to draw.

time before death could be seen as cruel as it robs them of days and hours where their lucid mind could find some closure. As the case of Sue Rodriguez pointed out many people do not wish to die under the influence of heavy drugs, and would prefer to end their lives in full control of what faculties they have left, a desire which euthanasia allows to a greater extent than palliative care.

2. *Active euthanasia is too strong to be legitimately permitted, but the weaker form of passive euthanasia could easily be permitted instead.*

The argument here centres on the distinction between active and passive euthanasia with the former typically considered to be worse than the latter because active euthanasia involves direct action with the aim of ending the life of the individual. Passive euthanasia, on the other hand, is often seen as nature simply taking its course once human interference is removed. Those who would support the former while rejecting the latter are rejecting the active role of the assisting agent rather than the death of the patient. This argument, though, has interesting repercussions for the euthanasia debate as a whole. If passive euthanasia – or "letting die" as it is usually termed – is allowed it requires a substantive recognition that any further continuation of treatment (i.e. life support) would be futile. Seay insists that this recognition further necessitates the recognition that the life provided by the continuation of this "futile" treatment would be of such diminished quality that it would be better to have life not continue (526). Passive euthanasia, then, allows for the consideration of quality of life in such a way that it can be the difference between a patient's being indefinitely kept on life maintaining equipment and their being removed from said technology. To maintain consistency the discussion of quality of life

must be allowed to enter into the discussion of the continuation of a life *not on life maintaining equipment*, in other words, if we are to allow considerations of quality of life in regards to passive euthanasia they must also be allowed into the discussion of euthanasia as such. After allowing considerations of passive euthanasia any refusal to consider active euthanasia must be justified on grounds other than the activity or passivity of the treatment. Those who would maintain that there can be a distinction between activity and passivity must take a further look at the distinction between active and passive in regards to treatment. If a construction worker were to fall on a piece of rebar which punctured their shoulder, the doctor would, eventually, treat the injury by removing the offending piece of metal. This would be considered an active treatment. A passive treatment would be of the sort that is often suggested for the common cold, which is simply to wait for the body's immune system to fight off the illness. This is passive treatment because nothing is being done by the doctor that would not have happened naturally. Passive euthanasia, the removal of life supporting technology, is not a passive form of treatment because the doctor must remove the machines in the same way as they would remove the rebar from the construction worker. As the technology exists today[39], turning off mechanical respiration is fundamentally *active*, insisting that it is passive, because death results from an underlying condition, does not make the form of euthanasia any less active. A doctor respecting a patient's Do Not Resuscitate (DNR) order – which

[39] An intriguing thought experiment was proposed in response to this point: imagine a machine that would shut off a patient's life support automatically and by default unless the machine had regular input from an external person. The turning off of the life support would no longer be an active process as it would only require the refusal to act and would therefore become the definition of passivity. The issue with this is that the active element is not eliminated as much as it is transferred. Where previously turning off the machines was the active process, under this thought experiment the activity becomes connecting the patient to the machine knowing that any future passivity would result in the end of the patient's life. Activity, however temporally distinct from the death, is still required to end the patient's life.

requests the physician to not attempt any heroic life saving measures (such as intubation, or the insertion of a feeding tube) could be considered passive euthanasia because it is here that the doctor is, quite clearly, not doing anything.

3. *There can be no euthanasia legislation that could prevent all instances of abuse from occurring, nor could there be completely effective enforcement of the legislation. There will always be the risk of abusing euthanasia, and as such euthanasia should not be allowed.*

The difficulty of effective legislation cannot serve to be a reason against legislation. Care must be taken when enacting any new legislation to ensure, as much as is possible, that it is safe from possible abuse. If there is a reasonable concern that a certain element of the legislation will be abused this should serve to indicate where care must be taken when describing the scope of the legislation. In the case of euthanasia there is, of course, a risk that there will be instances of abuse – in much the same way as legalizing alcohol consumption faced the risk of impaired driving. The objection seems to take it that the existence of the possibility of abuse is a reason to avoid the legislation entirely, but it forgets that the law is fluid, and can change its scope in light of newly discovered issues in order to preserve its spirit. A more interesting question concerns the abuses in countries where euthanasia is *not* legal. Earlier (at p.77) mention was made of the issues regarding the tacit approval of euthanasia independent from any form of legislation, and it is to this that I would like to return now. That euthanasia is illegal does not mean that it is not practiced. In countries with no euthanasia legislation people who wish to request euthanasia would be forced to look to forms of black market euthanasia,

one without the safeguards that legalized euthanasia would have put in place. One need only look to the illegal abortions performed before the procedure became legal in the late 1960s to see the consequences of not legalizing euthanasia. Abortions were often performed under horrendous conditions and the results could have been fatal. Legalizing abortion brought the practice under control, and allowed law makers to put restrictions and standards on the procedure such that the problems with pre-legal abortions were no longer prevalent. There are also issues with control in countries where euthanasia remains illegal; Clark mentions a Dutch lawyer commenting on the state of euthanasia legislation in the world as saying "that in Britain, in France and in the United States, doctors have exactly the same difficult decisions to make, but they find other ways – ways that are not controlled by society, not reported frankly. In the end... that is much more dangerous for society" (Clark, 255f. Quoted from The Guardian, November 3rd 1992). For in countries where there are no official channels to go through *all cases of euthanasia are illegal.* It is naive to assume that some form of euthanasia does not occur in these countries, but with no mechanisms to deal with cases of abuse there is a much greater risk. The risk of abusive, secretive, euthanasia far outweighs the risk of abuses of legally controlled euthanasia.

4. *Legalized euthanasia could be used as a cover for murder.*

It is possible that legalizing euthanasia would allow rare cases of murder to be hidden under the guise of merciful euthanasia. However, it is also possible for murder to be masked by suicide, accidental death, drinking, death by misadventure, or by natural death. The point is, if someone were sufficiently motivated to commit murder, euthanasia

would provide them with no more cover than they already have given any of the variously mentioned circumstances. It must be recognized that this would provide those inclined to murder with another viable option for hiding their crimes, but there is no reason to suggest that this particular method would be any more successful than the currently existent means. If anything the limited permissibility of euthanasia – limited to health care professionals now and for the foreseeable future – would result in an equally limited section of the population that could believably claim to have euthanized someone that they had murdered. To illustrate this point, assume that euthanasia were legalized and rigidly monitored. Under these conditions there would be exceptionally limited situations in which a person's murder could be hidden by euthanasia. Whereas an accidental death could be faked by anyone with the intelligence to plan the murder, euthanasia is not an option that would be available to the general public. Importantly murder is often suspected in the cases mentioned above if even the smallest detail seems out of place, this due diligence would undoubtedly be used in euthanasia as well. Witness the aforementioned cases of Harold Shipman and Colin Norris.

Concerning Death as Such

1. *Death can never be better than life. The assumption that euthanasia could be a benefit to some people is fundamentally mistaken.*

This argument might also be called the "life is sacred" argument, or it could, as Gay-Williams does, attribute the wrongness of death to humanity's natural inclination to preserve life (quoted in Dieterle, 139). But these formulations of the argument do not necessarily mean that death is *always bad.* Firstly, requiring a terminally ill patient to continue living beyond their willingness to submit themselves to the indignity of their suffering goes far beyond the well-meaning sentiments of the idea of life as sacred. Secondly, in response to Gay-Williams, drawing a normative conclusion from the facts of nature is notoriously fallacious (Ibid.), and can be utilized to justify many things that one would not want to consider 'moral'. The fact is that the majority of species do not mate for life, and, in fact, that many species can have multiple partners (this is to say nothing of the mating ball of the common garter snake). It is unlikely that people using the argument from nature to refuse euthanasia would be willing to further use it to justify polygamy. It is this argument against euthanasia where we are able to see the most succinct formulation of the issue that separates those who are opposed to euthanasia from those who are in favour of it in certain circumstances. The former reject euthanasia because life is sacred and it is morally wrong to interfere with something that is sacred[40]. The latter accept euthanasia because there are circumstances where life – to say nothing of it being sacred or not – is no longer worth living. This divisive element will come to be

[40] It will be shown later that what is, in fact, meant by the 'life is sacred' argument is a rather limited form of human life. This will ultimately be the factor that undermines the entire argument.

rather important at the end of the current section where we will turn to a more in depth discussion of the notion that life is sacred.

2. *Killing is necessarily wrong, euthanasia is a form of killing, and therefore we should not justify euthanasia.*

As appealing as this argument might seem on first blush it forgets that there are any number of situations where society not only excuses killing – in the case of self defence – but actively encourages it – in times of war, or with capital punishment. Those who still wish to reject euthanasia might argue here that the cases offered as a counter example are not the same as euthanasia because those killed in the former cases are guilty of some offense while the person involved in euthanasia would typically be innocent. This may be true, but it does not matter here. To consider guilt or innocence in questions of euthanasia is a category mistake. Focusing on the guilt or innocence of the patient who wishes to end their life is to miss the point of the request, which is to end their suffering. Moral desert would be at issue in questions of capital punishment, because surely it is wrong to kill a person for a crime that they did not commit. Insisting that the patient's innocence be taken into consideration in regards to their request to end their life is to ascribe importance to a category – moral desert – that has no bearing on the issue at hand (Seay, 528). To deprive these people of the relief that they have asked for because they are innocent of any crime is absurd, and however well meaning this argument against euthanasia might be, it should not factor in to any discussion of a justification of euthanasia.

Philosophical Issues

1. *Kant rejects the possibility of suicide because it treats one's self as a means to an end. Kant would reject euthanasia along the same grounds, because the idea of euthanasia is internally inconsistent with the idea of self-love.*

Kant rejects suicide in The Metaphysics of Morals by refusing to allow that a person could use themselves as merely a means to an end. Particular to suicide, the person who kills themselves to relieve some pain treats themselves as merely a means to achieve the end of relief from suffering. Clark refers to the Kantian argument against suicide by referencing Christine Korsgaard's analysis of the problem. The relief of pain that the suicide seeks is good precisely because the individual desires it, but if the individual were to kill themselves they would destroy the thing (the rational being) which makes valuing possible (254), the individual would be treating their rational being as merely a means to the end of relieving suffering. The suicide who desires to kill himself to achieve a state where there is no longer pain misunderstands what suicide consists of, and, if he were successful in ending his life, he would destroy everything that made desiring possible which would undermine the whole of desire.

Gunderson would also accept the Kantian refusal of suicide pointing out the inconsistency in one's willing to die. Kant uses the term Self Love while pointing out a contradiction in the idea of suicide. Most suicides kill themselves out of an excess of self love that promotes a desire not to suffer, which, for Kant, is inconsistent because suicide defeats the purpose of self love, which is the furtherance of life (Gunderson, 278). Gunderson questions whether furtherance of life can really be the purpose of self love, but goes no deeper into this discussion. Instead Gunderson returns to the question of

suicide, discussing suicide independent of self love, as a question concerning reasoning in the finite being. The suicide wishes to end reasoning as a finite being, but this is fundamentally inconsistent with the idea that, as a rational being, the individual necessarily wills the continuation of rational beings (Ibid.). It is this rational agency which Kant sees as constituting humanity (Gunderson, 279). Gunderson goes on to discuss the possibility of extending Kant's refusal of suicide to a refusal of euthanasia (283) maintaining that the Kantian focus on rationality that defines humanity, and which, further, cannot be violated cannot be extended to all cases of euthanasia. Gunderson insists that Kant would have to accept that certain individuals, once robbed of their rational agency by an illness such as ALS, could be legitimate candidates to have their lives ended (Ibid.).

In this way the Kantian argument simultaneously refuses to admit the relatively beneficent form of euthanasia that this paper has so far discussed while also allowing the strongest form of euthanasia (that of involuntary active euthanasia) which this paper has explicitly denied ever being legitimately justified. Kant's arguments in favour of rational agency would also go against certain forms of palliative care, especially those that eliminate rationality, such as terminal sedation. The Kantian rejection of suicide rests on a desire to maintain the conditions, universally, for rational agency in such a way that nothing that is wilfully directed against rational agency can possibly be permitted. However, Gunderson insists that the respect for rational agency that he advocates along Kantian lines "requires both *sustaining* the conditions of rational agency and *respecting decisions* made by rational agents. A supposed kingdom of ends in which rational decisions were not respected after the loss of competence or death would be less

respectful of humanity and hence not a genuine kingdom of ends" (Gunderson, 283f, emphasis added). This must mean that the Kantian argument against suicide, turned towards euthanasia, is not against euthanasia in all cases, and that there are circumstances (such as the loss of rationality as a result of extreme suffering) where euthanasia could be a legitimate consideration. The issue with suicide and euthanasia in regards to an individual who has not lost their rational agency centres on the concept of respect for rationality which Clark does not see as a legitimate reason for insisting that an individual be made to suffer. The Kantian argument requires that rational agency be maintained so far as is possible lest it undermine the idea of rational agency itself, using this to insist that people in incredible pain limit their analgesic doses, or to deny euthanasia as a whole, relies on an idea of rationality that is often stronger than most. Clark responds to this idea rather succinctly:

> "[While the suicide] is still alive the subject can value a life which is not concluded with protracted distress and misery, he can value the prospect that his life will not end in senseless indignity. Indeed many of us would value a life without such an end more than one with it, and the fact that once it has ended we are no longer around to value it does not nullify its value" (Ibid.).

2. *Talking of Pure Autonomy necessarily requires accepting bad forms of euthanasia.*

The earlier discussion of suicide and euthanasia featured in this paper made reference to a desire to see personal autonomy taken to a rather extreme level in order to account for a justification of euthanasia that cannot make reference to physically identifiable suffering. The idea of autonomy increased in this way makes room for some

rather unwelcomed consequences, as Jurriaan De Haan notes in his article "The Ethics of Euthanasia: Advocates Perspectives" It would not be unfair to classify De Haan as a supporter of certain forms of euthanasia, and the above article puts forward two different conceptions of justification of euthanasia. The first is what De Haan calls The Pure Autonomy View (TPAV in the original) which sees that *only* autonomy matters when it comes to justifications of euthanasia (163). Any judgement relating to quality of life should be avoided under this view as it is epistemologically impossible for a doctor to assess a patient's quality of life (157). For De Haan an autonomous decision is important, and a decision is autonomous if the patient "has the ability to understand what options he has and what the pros and cons of these options are and the ability to rank these options and to choose the option that is ranked highest" (163). The issue with this, which De Haan rightly points out, is that such a justification of euthanasia would allow, without limitation, justifications of euthanasia that are based on bad autonomous decisions (162). The problem with this is that under TPAV there can be no external evaluation of the decision making process beyond an evaluation of the subject's autonomy.

Not wishing to allow such forms of euthanasia De Haan proposes The Joint View (TJV) which takes TPAV and factors in the existence of suffering. The inclusion of suffering allows external observers (such as family, friends, or the physician) to weigh in, as it were, on the subject's request for euthanasia, and it is here where we get closer to the sort of euthanasia that this paper would like to justify.

3. *Contributing vs. Enabling Factors.*

De Haan's article introduces another important distinction into the consideration of euthanasia, the distinction between the contributing factor and the enabling factor (165f). A contributing factor is one that contributes to the rightness (or wrongness) of an action, whereas an enabling factor is one that enables the contributing factor to play its right-making or justificatory role. The issue that De Haan introduces is that the existence of suffering is an enabling factor, that is, it *is not* a contributing factor and so it cannot be used as a means of making a particular instance of euthanasia right (or wrong). Autonomy is a contributing factor, as the lack of an autonomous decision would make the possible euthanasia wrong. Suffering, though, does not play the same role; it is an enabling factor which allows the autonomous decision to play its right-making role. If suffering were not present, then autonomy could be used to generate a bad justification of euthanasia, as was seen in the previous question. Both autonomy and suffering are necessary to euthanasia, and while the former does play a right-making role in regards to the justification of euthanasia, the latter does not. The existence of suffering, as De Haan puts it, constitutes the lack of a conclusive reason against euthanasia (166).

If, then, suffering is not a factor such that it can play a right-making role in euthanasia, what role does it play? It would seem that suffering no longer serves a justificatory role in euthanasia, and that, as such, most of the discussion of euthanasia has been undermined, but this is not the case. Suffering plays a necessary role in questions of euthanasia, and, as we have just seen (in TJV) it *needs* to be present in order to avoid the negative consequences of TPAV. That the existence of suffering does not play a directly justificatory role, in the same way that an autonomous decision does, is not a reason to

discount the importance of suffering in the discussion. Indeed, suffering might play a more important role in the justification of euthanasia once we remember that there could be circumstances where a patient, incapable of autonomous decisions, could legitimately be euthanized based on the existence of suffering. Such a case might be the individual who has made their wishes known both verbally and in writing, who falls into a coma and is removed from life support (passive euthanasia) by a guardian or proxy. It would be wrong to discount suffering on the basis that it does not play the same justificatory role that an autonomous decision does.

4. *If a patient has a right to request euthanasia, does that not then require that some other individual has a corresponding duty to provide the assistance? If so, how can we legitimately require an individual (the physician) to provide help if it goes against their conscience? If it is decided that there is no corresponding duty, must we not, then, say that the individual does not have the right to request euthanasia?*

On the surface this appears to be a rather difficult problem, for any right requires that some other individual have a corresponding duty to help attain that right (Huxtable & Möller, 124). The problem stops, though, once it is realized that the right that is being asserted by the person who wishes to die is the right to request euthanasia and to have this request reasonably considered by those in a position to help *should they be willing to help*. If the patient approaches their physician and asks for help in dying, and that physician refuses to provide the necessary aid, the patient's right has been exercised, and that is where the issue stands until another individual is approached. There should never be a duty to help someone die. Dieterle points out that the conflation of the right to

request with the right to be assisted is a misconstruction of euthanasia policies (132). The above view comes from a correlative theory of rights and duties (Seay, 518; Lyons), which is mistaken in the case of euthanasia because the purpose of the rights is not to secure a claim on certain benefits. The purpose of rights in the case of euthanasia legislation is to protect the autonomy of the individual by ensuring their ability to make a choice and have that choice be legitimately recognized as rational (Seay, 521), and potentially recognizable.

Samar provides a discussion of active and passive rights (104ff) in an attempt to further distinguish the concept of rights beyond the previously discussed negative and positive rights of Mill, Constant, and Beetham. Samar sees passive rights as being those that afford the subject a particular benefit. In this respect passive rights are closely related to and involve the idea of positive freedom in that a passive right requires the respondent to afford the rights holder a certain benefit that is in the former's ability to grant. In contrast to this active rights permit the holder of the right to perform a particular action. This sort of right is related to negative freedom in that others have the duty to not interfere with the rights holder's exercise of their rights. Samar distinguishes between the two saying "the relevant difference between active and passive rights is that while in the former case the holder of the right is free to perform certain actions, in the latter case the holder of the right merely has a valid claim against the respondent to afford the holder certain benefits" (105).

Using this distinction we can see that the patient has the active right to request euthanasia but there is no passive right to be granted euthanasia. The patient has no (passive) right to euthanasia such that the physician would be duty-bound to assist with

the suicide against their conscience. The patient must actively locate a physician for whom euthanasia fits into their belief structure. In the same way that the physician is not duty bound to acquiesce to a patient's request for euthanasia, neither does the physician have a duty to preserve the patient's life. Despite the standard medical presumption in favour of life, the preservation of life is not at all unconditional, but rather dependent on *the patient's decision* whether to exercise his or her right to life or not. On this conception of rights, it seems, the doctor has a strict duty never to intentionally kill the patient *so long as the patient does not wish to be killed*; but if the patient does competently express a desire to die, under circumstances where it would be rational to do so, and if that is what he or she does desire, then the patient has waived the right to life, and then the physician no longer has a moral duty to refrain from intentionally killing him or her (Ibid).

Justified Euthanasia

The Problem of Justification

Having completed the above analysis of the arguments against euthanasia I must admit that while I consider the counter arguments to be serious refutations of the arguments against euthanasia I can see no reason why this should be so for those who still happen to believe that euthanasia should not be allowed. This problem comes down to the basis of one's beliefs. At the outset of this work I admitted to an underlying commitment to a more liberal conception of autonomy and this has not changed in spite of the various arguments that have been presented against euthanasia. I can only imagine that this would be the case, as well, for those who might have

argued against euthanasia. For the most part moral arguments work within a moral framework founded upon underlying beliefs. For instance the orthodox Jew is unlikely to eat pork or mix meat and milk in the same meal for no particularly rational reason. The same problem occurs with euthanasia. Given my underlying belief in personal autonomy it is unlikely that I would ever support a system that favours a group-minded belief structure. Simultaneously, an Orthodox Catholic is unlikely to turn his back on Church teachings based on my arguments in favour of personal autonomy. The way to proceed here is to change from using particular counter arguments to exposing what might be a contradiction within a foundational belief. In dealing with the arguments against euthanasia this paper proposed answers to the particular problems that the arguments suggested. The issue is that, on their own these answers are themselves open to criticism and rebuttal. There is no particular reason – beyond the underlying beliefs that each person brings to an argument – to support one argument in favour of justifying euthanasia over the argument against euthanasia. When compared in a one to one relationship the arguments are too evenly matched. However this is no reason to declare a stalemate; the discussion can continue once a few alterations are made to the process. In the opening quote Peirce referred to the standard conception of a chain of reasoning, pointing out that the chain is only as strong as its weakest link. One weak premise (or sub-argument) can undermine an entire structure of argumentation and this is the problem that the arguments against euthanasia (and the responses) are suffering from. If, however, we take the myriad arguments as offering a matrix of argumentation then the relative merits and worth of the whole argument can be addressed. The remainder of this paper, therefore, will turn to a discussion of both sides of the

euthanasia debate before ultimately coming down in favour of justified euthanasia on the balance of the arguments. In order to examine the whole argumentation it is first necessary to analyze the underlying factors of each. Previously this paper placed respect for personal autonomy in the face of suffering as the most important element of a justification of euthanasia; this remains. In discussing the arguments against euthanasia it was found that the sanctity of life was the characterized as being the impetus for most arguments against euthanasia. For this reason the idea that life is sacred will be analyzed further before both sides of the issue are compared and measured on the balance of their arguments.

The Right to Life or Life is Sacred Argument: Redux

Supporters of euthanasia will typically encounter a number of arguments against the legal or moral practice of allowing euthanasia to be carried out. There is one idea that permeates the majority of these arguments and that is the presumption that life is sacred. This belief, which encompasses both euthanasia as well as suicide, serves as a foundation to other arguments and should not itself count as an argument as it provides few, if any, reasons to hold it as being true. This is not to say that it is not important because it has been a major belief of many religions (at least the Judeo-Christian religions). Within Christianity this belief originated with the works of St. Augustine and, centuries later, St. Thomas Aquinas. Augustine's prohibition on suicide came about in response to the Donatist sect of Christianity which saw its members either killing themselves or having others kill them shortly after baptism in order to ensure their entrance into heaven. In his City of God Augustine writes "It is not

without significance, that in no passage of the holy canonical books there can be found either divine precept or permission to take away our own life, whether *for the sake of entering on the enjoyment of immortality*, or of shunning, or ridding ourselves of anything whatever" (Book I, Chapter 20 emphasis added). This is addressed specifically against the Donatists and the closely allied Circumcellions. The following several chapters of the work continue with the condemnation of suicide. A century later, the influence having spread, suicides were forbidden proper burial at the First Council of Braga (563CE). The most lasting influence on the question of suicide in regards to Christian orthodoxy came from Thomas Aquinas whose Summa Theologica set out, among other things, a threefold rejection of suicide:

> First, because everything naturally loves itself, the result being that everything naturally keeps itself in being, and resists corruptions so far as it can.... Hence suicide is always a mortal sin, as being contrary to the natural law and to charity. Secondly, because every part, as such, belongs to the whole. Now every man is part of the community, and so, as such, he belongs to the community. Hence by killing himself he injures the community, as the Philosopher [Aristotle] declares (Ethic. v, 11). Thirdly, because life is God's gift to man, and is subject to His power, Who kills and makes to live. Hence whoever takes his own life, sins against God... as he who usurps to himself judgment of a matter not entrusted to him.
>
> (Second Part of the Second Part, Question 64, Article 5)

This tripartite rejection of suicide as being against nature, the community, and God has persisted since, being used as recently as the 1992 where it contributed to the Catechism of the Catholic Church (§2281). From the above we can see that the argument that life is sacred originated within this prohibition on suicide which was itself influenced by a practical question concerning a splinter group of Christians rather than anything said in

the Bible. Of the suicides mentioned in the Bible[41] none of them are condemned. In fact, some of the suicides and the reactions to them directly conflict with the reactions to suicide that the Church exhibited.

The conception of life as being sacred originated with Aquinas and has maintained a rather strong presence ever since. The pro-life argument regarding the sanctity of life is influenced mostly by the notion that life is the gift of God and that suicide is wrong because it sins against God's love. So pervasive is this idea in Western culture that the sanctity of life is often supported by the religious and nonreligious alike. The origin of the argument within a religious framework does little to dissuade those who might not believe in a God; as such, any further discussion of the sanctity of life should be read as being distinct from any religious feelings. In fact the sanctity of life will occasionally be used interchangeably with the right to life. The purpose of this distancing is to avoid conflating all those who consider life to be sacred into a singularly large group based on religious notions. This is done for two reasons. First, "sacred" can mean a

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[41] There are seven (eight if Jesus is counted):
Judges 9:54 – Abimelech [1] asked his armour-bearer to kill him before he died from a skull fracture.
Judges 16:26-31 – Samson [2] killed himself to avoid being "made sport of" by the Philistines. Samson earns a place amongst the saints for this act (Hebrews, 11:32).
1 Samuel 31: 3-6 – Saul [3], wounded and defeated in battle, asked his armour-bearer to kill him. When the aide was afraid to do it, Saul fell on his own sword. The armour-bearer [4] then did likewise.
2 Samuel 17:1, 23 – Achitopel [5] planned to overthrow David. Failing he put his household in order and hanged himself. Interestingly, he was buried in his father's sepulchre, in contrast to the Council of Braga's decision.
1 Kings 16:18 – Zimri [6] tried to usurp the throne of Israel, but, failing, burned down the palace around himself.
Matthew 27:4-5 – Judas Iscariot's suicide after betraying Jesus is generally seen as an appropriate act of remorse.
John 10:18 – It could be argued that Jesus' saying "No man taketh it from me, but I lay it down of myself" in reference to those who wished to crucify him amounts to a sort of suicide.

number of different things, not all of them religious, and second, it is irresponsible to ascribe religious affiliation to anyone unless they themselves have explicitly stated their position as being religiously motivated.

Joel Feinberg, in the oft-cited article "Voluntary Euthanasia and the Inalienable Right to Life", argues that suicide and euthanasia cannot be permitted because individuals have an *inalienable* right to life and as such, life cannot properly be given away (93). The problem with Feinberg's argument is that he relies almost entirely on definitional arguments as to the meaning of inalienable, and when not relying on Webster's dictionary (111) his arguments are more than a little flippant. While discussing whether or not the right to life can be forfeited – a serious question that has generated much discussion – without even considering other serious alternatives to his position he maintains that the *only way* a suicidal person would be able to forfeit or waive their right to life would be to murder someone else first (112). If this were the only problematic point in his paper it could possibly be excused as overconfidence, but it is not. At the start of the article, while trying to illustrate the problem that an inalienable right to life might present to those who would defend a right to die, Feinberg insists that if they wish to maintain the right to die they must reject the inalienability of rights which he calls "virtually un-American" (93f). The patriotism of the right to die movement should not be at issue, and Feinberg's characterization illustrates his unwillingness to take the question seriously. Immediately following this characterization Feinberg sets the parameters of his discussion by "[interpreting] "the right to life" in a relatively narrow way, so that it refers to "the right not to be killed" and "the right to be rescued from impending death," but not to the broader conception, favoured by many manifesto writers, of a "right to live decently"

(94). Not only is this an example of a sort of begging the question argumentation but the ad hominem shows Feinberg's unwillingness to treat those who might hold the right to die with respect. Highlighting the problems with Feinberg's article is not an attempt to discredit the right to life argument as a whole, it is only a way of illustrating the issues that can occur when the sanctity of life is taken to be true without question.

Avoiding these problems, Susan Chetwynd discusses the right to life argument as possibly being understood as being either a negative or a positive right. This is a useful distinction, and one that Feinberg never made. The right to life understood as a negative right can be read as a right to have your life protected from others, a duty on others not to act to end your life. A right to life in a positive sense goes further and places on people a duty to "promote or preserve your life" (175). The positive sense of the right to life does not allow for the possibility of suicide, assisted or otherwise, because others will be duty bound to help you to continue your life, even if you no longer want your life to continue. This is the closest sense to inalienable that Chetwynd takes the right to life. The negative right, on the other hand, has no such requirement and this could allow an individual to waive their right to life in regards to specific people (such as doctors) while still retaining the right not to be killed against other individuals.

In discussing the right to life as either a negative or positive right, Chetwynd introduces an interesting parallel between the right to life and property rights (176). Chetwynd does not mean for this parallel to be taken literally, it is meant only to illuminate a possible way of understanding the right to life. Chetwynd introduces the idea of property held in trust as being a parallel for the argument that life is sacred, where, in the parallel property held in trust does not belong to the trustee, but is given to them on

the assumption that they will act only for the benefit of the owner of the property (177). She holds that this view is generally held by the religious (Ibid) and while I have tried, above, to include those secular individuals who would hold the sanctity of life I see no reason to disagree with her statement other than it being only slightly less inclusive – though no less correct – than the one presented in this paper. In contrast to property held in trust is property held absolutely where the possessor of the property can do with the property what they like so long as their actions do not harm others (177f). Similarities can be seen here with the liberal conception of autonomy in that both require only that individuals do not interfere with the use and disposal of property (178) unless the property holder explicitly requests assistance. Property held absolutely would be akin to the common understanding of the right to die movement. The parallels between property rights and the right to life/right to death have the added benefit of providing a lens through which to read another common argument against euthanasia. This argument, discussed elsewhere in the paper, holds that euthanasia should not be made legal because those that are allowed to perform euthanasia would come to devalue life to such an extent that they would go around killing indiscriminately, becoming a sort of Harold Shipman. The property rights parallel attempts to extend this concern and in so doing highlights the unreasonable nature of the concern. In the property rights view it would be like a demolitions expert becoming so disenfranchised with the value of old buildings so as to begin demolishing them freely and without concern for those to whom the building(s) is/are important. In neither case is there a reason to assume that allowing the original action (assisting with a suicide or demolishing a building) will result in the slippery slope consequences that the argument insists will occur.

Returning, briefly, to the discussion of property held in trust we are able to see how an individual might be able to dispose of property that they do not own. If this is the case we might be justified in extending this to the argument that life is sacred. Property held in trust requires the trustee to act only for the benefit of the property owner, but there is no reason to assume that the owner is always and only benefitted by maintaining the property. Part of holding something in trust is using judgement in regards to hazards and concerns related to the property. If I am holding my father's stock portfolio in trust until he recovers from surgery (for example) I would be remiss if I refused to see the stock before it dipped below the purchase price on the grounds that it is always better to have the stock than not to have it. When applied to the life is sacred argument we might be able to say that it could be appropriate to end a life (held in trust) once it got to a point where it was no longer as valuable as it had been originally. This is, in fact, the entire argument for euthanasia.

Regardless, at first glance the argument that life is sacred appears to be a rather strong argument against suicide (and, in turn, against euthanasia) and to many it may remain conclusive. However, there appears to be a significant issue with the argument that has, so far, remained underexplored. The argument that life is sacred is particularly strong if it is taken to be a prohibition on ending life. If an individual holds that all life, no matter how it be conceived, is sacred – however that term be defined – it would be more than difficult to argue, against this, that there are situations in which life can be ended without issue. However, this is categorically not what is intended by the argument that life is sacred. If it was it would require prohibitions not only on suicides and euthanasia, but also on the killing of animals for food, sport or research, deforestation,

and possibly even on the use of anti-bacterial soap. But this is not the case and holding the right to life need not require people to also be strict vegetarians or anti-logging activists. From this it could be taken that the right to life argument should be read as meaning the right to *human* life, but this is not the case either. Maintaining a respect for all human life would require also being opposed to capital punishment, killing in self-defence, or killing in a theatre of war. In the literature opposed to euthanasia, though, the right to life is not read this strictly and it is not typically considered contradictory to hold the sanctity of life at the same time as being in favour of the death penalty. From this it might be possible to insist that the right to life should be read as the right to *innocent* human life, but this is problematic for two reasons. First, if the right to life is meant to read the right to innocent human life it could result in innocent humans being placed in positions that they do not wish themselves to be in without any hope of reprieve. Secondly, the qualifications of "innocent" and "human" placed on the right to life have introduced a question of degree that limits the applicability of the right to life. With the issue of degree in place the right to life loses a good deal of the strength that it otherwise would have had, and it leaves the right to life open to the question of the quality of life.

Applying the right to life to only innocent human lives could force these innocent people into highly negative situations. In the instance of terminal illness not allowing the individual to explore the possibilities of suicide or euthanasia forces them to endure extreme pain and suffering. Sue Rodriguez serves as a perfect example of the degradation that a patient with a debilitative disease can suffer. This is problematic when compared to the question of life imprisonment wherein criminals are incarcerated with no hope of parole. Various studies have been conducted to illustrate the negative consequences that

life imprisonment can have on a prisoner. Gauthier de Beco highlights how various countries and governments have challenged the practice of life imprisonment on the basis of human dignity (412f). De Beco discusses the problems of life imprisonment in terms of the question of proportionality. Life imprisonment is not necessarily problematic as there are cases where a prisoner might be unfit for any eventual re-admittance to society[42] but such cases are far from the norm. A sentence could be considered degrading and inhumane if it is disproportionate to the crime committed (413). Further, "[a] disproportionate sentence is a kind of inhuman, cruel or degrading treatment and 'to attempt to justify any period of penal incarceration ... without inquiring into the proportionality between the offence and the period of imprisonment is to ignore, if not to deny, that which lies at the very heart of human dignity" (Ibid). All prisoners have a right to rehabilitation as enshrined by the International Covenant on Civil and Political Rights (ICCPR) which has been signed by the vast majority of countries throughout the world. Article 10(3) of this covenant cites the "essential aim" of the penitentiary system being the treatment of prisoners towards their "reformation and social rehabilitation". As De Beco further states "An offender must thus be given some hope for release, even when he is serving a life sentence. The recognition of the right to rehabilitation implies that the prisoner may benefit from the appropriate treatment with the purpose of returning to society" (414). This requires that the treatment of all prisoners must maintain a respect for the prisoner and present them with a possibility of rehabilitation even if the prisoner is unlikely ever to go free.

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[42] In Canada this might mean Paul Bernardo or Clifford Olson

What this has to do with the terminally ill patient depends on how closely the patient is paralleled by the inmate. While the parallel is not perfect the patient and the prisoner do share a significant degree of similarities. As discussed earlier, during the definition of autonomy, the nature of patienthood is at least partially characterized by dependence of one sort or another (Secker, 50). Where the prisoner is required to listen to the guard or the warden the patient should listen to the doctor. In the case of the bedridden patient the parallels between the hospital room and the jail cell are not uncommonly drawn and they centre on the patient's perception of being unable to move beyond the four walls of the room. The major difference between the prisoner and the terminal patient is that the prisoner should always have the possibility of rehabilitation spurring them, while the patient does not have any such solace. In effect we could say that the prisoner, by virtue of the continual promise of rehabilitation, is granted something that the patient is not: hope for the future (De Beco, 414). Refusing to allow the question of suicide or euthanasia to be reasonably entertained condemns the patient to wait for their inevitable death. The negative impact of the life sentence is characterized by Murphy as being "a kind of slow torture and psychic mutilation" (qtd. in De Beco, Ibid) and De Beco agrees with Shellef in saying that "life imprisonment is akin to death and results in a denial of dignity, because 'a human life involves not just existence and survival, but the unique development of a personality, creativity, liberty, and unfettered social intercourse" (Ibid). By requiring the patient to endure their illness until such time as they die our society could be seen as valuing the humanity of the dying patient *less than the humanity of a criminal.* The only 'crime' the patient would have committed is getting sick, over which they had no control. In the case of the terminal patient the

situation is dire because there is little chance that they will live to see a life free of the disease and the associated pain and suffering. Drawing the parallel to the prison system, as above, we can see how a terminal diagnosis could be closely proximate to a life sentence, and it is psychologically damaging for precisely the same reasons. The rigid schedule of medication and tests; the physical limits of the hospital room or of the physical disabilities all impose limits like those that one would expect to find in a prison. A terminal illness is significantly more damaging, however, because a rigid determination to remain faithful to the drug regime and an unshakable devotion to the doctors and medical team can only see a marginally longer life that will, nevertheless, end in death. By refusing to allow the individual with a terminal or degenerative illness to explore the options of euthanasia or physician assisted suicide we are effectively condemning them to psychological (and physical) suffering worse than that experienced by inmates with a life sentence.

Conclusion

Having presented numerous arguments in favour of justified euthanasia it could be said that each argument in isolation is not necessarily stronger than the individual arguments against euthanasia. As such it would be a mistake to champion any one argument as the definitive reason to support (or reject) euthanasia. However, when taken together in collaboration the arguments supporting a justified euthanasia provide a more convincing approach than those against. Whereas the arguments against justified euthanasia rest almost exclusively on the argument that life is sacred – an argument that has been shown to have a historically pragmatic and human, rather than divine, origin – the cable of reasoning (if we can extend Peirce's analogy) is based primarily, but not exclusively, on a respect for personal autonomy in the face of unremitting pain and suffering. And whereas the arguments against euthanasia would apply equally in all cases of euthanasia and suicide, the arguments in favour offer a much finer, more delicate distinction. Hoffmaster insists that "law... is a blunt instrument" ("Designer Death vs. Merciful End") but surely this is an oversimplification of the idea of law. It is the case that laws are intended to apply in broad cases and that it is not always possible to tailor a law to meet specific instances, however it is also the case that laws develop over time, and that laws can change after periods of public debate. *This* is the strength of law, not the unwavering blunt instrument that Hoffmaster sees. Previously this paper discussed the idea of the slippery slope style of argument as being an argument of the status quo, an argument that considers change to be anathema. The same could be said about Hoffmaster's comment – which was made on television during the Sue Rodriguez case – and based on the comment it would not be far off the mark. Change itself is neither bad

nor good, and the same goes for arguments that seek to suppress change or maintain the status quo. The Jim Crow laws were a negative change, while the abolition of slavery was positive. The issue that I take with the life is sacred argument – and most other arguments against euthanasia – is that they function to deny an individual's ability to determine for themselves how they are going to live (or end) their lives. To paraphrase what was said above (p. 25) to deny one autonomy is, ostensibly, to deny them all.

More disturbingly, denying the possibility of justified euthanasia condemns the individual who wishes to end their lives to live a life that they no longer wish to live. It strips them of their decision making power in possibly the most serious instance in order to protect a potential future from a possible harm. The worry should not be that allowing euthanasia will strip various other social values away but that not allowing it could see other freedoms be rolled back in the future. I do not want to make the connection here too strongly for fear of being mistaken to say that euthanasia should be considered a fundamental freedom, this goes too far. I also do not want to appear to be using a slippery slope argument against those who would oppose euthanasia, for I am far too sensitive to hypocrisy.

What I mean to do is point out that change need not be complete and everlasting. If euthanasia were to become a justifiable medical option for individuals to entertain, society would be able to see firsthand the consequences of the decision, and if it did produce a culture of death and depravity like those who argue against euthanasia have warned – which I do not think will ever happen – then the freedom to request euthanasia and have the respect treated seriously can be revoked by the same process of change that brought it into legal standing to begin with.

Finally I hope that the justification of certain forms of euthanasia that this work has presented as being justifiable will serve as a comfort to those who might one day need to request assistance in dying. I hope that it is a comfort in that they will know that should the time come, that they will be able to end their lives according to the values and preferences that they have lived by and have their final act be remembered as a rational response to their suffering.

The End

"Grave men, near death, who see with blinding sight
Blind eyes could blaze like meteors and be gay,
Rage, rage against the dying of the light"
-Dylan Thomas

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