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ARTICLE

Existential Suffering as a Legitimization of Euthanasia

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Abstract
Several countries have legalized euthanasia on the basis of medically diagnosable suffering over the last decennial; the criteria to which they adhere differ. The topic of this article is euthanasia on the basis of existential suffering. This article presents a recent proposal to legalize euthanasia for people who experience such suffering and then discusses the issue of what the value of life may be, and whether the standard that life is normally something positive should be accepted. This provides the foundation to answer the question of whether euthanasia on the basis of existential suffering should be allowed.

Keywords: euthanasia; assisted suicide; existential suffering; completed life

Introduction

The controversial nature of the issue of whether it should be legal to perform euthanasia or assist in another's suicide has waned, and several countries have legalized these options, but it would not be realistic to expect a universally accepted perspective to be forthcoming. While this observation may be made with respect to the issue in general (i.e., whether euthanasia or assisted suicide should be accepted *at all*), I will focus on a specific aspect and presume that euthanasia[1] as such is acceptable in certain cases of suffering whose cause may be medically diagnosed. I say "certain cases" since those who accept that euthanasia should *in principle* be allowed in cases of medically diagnosable suffering may differ amongst themselves with respect to the criteria that should be in place, and the countries referred to above do not adhere to (precisely) the same criteria. This is not the topic of the present inquiry, which is rather focused on answering the question of whether it should be allowed to perform euthanasia in cases where medically diagnosable suffering is absent.

A recent proposal in the Netherlands to allow euthanasia in such cases is presented in section "The Right to Euthanasia." The basis for euthanasia in terms of a natural right is examined in order to determine whether a right to euthanasia may be defended on such a basis. I do not start from the premise that an inalienable right to euthanasia exists and should be acknowledged, nor would I base such a right on moral considerations, on account of the fact that no compelling reasons exist to conclude that either of such foundations must be acknowledged to exist and it is not clear, even if this were the case, that such a right must cogently be derived from one of them or both.

I will rather limit myself to considering the interests that are at stake and inquiring how they may best be served. The word "best" is problematic, however, especially in light of what has just been said. I will not, however, attribute a special meaning to this word and hold that no absolute standard is to be adhered to. It is not clear what this standard should be (or which of the existing candidates that are presented, from different perspectives, should be opted, in favor of its alternatives, foregoing the issue here of whether it might *exist*, waiting to be discovered, in the first place). An additional problem is that the freedom of someone who would not accept that standard would be curtailed, since the standard would be forced on such an individual.

What I present as an answer to the main question presented above is, accordingly, simply a reflection of what policy is most *desirable*, at least according to me, for which I present arguments in the hopes of convincing those who read this article. Before presenting that position in the section "The Individual Suffering," I will analyze what the value of life might be and how this may be determined. This is what is undertaken in the section "The Meaning of Life and the Meaning of 'Life.'" The question of whether life is worth living is one of the most challenging ones with which may be confronted. I have tried to do justice to the complexity of this question without losing sight of the practical, concrete issues those who are confronted with it in the darkest moments of their existence face.

The Right to Euthanasia

When addressing the issue of whether it is desirable to legalize euthanasia and, if so, under what conditions, it is important to acknowledge that different interests are at stake and that the issue may be approached from different perspectives. Important considerations will be addressed in the following sections. The present section is focused on representative legislation, so as to provide a relevant context. The Netherlands is a pioneering country in legalizing euthanasia and if a recent bill is passed, a new category—to which specific criteria apply—in which euthanasia is allowed will be introduced; Dutch legislation and jurisprudence will, accordingly, feature prominently here.

In order to perform euthanasia legally in the Netherlands, a number of criteria must be met. Those that are relevant for the purposes of this article are that it must be performed by a physician, who must hold the conviction that the patient's suffering is unbearable, with no prospect of improvement.[2] ("With no prospect of improvement" is the translation of the Dutch word "uitzichtloos," which may alternatively, more dramatically but arguably also more accurately, be rendered as "prospectlessness.") The suffering may be physical or have a psychiatric disorder as its cause.[3] From a practical point of view, the limits of what medicine can accomplish, in some cases, must be acknowledged,[4] while principally it is justified to say that "If there are no logical differences between mental and physical disorders, there is a strong prima facie case for the possibility and acceptability of psychiatric active voluntary euthanasia (AVE) and physician-assisted suicide (PAS)."[5] The assessment of a request made by someone with a psychiatric disorder does bring with it specific difficulties for physicians.[6]

Importantly—irrespective of the cause of the suffering—it must be determined what "with no prospect of improvement" and "unbearable" mean. Insofar as the absence of a prospect of improvement is concerned, the possibility of improvement is decisive: "The medical judgment is decisive in ascertaining the absence of a prospect of improvement of the suffering. It must be certain, according to medical expertise, that the patient's situation will deteriorate and cannot be relieved. The absence of a prospect of improvement is thus objectified."[7] A *medical* standard is thus decisive in determining whether the suffering must be deemed to be without a prospect of improvement or not. The same standard is used for the criterion "unbearable," but the patient's perspective is decisive here: "The unbearableness of the suffering must also be determined in order to decide the issue whether euthanasia may be performed, but it is, in contradistinction to the absence of a prospect of improvement of the suffering, a factor that is highly subjective and difficult to objectify."[8]

It is justified to point to the subjective nature of unbearableness (and the modifier "highly" might have been omitted), but that means that the very justification of the necessity of the criterion becomes debatable. After all, if "unbearableness" is qualified as the point at which the patient's suffering is such that he feels the need to request euthanasia, no one who requests euthanasia may be said to fail to meet the criterion. (A—secondary—point to consider is that the suffering cannot truly be unbearable, for if it were, the patient would not be able to endure the suffering and—presumably—die as a result, rendering the issue moot.)

Being tired of life is not a sufficient condition for euthanasia,[9] nor is the conviction that one's life is completed.[10] A bill proposed by Pia Dijkstra, a member of the House of Representatives for political party Democrats 66, aims to address this issue by legalizing assisted suicide (but not euthanasia in the strict sense) for those who consider their lives completed and are at least 75 years old.[11] The suffering the

bill addresses is "suffering from life," resulting from the experience of a completed life.[12] So-called "end-of-life supporters" (who must have completed special training) rather than (as in the case of euthanasia in the strict sense) physicians are to provide the means to make the suicide possible; the general practitioner of the person who has made the request will be consulted, provided that person consents. Procedures will be in place to prevent requests being made based on "outside pressure."[13]

The age limit of 75 years is defended in the bill on account of the consideration that young persons will usually have a long life before them, in the course of which problematic circumstances may take a turn for the better, for example, by means of medical treatments yet to be developed.[14] Is legalizing euthanasia (or assisted suicide) in such cases desirable? One may hold that such legislation is too radical, but it may, conversely, be argued that it is not radical enough. I will present my perspective in the final section, in the wake of the present section and the section "The Meaning of Life and the Meaning of 'Life.'"

One may argue that (some cases of) euthanasia should be allowed by appealing to a human right, where "human rights" may be defined as follows: "At their most fundamental, core human rights are considered as the transcendental moral principles on which positive law is founded."[15] Specifically, one may, insofar as the jurisdiction of a member state of the Council of Europe is concerned, appeal to articles 2 and 8 of the European Convention on Human Rights (ECHR). In *Pretty v. United Kingdom*,[16] the European Court of Human Rights (ECtHR) rightly ruled that the rights guaranteed in those articles (namely, the right to life and the right to respect for private and family life) do not confer the right to die. The rights in question are *negative* rights and thus require the *absence* of government interference; an interpretation of the articles according to which they would confer a right to die is incompatible with the nature of these rights.

A yet more relevant case for the present discussion is *Haas v. Switzerland*,[17] in which the ECtHR, while holding that the right to decide by what means and when one ends one's life is an aspect of article 8 ECHR, this must be distinguished from a right to obtain the means to end one's life.[18] Specifically, it might have been possible, under Swiss law, to obtain such means, but the applicant in this case would have to undergo a psychiatric assessment so that it could be ruled out that his desire to commit suicide was a symptom of mental illness; the ECtHR ruled that the restrictions were legitimate and necessary.[19]

Alternatively, one may appeal to substantive due process, invoking fundamental rights that may not be restricted. This was the central issue, with respect to the right to assisted suicide, in *Washington v. Glucksberg*.[20] The Supreme Court ruled that the right could not be invoked on that basis, referring to the rejection in the past of the legalization of assisted suicide.[21] What is problematic here is that the possibility to invoke the right depends on a—presumably—contingent tradition, which means that it is not truly a fundamental right. Should one, by contrast, hold that a natural right, in isolation from the circumstances as they have developed in a specific country, be at issue, another difficulty presents itself, namely, what, if anything, a natural right might mean. This is a general issue in philosophy; with respect to the topic at hand, I remark that even if one should accept the existence of natural rights, it would need to be made clear whether or not a right to euthanasia, in particular, would exist, so that those defending such a right would be confronted with a twofold burden of proof.

Chemerinsky raises the question: "[…] is the right to physician-assisted suicide so fundamental to autonomy that it should be deemed a fundamental right? Put another way, is it sufficiently analogous in its importance to the privacy rights which the Court has previously protected that the right should be worthy of being deemed a fundamental right?"[22] He argues against an originalist interpretation of the Constitution, pointing out that other rights than the right to PAS have been acknowledged by the Supreme Court to be fundamental without appealing to the original text of the Constitution. Yet that does not mean that those rights *are* indeed fundamental rights, but only that the Supreme Court considers certain rights to be fundamental. So the crucial question still remains to be answered, namely, what, if anything, are "fundamental rights"?

Chemerinsky approaches the issue by focusing on autonomy, thus *presupposing* autonomy to be a guiding principle, not indicating *why* it should be respected. He may be correct in saying "If any aspect of autonomy is to be deemed fundamental, surely it is the right to choose to die,"[23] but even apart from the fact that autonomy is not the only relevant factor to consider, an appeal to its importance takes away nothing from the burden of proof if such an appeal is made in the context of "fundamental rights."

This view is not to be equated with the idea that it is simply *desirable* that the right to PAS should exist; such an alternative has the benefit of being relieved from the burden of proof just mentioned, but admittedly faces the issue of relativism, since it raises the question of *whose* perspective should be decisive in determining what is "desirable." This should in a democratic state presumably be that of the majority of the people, whose preferences and convictions may gradually change; an appeal to tradition is possible, such as in *Washington v. Glucksberg*, but this raises the question—if the perspective thus found differs from the present perspective—why ideas that prevailed in the past should dictate how one should act or think in the present.

Incidentally, when Chemerinsky appeals to the majority position when he argues that the issue should be left to "the political process," he also points to the importance of interpreting the Constitution as including a fundamental right to PAS,[24] apparently expressing a belief that the majority view will (continue to) correspond with such an interpretation.

An appeal to "(human) dignity" is no less problematic. Even if this is presumed to have a meaning, it is clear that defenders of "dignity" do not agree on what this is, which results in different positions: one may associate "dignity" with the protection of life, with the corollary that one's life should not end prematurely—leaving the issue here what "prematurely" means, since this depends on what is understood by a "natural" life (which depends, inter alia, on whether one considers the accomplishments of modern medicine that lead to a prolonging of the lives of some individuals something natural, or not)—or, conversely, with respect for the freedom to decide for oneself when the time has come to die,[25] if necessary or desirable by means of euthanasia.[26] In addition, one may defend the idea of a person as no mere means to advance society's ends[27]; in this case, the difficulty presents itself at another point in the argumentation, namely, at the point it must become clear *why* this directive should be accepted.[28]

Biggs concedes that "dignity" is not easy to grasp, but maintains: "[…] in spite of its susceptibility to misinterpretation and sophistry, dignity clearly does play a valuable role in contextualizing people's perceptions of death and dying, especially as it appears to embody a spirit of self-determination that advocates of voluntary euthanasia crave."[29] Incorporating an idea into one's perceptions must be distinguished, though, from justifying an appeal to that idea. As Singer remarks, "'Death with dignity' can mean almost anything, depending on what one considers a dignified way to die."[30]

There is, then, no fundamental right to euthanasia or it is at least not clear what the basis of such a right would be. This state of affairs must not be confused with the issue of the *desirability* of realizing such a right. It is ultimately the legislature that decides on the matter of legalizing euthanasia. In a democratic state, the majority of the people supposedly—indirectly—support the law. A people is composed of individuals whose votes (should) be decided individually, and I have a particular view I deem most desirable; as I said above, this will be expounded in the final section. That does not mean, though, that I consider my view to be an expression of a natural right, and by saying "most desirable" rather than "right" or "just," I express a relativistic stance. It is difficult for me to say on what basis I have come to accept this particular viewpoint rather than another, since I cannot go back in time and create an alternative reality in which I would exchange one or more factors that may or may not have decided my viewpoint for one or more other factors and I accept, accordingly, what I hold as tentative. It is always wise to analyze legal matters carefully, but a radical skeptical stance, on the basis of which suspension of judgment is accomplished, is not possible lest no legislation be realized at all.

The Meaning of Life and the Meaning of "Life"

The question of why it is a problem if a life is terminated prematurely is rarely raised in euthanasia debates, which is surprising, given the existential perspective that is at issue, besides the medical perspective.

Aristotle considers death the most fearful thing, since nothing can be good or bad for someone who is dead.[31] "Bad" is mentioned here as well as "good," but this may be explained by the fact that Aristotle defines an *active* life in accordance with virtue as the function of man and a necessary condition for his happiness.[32] By contrast, Lucretius, following Epicurus, maintains that death does not concern human

beings[33] since one's soul, given that it does not remain as a separate substance after death, is mortal.[34] Which of these views (if any) one is willing to accept depends on one's metaphysical bent and it seems too hopeful to expect a definitive answer to the question which of these views may be true to be forthcoming anytime soon.

A similar metaphysical perspective may be said to support the idea of an "intrinsically valuable" life that is often presented: "[…] while life is instrumentally valuable to us as we pursue other goods, it is also intrinsically valuable. Something X has intrinsic value to the extent that the value of X is due to what X fundamentally is, apart from X's relations to other things."[35] In accordance with such a viewpoint, one may hold that "[…] life demands from us levels of commitment directed toward its maintenance and furtherance that are in broad accord with a reasonable life narrative and ground projects […]."[36] One may, accordingly, maintain: "We believe that it is *intrinsically* regrettable when human life, once begun, ends prematurely. We believe, in other words, that a premature death is bad in itself, even when it is not bad for any particular person."[37]

Still, does it make sense to speak of something being intrinsic? An evaluator always seems necessary in order to determine whether something is valuable, and to what degree. It is conceivable that something is valuable according to *every* or even *every possible* evaluator, that is, everyone now existing and everyone who will exist and anyone that might have existed, but that would (merely) mean that it has an *objective* value. An objective value differs from an intrinsic value: if all evaluators would cease to exist (and thus cease to value anything), no objective value would remain, while what had an intrinsic value (whatever this might mean) before would—supposedly—not lose this. This is difficult to grasp.

A more promising approach might consist in listing the values that are actually at issue. This is what Bullock does. Given that one may question whether self-determination provides a proper basis for the patient's well-being, Bullock presents a list of purportedly objective interests,[38] so as to identify "[…] the substantive goods that contribute to the well-being of an individual and holds that they are good for the individual independently of that individual's preferences."[39]

Bullock rightly observes: "[…] the concept of 'autonomy' is vague and has various meanings in different contexts."[40] Autonomy may be used in two senses: first, the fundamental—and literal—sense of imposing a law (and specifically a putative "moral" law) on oneself, associated with the notion of "free will," and, second, the sense of legal autonomy, that is, the liberty of citizens, at least those "of sound mind," to perform legal acts.

Autonomy in the second sense, notwithstanding the objections raised by Bullock, may be defended (if one refrains from also appealing to autonomy in the first sense); suspension of judgment or even denial with respect to the existence (or even meaning) of the former is compatible with acceptance of the latter, an issue to will I return below. For completeness, it must be added that Bullock's stance on autonomy is nuanced: she promotes "autonomy as a side-constraint on action," which serves as a type of failsafe: even if one acts in accordance with the individual's objective interests, his withholding consent must be respected.[41]

Among the objective interests are listed (inter alia): "life, consciousness, and activity," "pleasures and satisfactions of all or certain kinds," "happiness, beatitude, contentment, etc.," "morally good dispositions or virtues," "just distribution of goods and evils," and "freedom."[42] It is not clear, however, why (all of) these would be objective. Life is, after all, only an interest for those who *want* to (continue to) live. "Pleasures" will presumably be desired by everyone, but *which* pleasures are desired depends on the individual, so that speaking of generic pleasures is little illuminating; the same applies to "happiness." As for "morally good dispositions or virtues," this may be specified in various ways, presuming that it has a meaning at all; the same applies to "just distribution of goods and evils."

As for "freedom": this is precisely what is under discussion, and whether autonomy as a side-constraint suffices may be doubted. Notwithstanding the empirical analyses to which the author, arguably justifiably, refers,[43] if the absence of self-determination—in accordance with the *second* sense of "autonomy" outlined above, suspending judgment, incidentally, with respect to what "self" might mean—is a reason to substitute "objective interests" for individual preferences, there is no principled reason to distinguish between end-of-life decisions and certain other types of decisions. End-of-life

decisions have a far-reaching effect, but so does buying a house or marrying someone, with respect to which people are normally allowed to act in accordance with their preferences.

It may be objected that what has been said is unjustifiably flippant, if only because carrying out an end-of-life decision is irrevocable. One may imagine someone who requests euthanasia but reverses his decision before the euthanasia is performed; if the euthanasia had been performed, he would have died. Similarly, euthanasia may have been performed on people who, likewise, would have reversed their decision if the period between the request and the act had been longer. It is of course not possible to determine whether this is the case since any relevant response would have to be provided by people who have already died. How much weight does the fact that a hypothetical person would in time—in hindsight—come to reconsider his request, given the irrevocability of the act, carry?

First of all, euthanasia is only possible if strict procedures are adhered to, ensuring that a lasting desire to die exists, and the individual's request is voluntary and well-considered.[44] That does not exclude the possibility that euthanasia is performed on people who would have revoked their decision but merely reduces the likelihood that such cases occur, and presumably no procedure is foolproof, but the alternative is that *no one* should be granted euthanasia,[45] which would come at the expense of all those who suffer without ever wishing to revoke their decision, who would either have to keep suffering until they die of natural causes or resort to alternative, possibly gruesome, means to end their lives without assistance. The prolonged suffering such people experience—before ultimately dying from another cause than euthanasia—is no less irrevocable than the pleasures of which those who might have come to regret their decision are deprived.

What is important to consider here is that—however harsh this formulation may come across—all euthanasia means, as far as can be assessed without taking a conception of the afterlife into consideration, is that life is shortened by a certain amount of time. One may object that the possibility of an afterlife *does* have to be taken into consideration, but there is no consensus with respect to whether an afterlife exists and, if so, what this might look like, nor do I have anything to contribute here myself to provide clarity on the matter.

Still, one may hold that an entity (specifically, a deity) may exist that judges and punishes those who commit suicide or invoke the aid of others to let their life end. It is difficult to ascertain what the basis of such a deity's judgment would be, apart from the preliminary issue of the difficulty of ascertaining that it exists in the first place. Barring the ability to determine that the tenets of a specific religion are true, the individual is left to his own devices. One may resort to Pascal's wager: by wagering that He exists, one presumably either has nothing to lose (or gain)—namely, if He does not exist—or everything (an eternity of life and happiness) to *win*—namely, if He does exist—whereas wagering that He does *not* exist will either—if He indeed does not exist—result in the first situation (so that one will neither gain nor lose anything) or in the outcome that one has everything to *lose*.[46] Several objections have—rightly—been levelled against this line of thought, which do not have to be discussed here. I add to them the following consideration, which is relevant for the present theme.

If *faith* is decisive, nothing can be said of God by means of reason. This is in line with what Pascal observes: "If there is a God, He is infinitely incomprehensible, because, having neither parts nor limits, He does not stand in any relationship to us; consequently, we are incapable to know either what He is or whether He exists."[47] Taking seriously the meaning of faith means that *nothing* can be said of God's ideas of what is right and wrong without appealing to faith, and there is no reason to presuppose that God (in this sense) would consider suicide or euthanasia something "wrong." Indeed, He may be of such a nature as to think ending one's life or having it ended something "right," rewarding those who let their lives end prematurely with an eternity of life and happiness.

This consideration is of course only relevant if the individual contemplating euthanasia believes in such an entity, unless it would be deemed acceptable to resort to paternalistically forcing a view on individuals. Those who do not subscribe to a religious worldview would merely consider the pains and pleasures that are to be expected if they continue to live; since they opt for euthanasia, they apparently expect to experience more pain than pleasure if they continue to live. (I admit that this is a simplistic analysis compared to what is actually at stake, if only because "pleasure" and "pain" may be defined in various ways and, related to that issue, it may be difficult to balance them. I have not explored these issues

since it is not relevant to present a general account here: in line with what will be argued in the final paragraph, the individual's judgment is decisive in this respect.)

The positive and purposive nature of life, with the corollary that it should in principle be preserved is not proven, and is perhaps unprovable. It may be a heritage of a mix of Christian[48] and Aristotelian tenets. By contrast, a negative appreciation of life is promulgated in Hinduism, Buddhism, and Jainism, where the goal to be achieved is extinction (ceasing to exist), so that one does not reincarnate. Suicide or euthanasia would express a desire (namely, the desire to end one's suffering), on the basis of which reincarnation would follow, so that this goal would not be reached.

One may oppose legalizing euthanasia without appealing to religious ideas, but such a position does mean that one has adopted—explicitly or implicitly—a positive outlook on life. Importantly, such an outlook is nonneutral. All that may be said of life in a neutral sense is that it *exists*, manifested by someone's beating heart and breathing (forgoing here cases in which someone is kept alive by means of life support).[49]

The question that presents itself is who should decide whether life is something positive or negative. There is no compelling reason for the state (or society) to decide this for the individual, so that the individual's judgment is decisive.[50] One may hold that defining life in terms of pain and pleasure is (too) reductionist, or that pain itself has a certain meaning, and even attempt to persuade someone of the positive nature of life, but *forcing* a worldview on someone would be unacceptable. Having a worldview does not, of course, in and of itself result in anything. Once a request for euthanasia is made, however, the issue is no longer theoretical. If physicians decline such a request on the basis of other considerations than procedural ones (legitimate concerns existing when, e.g., there is doubt whether the individual making the request is competent), they evidence nonneutrality (or even paternalism). Incidentally, it may be defended that physicians whose worldview is incompatible with performing euthanasia should have the right to decline a request on that basis; whether a physician may invoke his worldview in such a case depends on whether the tasks a physician may normally be expected to perform include euthanasia.

Should one hold that "Physicians should help patients at the end of their lives find the 'why' they have lost to enable them to endure their abhorrent 'how' if they so desire and not resort to physician-assisted suicide and euthanasia,"[51] a "why" (i.e., a meaning of life) is *presupposed* to begin with, in accordance with which something worthwhile for which to keep living supposedly exists. Relieving the individual's suffering without resorting to euthanasia may be an alternative,[52] but if this option is available, the issue may be moot and, besides, it should not be used as a means to dodge the main question *who* is to decide whether the individual's suffering is truly relieved.

The foregoing is not sufficient, however, to determine whether performing euthanasia should be allowed in cases where no medically diagnosable suffering is involved (irrespective of whether one accepts "unbearableness" and "absence of a prospect of improvement" as qualifiers), for some important matters are still to be considered. These will be addressed in the next section.

The Individual Suffering

I have argued that the perspective of the individual should be decisive in assessing the value of life rather than a prevailing worldview (implicit or explicit). The *theoretical* question of what view on life an individual may have immediately leads to the *practical* question whether and, if so, in which cases individuals should have the right to euthanasia. Now that the necessary background has been presented, the present section can focus on the remaining issues.

If euthanasia is legal in (certain) cases where the individual suffers from a medically diagnosable cause, it seems difficult not to allow it in (certain) cases where the suffering has another cause. After all, the individual seems to be the proper judge to decide whether the suffering is so grave that ending one's life is the most desirable outcome. It is unclear why the *cause* of the suffering should be a relevant issue. If there is a reason to think it may more easily be relieved without resorting to euthanasia in one type of case than in the other,[53] there is a reason to ensure that the individual requesting euthanasia is informed about possible alternatives (which should, incidentally, be—and presumably already is—part and parcel of any

procedure following a request, so irrespective of the cause of suffering), but even if it is supposed that the suffering could in similar cases (disregarding, *arguendo*, the difficulty of comparing different cases of existential suffering) be relieved, it is still the individual who is to decide whether such information is relevant, and whether he would thus (nonetheless) resort to euthanasia.

Schmidt speaks, in this respect, of the "Argument from Arbitrary Difference": "The central argument for CLE [completed life euthanasia] is what I call the *Argument from Arbitrary Difference*: if a concern for people's autonomy and well-being justifies medical euthanasia, it also justifies CLE. Drawing a distinction between the two is morally arbitrary."[54] In addition to that principal argument, one may point to the pragmatic considerations that medical cases may be difficult to demarcate from nonmedical ones[55] and that the domain of "medicine" is not clearly demarcated.[56]

One may argue, then, that since physicians may face their patients' existential suffering, which does not significantly differ from the suffering they are trained to address, if euthanasia is allowed on the basis of medically diagnosable suffering, it would be inconsistent not to allow euthanasia on the basis of existential suffering.[57] This position is defensible, but physicians do not have specific expertise to address this issue. It is for this reason that the Dutch Supreme Court ruled that a physician should not try to help people who experience such suffering, and should instead seek others who could assist in finding a meaning in one's existence.[58]

The Court fails to indicate, however, whom those others might be; this will presumably depend on the circumstances, and a priest, rabbi, imam, or humanistic therapist, amongst others, are conceivable options. More importantly, though, should none of such counselors—for whatever reason—be able to provide a solution for the individual's suffering, no (further) recourse appears available. The introduction of end-of-life supporters has, as was mentioned in the section "The Right to Euthanasia," been proposed in the Netherlands; they may, for individuals who are resolved that no means exist to end their suffering save those an end-of-life supporter may provide, provide those means.[59]

Importantly, though, if what was argued in the section "The Meaning of Life and the Meaning of 'Life'" is accepted, there is no reason to use the proposed age limit. If individuals' own judgments in assessing whether they suffer existentially or whether their life has value are decisive, the age limit could instead be 18 years, 21 years, or somewhere in between; this might be a difficult delimitation issue. The idea of a "completed life" is thus fully individualized by separating it from the notion that there is normally (whatever that may be taken to mean) something to complete, which an age limit of 75 years suggests.

The reader is reminded here that end-of-life supporters will not be allowed to perform euthanasia in the strict sense, which will remain a task reserved for physicians, and will only be involved in assisted suicide. If suicide itself is not illegal (so that the corpse of a self-murderer is not treated irreverently as a form of punishment, presumably in the guise of some sort of [vicarious] atonement, and someone who attempts to commit suicide and fails is not punished), then assisted suicide should not be illegal, either. After all, the individual who ends his life is the same in the first case as in the second, the only variable being the means that are provided by the person who assists.[60] The suicide of someone who acquires a rope and hangs himself is assisted, in a sense, by the storekeeper who sells it, which is not thereby punishable. The phrase "in a sense" is apt, for there is no assisted suicide if the storekeeper does not know what it is intended to be used for (or if he is lied to, and is told it is to be used for something legal), while his action is punishable if he knows the rope's purpose and sells it nonetheless, thus willingly facilitating the suicide.

A final issue to consider is the danger of a "slippery slope": if euthanasia (and in the case under discussion assisted suicide) is not just allowed in cases of medically diagnosable suffering and the only criterion is the individual's assessment of his own life (i.e., whether he experiences suffering sufficient—by his own standards—to request euthanasia or considers his life completed, based on a subjective definition of "suffering" or "completed life"), some people may feel pressured to make a request they do not truly want to make.

This concern should not be dismissed, but, first, it may also be expressed in the case of *medically* diagnosable suffering, so that it could be used as an argument not to legalize euthanasia for *any* situation, an outcome that seems too severe, unless one already thinks that euthanasia (and specifically assisted

suicide) should not just not be extended to cases where nonmedically diagnosable suffering is involved but should not be allowed under *any* circumstances, and, second, I remind the reader here that precautions are in place to ensure that the request expresses a genuine desire to die.

This does not mean, though, that a critical stance is unacceptable, and one may legitimately question whether implementing a procedure that seems sound might have unforeseen effects. It is difficult to assess whether and, if so, to what extent such effects have already manifested themselves. On the one hand, one may point to historical examples of accepted killings in exceptional contexts and circumstances that have not resulted in a general devaluation of human life,[61] and maintain that the Nazi euthanasia program is an irrelevant example since nonvoluntary euthanasia was allowed from the start,[62] while, on the other hand, data appear to suggest that the permissibility of voluntary euthanasia has led to nonvoluntary euthanasia.[63]

In any event, given the (dire) position of those whose suffering can only be relieved by the radical means discussed here, the best course of action would be to focus on improving the procedures, if necessary. Only then may the interests of everyone involved be said to be taken seriously.

Conclusion

Whether being alive is something positive or negative must be determined by the living. If "the living" is interpreted collectively and life is deemed something positive, with the outcome that euthanasia is forbidden or only allowed in cases of medically diagnosable suffering, an individual whose assessment of (his own) life differs from the assessment of the majority has no right to euthanasia, unless this assessment has a medically diagnosable cause. I have argued that existential suffering should also be acknowledged as a reason to perform euthanasia (or, specifically, to assist in another's suicide). Only thus may the imposition of the idea that life is something positive, with the corollary that one should in principle (continue to) live, on individuals be forestalled.

The issue is not whether there is a *right* to die, but whether there is a *duty* (to continue) to live. The onus is not, then, on the individual who wants to die to prove that he has such a right, but, conversely, on those who keep him from dying by means of euthanasia to prove that he has a duty to live. This given does not preclude the justification of using a procedure to ensure that the individual's request to have his life ended or receive aid to do so himself is voluntary and well-considered, and that there is a lasting desire to die.

The foregoing is not taken to mean that an absolute right (a "natural" right) to die exists and that legislation that conflicts with the acknowledgement of such a right is therefore invalidated. I have not argued that such a right exists, if only because I would not even know where to begin if it were my intention to do so. I have rather expressed what situation I deem most desirable, having no recourse to a superior standard to make my case. This does not take away anything from the importance of the issue of taking existential suffering seriously.

Notes

1. "Euthanasia"—as a working definition—here refers to both euthanasia in the strict sense (i.e., a person's voluntary death by means of little or no pain, brought about by another than that person) and assisted suicide (i.e., a person's suicide that is brought about with the aid of another than that person), unless otherwise indicated. Incidentally, "euthanasia" is thus equated with "voluntary euthanasia," not because "nonvoluntary euthanasia" would not qualify as euthanasia but because nonvoluntary euthanasia is not an issue in the present inquiry; for the same reason, "euthanasia" is equated with "active euthanasia." "Euthanasia" in the literal sense has a very broad sense, but this will not explored here in order not to needlessly complicate matters; as I just indicated, I will use a working definition here.
2. The relevant legislation where these and the other criteria are listed is the Termination of Life on Request and Assisted Suicide Act. Euthanasia is illegal on the basis of articles 293 and 294 of the

Dutch Criminal Code, but euthanasia performed by physicians is not punishable as long as they adhere to the criteria specified in said Act.

3. *Dutch Supreme Court*, June 6, 1994, at 5.2.
4. Berghmans R, Widdershoven G, Widdershoven-Heerding I. Physician-assisted suicide in psychiatry and loss of hope. *International Journal of Law and Psychiatry* 2013;**36**(5/6):436–43, at 442.
5. Parker M. Defending the indefensible? Psychiatry, assisted suicide and human freedom. *International Journal of Law and Psychiatry* 2013;**36**(5/6):485–97, at 487.
6. For example, Hatherley JJ. Is the exclusion of psychiatric patients from access to physician-assisted suicide discriminatory? *Journal of Medical Ethics* 2019;**45**(12):817–20, at 818.
7. Parliamentary Documents: House of Representatives, 1993/1994:23877, no. 1, at 4. The original text reads: "Voor de uitzichtloosheid van het lijden is het medisch oordeel bepalend. Naar medisch vakkundig oordeel moet vaststaan dat de situatie van de patiënt verergert en niet te verbeteren is. Aldus wordt de uitzichtloosheid geobjectiveerd."
8. Parliamentary Documents: House of Representatives, 1993/1994:23877, no. 1, at 5. The original text reads: "De ondraaglijkheid van het lijden dient voor de vraag of euthanasie mag worden toegepast evenzeer te worden vastgesteld, maar is, in tegenstelling tot de uitzichtloosheid van het lijden, een in hoge mate subjectieve, en moeilijk te objectiveren factor."
9. Parliamentary Documents: House of Representatives, 1999/2000:26691, no. 6, at 30; 1999/2000:26691, no. 6, at 70; and 2007/2008:31036, no. 3, at 5, 6.
10. Parliamentary Documents: House of Representatives, 2007/2008:31036, no. 8, at 3.
11. Parliamentary Documents: House of Representatives, 2019/2020:35534, no. 2, at 1–10.
12. Parliamentary Documents: House of Representatives, 2019/2020:35534, no. 3, at 2.
13. Parliamentary Documents: House of Representatives, 2019/2020:35534, no. 3, at 23, 36.
14. Parliamentary Documents: House of Representatives, 2019/2020:35534, no. 3, at 20.
15. Tiensuu P. Whose right to what life? Assisted suicide and the right to life as a fundamental right. *Human Rights Law Review* 2015;**15**(2):251–81, at 252.
16. *ECtHR, Pretty v. United Kingdom* (Apr. 29, 2002), Application No. 2346/02.
17. *ECtHR, Haas v. Switzerland* (Jan. 29, 2011), Application No. 31322/07.
18. *ECtHR, Haas v. Switzerland* (Jan. 29, 2011), at 51, 52.
19. *ECtHR, Haas v. Switzerland* (Jan. 29, 2011), at 56–8.
20. *Washington v. Glucksberg*, 521 U.S. 702 (1997), at 720, 721.
21. *Washington v. Glucksberg*, 521 U.S. 702 (1997), at 728.
22. Chemerinsky E. Washington v. Glucksberg was tragically wrong. *Michigan Law Review* 2008;**106**(8):1501–16, at 1506.
23. See note 22, Chemerinsky 2008, at 1507.
24. See note 22, Chemerinsky 2008, at 1515.
25. For example, Biggs H. Euthanasia, *Death with Dignity and the Law*. Oxford: Hart; 2001, at 15, 29; Neeley GS. The constitutional right to suicide, the quality of life, and the "slippery-slope": An explicit reply to lingering concerns. *Akron Law Review* 1994;**28**(1):53–77, at 76.
26. See Doomen J. Dignity in life and death. In: Doomen J, Van Schaik M, eds. *Religious Ideas in Liberal Democratic States.* Lanham, MD: Lexington Books (Rowman & Littlefield); 2021:85–104, at 90–2 for an overview.
27. See note 25, Neeley 1994, at 65–7.
28. The author does not refer to Kant, but his perspective does come to mind. A discussion of Kant's ideas would unwarrantably diverge from the discussion at hand; I refer the reader to Doomen J. Beyond dignity. *Archiv für Begriffsgeschichte* 2016;57:57–72, at 59–61.
29. See note 25, Biggs 2001, at 157.
30. Singer P. *Practical Ethics.* Cambridge: Cambridge University Press; 2011, at 156.
31. Aristotle, *Ethica Nicomachea.* Opera, Vol. 2. Darmstadt: Wissenschaftliche Buchgesellschaft; 1831 [±350BC], at 1115a.
32. See note 31, Aristotle 1831, at 1098a, 1098b.
33. Lucretius. *De Rerum Natura.* Berlin: Georg Reimer; 1871[±60BC], Book 3, 830, 831, at 105.

34. See note 33, Lucretius 1871, Book 3, 798, 799, at 105; and 830, 831, at 105.
35. Paterson C. *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach.* Aldershot: Ashgate; 2008, at 51. Similarly, Dworkin states: "Something is intrinsically valuable […] if its value is independent of what people happen to enjoy or want or need or what is good for them." Dworkin R. *Life's Dominion.* New York, NY: Alfred Knopf; 1993, at 71. The idea of "(human) dignity," discussed in the previous section, is associated with the idea of an intrinsic value (see note 25, Biggs 2001, at 145) and with the inherent value of one's own life (Dworkin 1993, at 238).
36. See note 35, Paterson 2008, at 78.
37. See note 35, Dworkin 1993, at 68, 69.
38. Bullock E. Assisted dying and the proper role of patient autonomy. In: Cholbi M, Varelius J, eds. *New Directions in the Ethics of Assisted Suicide and Euthanasia*. New York, NY: Springer; 2015:11–25, at 17, 18.
39. See note 38, Bullock 2015, at 17.
40. See note 38, Bullock 2015, at 13.
41. See note 38, Bullock 2015, at 20–2.
42. See note 38, Bullock 2015, at 17, 18.
43. See note 38, Bullock 2015, at 14–6.
44. "Lasting" (the translation of the term "duurzaam," which is used in the bill) (Parliamentary Documents: House of Representatives, 2019/2020:35534, no. 2, at 2) must be differentiated from "absence of a prospect of improvement" of medically diagnosable suffering (see note 2). In the case of medically diagnosable suffering, the suffering is expected to be such that no prospect of improvement exists as a result of a lack of medical means to alleviate it, while "lasting" in the present sense refers to the fact that the person making the request has a lasting desire to die.
45. In line with what Sudarshan argues (Sudarshan S. The irrevocability of capital punishment and active voluntary euthanasia. *Journal of Applied Philosophy* 2021;**18**(3):431–43, at 436, 437).
46. Pascal B. *Pensées.* Œuvres Complètes, Vol. 1. Paris: Librairie de L. Hachette et Cie; 1869 [1669], Article X, at 303–5.
47. See note 46, Pascal 1869, Article X, at 303. The original text (with the original spelling) reads: "S'il y a un Dieu, il est infiniment incompréhensible, puisque, n'ayant ni parties ni bornes, il n'a nul rapport à nous: nous sommes donc incapables de connoître ni ce qu'il est, ni s'il est."
48. Compare Simmons K. Suicide and death with dignity. *Journal of Law and the Biosciences* 2018;**5**(2):436–9, at 439.
49. It is in this sense that Marcus Aurelius speaks of life. Seeking to consider things as they are in themselves (Marcus Aurelius Antonius. *Ta Eis Heauton.* Leipzig: B.G. Teubner; 1903 [180AD], Book Δ, ιά, at 34), he indeed identifies life with such physical elements (Book Z, ιέ, at 67).
50. Compare Schramme T. Rational suicide, assisted suicide, and indirect legal paternalism. *International Journal of Law and Psychiatry* 2013;36(5/6):477–84, at 480, 482, and the dissenting opinion of Justice Brennan in Cruzan v. Director, Missouri Department of Health, 497U.S. 261 (1990): "[…] the State has no legitimate general interest in someone's life, completely abstracted from the interest of the person living that life, that could outweigh the person's choice to avoid medical treatment."
51. Sprung C, Somerville M, Radbruch L, Collet NS, Duttge G, Piva J, et al. Physician-assisted suicide and euthanasia: Emerging issues from a global perspective. *Journal of Palliative Care* 2018;**33**(4):197–203, at 199.
52. See note 51, Sprung et al. 2018, at 200.
53. In addition, "[…] what is diagnosed is the condition and not the suffering; physical conditions are objectively diagnosable while physical suffering is not or less so." Raus K, Sterckx S. Euthanasia for mental suffering. In: Cholbi M, Varelius J, eds. *New Directions in the Ethics of Assisted Suicide and Euthanasia*. New York, NY: Springer; 2015:79–96, at 89.
54. Schmidt A. Should we extend voluntary euthanasia to non-medical cases? Solidarity and the social context of elderly suffering. *Journal of Moral Philosophy* 2020;**17**(2):129–62, at 132.
55. See note 54, Schmidt 2020, at 134, and see note 53, Raus, Sterckx 2015, at 89.
56. See note 53, Raus, Sterckx 2015, at 89.

57. Varelius J. Medical expertise, existential suffering and ending life. *Journal of Medical Ethics* 2014;**40**(2):104–7, at 106.
58. *Dutch Supreme Court*, Dec. 24, 2002, at 5.
59. Complementing what he argues, Varelius points to such an alternative: persons with a special expertise on existential questions may, provided that they meet the same standards as physicians insofar as the procedural requirements are concerned, be preferable to physicians (see note 57, Varelius 2014, at 107).
60. Compare note 50, Schramme 2013, at 484.
61. See note 25, Neeley 1994, at 60, 61.
62. Lesser H. Should it be legal to assist suicide? *Journal of Evaluation in Clinical Practice* 2010;**16**(2):330–4, at 332.
63. See note 51, Sprung et al. 2018, at 198.

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