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Criteria for Active Euthanasia and Physician-Assisted Suicide

By

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Abstract

Internationally, there are varying laws regarding physician-assisted suicide (PAS) and active euthanasia. In the United States, PAS is legal in Right to Die states like Oregon. These states necessitate that patients seeking PAS be terminally ill, often with 6 months or less left to live. There are also countries that allow for active euthanasia, with the majority of these countries also requiring that the patient be terminally ill. Belgium and the Netherlands are two countries that do not necessitate terminal illness in their criteria, but instead utilize the category of unbearable or constant suffering, which has, controversially, led to individuals being granted active euthanasia for existential and psychological suffering due to non-terminal illness, including mental illnesses. This essay contains a literature survey that examines key arguments from both the 1970s and 2000s to highlight the emergence of two distinctive branches in the PAS/active, voluntary euthanasia debate. These distinctive models of criteria diverge in the balance between autonomy and humanitarian-relief of suffering, as well as the justification for the termination of life as facilitated by medical doctors, as demonstrated in Oregon and The Netherlands and Belgium. Therefore, Right to Die models of PAS exercised in states such as Oregon should not be extended to scenarios where the patient is not terminally ill without major reconstruction.

Criteria for Active Euthanasia and Physician-Assisted Suicide

In the United States, active euthanasia is illegal and physician-assisted suicide (PAS) is legal in a handful of states, namely California, Colorado, Montana, Oregon, Vermont, and Washington. There are other states where PAS is not legal but is also not criminalized, such as North Carolina and Massachusetts. Though active euthanasia is currently out of the picture in the U.S, internationally, active, voluntary euthanasia is legal in Belgium, Colombia, Japan, Luxembourg, and The Netherlands (“Euthanasia Regulations Around the World”). An additional variable within the landscape of permitting or denying a patient’s request to die that is often taken for granted in philosophical and bioethical discourse is the attached criteria. While Right to Die states like Oregon require that an individual be diagnosed with a terminal illness to qualify for PAS, the Netherlands and Belgium are two countries that do not necessitate terminal illness, but instead utilize the category of unbearable or constant suffering, which is not limited to the suffering produced by a terminal illness or even physical suffering. This language has led to the controversial precedent in both countries for granting euthanasia to individuals who are existentially depressed or mentally ill. This begs the question, which scenarios qualify for the termination of a patient’s life? Do only certain kinds of illness or suffering warrant PAS and/or active euthanasia. Is the sustained desire not to live sufficient?

Some individuals and groups who are opposed to the act of euthanizing patients may use these northwestern European countries to construct slippery slope arguments against the legalization of any process which supports a patient in actively ending their life. But when considering the data on regions that practice both PAS and active euthanasia, it is clear that this

is a minority development and that there is not an established causative relationship between the two outcomes. Yet, what is less readily apparent is how the relevant philosophical and bioethical literature corresponds to the two different approaches and justifications of PAS and active euthanasia.

This essay will survey key literature related to PAS and active euthanasia to elucidate the diverging intellectual and ethical investments, values, and priorities within the larger discourse, demonstrated by the diverging criteria for euthanasia in Oregon, a PAS-state requiring terminal illness with 6 months or less to live, as well as the Netherlands and Belgium, two countries with the benchmark of constant and unbearable suffering. This essay will also aim to demonstrate the emergence of two distinctive branches in the PAS/active, voluntary euthanasia debate. These distinctive models of criteria diverge in the balance between autonomy and humanitarian-relief of suffering, as well as the justification for termination of life facilitated by medical doctors, as demonstrated in Oregon and The Netherlands and Belgium.

The publication dates of the articles surveyed will range from dated to contemporary, so as to highlight any trends, shifts, or pattern in the literature. This essay will be operating under the ethical position that active euthanasia vs. PAS does not carry significant moral distinction but that any situation where PAS would be morally justified, active (voluntary) euthanasia would be similarly justified. The essay will be focused on the diverging endorsed criteria for empowering a patient to actively end their life, demonstrated by Oregon and The Netherlands/Belgium. Therefore, Right to Die models of PAS exercised in states such as Oregon should not be extended to scenarios where the patient is not terminally ill without major reconstruction.

Terminology and History:

Physician-assisted suicide (PAS) is the process by which a patient takes their own life with the assistance of a physician. This is often carried out by the prescription of a lethal dose of drugs. Euthanasia also involves the intentional termination of a life but is perpetuated by another party instead of merely assisted by one. In addition, there are the categories of 1.) involuntary and voluntary euthanasia and 2.) active and passive euthanasia. Euthanasia is voluntary or involuntary depending upon if the individual being euthanized consents. For legal and medical purposes, voluntary euthanasia would be the most pertinent form, but cases where a patient is unable to give consent due to diminishing cognition and consciousness are also commonly debated.

A physician administering a lethal dose of drugs would be a classic example of active euthanasia because the physician is directly terminating a life. Passive euthanasia, conversely, involves indirect means of ending a patient's life, such as discontinuing life-saving treatment. As one could imagine, these sub-categories of orchestrating death combine in a myriad of ways and creates scenarios with unique ethical and legal considerations. Philosophical and bioethical discourse has historically wrestled with these variables, arguing for which set of conditions best allows for the ethical termination of a patient's life, yet none of these distinctions relate directly to question of criteria.

In the United States, every state that has legalized PAS has set the parameter of terminal-illness around a reasonably proximal and foreseeable death, often with the additional, specific criteria of six or less months to live. It does not follow that only PAS states/nation will necessarily have the requirement of terminal illness, or that, hypothetically, a PAS state/nation could not adopt a suffering rather than terminally-ill centered model. In the five countries which

permit voluntary, active euthanasia, Japan and Colombia necessitate the presence of a terminal illness. Luxembourg does not require terminal illness but does require that the suffering be a result of injury or physical death disease.

Conversely, Belgium and the Netherlands' criteria for euthanasia does not necessitate terminal or even physical illness, but instead grants permission based upon the constancy and unbearableness of the patient's suffering, be it physical or mental. The acting physician must also determine that there are no other reasonable solutions (that the patient is willing to experiment with) to the patient's suffering. The vast majority of individuals being euthanized in these countries are still terminally ill, but in addition to physical conditions that are not terminal such as blindness (Trott, "Deaf Belgian twins end lives"), there has been a consistent increase in the annual number of patients granted euthanasia who suffer from depression (clinical as well as existential), anxiety, and other mental illnesses like eating disorders, PTSD, and body dysmorphia (Boztas, "Netherlands Sees Sharp Increase"). This has drawn concern from mental health and disability advocates in and outside of these countries who worry about the vulnerability of these populations and the message it sends regarding society's view of the lives of the mentally ill.

The 1970's: Rachels, Brandt, and The Ethics of Suicide:

"Active and Passive Euthanasia" by James Rachels was a seminal piece of literature in the euthanasia debate, which was published in 1975. Rachels was arguing against the belief that passive euthanasia is morally superior to active euthanasia, which is a position that was and still is endorsed by the American Medical Association. In the subtext of this argument is also an argument about which cases warrant the granting of life-terminating actions by physicians.

Rachels starts with the following scenario “a patient who is dying of incurable cancer of the throat is in terrible pain, which can no longer be satisfactorily alleviated. He is certain to die within a few days, even if present treatment is continued” (Rachels, 1). Rachels then continues to describe how, in the above scenario, said patient requests that life-prolonging treatment be stopped, as the pain is too great, which is a request that the family supports. If the physician agrees with this step and complies, the physician is participating in passive euthanasia. But, by stopping life-prolonging treatment instead of administering a life-ending agent, “it may take the patient longer to die, and so he may suffer more than he would if noire direct action were taken and a lethal injection given” (2). While the initial request was granted based on the prevention of suffering, if the active approach is abated, it leads to more suffering rather than less, which subverts the humanitarian impulse that led to the decision in the first place.

Secondly, Rachels argues that the commitment to avoid “killing” (active) even in situations where letting die is considered permissible leads to faulty decision-making regarding life and death, stemming from our belief that it is always worse to kill than to let die. Rachels gives examples of passive agents, with the desire to kill an individual, permitting that individual’s death and, conversely, of an agent actively killing someone. Importantly, in all of these examples, the subjects share murderous intent and are causally responsible regardless of passive vs. active classifications. Both cases are morally reprehensible as they lead to the same result. And in the same way, when the reason for facilitating a patient’s death is justified, passive vs. active leads to the same result, and thus the passive approach is not superior. Lastly, Rachels discusses a reason why the passive approach is preferred by her critics, which is that the passive approach allows the doctor to not be directly responsible for the patient’s death. But Rachels argues that they are still participating in the result through the passive model by withholding

treatment, so the difference is a shallow one, and that even if it is motivated for reasons of legal protection, doctors should resist being accountable to a standard that is not morally defensible.

“The Morality and Rationality of Suicide” by Richard Brandt was published in 1975 and is not specifically about euthanasia or PAS but highlights ethical considerations for self-annihilation which correspond with the contemporary context of Oregon and Belgium and the Netherlands. In “The Morality and Rationality of Suicide”, Brandt analyzes the problem of suicide from the lens of contemporary philosophy. He begins by assessing the morality of suicide, or the relative blameworthiness of those who commit suicide. Even in situations where the action of suicide is believed to be morally wrong, if the agent who commits suicide does so because of a dominating affective state, can the individual really be considered morally blameworthy? Brandt casts doubt on the notion that one can be blameworthy based solely on an action, stating that blameworthiness resulting from an action is anchored by the notion that the action stems from a character-deficiency, or that said action is a reflection of the individual’s flawed character. But what character flaw is connected to suicide? Brandt also argues that suicide could be motivated by positive traits, like dutifulness. This would mean that the agent’s action does not warrant blame, even if the agent miscalculated the situation and shouldn’t have committed suicide. For example, if a man committed suicide because he thought his medical bills would bankrupt his family, and he was actually mistaken in that calculation, his actions were still motivated by a positive trait and not a negative one such as cowardice, therefore he is not worthy of moral blame.

After assessing the issue of blame, Brandt explores situations where suicide is morally justified or objectively right. First, he explains that the critics of suicide must at least acknowledge that the moral obligation to not kill oneself can come into contention with other

moral obligations in certain circumstances, problematizing unconditional moral prohibitions. For example, if one had to sacrifice themselves for the sake of their families, there are two contradictory obligations bearing weight on the situation. So, instead, the charitable view of those who admonish suicide is to say that their position is that suicide is unacceptable when it is based on one's own personal welfare. Next, Brandt gives a defense of committing suicide if it is in line with one's welfare.

According to Brandt, if an individual would rather die shortly than continue living after having considered the best possible "world course", than it is rational for them to act on that desire by terminating their life. To consider one's world course, a person must imagine what it would be like for their life to terminate at different points: now, in 5 years, in 20 years, and then see which route is most desirable. He calls for the consideration of a world course instead of a life course because the impact of the person's death on the world is also considered. By "world" Brandt means everything outside of one's own life that they care about, such as their partner, entire family, or community. Brandt explains that the person would need to meditate on their answer to the world course question and not be in the middle of a particularly emotionally frantic episode, so that it can be a rational as opposed to rash decision. By carefully considering world courses, individuals may realize that the long-term scope of the entirety of their desires lend themselves better to living longer, but, they may also not.

If an individual is to consider all the factors and meditate on the question of their ideal time of death and it is still presently, than they are entitled to do so, according to Brandt. Brandt answers the criticism of this position based on the unpredictability of the future, which is the argument that a person who does not know what the future holds shouldn't be able to terminate their own life based on their feelings about the future. He argues that this argument could go both

ways and that anyone who has come to a reasoned conclusion could also say that the unpredictability of the future rules in the favor of acting on their decision, because there is no certainty that features of their world course will change drastically. Brandt directly acknowledges individuals who are not terminally-ill and are instead depressed and no longer wish to live. He argues that the above criteria still apply to these individuals, as long as they are aware that depression has a tendency to limit our imagination, skew our reasoning abilities, and curtail our motivation. He argues that irrational suicides are not the result of the influence of factors like depression, but the compulsion towards a rash decision.

“Active and Passive Euthanasia” by James Rachels and “The Morality and Rationality of Suicide” by Richard Brandt, both published in 1975, present two completely different frameworks for the consideration of PAS/euthanasia. The respective arguments were geared towards different audiences. Rachels was responding to the American Medical Association and Brandt was contributing to a collection of essays about suicide, so it is not necessarily the case that these two authors are in opposition or that their views could not be complementary, but rather that the differences are notable in how they shed light on the distinctive ethical defenses of terminating patients’ lives.

In “Active and Passive Euthanasia” by James Rachels, one can see the emergence of PAS/active euthanasia defenses closely relate to what is still the standard in U.S Right to Die states such as Oregon. At the time the article was published, there was no Right to Die states in the U.S, but Rachels’ example still presented physical suffering in the face of a terminal-illness with a closely impending death as the standard scenario warranting active, voluntary euthanasia, and is therefore an early intellectual argument towards PAS. Though Oregon is a PAS state and what Rachels details is active euthanasia, one can assume that the author would find both

scenarios morally justified, as PAS is still more “active” than passive euthanasia. Though personal agency is highlighted in that the patient initiated the request to cease life-prolonging treatment, the scenario made sure to express the family’s acceptance and the physician’s uncomplicated and obvious approval, putting the brunt of the proposed actions’ defense on humanitarianism in the face of terminal and physical suffering instead of personal liberty.

Conversely, “The Morality and Rationality of Suicide” proposes a model that closely resembles what is legislated in Belgium and the Netherlands. In both countries, it is required that the individual undergo a process and waits out a trial period to discuss their motivations with a skilled professional and have their desire approved based on the unbearableness and constancy of their qualms. While this, on its face, presents more obstructions than Brandt’s world-course consideration process proposes, the subjectivity of “unbearableness” essentially puts the onus on the individual to assess the implications of their suffering, namely if it is severe enough that they don’t wish to bear it any longer via continuing their lives. It is a subjective form of suffering in that it is not biologically terminal -- it doesn’t necessitate that the person will die in the same way suffering from a terminal disease will, where the suffering is merely a secondary characteristic of what their PAS/active euthanasia is actually granted based upon, such as with the case of Oregon.

In conclusion of this segment of the literature review, Brandt determines that a suicide is rational and therefore ethical if it is the result of principled consideration, which puts personal liberty and agency far above the argument in Rachels’ article. Brandt’s arguments corresponds to the cases of The Netherlands and Belgium more directly, as The Netherlands and Belgium both require that the decision not be rash and have a process in place to guarantee that the request is sustained, while also prioritizing the patient’s own perception of their life-course once it is

determined to be a stable request. Still, Brandt's argument is about suicide, and while voluntary euthanasia is a form of suicide, in this context, it has the added component of endorsement by and participation from the state via the medical institution. It is possible that Brandt would agree that it is an individual's morally justified human and civil right, but that it shouldn't involve the collaboration of either the medical community and/or the state via legislation.

At the time both of these arguments were written, the euthanasia debate had just begun in both related regions, and it would be another 10 years before legislation would begin to formulate in The Netherlands and Belgium (Deliens et al, "The euthanasia law in Belgium and the Netherlands"). In the United States, the AMA still holds that active euthanasia is unacceptable, demonstrated by the following statement directly from the AMA website:

"Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations" ("Code of Medical Ethics").

The question of the role of the medical institution is where contemporary literature can add clarification, as the appropriate role of the medical and/or psychiatric institution within these modes of end-of-life action, especially outside of the scope of terminal illness, is a contemporary point of contention in ethical and bioethical discourse, with both models existing in the international legislative landscape.

De Haan, Varelius, and Autonomy:

Jurriaan De Haan details his position on the rightful role of autonomy in euthanasia in his article "The ethics of euthanasia: Advocates' perspectives", which was published in 2002. This was a time when only the Netherlands had fully legalized active, voluntary euthanasia. De

Haan's article has significance in that it is very well circulated in its field and often referenced within contemporary euthanasia discourse.

De Haan begins by praising euthanasia practices in the Netherlands, explaining that euthanasia is granted based upon both the patient's voluntary choice, as well as the unbearableness of their suffering. Therefore, the current law is invested in physicians respecting individual autonomy, but also pursues the patient's benefit. The reasoning contained within this criterion can also be described as a joint view of anatomy, because it requires both autonomy and the doctor's unique discretion to permit euthanasia. De Haan argues that, while the law itself acknowledges that euthanasia is outside of a doctor's normal medical duty, physicians can still weigh in due to their status as collaborators to the act and the agent within the patient-doctor dynamic who possess medical knowledge as well as, ideally, knowledge of the patient's own values regarding life and suffering. The author argues that doctors inevitably play this role throughout their medical practice because there are constantly matters that are both subjective yet lend themselves to a doctor's unique medical insight within their practice. So, in conjunction with the first requirement of the joint view, it is possible and necessary that a doctor's pursuit of the patient's best interest be involved in euthanasia.

But there is also the pure autonomy view, which argues that autonomy in and of itself justifies euthanasia. Specifically, the pure autonomy view argues that "euthanasia is morally justified just because of the patient's voluntary, well-considered and sustained, that is autonomous, request for euthanasia" (156). Therefore, according to this view, the only gatekeeping a physician would reasonably perform is to make sure that the patient is of their right mind and is not being rash, similarly to the argument generated by Brandt presented in 1975. But according to De Haan, this view leads to counter-intuitive results, where any reason to

pursue death is given a stamp of approval as long as it is representative of the patient's will, since doctors will not be encouraged to weigh in with judgements regarding if their pain or suffering warrants death or not. He also goes on to discuss the risks to the integrity of the medical community if doctors are to collaborate in instances where the suffering is not unbearable, as it can lead to charges of maleficence. The value of autonomy does not justify euthanasia on its own as euthanasia is not self-regarding, but instead affects society in numerous ways.

In biomedical philosopher Jukka Varelius' essay "Illness, suffering and voluntary euthanasia" published in 2007, the author examines the belief that suffering due to illness or suffering at all must be present for euthanasia to be a viable option, arguing that there is no "good reason" for this tradition. According to Varelius, a person who desires euthanasia for reasons outside of terminal illness or even suffering should be granted their request, as these categories of "bad things" are not the only "bad things" that could reasonably lead to the sustained desire to die in an autonomous being. First, the author questions the proposition that only one who is suffering may rationally desire death, stating that "one may be in pain, but not suffer; one's desires may remain dissatisfied without this being connected to suffering; one may be deprived of liberty, but not suffer". Here, Varelius is addressing the fact that some people regard "suffering", in the sense of being in pain or facing hardships, as ultimately desirable because they believe it gives life meaning, whether spiritually and/or through building character. Thus, in the same vein that someone who is ill may not "suffer" as such, another person may forgo suffering but still find themselves lacking the desire to continue living, whether for social, political, or existential reasons. The individual could be tired of living or have continuous feelings of uselessness, for example. The author also provides the example of a man who is

given a choice by a dictatorial government to either end his own life or have his whole family killed, and because he values being a national hero above all else, decides to ask his friend to assist him in ending his own life.

Some would argue that the above example is not applicable to active, voluntary euthanasia laws because the individual's life has been compromised by a corrupt government instead of their own suffering and the immediate threat is on his family and not on his own quality of life. But the author argues that euthanasia should not only apply in cases of suffering, but in all situations that are inescapable in the sense that death would be the only possible way of avoiding whatever they subjectively believe renders life undesirable to continue living. Varelius anticipates the criticism that a physician's intervention is not applicable in cases where physical suffering is not at stake, arguing that physicians are not only tasked with ending suffering, but empowering patient's autonomy in all biomedical matters. According to Varelius, euthanasia is appropriate in all cases where the act is a benefit for the dying person in the sense that it would help her to avoid something bad in her life that can't be solved otherwise and that she wants to avoid enough that dying is her decision.

Varelius then goes on to interact with the position of Jurriaan De Haan and the role of autonomy in his argument. De Haan credits the Netherlands for including the clause of unbearable suffering because it anchors the approval or denial of euthanasia requests in the realm of medical knowledge and wisdom, as opposed to pure autonomy, which he argues leads to counter-intuitive results granting justificatory power to requests for euthanasia irrespective of whether or not they are good or bad decisions. Conversely, Varelius defends the position that there is room for an operating standard within euthanasia criteria beyond autonomy even if that standard is not "suffering", as there are other states or factors that could cause an autonomous

person to reasonably desire the escape of death. She also argues that people who do hold to a pure autonomy view most likely do not believe there can't be good or bad reasons for euthanasia, but that those reasons are determined subjectively on the basis of "preferences and attitudes of favor and disfavor of autonomous agents".

When comparing Jukka Varelius' essay "Illness, suffering and voluntary euthanasia" and Juriaan De Haan "The ethics of euthanasia: Advocates' perspectives", earlier noted philosophical strategies, values, and investments are brought into clarity in the PAS/active, voluntary euthanasia literature, as well as different points of contention in the contemporary ethical and legal landscape. As in the case of Rachels and Brandt's arguments, the ratio of agency and autonomy vs. management of physical suffering play telling roles. One factor to note is that while De Haan's article is in praise of The Netherlands, the argument itself does not necessarily put his position on the side of The Netherlands and Belgium's criteria for PAS/active euthanasia vs. the Right to Die model exemplified in Oregon. While he doesn't ground his reliance on the concept of suffering in physical suffering or generalized suffering due to a physical and/or terminal illness, his elevation of the doctor's role in exercising medically-pertinent discretion causes one to wonder what he would think of the more contemporary, and currently multiplying, cases involving more complicated notions of suffering, as this article was written in 2002.

While euthanasia in Belgium and The Netherlands require participation and approval from medical doctors, in the cases of existential depression and mental illnesses, medical doctors do not have the ability to say that treatment has truly been exhausted or that the person's condition will necessarily worsen or deteriorate over time, as existential and psychological suffering due to mental illness or anguish is not as readily measurable in the way a terminal illness is. Thus, they must appeal to the patient's freedom of choice and insight into their own

condition. This is not to say that mental illness is not as excruciating or severe as a terminal illness, but that the kind of assessment a medical doctor could perform on the patient's situation would not be as insightful, something reflected in the lack of restrictions beyond persistency of request and the perception of the unbearable nature of their reported suffering. Arguably, The Netherlands and Belgium's approach to euthanasia is required to rely more heavily on autonomy than De Haan seems comfortable with, and that his model would fit more with the case of Oregon contemporarily, where the patient's best interest can be qualified by a physician if they autonomously decide to respond to their suffering with the option of terminating their life.

Conversely, Varelius does not require that individuals who do not wish to continue their life suffer in the way that is comparable to the standard narrative surrounding those who qualify to be euthanized. She argues that the wave of philosophers stressing individual autonomy in biomedical ethics promotes the view that the proper goals of medicine are ultimately determined by the autonomous decision of a patient, so that euthanasia can be performed in the name of promoting a patient's wellbeing or because it is their sustained desire given their life circumstances. To demonstrate the connection to Belgium and The Netherlands' approach to PAS/active euthanasia criteria, Wim Distelman, who was appointed by the Belgian Council of Ministers to serve as the chairman of the Federal Control and Evaluation Commission (the committee which reviews euthanasia deaths to insure that doctors have complied with the law), stated the following in regards to the "incurable" clause in the legislation: "We at the commission are confronted more and more with patients who are tired of dealing with a sum of small ailments—they are what we call 'tired of life [...]' If you ask for euthanasia because you are alone, and you are alone because you don't have family to take care of you, we cannot create family" (The Death Treatment, Aviv). Distelman is one of the most liberal practitioners of

euthanasia, who pushes the envelope in regards to a suffering individual's autonomy. While these countries still exercise discretion over what they consider reasonably incurable, Varelius' autonomy-heavy approach certainly fits in more with Distelmans words than Oregon's Right to Die movement, which necessitates terminal illness.

These two articles demonstrate the opposing contemporary views on the proper role of the medical community within the gamut of end of life choices. While De Haan advocates for the role of the medical doctor in PAS/euthanasia, it is as a gatekeeper who uses her medical knowledge and professional discretion to weigh the patient's autonomy against the objective "badness" or "goodness" of their death to determine if it is reasonable and/or medically justified. Varelius also includes the medical doctor in her proposal, but with the view of the doctor as facilitator of bioethical justice, with her calculation of bioethical justice prioritizing personal agency and autonomy as opposed to a figure who is to discern what sort of bad situations warrant death, as long as these bad situations are ones that the patient reasonably believes are unavoidable. She argues that those who are suffering due to terminal illness should not have monopoly over the granting of PAS/euthanasia, as those are not the only situations that are "terminal" in their reasonably perceived hopelessness.

Conclusion:

In conclusion, through this survey of literatures from two different eras in biomedical and philosophical development, we can see the emergence of two distinctive branches in the PAS/active, voluntary euthanasia debate. One area where the two models of criteria diverge is the balance between autonomy and humanitarian-relief of suffering, as well as the justification for termination of life facilitated by medical doctors.

One can see that the correct notion of suffering is a loaded question within this debate,

which calls for further philosophical examination. In the Right to Die states, while release from suffering is part of the defense, it is not enough on its own. The language of dignity takes precedence over the notion of agency, and both are rooted in the end-of-life landscape uniquely, “adding a voluntary option to the continuum of end-of-life care, these laws give patients dignity, control, and peace of mind during their final days with family and loved ones”, as stated by the Death with Dignity non-profit in the U.S, which has played a pivotal role in advocating for PAS legislation throughout the movements history (“Death with Dignity Acts”).

In the Right to Die states like Oregon, the role of autonomy and relief of suffering are limited to the end-of-life landscape, leaving less room for ambiguity in the quality and nature of the patient’s suffering -- as it must be due to a terminal illness. This is arguably beneficial in that it maintains the integrity of the medical doctor in collaborating in a patient’s death, given the ambiguity of unbearable or constant suffering as the main criteria. Suffering is a secondary to the patient’s status of terminally-ill in Right to Die states. It is one argument for why the terminally-ill should be able to make their own decisions when the quality of their life is already verifiably compromised, but it is not the only reason. Beyond escaping pain, Death with Dignity advocates highlight personal agency and control over their own impending death. But can the same principles that allow one to hasten their impending death be applied to individuals who are not terminally-ill without compromising the medical institution?

In Varelius’ and even Brandt’s calculations, one can see a model where the doctors role is to safeguard in a more liberal way, making sure that the person is not delusional or temporarily in a heightened emotional state in their subjective calculation, and that their problem is unsolvable from their perspective. This begs the following question and investigation: what is the proper role of the medical doctor within the realm of decision-making regarding the termination

of life that is not terminal, and therefore already in the realm of end of life care. As far as the role of her credentials and expertise, is the involvement of the medical actor even appropriate or logical? If not the medical institution, is there a body within the state that should be regulating this activity, or should assisted-suicide and euthanasia only be legalized in the face of terminal illness, as it requires a level of conviction in the relative goodness or badness of collaborating in a death that doesn't exist? In 2016, The American Psychiatric Association released the following statement regarding the euthanasia of non-terminally ill patients: "The American Psychiatric Association [...] holds that a psychiatrist should not prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death" ("Position Statement on Medical Euthanasia"). While autonomy is a value that should be promoted in health care, the proscription against helping psychiatric patients to commit suicide is too integral to the ethos of the medical field to transition to a pure autonomy model. While psychiatrists may be the actors within the contemporary umbrella of health care with the most authority on the subject, their collaboration may do more harm than good.

Though other life conditions besides terminal illness cannot be proven to produce a lesser quantity of suffering, the quality of the suffering differs in that it is not due to terminal illness and is therefore outside of the scope of end-of-life care, making the future quality of the given life subject to termination unpredictable. Someone may make this argument in the case of terminal illness, as medical discoveries could render the person's illness no longer terminal. But in reality, medical advances are slow, and doctors can speak to the patient's state with more authority. This is an important element in maintaining the integrity of the acting medical professional, as the lack of authority to weigh-in meaningfully with their given expertise makes it inappropriate for them to weigh-in so decisively on the relative quality of a life marked with

suffering. Here, one can see how models which rely on a humanitarian end-of-life approach are not likely to evolve into what is permissible in The Netherlands and Belgium without considerable reconstruction, as their preliminary parameters are objective and rely less on the patient's personal assessment. Though they account for suffering, they are not based on suffering, whether physical or psychological. The Netherlands and Belgium also require that medical doctors exercise discretion in permitting or disallowing euthanasia, but because euthanasia can be granted based on forms of existential suffering and mental and psychological illness that cannot be decisively or objectively labelled as untreatable, therapeutically-futile or "terminal", the countries rely too heavily on the individual's autonomy to be safeguarded by medical doctors based on their expertise. This is made apparent in that the suffering has to be constant and/or unbearable, which are subjective markers reliant on self-reporting as opposed to medical science.

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