**Euthanasia as life-extension**

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**Introduction**

Although genuinely new and novel arguments surrounding the permissibility of euthanasia have been thin on the ground in recent years, the issue itself is going through a period of intense public scrutiny, with multiple attempts to secure a legal basis for a ‘right to die’ in the UK, as well as increasing legislation across the world.[[1]](#endnote-1) Amidst such debate, I want to return to some foundational moral arguments and consider a potentially new approach. This involves taking a perspective on the overall life of an individual and arguing that euthanasia has the potential to *extend* rather than shorten life in certain cases. This seemingly paradoxical claim does not offer a definitive or knock-down argument in the euthanasia debate but it does offer an additional type of argument in favour of euthanasia. Furthermore, such a consideration might be particularly suited to understanding euthanasia’s place within, for example, the medical profession, where intentionally seeking to shorten life is often seen as problematic when considered alongside the goals of medicine. This is not an argument for the prolongation of life at any costs. Instead, it forms part of a ‘whole of life’ view that an individual may have about themselves (Dworkin, 1994, pp. 222-229).

The inspiration for considering a life-extension approach is the case of the Belgian Paralympic medal-winning athlete Marieke Vervoort. Vervoort, who won medals at the London and Rio Paralympics, suffers from progressive tetraplegia, an incurable degenerative spinal disease which causes seizures, rising paralysis, failing eyesight, and reflex sympathetic dystrophy resulting in constant and excruciating pain. Now nearly 40, Vervoort was diagnosed with the condition when she was 15 and has lived with the inexorable progress of her disease ever since. She signed her euthanasia papers in 2008 but it was not her intention to undergo euthanasia at that point, as her numerous medal successes clearly illustrate. It was Vervoort’s claims that she would have already taken her own life if she had not had the option of planned euthanasia available to her in Belgium,[[2]](#endnote-2) that have given such a strong practical realisation to this perspective as a potential line of argument in the euthanasia debate. This is made all the more apparent as, it seems, Vervoort’s view is not an isolated case of this way of thinking about one’s own life and euthanasia, with similar cases also coming to light.[[3]](#endnote-3) This raises a timely question as to whether this consideration genuinely offers us a form of new and persuasive argument in favour of (certain types of) euthanasia or is it simply an expression of the intentions of the individual? I will argue that not only does it provide supporting argument in favour of euthanasia, it also provides an important counter-argument to certain types of sanctity of life arguments that are often utilised as overriding considerations against any individual wanting to claim a right to end their life in this way.[[4]](#endnote-4)

**Definitions and Concepts**

The sorts of arguments that can be utilised either for or against euthanasia can change quite markedly depending upon what we actually mean by ‘euthanasia’ or upon what the circumstances and intentions surrounding certain acts are. This is particularly important in the case of the life-extension argument, as it directly supports only certain kinds of euthanasia.

Although there is no one, universally agreed definition, there are enough common or shared features amongst various the definitions to allow euthanasia be broadly defined as:

the intentional bringing about of the death (or shortening of life) of the patient where this is done for the patient’s own sake (their best interests).[[5]](#endnote-5)

However, different aspects also have to be distinguished in terms of:

1. how it is being done;
2. to whom it is being done;
3. what is being done; and
4. why it is being done?

With respect to (i), euthanasia can be distinguished in terms of the way in which the euthanasia is carried out. This usually takes the distinction between active and passive forms of euthanasia. Active euthanasia is the deliberate killing or hastening of death of a patient by taking some action that is intended to bring about their death, for the patient’s own sake (such as by administering a lethal injection). Passive euthanasia differs by allowing a patient to die intentionally by omitting to take some action which would, if performed, have lengthened the life of the patient or prevented their death. Passive euthanasia primarily occurs through withdrawing or withholding life-prolonging treatment. Although there is debate as to whether there is, practically or morally, any difference between active and passive forms of euthanasia (Rachels, 1975), I shall take the well-supported view that such a distinction can be usefully maintained (Garrard and Wilkinson, 2005). As I shall discuss later, the life-extension argument for euthanasia will have most bearing on active euthanasia.

With respect to (ii), we gain another distinction between voluntary, non-voluntary, and involuntary euthanasia. Voluntary euthanasia is euthanasia autonomously requested by the patient. It requires the patient both (a) to be sufficiently informed and competent to request or consent to it and (b) does in fact consent to it. The issue of whether both of these requirements can be achieved through the use of advance directives or other means of substituted judgements, such as using proxies, has been an important contemporary topic.[[6]](#endnote-6) The Vervoort case is one where a pre-existing advance decision has been used to voluntarily request euthanasia. However, this was a prudential rather than necessary step for Vervoort, where it is physical ability rather than mental competence which is primarily at stake. Non-voluntary euthanasia is where the individual is not sufficiently mentally competent to request euthanasia or may be competent but is unable to communicate their request or consent to it (such as with Locked-in syndrome). Involuntary euthanasia occurs against either the patients stated wishes or where the patient, although competent, is not consulted.

With respect to (iii), it is important to distinguish between ending one’s own life, physician assisted dying, and euthanasia. The definition of ‘suicide’ can itself be problematic and can carry implicit negative connotations. Therefore, I will use the phrase ‘ending one’s own life’ instead, which I define as:

the act of taking one’s own life intentionally and voluntarily (without assistance from another person).[[7]](#endnote-7)

Although the moral permissibility of ending one’s own life is not the issue under discussion here, there is an important step between this and euthanasia that it is worth distinguishing – physician assisted dying (PAD). PAD can be defined as:

ending one’s own life in a way that is carried out by that individual with assistance from another person (which, in the case of physician assisted dying, is a doctor or equivalent health professional).

The relevant classificatory distinction here is the involvement of another person, even though the act itself is carried out by the subject. For example, a third party could provide the means for carrying out the act of ending one’s own life by setting up apparatus and a doctor prescribe the lethal drugs to be utilized. This involvement of a third party has raised a considerable number of additional issues than those associated with taking one’s own life without assistance (Dworkin, Frey, and Bok, 1998; Battin, 2005).

Whilst life-extension arguments are potentially applicable to the case of PAD, the focus here is on active voluntary euthanasia (AVE). One important reason for this is that questions surrounding involuntary or non-voluntary euthanasia take us away from any notion of individual choice. Life-extension considerations strongly imply they must be accompanied by consensual future-planning on the part of the individual involved. Furthermore, arguments concerning the ethical permissibility of AVE would apply a fortiori to passive euthanasia and PAD. The thought is that if PAD is deemed to be morally identical or even less ethically problematic than AVE, then arguments supporting the more ethically demanding procedure would also support similar but less ethically demanding procedures.[[8]](#endnote-8)

It is worth noting that throughout all the different distinctions considered so far, nothing refers to any reasons that a subject may have for requesting euthanasia and very little as to the motivations of the third party carrying out (or assisting with if PAD) the termination of life. As such, these definitions remain neutral on distinction (iv), which often concerns whether euthanasia is only for those with a terminal illness and/or unbearable suffering caused by an uncurable condition. Although many might consider euthanasia to only be applicable in cases where all of these elements are present, as holds in Vervoort’s home country of Belgium, euthanasia is reserved for those suffering with incurable conditions, the account here allows scope for euthanasia to be applicable to other individual circumstances. This might include cases where the person requesting euthanasia would not be considered terminally ill, such as permanent paralysis or progressive dementia, and potentially other circumstances, such as ‘life fatigue’ (Huxtable and Moller, 2007).

These distinctions allow a precise picture of the life-extension argument in the case of Vervoort. In Belgium, euthanasia has been legal since 2002 and takes the form of AVE, as the Act specifies that euthanasia means “the intentional termination of life by a person other than the person concerned, at the latter's request.”[[9]](#endnote-9) Not only must the person be competent when making the request and do so voluntarily, the medical condition of the patient is also relevant. Belgian law requires that the patient must be in a persistent and unbearable state of physical or psychological suffering that cannot be otherwise alleviated. Furthermore, this state must be the result of a serious and incurable disease or accident-induced condition. Vervoort’s condition, a form of aggressive and incurable tetraplegia causing progressive physical deterioration, rising paralysis, and unbearable pain, long ago met these requirements to the satisfaction of her own physician and the independent consultant physicians also required to authorize the euthanasia request. As Vervoort’s condition progresses past the point where she would be able to take her own life or even make use of PAD due to her increasing paralysis, she holds that her established euthanasia request has allowed her the extra years of life that she would otherwise have had to forego. Her reasoning is that this request can be enacted upon at a point of her choosing, rather than limiting her only option to end her life to a point where she could still do so without assistance.[[10]](#endnote-10) This is something Vervoort confirmed in an interview shortly after the Rio Paralympic Games:

“When I didn’t have those papers, I would have committed suicide. I hope other countries like Brazil can talk about it. It makes people live longer. It doesn’t mean that when people sign the papers, they have to die two weeks later. I signed my papers in 2008. Look now, 2016 and I won the silver medal.”[[11]](#endnote-11)

**Applying Life-Extension Considerations to Key Arguments Surrounding the Ethics of Euthanasia**

The question as to whether this sort of life-extension argument really does contribute to the debate as to the ethical permissibility of euthanasia is an intriguing one. By itself, it would form, at best, only a weak, rebuttable consequentialist line of argument that more life years might result for an individual if it were allowed on these grounds. However, that would be to miss the point of both the context in which it is being employed and the unusual intentional basis of the argument itself. Therefore, rather than considering it in isolation, I want to consider whether it can be a consideration that genuinely strengthens arguments in favour of the moral permissibility of AVE and whether it meets any of the objections offered against AVE.

There is no doubt that the practice of euthanasia puts great tension on our duty of care towards individuals. On the one hand, its practice seems to contradict a central guiding moral principle often found in medical settings of non-maleficence - do no harm. This line meets its most radical utilisation with sanctity of life arguments, the view that a person's life is inviolable and of value regardless of disability, pain and suffering. Supporters such as Keown (2002) and Gormally (2000), believe that this means intentionally killing an innocent person – even if they request it through euthanasia – can never be justified. As Keown puts it, “The ‘right to life’ is essentially a right not to be intentionally killed.” (Keown 2002, p. 40)

On the other hand, the moral permissibility of euthanasia is implied by two other principles. One is respect for individual autonomy - where, for example, if I am a rational and well-informed person and decide that I want to die because I believe it is in my interests not to live anymore (such as to prevent further intolerable suffering) then my decision should be respected. The second is the promotion of beneficence or best interests, by preventing needless suffering in cases where, for example, a patient is terminally ill or suffering from physical and/or psychological pain that cannot be relieved. These ethical concerns are not the only ones in play, many of which break down into much finer, more nuanced arguments, but as basic and often-cited guiding ethical principles, they are the first areas for consideration for the applicability of life-extension arguments.

*Sanctity of Life*

If we start with the most radical (secular) line of objection to the permissibility of euthanasia – sanctity of life arguments based on what is generally known as “vitalism” – we are unlikely to find much ground given in response to a counter-argument utilising life-extension considerations.[[12]](#endnote-12) Defending the view that a person's life has absolute, intrinsic, worth and so is of value regardless of disability, pain and suffering is a position granting no exceptions. It is therefore not subject directly to considerations of ‘more’ and ‘less’ when it comes to life. Although a supporter of the vitalism view would doubtless consider that a greater length of life for an individual is better than a shorter one, they would not be willing to accede to euthanasia requests. Rejecting euthanasia based on the intrinsic value of life holds, according to Dworkin (1988), regardless of whether it is in a person’s best interests to die or whether a person has autonomously chosen to waive their own right to life. This is because the sanctity of life is not identical with the value that any one individual may have for their own life. Instead, it simply holds of all lives. The addition of a life-extension argument would therefore not add any further justification. To do so would effectively be offering a justification for what they view as an intrinsic wrong (euthanasia) by appeal to another intrinsic wrong (‘suicide').

Although less radical than vitalist positions, many secular ‘inviolability of life’ arguments still premise themselves on the innate or intrinsic good of life, as opposed to any quality of life consideration. However, the way in which the basis for this intrinsic good is established can leave open a route for counter-argument based on life-extension considerations. Most often, the foundation of secular sanctity of life positions are provided by appeal to some innate human characteristic, such as rational capacity, which is seen to give humans their innate worth and which grounds their ‘right to life’. This innate value is also characterised as an impersonal value of a human life, that is “different from its personal value – that is, the value it has for the individual whose life it is…and of what the person himself autonomously desires his life to be like.” (McMahan, 2002, p. 331).

One of the most prominent explanations as to what grounds the sanctity of human life is Dworkin’s (1994, p. 84) account of the “complex creative investment” that has been made in the life.[[13]](#endnote-13) This means that, due to the time, energy, resources, effort, and so on that have been invested in both the creation and development of a human life by others and the individual themselves, such life has its intrinsic value. However, this view has been subject to substantial criticism by McMahan (2002), who argues appeal to the sanctity of life cannot be a plausible objection to euthanasia or taking one’s own life on this basis, claiming: “For the fact that an investment has been made in a life does not make it important that the life should be preserved irrespective of what its character will be” (2002, p. 465). Dworkin’s account holds that taking one’s own life or euthanasia would be a *waste* of this investment; but McMahan’s point is that there is no waste of investment if that life has already yielded all the good that can come from such investment and will not yield any further good. Prolongation of life in such cases will not only fail to advance that investment, further investment in prolonging a life of misery would be seen to be a squandering of investment on something that will yield no further value.

This criticism gives an interesting role for life-extension considerations for sanctity of life claims of this type. If we link sanctity of life to a fullness of investment with a life, then it would not offer a compelling basis for rejecting euthanasia claims in cases like Vervoort’s. This is based on the rationale for euthanasia as life-extension: that it allows an individual to glean more life – life still able to continue to yield the goods of the investment in it – than they would otherwise have been able to if AVE was not available to them. Indeed, this actually makes the case stronger for AVE and, potentially, even PAD than it does for choosing to take one’s own life without assistance.[[14]](#endnote-14) This is based on a desire to not waste life opportunities until one is not only past the point of being able to self-intervene to take one’s own life, but also past the point of life having *any* opportunity whatsoever for that person. This means that life is not being wasted but is, instead, fuller because of a life-extension that AVE offers that individual, making it appear compatible with this type of sanctity of life position (or, at least, a means of addressing the concerns such a view has raised against AVE). Although this will not meet absolutist views as to the sanctity of life, such as vitalism, it does offer a response to a grounded secular account of sanctity of life position.

It may be objected that this use of the life-extension argument makes the error of conflating an intrinsic, impersonal value of the good of life with a qualitative, personal, or subjective value of the good of life. Although the life-extension argument can be used to support certain positions for AVE that do rely on appeal to quality and personal value of life, this particular use in the case of sanctity of life is not one of them. The reason it can avoid this charge is because Dworkin’s complex, creative investment explanation as to why we may consider life inviolable or sacred only gains meaning if one considers what value is generated by appeal to such investment. It is not that a life-extension argument is being used to assert a further claim to being in the best interests of the person seeking AVE, or that it is another form of autonomously waiving a right to life, both of which are asserting a personal value to the value of life. Instead, it is respecting the basis of the impersonal value where the investment in that person’s life is recognised to the point at which death would not be, to use Dworkin’s phrase, a ‘waste’ of that investment. By extending the life to the point at which all potential has been realised; where all investment has been fully ‘redeemed’, and where nothing more can be achieved, the sanctity of life is being honoured. This is not a claim about the badness of a life for a given individual; something that would be a personal value rather than an impersonal one. It is a claim that AVE can allow an individual to travel to the point of their personal negative evaluation of their life but also that of the more objective position as to what counts as determining that sanctity. This is the point where, due to both physical and cognitive decline, that life has maximally accomplished all that the creative investment involved in it could ever have yielded.[[15]](#endnote-15)

*Appeals to autonomy*

Life-extension considerations can also be utilised as part of a positive argument in support of euthanasia when working in tandem with other important pro-euthanasia arguments. Given the prominence of arguments for AVE based on promoting individual autonomy, it is apt to consider how appeal to a life-extension argument can be used in such cases.

Appeals to respecting individual autonomy are relatively straightforward.[[16]](#endnote-16) They build from the premise that an autonomous individual has a right to determine and shape their own life through their own choices. Accordingly, such an individual’s decisions carry an overriding moral weight when it comes to determining what treatments and actions should or should not be carried out towards them. It is their own values that determine what worth they give their continued existence and, should they decide to do so, they can request that their life ends. Furthermore, should there be such a thing as a right to life, it is part of being an autonomous agent that allows us to waive such a right concerning our own lives.[[17]](#endnote-17)

Certain caveats apply to the application of autonomy arguments for euthanasia, even where it is held that our autonomous views as to our continued existence should be respected. One is that autonomy-based arguments only support voluntary (active or passive) euthanasia. As discussed, it is the defining feature of involuntary and non-voluntary euthanasia that they do not seek to respect the autonomous views of the individual. The other notable caveat is that whilst autonomy arguments support the right of an individual to end their own life, they do not settle the question of the manner of death. They may support taking one’s own life but not PAD or any form of euthanasia. The major reason for this is that PAD and all forms of euthanasia involve a third party. As respect for autonomy does not extend to simply fulfilling any request an autonomous individual may make, additional arguments need to be in place to support the role of a third party in such cases. This would require that much of the groundwork for the moral permissibility of PAD or AVE already be in place, as it would not be possible to generate a third-party obligation on the basis of respecting the autonomy of the patient if that request is to participate in an immoral action.[[18]](#endnote-18)

However, leaving aside the debate concerning third parties, the question at hand is whether life-extension arguments themselves are able to support autonomy-based arguments for AVE. The first, and simplest, way this might be achieved is simply by providing the basis for a rational, considered, autonomous decision. This is exactly the sort of rationale offered in the Vervoort case, where an individual knows they have a degenerative condition and also has a firm conviction that they would not wish to continue living after a certain point of physical or cognitive decline but, nevertheless, values the experience of living past the point where they might be able to take their own life. By allowing such future-orientated preparation for a decision to request AVE at a certain point in their condition, individuals like Vervoort can exercise their autonomy through maximising the values they have regarding their own lives.

There would also be additional advantages for autonomy-related concerns that might arise through this future-orientated process of requesting AVE. Notably, it allows substantial scope to determine the soundness of the expressed autonomous wish to die. This occurs in two ways. One way is that the individual can experience more of life with a declining state and thereby allow themselves a greater understanding as to what it is to live with such a condition. As such, they will be able to form an accurate as possible picture of their conviction that life would not be worth living after a certain point with a degenerative condition. Another is that they also have the greatest possible amount of time to reflect upon and to rescind (should they wish) the request for AVE. Hence, the quality of their autonomous decision is given every opportunity to form or be rejected because they are able to live past a point where they would otherwise have taken their own life. This does not, of course, mean that all problems surrounding appeals to autonomy as a basis for euthanasia are met. Substantial safeguards still need to be in place to ensure genuine autonomous decisions to request AVE are being made. Some of the potential problems may even be exacerbated by protracted life span after a request for AVE has been appropriately created but not yet initiated. For example, certain groups may be subject to certain kinds of emotional or psychological pressures to make a choice to end their life, genuine or perceived, even where this does not amount to coercion.[[19]](#endnote-19) Therefore, additional questions of, for example, ‘authenticity’ for autonomous decisions may be additional vital considerations.[[20]](#endnote-20)

*Appeals to beneficence*

The other major line of supporting argument for the permissibility of euthanasia is an appeal to beneficence. The moral principle of beneficence is one that requires us to prevent avoidable suffering in others by contributing to or promoting their welfare.[[21]](#endnote-21) When used in support of euthanasia, this line of argument is advanced on the basis that sometimes the suffering (be it physical, psychological, etc.) that a person is experiencing can only be relieved through death. In such cases, it may therefore be that what will most benefit the patient is to bring about their death. In keeping with the principle, such a person’s death should be brought about as swiftly and painlessly as possible to avoid any additional suffering. It is therefore often the case that appeals to beneficence promote active rather than passive forms of euthanasia.[[22]](#endnote-22)

Appeal to beneficence is rarely utilised by itself but rather usually in conjunction with respect for autonomy considerations.[[23]](#endnote-23) Even where the focus is solely upon beneficence, the types of argument raised by including life-extension considerations are markedly similar to those that support autonomy-based ones. This is largely due to the nature of the predicted suffering made by the individual also being a part of their value-based considerations that inform their autonomous judgement. In beneficence terms, the advantages are more about providing additional scale of support rather than a new type of beneficence consideration. The specific support life-extension considerations offer beneficence arguments is primarily twofold. Firstly, by enabling a person to live longer than they otherwise would have, they are able to experience more of a life that they still consider worth living, thereby increasing the sum-total of positive experiences. It is not something that has to be cut short by the requirements of physical or cognitive limitations that might impede taking one’s own life. Secondly, the individual not only is able to secure a release from what they hold to be a state of unbearable suffering, they also gain the psychological benefits that such pre-planning brings with it. Hence beneficence-based arguments in support of euthanasia that make use of life-extension considerations offer individuals more experience of positive welfare and a guaranteed end to suffering once a certain state has been reached. In this sense, life-extension considerations help maximise the benefits that beneficence arguments attempt to bring.

**Challenges to considering euthanasia in terms of life-extension**

Although life-extension considerations offer both support to existing arguments in favour of euthanasia and counter-arguments to certain sanctity of life objections, their application still presents challenges. One notable problem is a moral debate about the nature of life-extension. Such debates usually focus on the ethics of *substantially* extending the term of one’s natural life, often through utilising advances in technology to enhance the human body so that the natural life span is extended by a significant number of years (Ackerman, 2009). However, in the euthanasia context it is life-extension in the sense of a prevention of artificial *curtailment* of life (e.g. taking one’s own life) rather than an artificial *prolongation* of natural life span (via, for example, genetic enhancements).[[24]](#endnote-24) This leaves open debate on what, if any, the moral difference might be between the prevention of the curtailment of someone’s life (their taking their own life) and the active prolongation of life (through treatment, enhancement, etc). The answer to this question may impact on the use of life-extension arguments in the euthanasia debate if, for example, it turns out that actions preventing threats of taking one’s own life do not form a basis for constituting actions that genuinely extend life.

There is a related issue that concerns intentions to take one’s own life. For AVE to be seen as life-extending in the sense discussed here, the threat of taking one’s own life at an earlier stage if denied access to AVE has to be genuine. However, the only way of accessing the veracity of such a claim is by assessing the intentional state of the individual making the claims of their intention to take their own life. There are two significant reasons why this might pose difficulties for allowing AVE on these grounds. First, because it is difficult to verify a purely intentional claim. However, although difficult, it is far from an insurmountable problem, as all sorts of claims about values, attitudes, intentions, etc. are regularly assessed in many areas of life without undue problem. The second reason, perhaps only a particular aspect of the first problem, is a concern that because the life-extension consideration is based on an intentional claim to taking one’s own life, it might be subject to abuse. The thought here is that if what is justifying the request for AVE is an individual claiming they would otherwise take their own life, to what extent can that claim be considered a voluntary one arising from an individual’s own desires? Again, I do not think this an insurmountable problem but it is certainly one that would require attention when considering any safeguards surrounding the use of a policy that accepted life-extension arguments as a legitimate consideration when requesting AVE.

**Conclusion**

Vervoort’s case is remarkable because it illustrates how someone can be living an extremely full and successful life and yet still rationally want to choose euthanasia as a way of making sure they maintain control over their life in the knowledge that they do not want to continue to live under certain circumstances. Whilst only a few key arguments have been discussed here, there remain numerous aspects of the euthanasia debate upon which life-extension considerations might have some bearing. These include arguments that centre around the use of advance directives, slippery slope arguments, concerns about the impact upon palliative care and end of life services, and the nature of the relationship between patient and health care professionals. However, it would seem that the possibility of seeing AVE as life-extension rather than life-shortening has the potential to advance the euthanasia debate in terms of both supporting exiting pro-euthanasia arguments and meeting certain types of sanctity of life objections.

**REFERENCES**

Ackerman, F.N., (2009). Death is a Punch in the Jaw. In: B. Steinbock, ed. *The Oxford Handbook of Bioethics*. Oxford: Oxford University Press. pp. 324-348.

Battin, M. P., (2005). Euthanasia and Physician-Assisted Suicide. In: H. LaFollette, ed. *Oxford Handbook of Practical Ethics*. Oxford: Oxford University Press. pp. 673-704.

Beauchamp, T. and Childress, J., (2001). *Principles of Biomedical Ethics.* 5th ed. New York: Oxford University Press.

Biggs, H., (2001). *Euthanasia, death with dignity, and the law*. Oxford: Hart Publishing.

Brandt, R., (1975). The Morality and Rationality of Suicide. In: S. Perlin, ed. *A Handbook for the Study of Suicide.* Oxford: Oxford University Press. pp. 61-76.

Brock, D. W., (1993). *Life and death: Philosophical essays in biomedical ethics*. Cambridge: Cambridge University Press.

Buchanan, A.E. and Brock, D.W., 1990. *Deciding for others: the ethics of surrogate decision making*. Cambridge: Cambridge University Press.

Buchanan, A., (1988). Advance directives and the personal identity problem. *Philosophy*

*and Public Affairs.* **17**(4), 277–302.

Bullock, E.C., (2015). Assisted Dying and the Proper Role of Patient Autonomy. In: M. Cholbi and J. Varelius, eds. *New Directions in the Ethics of Assisted Suicide and Euthanasia*, Springer International Publishing. pp. 11-25.

Cholbi, M., (2011). *Suicide: The Philosophical Dimensions*. Peterborough, Ontario: Broadview.

Cohen-Almagor, R., (2009). Belgian euthanasia law: a critical analysis. *Journal of Medical Ethics.* **35**(7), 436-439.

Degrazia, D., (1999). Advance directives, dementia and the ‘Someone Else Problem’. *Bioethics.* **13**(5), 373–391.

Dixon, N., (1998). On the Difference between Physician-Assisted Suicide and Active Euthanasia. *Hastings Center Report.* **28**(5), 25-29.

Dworkin, G., (1988). *The Theory and Practice of Autonomy.* Cambridge: Cambridge University Press.

Dworkin, G., Frey, R. G. and Bok, S., (1998). *Euthanasia and Physician-Assisted Suicide: For and Against*. Cambridge: Cambridge University Press.

Dworkin, R., (1994). *Life’s Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom*. New York: Vintage Books

Feinberg, J., (1978). Voluntary Euthanasia and the Inalienable Right to Life. *Philosophy and Public Affairs.* **7**(2), 93-123.

Frankfurt, H.G., (1971). Freedom of the Will and the Concept of a Person. *Journal of Philosophy.* **68**(1), 5-20.

Garrard, E, and Wilkinson, S., (2005). Passive Euthanasia. *Journal of Medical Ethics.* **31**(2), 64-68.

Gormally, L., (2000). Euthanasia and Assisted Suicide: 7 Reasons Why They Should Not be Legalized. In: D. Dickinson, M. Johnson, and J. Samson Katz, eds. *Death, Dying and Bereavement.* 2nd ed. Sage: London. pp. 286-89.

Gray, W., (1999). Right to die or duty to live? The problem of euthanasia. *Journal of Applied Philosophy.* **16**(1), 19-32.

Huxtable, R. and Moller, M., (2007). ‘Setting a Principled Boundary?’ Euthanasia as a Response to ‘Life Fatigue’. *Bioethics.* **21**(3), 117-126.

Jackson, E., (2009). *Medical Law: Text, Cases, and Materials*. Oxford: Oxford University Press.

Keown, J., (2002). *Euthanasia, Ethics and Public Policy: An Argument against Legalisation*. Cambridge: Cambridge University Press.

Mackenzie, C. and Stoljar, N. eds., (2000). *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*. New York: Oxford University Press.

McMahan, J., (2002). *The Ethics of Killing: Problems at the Margins of Life*. New York: Oxford University Press.

Paterson, C., (2003). On Clarifying Terms in Applied Ethics Discourse: Suicide, Assisted Suicide and Euthanasia. *International Philosophical Quarterly.* **43**(3), 351–358.

Pellegrino, E, and Thomasma, D., (1988). *For the Patient’s Good: The Restoration of Beneficence in Health Care*. New York: Oxford University Press.

Rachels, J., (1975). Active and Passive Euthanasia. *New England Journal of Medicine.* **292**(2), 78-80.

Scanlon, T., (1993). Value, desire and quality of life. In: M. C. Nussbaum and A. Sen, eds. *The Quality of Life.* Oxford: Clarendon Press. pp.185–200.

Shaw, D.M., (2015). Saving Lives with Assisted Suicide and Euthanasia. In: M. Cholbi and J. Varelius, eds. *New Directions in the Ethics of Assisted Dying and Euthanasia*. Springer International Publishing. pp. 185-192.

Westwood, S., (2017). Older Lesbians, Gay Men and the ‘Right to Die’ Debate: ‘I Always Kee a Lethal Dose of Something Because I don’t Want to Become an Elderly Isolated Person’. *Social & Legal Studies.* **26**(5), 606-628.

Wrigley, A., (2007a). Personal Identity, Autonomy and Advance Statements. *The Journal of Applied Philosophy.* **24**(4), 381-396.

Wrigley, A., (2007b). Proxy Consent: Moral Authority Misconceived. *The Journal of Medical Ethics.* **33**(9), 527-531.

Wrigley, A., (2015). Moral authority and proxy decision-making. *Ethical Theory and Moral Practice.* **18**(3), 631-647.

Wrigley, A., (2018). Consent for Others. In: A. Muller and P. Schaber, eds. *The* *Routledge Handbook of the Ethics of Consent.* Oxford: Routledge. pp. 322-333.

1. There are numerous examples. Concerning euthanasia in the UK: *R v Cox* [1992] 12 BMLR 38; *R v Inglis* [2010] EWCA Crim 2637; *R (Nicklinson) v Ministry of Justice* [2012] EWHC 2381 (Admin). Concerning assisted suicide in the UK: *R (on the application of Pretty) v Director of Public Prosecutions* [2001] UKHL 61; *Pretty v United Kingdom* (2002) 35 EHRR1; *R (on the application of Purdy) v Director of Public Prosecutions* [2009] UKHL 45; *R (Martin) v Director of Public Prosecutions* [2012] EWHC 2381 (Admin); *Airedale NHS Trust v Bland* [1993] AC 789; *R (Conway) v Secretary of State for Justice* [2017] EWHC 2447 (Admin) and *R (Conway) v Secretary of State for Justice* [2018] EWCA Civ 1431. There have also been a number of attempts to change the law in the UK in recent years, including the Assisted Suicide (Scotland) Bill (2013), Lord Falconer’s Assisted Dying Bill (2014), Rob Marris’s Assisted Dying Bill (2015), and Lord Haywards’s Assisted Dying Bill [HL] (2016).

Outside of the UK, euthanasia is legal in Belgium (since 2002), Canada (known as ‘medical assistance in dying’ since 2016), Colombia (since 1997 but not implemented until clarified by their Ministry of Health in 2015), Luxembourg (since 2008) and the Netherlands (since 2002); while assisted suicide (but not euthanasia) has been permitted in Switzerland since 1942. A number of states in the United States have made assisted dying legal (but not euthanasia) including Oregon (since 1994), Washington (since 2008), Vermont (since 2013), California (since 2015), and more recently Hawaii (since 2018), with New Jersey due to take effect from 1st August 2019. [↑](#endnote-ref-1)
2. <https://www.rt.com/sport/359065-belgian-paralympian-euthanasia-paralympics/> (accessed 14/06/19). [↑](#endnote-ref-2)
3. Such as that reported by Alexandra Johnston concerning her brother’s suicide following his decline from Parkinson’s disease, at: https://www.stuff.co.nz/national/health/101604023/if-euthanasia-were-legal-my-brother-might-have-lived-longer [↑](#endnote-ref-3)
4. Notably, Dworkin’s (1994) ‘creative investment’ account of the inviolability of life. [↑](#endnote-ref-4)
5. These essential elements of the concept are widely accepted across all accounts of euthanasia, both in the ethical and the legal domains. See, for example, McMahan (2002, p. 456); Jackson (2009, pp. 874-5); or Keown (2002, pp. 9-17). [↑](#endnote-ref-5)
6. One of the most substantial discussions of this is Buchanan and Brock (1990). There is a wealth of other discussion, including Buchanan (1988); Degrazia (1999); Dworkin, G. (1988); Dworkin, R. (1994); and Wrigley (2007a; 2007b; 2015; 2018). [↑](#endnote-ref-6)
7. This definition, with minor variations of expression, is an *intentional* account and is found in numerous important philosophical discussions on the issue, for example: Brandt (1975); McMahan (2002); Paterson (2003); Cholbi (2011). [↑](#endnote-ref-7)
8. For arguments that AVE is no more morally demanding than PAD see Dixon (1998). [↑](#endnote-ref-8)
9. The definition of euthanasia is given in Chapter 1, Article 2 of the Belgian Act, available at: <http://www.ejustice.just.fgov.be/cgi/article_body.pl?language=nl&pub_date=2002-06-22&numac=2002009590&caller=summary> (accessed 04/04/19). For a detailed discussion of the legislation, see Cohen-Almagor (2009). [↑](#endnote-ref-9)
10. Interview from *The Telegraph*, 21/12/17, ‘Exclusive Marieke Vervoort interview – Paralympics star preparing for euthanasia: “I’m in so much pain. I’m done”’, available at: <https://www.telegraph.co.uk/paralympic-sport/2017/12/21/marieke-vervoort-paralympics-star-preparing-euthanasia-much/> (accessed 04/04/19). [↑](#endnote-ref-10)
11. Interview from *The Guardian*, 11/09/16, ‘Marieke Vervoort denies planning to kill herself straight after Rio Paralympics’, available at: <https://www.theguardian.com/sport/2016/sep/11/marieke-vervoort-now-my-fear-of-death-is-gone> (accessed 14/06/19). [↑](#endnote-ref-11)
12. I am here restricting discussion to secular accounts. Religious accounts are the province of theological rather than ethical debate. [↑](#endnote-ref-12)
13. The difference between something being *instrumentally* important and something being *intrinsically* important is discussed by Dworkin (1994, Ch. 3) as a means of capturing what a secular account of the sanctity of life might be. This position is critically assessed by McMahan (2002) alongside various other approaches to secular accounts of the sanctity of life, such as high cognitive and rational capacities, experiences, and biological complexity. [↑](#endnote-ref-13)
14. Taking one’s own life would require that the person choose to do so when still able to both physically and mentally, PAD allows a longer time span but still requires some ability (arguably, both physical and cognitive) to carry out the final act of taking one’s own life, even with assistance. AVE does not require either of these elements as long as a suitable advance decision has been created establishing a point of decline that might take an individual past their ability to physically participate in the manner of their death or past their cognitive ability to reason or communicate their wishes. This would presumably encompass every last scrap of potential that may be yielded from such a life. Even with no advance directive, AVE still allows life to continue past the point of complete loss of physical ability to participate. [↑](#endnote-ref-14)
15. It may be thought that those with severe cognitive or physical disability who are not declining but in a steady state might, under this account, be seen to have already accomplished all that they could. To avoid the ‘objective’ devaluation of their existence, it may therefore be argued that ‘being’ is itself an accomplishment and continued being the route to maximal accomplishment. Doubtless, supporters of the sanctity of life view would readily make such a case. However, I am here emphasising the use of this argument within the Active *Voluntary* Euthanasia (AVE) debate, where euthanasia is requested by a mentally competent person. This interpretation could therefore be applied as desired by any autonomous agent concerning their own life but for those people unable to request AVE it would simply be inapplicable. I am grateful to Sue Westwood for drawing this important concern to my attention. [↑](#endnote-ref-15)
16. The nature and role of autonomy is, however, a substantial topic which would take us way beyond the issue at hand. The classic foundational readings on the modern view of personal autonomy are Dworkin (1988) and Frankfurt (1971) There remain other accounts of the concept and the moral duty to respect autonomy which can lead to different views surrounding the intentional ending of one’s life. For example, Kantian conceptions of autonomy often reject the moral permissibility of taking one’s own life. [↑](#endnote-ref-16)
17. Right to life as an aspect of the euthanasia debate is discussed by e.g. Feinberg (1978); Gray (1999) and Biggs (2001). [↑](#endnote-ref-17)
18. The role of third parties is discussed in Brock (1993). [↑](#endnote-ref-18)
19. Feminist authors have raised concerns about women who, as a group, are more likely to not wish to be a burden on carers or family. Minority ethnic groups may also have communal, rather than individual autonomous, decision-making processes. I am grateful to Sue Westwood for highlighting these cases. [↑](#endnote-ref-19)
20. There is a great deal of important feminist literature on the nature of autonomy, including accounts of its social-relational nature and how oppression of agents can affect autonomy. A good selection of material on this topic can be found in Mackenzie and Stoljar, eds. (2000). See also Westwood (2017) for a discussion of how vulnerable groups can be disadvantaged or lack appropriate voice when considering ‘right to die’ issues. [↑](#endnote-ref-20)
21. This is a principle that received a great deal of attention from Utilitarian thinkers. However, its prominence in modern health care ethics can be seen in Pellegrino and Thomasma (1988) and in Scanlon (1993). There remains a good overview of the principle in Beauchamp and Childress (2001, Ch. 5). [↑](#endnote-ref-21)
22. It is worth noting, however, that whilst beneficence might support active euthanasia as morally preferable to passive, it may also support on certain readings involuntary and non-voluntary euthanasia if beneficence is the sole – or primary – moral principle being considered. [↑](#endnote-ref-22)
23. Brock (1993) discusses not only patient well-being but also how autonomy-based arguments directly link to issues of suffering as a basis for arguments in favour of assisted dying. Whether patient well-being or best interests may be treated as objective and independent of self-determining choices remains an interesting question (Bullock, 2015). [↑](#endnote-ref-23)
24. There may be another, third, interpretation of ‘life-extension’ in this context if it is seen as akin to ‘saving lives’. Standing debates about the saving lives aspect of euthanasia focus on organ donation after assisted dying (Shaw, 2015). AVE might be an unusual variant of the saving lives debate here, where the person who dies and the person who has their life saved are one and the same. [↑](#endnote-ref-24)