Should Elderly be Saved from Themselves?

On Paternalistic Interference with Healthy Suicidal Elderly

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Master's Thesis in Political Science
Specialisation: Political Theory
Nijmegen School of Management
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Academic Year: 2018-2019
Supervisor: dr. Bart van Leeuwen
Word count: 24.919
Date of submission: 21 June 2019

19 October 2019: Minor revision regarding the representation of D66's 'completed life' bill (§2.4/§2.5) and corresponding criticism of the bill (§5.2) with respect to the potential use of this thesis by policy-makers.

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ABSTRACT

The discussion on the permissibility of assisted-suicide has been reignited in The Netherlands following the 'worthy end-of-life' legislative proposal. More commonly referred to as the 'completed life' (voltooid leven) bill. This legislative proposal aims to provide healthy elderly who consider their lives completed and no longer worth living with the opportunity for receiving life-ending medication. This thesis investigates the legitimacy of paternalistic interference and the limits of personal autonomy with regards to this advanced case of assisted-suicide by discussing three positions within the theoretical debate on paternalism. These are the 'respect for autonomy', 'soft-paternalistic' and 'hard-paternalistic' positions, respectively. First, to investigate the respect for autonomy position, the framework of liberty and autonomy by John Stuart Mill is discussed. Following Mill's insights on the subjectivity of human experiences, I argue that the autonomy of individuals should eventually be respected in the case of completed life, because in the end, it must be concluded that external actors can never fully understand the pain that individuals experience. Yet, I also conclude that Mill's framework is inadequate for maximizing individual and societal welfare in the case of completed life. Contrary to Mill, I argue that external actors can, initially, aid individuals in deciding what is valuable to them through paternalistic interference. Secondly, I conclude that soft-paternalistic interference is necessary to ensure elderly are making sufficiently voluntary requests for assisted-suicide. Thirdly, I propose and discuss a theoretical framework consisting of four conditions in which hard-paternalistic interference with healthy suicidal elderly, who consider their lives completed and no longer worth living, should be permissible. Accordingly, I conclude that temporary hard-means-paternalistic interference is optimal for dealing with healthy suicidal elderly who request assisted-suicide in the case of completed life.

Keywords: *assisted-suicide, autonomy, completed life, elderly, euthanasia, hard-paternalism, John Stuart Mill, soft-paternalism.*

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION

1.1 Completed life: introduction

Medical-ethical questions surrounding assisted-suicide were prominent during the 2017 Dutch parliamentary elections and the subsequent cabinet formation. The discussions on assisted-suicide were fuelled mainly by a progressive liberal political party called Democraten '66 (D66). Prior to the elections, D66's Pia Dijkstra published a legislative proposal called 'worthy end-of-life'. More commonly referred to as the 'completed life' (voltooid leven) bill.[1] This bill is supposed to be separate from already existing euthanasia law which only deals with requests for aid-in-dying based on strict medical circumstances. It is argued that the current euthanasia law is inadequate because it is not inclusive enough. It is said that the existential suffering that elderly are dealing with is not covered by the current law. The new bill is to provide elderly that fall outside of the scope of the current law with the opportunity for assisted-suicide (D66, 2016). According to the legislative proposal, elderly from age 75 and up should gain the legal opportunity to receive life-ending medication when they consider their lives completed and no longer worth living (Dijkstra, 2016). In other words, through this legislative proposal, D66 intends to give elderly more personal autonomy in shaping the final phase of their lives.

Following the 2017 parliamentary elections, a successful cabinet formation partly depended on a cooperation between D66 and a Christian democratic party, the Christen Unie. Despite the religious origins of the Christen Unie, they opposed the bill from a secular point of view, arguing that the life-ending decision is not strictly an individual choice. According to the party, the choice itself has a much greater impact on surrounding entities like family and society, which should not be underestimated (Christen Unie, n.d.). Even though governing terms were eventually agreed upon, the issue of completed life was not included in the governing plans (Regeerakkoord, 2017). The topic has been too sensitive to properly decide upon at time of the cabinet formation. Judgement on the completed life bill has been

[1] 'Completed life' is the English translation of the Dutch term 'voltooid leven'. In the Dutch political and public debate, 'completed life' is the term that is predominantly used to describe the contents of the 'worthy end-of-life' bill. For this reason, I will use the term 'completed life' throughout this thesis.

postponed until a sounder judgement can be made about the necessity and implications of this kind of bill (Van Der Aa, 2018).

Completed life is an advanced case in the discussion surrounding assisted-suicide. The completed life bill seeks to legalize assisted-suicide in the case of healthy elderly who consider their lives completed and no longer worth living. The bill raises important and intertwined questions about autonomy and responsibility. Should the life-ending decision be a fully autonomous decision? Or should the government save citizens from themselves? Meaning that the state should make efforts to forbid assisted-suicide in the case of completed life. Freedom of choice and the freedom to shape your own life are of immense importance in modern-day liberal democracies. But should these values be the supreme guidelines for policy-making in the case of completed life?

1.2 Political theory debate: research question

In this thesis, the completed life issue will be examined from a secular perspective in political theory for two intertwined reasons. First, the argumentation used in the proposal by the initiator to defend her cause is secular in nature. Secondly, the debate and issues raised following the bill's first draft have been almost completely secular in nature.

The debate that will be discussed in this thesis is the debate on paternalism. Concretely, this is the debate between (state) paternalism on the one hand and personal autonomy on the other hand. This unresolved and ongoing debate within (liberal) political theory will be discussed because it covers the issues that are at the base of the completed life discussion. Specifically, the issues discussed in the debate surrounding paternalism are important for this thesis because they have consequences for the legitimacy of state policy on assisted-suicide in the case of completed life. Roughly speaking, in the debate, scholars debate about the content and extent of legitimate state action, how to best treat the autonomy of citizens and how autonomy ought to be valued in certain situations. Three iconic positions can be identified to further characterise the debate. These are the 'respect for autonomy', 'soft-paternalistic' and 'hard-paternalistic' positions, respectively. I will briefly introduce each position in order.

First, the 'respect for autonomy' position. To be autonomous means to rule yourself, to make decisions according to your own will. An autonomous decision is a decision that you yourself agree with. "The autonomous man, insofar as he is autonomous, is not subject to the

will of another. He may do what another tells him, but not *because* he has been told to do it" (Wolff, 1990, pp. 26 & 27, emphasis in original). Defenders of the respect for autonomy position argue for the importance of autonomy because individuals are happiest when they are allowed to exercise their autonomy (Mill, 2001). In other words, they argue people are happiest when they are free to shape their own lives and live according to their own vision of the good life.

Secondly, the 'soft-paternalistic' position. Paternalism is about making decisions on behalf of others without their consent, thus rivalling autonomy. In general, paternalists argue that it is legitimate for the state to overrule the autonomous decisions of its citizens when the state has the well-being of its citizens in mind (Dworkin, 2017). Specifically, defenders of the soft-paternalistic position argue that the state has a right to interfere with the autonomy of individuals for reasons of well-being under certain conditions. Soft-paternalists argue that the state can interfere with the decisions of individuals that are not sufficiently voluntary (Feinberg, 1986). Decisions that are not sufficiently voluntary warrant interference because it can be said that these decisions are not 'of one's own will'. Ignorance is one of the reasons a soft-paternalist would deem a decision not sufficiently voluntary. If an individual is ill-informed about the consequences of a decision, the state could force the individual to learn about these consequences. After the decision of the coerced individual is confirmed to be sufficiently voluntary, the state must respect the final decision of the individual. With soft-paternalism, no coercion is legitimate outside of decisions that are not sufficiently voluntary.

Thirdly, the 'hard-paternalistic' position. Defenders of the hard-paternalistic position argue that the state can legitimately interfere in the lives of its citizens without the preconditions argued for by soft-paternalists. Hard-paternalists recognize the voluntary decisions of individuals, but they still argue that there are situations in which it is justified to overrule the voluntary decisions of individuals for the well-being of those same individuals. There are situations in which the state should interfere with the voluntary decisions of individuals to save or protect them from the "[…] possibly damaging consequences of their own decisions" (Le Grand & New, 2015, p. 1). Hard-paternalists argue that citizens are best

respected when their well-being is preserved. Autonomy should take a backseat to the well-being of an individual if deemed necessary.[2]

This debate on the limits of personal autonomy and the legitimacy of paternalistic interference materializes in discussions about medical-ethical policies such as completed life. On the one hand, the state might have an obligation to respect the autonomy of its citizens by allowing citizens to receive life-ending medication based on their own independent judgements. But on the other hand, the state might have an obligation to protect the well-being of its citizens by stopping healthy citizens from ending their lives. A resolution in this debate is required to determine the legitimacy of state policy on assisted-suicide in areas such as completed life.

Considering the debate between these perspectives with the issue of completed life in mind, the main research question that will be addressed in this thesis is:

To what extent, or under what circumstances, does the state have a right or duty to interfere with the autonomy of its citizens regarding the medical-ethical issue of completed life?

1.3 Methodology

This thesis will make use of analytical political philosophy to formulate an answer to the main question. Analytical political philosophy focuses on figuring out what *ought* to be done considering empirical facts about human behaviour through a clear analysis of moral arguments and reasoning underlying a topic of interest (McDermott, 2008, p. 11, emphasis in original). Analytical political philosophy is the appropriate method for answering the main question because it allows to systematically investigate the debate on the limits of personal autonomy and the legitimacy of state paternalism to determine what the state should do regarding the issue of completed life.

[2] In this thesis the distinction between soft and hard-paternalism is made based on coercive interference with the *voluntary* decisions of individuals. Soft-paternalists do not interfere with voluntary decisions, while hard-paternalists do. Sometimes the distinction is made differently: “The terms “hard” and “soft” may differentiate between the methods used to induce paternalistic actions, where hard paternalism [...] advocates making some actions impossible, and soft paternalism merely recommends incentivizing certain preferable options” (Conly, 2013, p. 5). This latter distinction is not used in this thesis.

In what follows I will apply the debate to the concept of completed life. By applying the debate to completed life, important questions and dilemmas with regards to completed life will be uncovered. Discussing these questions and dilemmas will yield insights about the moral appropriateness of the 'respect for autonomy', 'soft-paternalistic' and 'hard-paternalistic' positions in this medical-ethical setting. In other words, this will yield insights about how autonomy and paternalism ought to be valued in the case of completed life.

1.4 Societal and scientific relevance

The political debate on completed life has reached a stalemate. Proponents and opponents of the completed life bill have provided their initial argumentations. Because of the sensitivity of the issue, further decision-making has been postponed until a sounder judgement can be made about the necessity and implications of this kind of bill. An analysis of the values underlying the debate can give further insight into the possible contents and justifiability of state policy on assisted-suicide in the case of completed life. It can help the political debate forward and give much needed clarity for further policy-making which makes it societally relevant.

Furthermore, this research also has scientific relevance. It can contribute to the academic debate on the limits of personal autonomy and the legitimacy of paternalism. No analysis has been done that investigates the concept of completed life with this debate in mind. This investigation will yield insights about the strengths and weaknesses of the arguments used in the debate with regards to defending or rejecting the liberalization of assisted-suicide in the case of completed life.

1.5 Outline and literary justification

To provide more context on this fairly new discussion on assisted-suicide, chapter two is dedicated to outlining important details about the concept of completed life as well as the historical and theoretical background of the completed life bill.

In chapter three the argument from the side of autonomy will be investigated. I will touch upon one of *the* origins of the autonomy perspective, that of John Stuart Mill. I choose to discuss Mill because he was one of the first to specifically discuss the importance of personal autonomy in relation to paternalistic interference by external actors. I also discuss

Mill because his line of thought especially, seems to have informed public opinion on completed life as well as the argumentation in D66's completed life bill.[3]

To start chapter three off, Mill's liberal utilitarian origins will be presented. Next, his framework for respecting autonomy, outlined in his seminal book *On Liberty* (1859/2001), will be introduced. Central to this book is the question: what is the extent to which society can legitimately exercise power over an individual by forcibly restricting individual freedom? I have chosen to discuss this book specifically because this central question touches upon the exact crux of the completed life issue. Should the life-ending decision be an autonomous decision or are limitations in order? Afterwards, I will extrapolate from Mill's views to define what he would have thought about (assisted-)suicide in the case of completed life. Lastly, I will reflect on these ideas to answer the first sub-question: *to what extent is Mill's framework of liberty and autonomy appropriate in the case of completed life?*

In chapter four the argument from the side of paternalism will be investigated. Specifically, soft-paternalism and hard-paternalism will be investigated in the context of completed life. Soft-paternalism will be discussed first. Joel Feinberg's thoughts on soft-paternalism will be presented. I will briefly present the contents of his work *'Legal Paternalism'* (1971) and *'Harm to Self'* (1986). I will roughly be following these works by Feinberg because they are, next to being representative of the central idea of soft-paternalism, also the most comprehensive on the subject. Furthermore, Feinberg investigates soft-paternalism in relation to euthanasia and (assisted-)suicide in *'Harm to Self'* which is especially useful for the purposes of this thesis. Accordingly, I will discuss soft-paternalism

[3] Here I will briefly illustrate this claim. In essence, Mill argued that "over himself […] the individual is sovereign" (2001, p. 13). The opinions of external actors should never be able to compel individuals to behave a certain way when it comes to purely self-regarding actions (Mill, 2001, pp. 13 & 70). In the public debate, the argument most commonly heard defending the autonomous life-ending decision in the case of completed life, is that external actors should not be able to impose their opinions onto others (Azaaj & Verheggen, 2017, p. 15). Furthermore, the legislative proposal by D66 argues similarly. On behalf of D66, Dijkstra argues that autonomy should be the supreme value with completed life, because elderly should have the right to be in charge of their own lives (Dijkstra, 2016, p. 12). External actors, such as family and physicians, may propose solutions to a perceived completed life, but elderly should never be compelled to explore any of these solutions (Dijkstra, 2016, p. 25).

when applied to completed life to answer the second sub-question: *to what extent is soft-paternalism justifiable in the case of completed life?*

Next, I will present the general idea behind hard-paternalism. Afterwards, a distinction between hard-means-paternalism and hard-ends-paternalism will be introduced. I will mainly discuss hard-means-paternalism because it is the more appropriate type of hard-paternalism for discussing the concept of completed life. Hard-means-paternalism touches upon the essence of the concept of completed life, which will become clear in §4.3.1. Lastly, I will discuss hard-means-paternalism when applied to completed life to answer the third and final sub-question: *to what extent is hard-paternalism justifiable in the case of completed life?*

Finally, chapter five will be the concluding chapter. I will summarize my findings and answer the main question. Afterwards, my final judgement on D66's completed life bill will be presented. Lastly, I discuss the merits and disadvantages of this thesis as well as recommendations for further research.

CHAPTER 2: COMPLETED LIFE BACKGROUND

This chapter will start off with some definitional clarifications regarding euthanasia, assisted-suicide, and completed life. Afterwards, I will elaborate on the concept of completed life. This includes the general experience of elderly who consider their lives completed and no longer worth living. Next, an overview of the euthanasia law that is currently active in the Netherlands, as well as the origins of the completed life bill, will be outlined. Thereafter, the main contents of the completed life bill will be outlined and discussed. Lastly, how the completed life bill compares to euthanasia legislation in rest of the world will be shown. Together, these elements will provide the reader with more context surrounding completed life.

2.1 Euthanasia, assisted-suicide, and completed life

Euthanasia translates to 'a good death' from Greek. Euthanasia is the practice of bringing about a good death and is considered to be a type of "mercy killing" (Kuhse, 1992). Euthanasia is understood as an act in which person A brings about the death of person B because person A and person B both think person B is better-off dead (Young, 2019). Person A acts on the wishes of person B.

The World Federation of Right to Die Societies (n.d., p. 1) argues that there is a distinction between euthanasia and assisted-suicide, which comes down to "a degree of involvement". In case of euthanasia, physicians themselves would be *administering* the life-ending medication. In case of assisted-suicide, physicians would only be *providing* the life-ending medication. Throughout this thesis, I will use the term *assisted-suicide* (and not *euthanasia*) when discussing completed life, because it more accurately describes the life-ending process in the case of completed life. This will be confirmed further when the completed life bill is discussed later in this chapter.

Next, I will elaborate on the concept of completed life. This is the conception of completed life that I refer to throughout this thesis.

2.2 The concept of completed life

The term 'completed life' has multiple connotations like 'done living' or 'suffering of life'. Completed life involves a situation in which elderly consider their lives completed and no longer worth living. The concept of completed life generally describes 'people that often are

of considerable age and to their own insights conclude that they no longer have a positive outlook on life, and as a result have developed a continual and active wish for death' (Schnabel, Meyboom-de Jong, Schudel, Cleiren, Mevis, Verkerk, Van Der Heide, Hesselman & Stultiëns, 2016, p. 34). This comes down to a form of existential suffering which is not necessarily connected to any medical conditions.

This next part is a brief summary of the findings of Van Wijngaarden, Leget & Goossensen (2015, pp. 260-262) who have done a phenomenological study on the experiences of Dutch elderly who want to end their lives under the common denominator of completed life. The general experience of completed life entails being disconnected from your life, unable to recognize yourself in your life. The experience can be characterized as a continual struggle between how life is and how it *ought* to be or "*a tangle of [the] inability and unwillingness to connect to one's actual life*" (Van Wijngaarden, et al. 2015, p. 262, emphasis in original). The experience of completed life is formed through a few elements of ageing and the experiences that are paired with ageing. These are (1) loneliness, (2) the pain of not mattering, (3) not being able to express oneself, (4) multidimensional tiredness and (5) the fear of becoming dependent. These factors can turn life into suffering and can cause elderly to conclude their lives are completed and no longer worth living. To briefly elaborate:

First, (1) elderly experience loneliness because they lack meaningful relationships. Family and friends have passed away around them. Secondly (2), *all* elderly experienced the feeling that they do not matter anymore. Most started off their explanation of the feeling of completed life as being 'done' with life, but later expressed to be sad because they felt like life was done with them instead. For instance, they were sad because they were no longer needed to practice jobs they have done their entire lives. Thirdly (3), the inability to express oneself. Elderly can no longer do, due to physical deterioration, what they once did in their lives, which causes them to lose connection to the self, expressed by the phrase: "*this is no longer me".* Fourthly (4), elderly display physical and mental tiredness. They are tired from regular old age, as well as becoming increasingly tired with life through monotony and boredom. On top of that, they grow mentally tired from possibly living with regret, trauma and "continuous fretting" about "missed opportunities and disappointments" which becomes more pronounced "in the silence of old-age". Lastly (5), elderly experienced fear of dependence. Dependence itself is viewed as "an unacceptable, abhorrent condition devoid of

dignity". Most elderly concluded that they would want to end their lives if they ever became dependent on caregivers.

Now that the concept of completed life is clear, the next section will touch upon the euthanasia legislation that is currently active in The Netherlands as well as the origins of the completed life bill.

2.3 Euthanasia and completed life in The Netherlands

In 2002 euthanasia law was implemented in the Netherlands. This law gives people who are *suffering unbearably* and have *no clear sight of recovery* the opportunity to pass away prematurely. From age 18 and up, a euthanasia request can be made independently by the patient without parental consent or parental involvement. Moreover, a few requirements need to be fulfilled before the euthanasia request can be carried out. The physician needs to be convinced that the patient's decision for euthanasia is well-informed and voluntarily made. Furthermore, the physician must inform the patient about one's options and must conclude together with the patient that there are no reasonable alternatives to euthanasia. Lastly, the physician needs to have at least consulted one other independent physician who also judges and approves the patient's request for euthanasia (Rijksoverheid, n.d.). Besides this, the physician also has the independent authority to decide to either continue the treatment or not continue the treatment. There is no 'right' to euthanasia in the Netherlands. After the treatment is done, the case is reviewed by a joint ethical, judicial and medical commission to ensure the rules have been followed (Rijksoverheid, n.d.).

Euthanasia and assisted-suicide are punishable offenses with maximum prison sentences of twelve and three years respectively when done without having fulfilled all the before mentioned conditions (Rijksoverheid, n.d.). The debate about the enlargement of the euthanasia law was fuelled in 2008, following the events of the so called Heringa-case. Albert Heringa was found guilty of assisting a suicide because he did not fulfil the required conditions while helping his 99-year-old mother (who considered her life 'completed') to pass-on (De Graaf, 2018).

In 2009, following the case, a group of well-known Dutch citizens launched an initiative called: 'Out of Free Will'. They pleaded that for people age 70 and up, self-determination, and not medical suffering, should be the most important value guiding life-ending decisions (Dijkstra, 2016, pp. 9 & 10). They also pleaded for an expansion of the euthanasia law as they

argued that existential suffering fell outside of the current medical restrictions of the euthanasia law.

Following the initiative, the discussion surrounding the societal need for an expansion of the euthanasia law picked up steam. Two political parties, D66 and GroenLinks (Green-socialists), opposition parties at the time, showed their political support for the initiative in 2012 (Dijkstra, 2016, p. 10). Afterwards, the seated government agreed the current euthanasia law was not inclusive enough, in other words, did not offer enough room to accommodate the many diverging cases of completed life, and showed their support for the initiative (Rijksoverheid, 2016).

Next, I will briefly present the main contents of D66's completed life bill.

2.4 D66's completed life bill

With the completed life bill, D66 wants to help elderly, from age 75 and up, who consider their lives completed and no longer worth living, with the process of dying. 'Protection of life' is important, but is not the primary guideline in this issue, because a good end-of-life has become more important (Dijkstra, 2016, p. 13). According to D66, the 'autonomy' of persons to decide their own fate is the prime focus (Dijkstra, 2016, p. 15). Autonomy should be the supreme value when it comes to life-ending decision-making, because elderly should have the right to be in charge of their own lives (Dijkstra, 2016, p. 12). The goal of the bill is to make life-ending medication more easily accessible to elderly by taking away (legal) barriers (Dijkstra, 2016, p. 16).

Still, D66 argues for some safety conditions that need to be fulfilled to ensure the law is executed with great care. These conditions have to be checked by an independently trained 'end-of-life supervisor', instead of a traditional physician, because it is argued that 'suffering of life' falls outside of the scope of expertise of the traditional physician (Dijkstra, 2016, p. 21). There are three conditions in total. These have to do with authenticity and due diligence. The first two are about authenticity while the last one is about due-diligence. The request for assisted-suicide must, first, be *voluntary*, secondly, be *well-considered (e.g. informed)*, and thirdly, be *durable*. The two conditions on authenticity are there to make sure that an elderly person requesting assisted-suicide does not act against one's own will. The durability condition is there to make sure that the request for assisted-suicide is not a temporary impulse, but is enduring (Dijkstra, 2016, p. 25). The two conditions regarding authenticity will

be checked through two mandatory conversations with elderly, in which the reasons behind their death wishes are explored (Dijkstra, 2016, p. 25). The conversations must take place over a course of at least two months. The two-month period is there to test if the end-of-life requests are durable (Dijkstra, 2016, p. 28). Furthermore, during these conversations, the supervisor must ask elderly if they are open to alternative solutions other than assisted-suicide. The supervisor can also propose possible solutions to the suffering of elderly. However, these solutions are only explored when the elderly person in question desires this (Dijkstra, 2016, p. 25). If the safety conditions have been fulfilled, the supervisor can *provide* but not administer the life-ending medication.

Now that the main contents of the bill are clear, I will very briefly analyse the bill in the next section.

2.5 Paternalism in the D66 bill

Even though the goal of the new bill is to further liberalize the process for assisted-suicide, the bill still has paternalistic elements in it.

First, there is the presence of the age-requirement. Individuals below the age of 75 are not allowed to apply for assisted-suicide. Dijkstra argues that people from age 75 and up have lived through the most significant part of their lives and are, with their life-experience, best able to judge whether their lives are still worth living or not. Even though they might not agree with this idea, younger people do not qualify for assisted-suicide in the case of completed life because a lot of unexpected things can still happen in their lives which can change their outlook on life (Dijkstra, 2016, p. 24). This age-requirement is a hard-paternalistic requirement. With this bill, the government would restrict the voluntary decisions of its younger citizens to protect the well-being of those same citizens.

Secondly, there is the mandatory step in the end-of-life process where the end-of-life supervisor is required to hold two conversations with elderly, in which they explore the reasons elderly have for wanting to die prematurely. This is to make sure that elderly make life-ending decisions that are authentic. If not convinced of the authenticity of the life-ending decision, the supervisor can deny requests for assisted-suicide by elderly for their own good. The safety conditions of authenticity are soft-paternalistic in nature. The supervisor must (temporarily) interfere to confirm that requests for assisted-suicide are voluntary and well-considered (e.g. informed).

Lastly, there is the mandatory (waiting) period of two months to test the durability of end-of-life requests. I would argue that the safety condition of durability is a temporary hard-paternalistic condition. It is hard-paternalistic because the supervisor would restrict the voluntary decisions of individuals for the good of those same individuals. It is for their own good because it protects them from ending their lives based on a temporary impulse.[4]

In the last section of this chapter, I will discuss how the completed life bill compares to euthanasia legislation around the world.

2.6 Euthanasia around the world

There are many diverging types of euthanasia legislation around the world. All of them controversial and heavily debated. Countries that are not mentioned here do not have legislation on the subject, are ambiguous on the subject because they do not have proper legislation[5] or have legislation that specifically forbids euthanasia at the time of writing. In most countries euthanasia and physician assisted-suicide are strictly illegal. At the time of writing this thesis, active euthanasia[6] and physician assisted-suicide are legal in The Netherlands, Belgium (FPS, n.d.), Australia (Baidawi, 2017), Canada (GOC, n.d.; Laurence, 2017) and Luxembourg (Atwill, 2008; Baklinski, 2009). In Colombia (Tegel, 2015) and Mexico City (Xinhua, 2017), only active euthanasia is legal. The practice of physician assisted-suicide alone is legal in parts of the United states of America (CNN, 2017; Gambino, 2014; Hendin, 1998), Germany (DW, 2011; Laurence, 2015; Oltermann, 2014), Switzerland (Harrison, 2017; Oltermann, 2014) and Finland (Lehto & Topo, 2012). Solely passive euthanasia[7] is legal in France (The Guardian, 2016; Willsher, 2014), the United Kingdom (Harrison, 2017; Kamouni,

[4] After discussing the autonomy-paternalism debate I will present my judgement on the completed life bill in the concluding chapter (§5.2).

[5] Japan is an example of this because the country has alternately allowed euthanasia through court rulings. These rulings have been used as a legal guideline for euthanasia, but the situation is still very much ambiguous because there is no official legislation (Hongo, 2014).

[6] Active euthanasia means that the physician actively administers a lethal substance to the patient (BBC, n.d.).

[7] Euthanasia is considered to be passive when the physician omits something that leads the patient to die. This could entail removing a life-support system or not performing life-extending surgery on someone, allowing one to pass away (BBC, n.d.).

2017), Sweden (SAPA-AFP, 2010); Mexico (Xinhua, 2017); Ireland (HSE, n.d.) and South Korea (Chang, 2016).[8]

In every country where any type of euthanasia or physician assisted-suicide is legal, *strict* medical conditions must be fulfilled. Terminal illness or at least unbearable and incurable suffering must be present for patients to qualify for euthanasia and assisted-suicide. The new completed life bill in The Netherlands does not opt for these strict medical requirements. This makes this legislative proposal unique in its kind, significantly pushing the boundaries of what is acceptable in already controversial discussions on euthanasia and assisted-suicide.

Now that the background of completed life is clearer, I will continue by discussing the first side of the theoretical debate that is underlying the completed life bill, which is the argument from the side of *autonomy.* In the next chapter, John Stuart Mill will be analysed because he is one of *the* primary authors that introduced the tension between personal autonomy and state paternalism.

[8] In countries where active euthanasia is legal, passive euthanasia is also allowed.

CHAPTER 3: THE AUTONOMY OBJECTION TO PATERNALISM

In this chapter I will outline and discuss the autonomy-paternalism debate from the side of autonomy. John Stuart Mill, originator of the modern-day perspective for respecting personal autonomy, will be discussed as the primary defender of the 'respect for autonomy' position.

In this chapter I will start with a brief introduction on Mill's upbringing and theoretical background. Next, I will outline the most important parts of his work *On Liberty* (1859/2001) to present the position that Mill defends against paternalism. Afterwards, I will extrapolate from Mill's framework what Mill would most likely have thought about (assisted-)suicide in the case of completed life.[9] Lastly, I will conclude with my thoughts on Mill's framework when applied to completed life and discuss *to what extent Mill's framework of liberty and autonomy is appropriate in the case of completed life.*

3.1 John Stuart Mill

John Stuart Mill (1806-1873) was one of the most influential political philosophers of all time. He is one of the visionaries that has laid the groundwork to the account of liberalism as we know it today. His way of thinking and his theoretical contributions were heavily influenced by his upbringing. Mill was raised in a peculiar way by his father James Mill and his godfather Jeremy Bentham. James Mill and Bentham were devoted to an intellectual project of government, management and morality and they wanted James's son John Stuart to carry on, evolve, and complete this project. They were working on a decision-making system that could give coordination to a society of individuals.

Bentham and James Mill endorsed utilitarianism, which was an important aspect of their governance project. Utilitarianism is the theory of utility. The theory prescribes that decisions are morally correct when they result in the maximum amount of utility (Wolff, 1996, p. 53). Utility is understood as happiness. A morally good utilitarian decision would be a decision that results in the largest amount of total happiness. Bentham developed a method of calculation, with which one could determine what decisions would result in the largest amount of total happiness. This calculation involved calculating happiness by determining the amount of pleasure and pain of an action. Bentham argued that the government should be run through "the greatest happiness principle" (Ryan, 2013, p. 696). Which meant that the

[9] Mill has not specifically discussed (assisted-)suicide in any way.

maximum amount of happiness was to be achieved by maximizing pleasure and minimizing pain. This was the supreme rule to be followed, even over human rights. Freedom was important, but only insofar it brought pleasure. We should not have the freedom to make ourselves miserable according to Bentham (Ryan, 2013, p. 698). Utilitarianism is a theory of *consequences,* in which the ends justify the means. If the greatest amount of happiness means sacrificing freedom, so be it. Before I discuss what John Stuart Mill thought about Bentham's utilitarianism, it is important to look at his upbringing and how it influenced his writing.

John Stuart Mill was taught according to the ways of "Benthamism", a rational education based on the philosophy of Bentham, with the purpose and hope that the young Mill would carry on this legacy (Ryan, 2013, p. 699). At age 19, the young Mill suffered an existential crisis resulting in a depression. After working with Bentham's theories for a long time, he asked himself: does this theory of the maximization of happiness apply to me? Could I receive happiness from following the theory? The answer was no (Ryan, 2013, p. 701). It must have felt paradoxical that the theory of happiness he had devoted his life to did not bring him happiness. Bentham's utilitarian theory was a theory that brought happiness to *others*. *Mill had a sore need to escape his tutors shadow and determine what he himself thought was important in his own life.* Although he stuck with the general idea of Bentham's utilitarianism, Mill adjusted the theory so that it matched his new outlook on life.

First, in Bentham's theory, there was no room for autonomy. There was no way to determine what you personally think is of worth in life, and there was no guide to self-development in Bentham's utilitarianism (Ryan, 2013, p. 702 & 709). The total amount of public welfare was all that was important. Mill thought that autonomously determining what is good in life, what you yourself think brings you pleasure and pain, was of supreme importance in maximizing happiness. Accordingly, Mill argued liberty was the most important instrument to happiness (Ryan, 2013, p. 708).

Secondly, Mill endorsed an "indirect" version of utilitarianism (Wolff, 1996, p. 130). While Bentham's theory was predominantly focused on *act utilitarianism,* which is a direct version of utilitarianism, Mill's theory was predominantly based on *rule-utilitarianism,* an indirect version of utilitarianism. Both moral theoretical frameworks have the maximization of utility as their prime goal. However, while act-utilitarianism focusses on the direct utility of actions and judges each action case-by-case accordingly, rule-utilitarianism focusses on the maximization of utility through rules. According to rule-utilitarians, actions are morally

justified when they are in accordance with an accepted moral rule. Furthermore, the moral rule is only adopted, if and only if, it's adoption would lead to a larger amount of total societal utility compared to a situation in which the rule was not adopted (IEP, n.d.). Accordingly, based on his indirect utilitarianism, Mill supports a system of rights based on the harm-principle. Adhering to the harm-principle (as a moral rule) would lead to a maximization of individual and societal welfare. Rights derived from the harm-principle include a right not to be harmed, and a right to personal autonomy, which will be discussed shortly.

3.2 On liberty: introduction

Now that it is clear what Mill's educational and theoretical background is, I will continue by discussing Mill's work *On Liberty* to situate the respect for autonomy position against paternalistic action by the state. In *On Liberty*, Mill developed a theory of liberty. Here, he investigated the concept and limits of *individual liberty*. The central question that Mill investigates in *On Liberty* is: what is the extent to which society can legitimately exercise power over an individual by forcibly restricting individual freedom? This touches upon the exact crux of the completed life issue. Should the decision to die be your own, or are limitations in order?

Even though Mill argues for the importance of 'freedom' in all human endeavour, Mill argues for some limits to individual freedom in name of individual well-being, as will become clear shortly. Freedom is an instrumental value in Mill's work. Freedom is an instrument necessary for fostering the most amount of happiness in society. Happiness is the only intrinsic value in Mill's framework, while freedom is not (Wolff, 1996, p. 138). If too much liberty were to have detrimental consequences for society, limits are in order according to Mill.

3.3 The harm-principle (1): preserving freedom

For people to be happy, they need to rule their own lives, and to be able to rule their own lives, they need to be free (Mill, 2001). There is almost no instance in which the government can tell people what to do. The personal preferences of individuals should be enough reason for them to do as they like, because following your own preferences is the only thing that provides happiness for ordinary people. Freedom in this sense is not only beneficial for individuals and their happiness but also for the development of society. Society improves the most when free people live inside it. As Mill himself put it best: "mankind are greater gainers by suffering each other to live as seems good to themselves, than by compelling each to live

as seems good to the rest" (Mill, 2001, p. 16). Yet, there are a few limits to this freedom. One of these is captured by the 'harm-principle'. Individual freedom is the source of happiness for people, and this individual freedom needs to be protected:

> "That principle is, that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant." (Mill, 2001, p. 13).

This means that the only instance where the government can restrict someone's liberty, by way of coercion, is if it can reasonably presume that the action of an individual will cause another harm. The state should let individuals do whatever they want as long as they do not harm anyone else in the process. A clear example of the harm-principle in action would be: drinking and driving. If one wants to drink oneself to the brink of death, then this should be allowed. However, if this person, in a drunk state, should want to drive a car, then the state should be able to go to lengths to prevent this, because the individual will be a danger to others.

Furthermore, people can have good or reasonable opinions about how other individuals should lead their lives. Therefore, Mill does not forbid individuals from trying to reason with others or persuade others from doing the things they do. For instance, health-experts might possess valuable information about the dangers of drinking. These experts could beneficially advise individuals to always drink in moderation. Yet, these external opinions should never be able to compel other individuals against their will. For Mill autonomy is an absolute right. "Over himself […] the individual is sovereign" (Mill, 2001, p. 13). Before getting more into this right and how far it extends or narrows through a definition of harm, it is important to touch upon what Mill argued in cases of self-harm.

3.3.1 Self-regarding and other-regarding harm

In general, as is probably clear from the last quote, self-harm is not a valid reason for inference. The state cannot legitimately interfere with an individual who wants to do something to one's own body or mind, as long as the action in question does not affect others (Mill, 2001, p. 13). Based on the way in which Mill speaks about non-interference in in cases of self-harm, David Brink (2014) notes that Mill primarily talks about 'non-consensual' harm

that is at the basis of the harm-principle. Where there is harm being done to individuals that have consented to the harm being done to them, no legitimate complaints by external actors can be made. From their consent we must assume that this mischief is what individuals desire for themselves. The key idea here is that the harm is completely *self-regarding*. Mill states:

> "[…] neither one person, nor any number of persons, is warranted in saying to another human creature of ripe years, that he shall not do with his life for his own benefit what he chooses to do with it. He is the person most interested in his own well-being: the interest which any other person, except in cases of strong personal attachment, can have in it, is trifling, compared with that which he himself has […]." (Mill, 2001, p. 70).

Mill states that, from a certain age, individuals should be able to do what they want with their lives without the possibility of interference by external actors. Mill is not trying to suggest that individuals are isolated entities who should not concern themselves with others. On the contrary, Mill admits that the actions of individuals do affect their fellow citizens. Morality is about the relationships we have with those around us. Individuals should be able to condemn the actions of other individuals. However, external actors do not have significant reason to interfere with the liberty of an individual in case of solely self-regarding harm.

Self-harm becomes a problem when it also causes harm to others, because then the action will become "*other-regarding"* and is not strictly self-regarding anymore (Wolff, 1996, p. 124, emphasis added). There are situations in which self-harm by an individual can lead to harming others, by for example endangering others with reckless driving. One can thus effectively harm others through self-harm. This tells us something about the extent of the right to autonomy as introduced earlier.

3.3.2 A definition of harm

The right to autonomy is restricted based on what we would define as 'harm' that can be caused by an individual to another individual. It is important to specifically define 'harm' because it influences the extent of a person's freedom. Mill argues that:

> "Each [person] should be bound to observe a certain line of conduct towards the rest. This conduct consists […] in not injuring the interests of one another; or rather certain interests, which, either by express legal provision or by tacit understanding, ought to be considered as rights" (Mill, 2001, p. 69).

> "Whenever, in short, there is a definite damage, or a definite risk of damage, either to an individual or to the public, the case is taken out of the province of liberty, and placed in that of morality or law" (Mill, 2001, p. 75).

On this account of harm, one can be forcibly restrained or punished if one's actions injure, or risk injuring, the legal or moral *rights-based interests* of others. Harm or self-harm, through drunk-driving, can injure the rights-based interests of others as already mentioned. But rights-based harm can also go beyond (the reasonable presumption of) direct physical injury. Individuals also bear social obligations towards others. Mill states:

> "I fully admit that the mischief which a person does to himself may seriously affect […] those nearly connected with him and, in a minor degree, society at large. When, by conduct of this sort, a person is led to violate a distinct and assignable obligation to any other person or persons, the case is taken out of the self-regarding class, and becomes amenable to moral disapprobation in the proper sense of the term" (Mill, 2001, p. 75).

If individuals violate *distinct and assignable* social obligations to other persons through self-harm, society should be able to punish or restrain these individuals. Mill does not fully explain what he means by distinct and assignable obligations. He does, however, offer some examples which provide clarification. Mill argues that police officers should not be drunk on duty. If they are, then they should be punished because their actions can have damaging consequences to others. Similarly, if others are financially dependent on you (e.g. children or a creditor), you should not incapacitate yourself, because you risk major damage to those dependent on you (Mill, 2001, p. 75). What in my view becomes clear from the examples is that distinct and assignable obligations are created when individuals take up significant or weighty social responsibilities. With significant or weighty I mean that the safety and livelihood of others are dependent on the individual.

Furthermore, Mill states that persons with "strong personal attachment" might be interested in the self-regarding or self-harming decisions of others (Mill, 2001, p. 70). This is because they could be deeply concerned about well-being of a person they have a strong connection with. Still, the interests that these individuals might have are not significant enough to warrant interference with the liberty of another. Psychological harm and offense do not constitute interference because individuals are not responsible for harm caused to the

feelings of other persons (Mill, 2001, p. 77). Psychological harm and offense are not part of rights-based harm.

In summary of the harm-principle as discussed so far, the government cannot interfere with the (self-regarding) actions of an individual as long as these actions are consensual and do not harm or risk harm to the rights-based interests of other individuals. Next, I will discuss the second part of Mill's harm-principle, which is specifically about paternalism.

3.4 The harm-principle (2): paternalism

Now that Mill's ideas about freedom and its restraints have become clear, his view on paternalism will be discussed. Again, the harm-principle states:

> "That principle is, that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant." (Mill, 2001, p. 13).

It becomes clear from the last sentence of the harm-principle that Mill was an opponent of paternalistic actions by the state. The state can only interfere with the liberty of action of individuals to prevent them from doing harm to others, their "own good" does not warrant interference.

3.4.1 Autonomy, individuality, and happiness

At first sight, Mill objects to any interference with the autonomy of individuals by the state for reasons of well-being. In other words, an objection to any form of paternalism. This is further substantiated in the following statements in *On Liberty:*

> "[…]with respect to his own feelings and circumstances, the most ordinary man or woman has means of knowledge immeasurably surpassing those that can be possessed by any one else. The interference of society to overrule his judgment and purposes in what only regards himself must be grounded on general presumptions; which may be altogether wrong, and even if right, are as likely as not to be misapplied to individual cases, by persons no better acquainted with the circumstances of such cases than those are who look at them merely from without. In this department, therefore, of human affairs, Individuality has its proper field of action." (Mill, 2001, pp. 70-71).

> "All errors which he is likely to commit against advice and warning are far outweighed by the evil of allowing others to constrain him to what they deem his good." (Mill, 2001, p. 71).

No one, except individuals themselves, can understand their own feelings, because they are the only ones who experience what they experience. The way someone feels about one's job, marriage, achievements, or any other aspect of one's life is incomparable to how anyone else might feel about them. If the state were to interfere in this personal experience, there is a good chance that it acts wrongly, which amounts to doing more evil than good. Mill states: "If a person possesses any tolerable amount of common sense and experience, his own mode of laying out his existence is the best, not because it is the best in itself, but because it is his own mode" (Mill, 2001, p. 63). This quote captures the essence of Mill's account against paternalism. Individuals should be allowed to be in charge of their *own* lives, because the expression of their differing individualities is what brings them happiness.

Furthermore, when individuals make their own choices, they must use their own reasoning, make their own judgements, and exercise self-control, which helps them with becoming better persons. To follow other people, you only need the ability to 'imitate' which diminishes your worth as a human-being (Mill, 2001, p. 55). According to Mill, human nature is not supposed to be a pre-programmed machine, but a living organism waiting to grow and to be developed. It is better to make autonomous choices, even if they are mistaken. These choices and mistakes make one grow as a person and gives one character, compared to living a risk-free or pre-programmed life.

3.4.2 Incompetence, rationality, and (soft-)paternalism

Even though Mill, in the general sense, does not allow paternalism for the reasons mentioned previously, there are some cases in which he does allow or even thinks it is a moral obligation to act paternalistically. One of these situations is with *incompetent* individuals. For instance, paternalism is allowed with children who have not yet reached the age of maturity. Children cannot properly think for themselves yet and require protection "against their own actions as well as against external injury" (Mill, 2001, p. 14). Furthermore, next to children, Mill included another group of incompetent individuals that might need (temporary) paternalism. Adults that have not yet reached a threshold of "normative competence" also need to be assisted in their decision-making (Brink, 2014). To make them more normatively competent, some development of their rationality is in order. Mill argued that good quality primary and

secondary education and civic participation are factors that can improve the normative competence of individuals (Brink, 2014). At first sight, this seems like a very strange condition in the pro-freedom doctrine that Mill advocates. Earlier, I showed that Mill argued that people should be allowed to make their own decisions even if they make wrong decisions. This is still true. Mill does not require individuals to make perfect decisions. Yet, at the same time, Mill is in favour of the argument that liberty is only useful for individuals when they can use it properly. For Mill, liberty is an instrument for individual happiness and societal progress, but only if used correctly (Wolff, 1996, p. 118). Only when a certain level of normative competence is reached can liberty be a valuable instrument to happiness. But when they finally are sufficiently normatively competent, when they have developed "mature deliberative faculties" (Brink, 2014), coercion in the form of paternalistic action is no longer permissible. The level of normative competence that individuals need to have before they can properly exercise their autonomy, seems to be a *minimal* level of normative competence. For Mill, individuals need to have a tolerable amount of "common sense" before we can assume that their autonomous choices are best for maximizing individual and societal happiness (Mill, 2001, p. 63).

Furthermore, (temporary) coercive paternalistic interference might even be a duty in certain situations according to Mill. Mill explicitly states that one could also be held responsible by society for not doing one's duty when failing to help a fellow citizen that might be in danger (Mill, 2001, p. 88). Helping is a duty in at least life-threatening situations. The example that Mill provides is commonly known as the 'broken bridge' example.

If you saw a group of individuals attempting to cross a bridge that was about to collapse and you have no time to check on their awareness about the impending danger[10], it is in the interest of the crossing individuals to forcibly hold them back from the bridge (Mill, 2001, p. 88). Mill argues there is no infringement of individual liberty here, because interference with one's liberty is defined as acting against someone's will, and one can reasonably assume that falling down a broken bridge is not something that one would want (Mill, 2001, p. 88).

[10] Awareness in the sense of 'knowing' about the danger at hand, but also awareness in terms of having proper control of your reflective faculties. The individuals that are about to cross the bridge should not be immature (e.g. child) "or delirious, or in some state of excitement or absorption incompatible with the full use of the reflecting faculty" (Mill, 2001, p. 88).

However, after the individuals have been made aware of the impending dangers, interference is off-limits again. Normatively competent individuals are the best judges of the risks they undertake.

3.4.3 Forfeiting liberty and (hard-)paternalism

An instance where Mill would argue for the interference with the autonomy of individuals is for the sake of their own autonomy. This might seem paradoxical at first but is defensible in Mill's framework. This is a special case in which Mill allows hard-paternalism. In other words, a case in which he allows paternalistic interference with the voluntary decisions of normatively competent individuals. This case is: slavery. This concerns, again, the element that Mill thought persons absolutely needed to possess to be able to lead happy lives, which is 'liberty'. Autonomously choosing to relinquish one's freedom is to defeat the purpose of being free:

> "He is no longer free; but is thenceforth in a position which has no longer the presumption in its favour, that would be afforded by his voluntarily remaining in it. The principle of freedom cannot require that he should be free not to be free. It is not freedom to be allowed to alienate his freedom." (Mill, 2001, p. 94).

First, being a slave defeats the purpose of the harm-principle which is to preserve liberty. Secondly, once individuals become slaves and their freedom has been relinquished, they cannot revert to their original state of independence anymore. There is a point of no return here. Individuals becoming slaves have no autonomy anymore, which would be demeaning of their human nature (Archard, 1990, p. 456). One could argue that denying a person's free choice to become a 'happy' slave might allude to the possibility that Mill values liberty intrinsically and not just instrumentally because possible happiness is denied in favour of liberty. However, this is not necessarily the case. Someone who leads the life of a slave, leads a life in which liberty is inherently of lesser instrumental value than that of a free person (Archard, 1990, p. 458). This means one cannot be an optimally happy slave within the Millian framework. If one is unfree, happiness cannot be maximized. This would validate forbidding slavery in Mill's framework, because it is harmful to the instrumental value of liberty and consequently harmful to the intrinsic value of happiness.

In conclusion of the second part of the harm-principle, the government cannot interfere with the autonomy of individuals for reasons of well-being because individuals know what's best for themselves; under the conditions that they are normatively competent, ripe

of years, aware of what they are doing and not forfeiting their liberty in the process. In case of incompetence, immaturity, and unawareness, temporary interference (soft-paternalism) is allowed, in case of forfeiting autonomy, full interference (hard-paternalism) is allowed. Now that Mill's liberal utilitarian framework of liberty and autonomy has been outlined, I will continue by extrapolating from Mill's views to determine what Mill would have thought about (assisted-)suicide in the case of completed life.

3.5 Mill and completed life

Mill has not specifically discussed (assisted-)suicide, but by following the framework he has laid out, it might become clear what he would have thought about (assisted-)suicide in the case of completed life. Of course, this is somewhat speculative, but the point is to flesh out a position that is fully consistent with Mill's liberalism.

To start off, (assisted-)suicide can without question be subsumed under the notion of self-harm. In the case of completed life, individuals would administer the life-ending medication themselves which makes it directly self-harm. As for self-harm, Mill argued that individuals should be the masters over their own bodies and minds as an integral part of autonomy and happiness.

Thus, at first sight, Mill would argue, in accordance with the notion of self-harm and the harm-principle as discussed earlier, that as long as one's decision to die is self-regarding, consensual, and does not harm the rights-based interests of other individuals, and as long as one does not forfeit one's liberty in the process, the (assisted-)suicide of an aware, mature and normatively competent individual does not warrant inference by society. But the crux of Mill's reasoning on self-harm, lies in the part on forfeiting one's liberty.

One could argue that with suicide, individuals are forfeiting their liberty, just like with slavery. There is a similar point of no return here that Mill could be opposed to. Suicide could be subsumed under this special case of self-harm in which individuals are using their liberty to never make use of their liberty again. If this comparison is correct, then suicide should also warrant hard-paternalism in Mill's framework. However, as will become clear, there are some key differences between the two cases which make suicide permissible and slavery impermissible according to Mill's own criteria.

First, a major difference between slavery and suicide is the possibility of making "future choices" (Archard, 1990, p. 458; Dworkin, 1972, p. 76). When individuals voluntarily choose to

enslave themselves, they are, henceforth, not able to make any future choices for the rest of their lives. Making an independent choice "*now* (to become a slave) is clearly outweighed by the evil of being unable, *ever afterwards,* to choose" (Archard, 1990, p. 458, emphasis in original). When individuals are enslaved, they will henceforth lead unfree existences. The value of their freedom is diminished for the rest of their lives. However, when one commits suicide, one's existence is nullified. Concretely, in the case of suicide, individuals do not put themselves in a position where their freedom is diminished by a lack of choice. The consequences of the decision to die do not reflect the negative nature of the consequences of the decision to enslave oneself.

Secondly, even though Mill clearly values a free life over an unfree one, Mill never alludes to the fact that a free life is always better than non-existence (Archard, 1990, p. 463). A free existence is not an imperative over any other state of existence other than an unfree one. A free life is useful insofar it brings happiness. When the value persons get from their free existence is diminished, they might have reasons to end their lives prematurely. To elaborate, freedom is *only* an instrumental tool to happiness according to Mill. When freedom is not helpful in the quest to happiness anymore, the instrumental value of freedom is diminished. When the pleasure of a free existence is overshadowed by the pain of existence, there might be a utilitarian case for a premature non-existence. In the case of completed life, one has done what one wanted to do in one's temporary stay on earth, which can result in having little pleasure left to go on. Or maybe individuals can no longer do what they loved to do before, due to physical or mental impairment that is caused by old-age. In these cases, the pains of life, or the pain of knowing you will not be able to experience any of your (previously favourite) pleasures anymore, might eclipse the pleasures, if any at all, that are left in life. In cases where one thinks that one's freedom cannot be put to sufficient use anymore, by calculation of utility, and in light of personal judgement, Mill would most likely argue that

there is sufficient cause for a premature life-ending decision.[11] If freedom is still to be of any use in the case of completed life, the life-ending decision could be the ultimate and final use of liberty as a tool for minimizing pain by way of non-existence.

Thus, I would contend that Mill's judgements in the cases of slavery and suicide would be different after all. Suicide would most likely not warrant hard-paternalism like slavery would.

3.6 Autonomy and completed life: reflection

Now that it has become clear what Mill's thoughts on (assisted-)suicide in the case of completed life would most likely have been, I will discuss Mill's framework to answer the question: *to what extent is Mill's framework of liberty and autonomy appropriate in the case of completed life?*

3.6.1 To what extent is Mill convincing?

Mill's general framework enjoys some empirical support. Especially among wealthy nations, it is shown that the level of happiness is higher when the level of freedom is also higher (Haller & Hadler, 2004; Rahman & Veenhoven, 2018; Veenhoven, 2000, p. 257). Furthermore, one study shows that the factor "capability" is important to the relation between freedom and happiness (Veenhoven, 2000, p. 257). When elevated levels of freedom (chance to choose) and the capability to use this freedom (information and inclination) are present at the same time, levels of happiness are higher among wealthy the nations.[12] As such, it seems that free

[11] At one point, Mill argued that certain pleasures should be valued higher than other pleasures (Ryan, 2013, p. 714). For Mill, pleasures that involve human activity (e.g. intelligent conversation) are qualitatively better than pleasures which animals can also enjoy (e.g. eating and sex). This would mean that individuals who are not able to enjoy these higher, more rewarding pleasures anymore, could make a better case for having a completed life. However, what is more likely in this situation is that Mill would argue against the idea of the ranking being used as a system of judgement by external parties, because these pleasures and pains are grounded in deep personal experience, which cannot be judged by external parties.

[12] A notable exception is "economic freedom", which, in tandem with "capability", has a negative effect on happiness in wealthy nations (Veenhoven, 2000, p. 257).

and competent individuals, especially in wealthy nations, would be in the best position to determine what makes them happy.

Furthermore, the liberal utilitarian case that can be made in favour of the autonomous life-ending decision in the case of completed life, based on Mill's theoretical framework as shown earlier (§3.5), seems to enjoy support among the Dutch population. Again, by calculation of utility, and in light of personal judgement, Mill would most likely have argued in favour of respecting autonomy with regards to the life-ending decision in the case of completed life when this would lead to higher levels of happiness (or more accurately, lower levels of pain). It is shown that 63% of the Dutch population thinks that a law that enables elderly to receive aid-in-dying, when elderly themselves think their lives are completed, should be implemented (Azaaj & Verheggen, 2017, p. 17). Among the proponents of the autonomous life-ending decision it is most commonly argued that individuals should not be able to impose their opinions on others (Azaaj & Verheggen, 2017, p. 15).

Moreover, I think Mill's argument for a moral right to autonomy resonates well with individuals who argue for an autonomous life-ending decision in the case of completed life because the reasons for suicide can be subjective. Understanding can go a long way, but I would agree with Mill that it is impossible to fully understand another human being's experience of life. Following Mill's insights on the subjectivity of human experiences, I would argue that personal autonomy should indeed, to a certain degree, be respected in the case of completed life. The state can have interesting ideas about how its citizens should lead their lives, but in the end, autonomy should be respected because it must be concluded that external actors can never fully understand the pain that individuals experience. Individuals seem to be in the best position to determine what course of action brings them happiness (or minimizes their pain).

Yet, even though I agree autonomy deserves respect in the case of completed life because understanding by external actors can *eventually* be lacking, I want to argue, contrary to Mill, that it is not impossible for external actors to *initially* aid individuals in deciding what is valuable to them through paternalistic measures, thereby positively impacting individual well-being. In what follows, I will discuss the appropriateness of Mill's framework of liberty and autonomy for maximizing individual well-being in the case of completed life in two ways. First, I will argue that Mill's general liberal utilitarian framework when applied to completed life (as outlined in §3.5) is sub-optimal for maximizing individual well-being because it does

not protect individuals from acting on episodic preferences for (assisted-)suicide. Secondly, I argue that Mill's minimalistic conception of normative competence for the use of autonomy is also sub-optimal for maximizing individual welfare, because it does not sufficiently protect individuals from possibly mistaken preferences for (assisted-)suicide in the case of completed life.

3.6.2 Autonomy, temporary preferences, and individuality

As mentioned earlier, in accordance with Mill's liberal utilitarian framework, if one thinks that one's freedom cannot be put to sufficient use anymore, by calculation of utility, and in light of personal judgement, Mill would most likely have argued that there is sufficient cause for a premature life-ending decision. The life-ending decision could be the ultimate and final use of liberty as a tool for minimizing pain by way of non-existence.

In my view, the weighing of pleasures and pains in Mill's framework rationalizes the short-term commitment to (assisted-)suicide and grounds the life-ending decision as the only option left to diminish pain. I would argue that the conviction to die, when based on a momentary calculation of pleasures and pains, is a weak conviction. The contemporary desire to die is a weak one, because desires can be fluid and can change through time depending on circumstance (FitzGibbon, 1997, p. 224). The conviction to die is based on the prediction that the pleasures in life are always going to be overwhelmed by the pains in life based on a singular moment in time. The chance that life might become better, through diminished pains or discovering new pleasures, is ignored in this calculation, because the calculation is a snapshot of a temporary life-state. The individual preference for prematurely ending life, even though sprung from intricate personal circumstances and experiences, might be *episodic*. If this is true, then I think we should be wary of conceiving of suicide as what Mill would call, a vital expression of individuality.

For Mill, suicide can be an expression of individual character. A mode of existence, or non-existence, that one has chosen for oneself. The expression of this mode is what would bring the individual happiness (as a minimization of pain in death). Even though this could be true, I think it should also be considered that choosing death is not necessarily a specific expression of individuality, because it could also be an expression of circumstances which might be subject to change. Completed life could be an expression that flows from temporary

circumstances that one finds oneself in, which means it might not be an expression that reflects one's true individuality, or true character.

To shield people who consider their lives completed and no longer worth living from committing suicide based on episodic preferences sprung from temporary circumstances, I want to propose a restraint on immediate autonomous decision-making in the form of a temporal-requirement. I would argue for the institution of a mandatory waiting period before suicidal individuals receive life-ending medication to test if their convictions to die are strong ones (e.g. not based on momentary or fluid impulses). The duration of this waiting period would be difficult to universally determine. I would reckon that the duration should be determined individually. The personalities of individuals, and the circumstances individuals find themselves in, differ, which influences the time it takes to determine if their preferences for (assisted-)suicide are temporary or not. However, I cannot say anything final on the specifics of this waiting period because this is not the domain of political theory. It would be wise to leave further elaboration of this proposition to the medical professionals trained to determine such matters (e.g. psychologists and physicians).

Next, I will discuss how Mill's minimalistic conception of normative competence for the use of autonomy is sub-optimal for maximizing individual welfare in the case of completed life.

3.6.3 A heightened standard of rationality

One could argue that autonomy should not in and by itself have high moral standing because it can lead to stupid and despicable behaviour when used wrongly. Autonomy should not be left unchecked. Even though one would experience one's life in one's own way, this should not mean the right to self-determination is an absolute right. Initially, Mill seems to eliminate this criticism by construing autonomy as a capacity. Individuals need to be normatively competent so that they can properly decide on their preferences. This, to an extent, makes sure that autonomy is not used stupidly. Yet, this is still just a *minimal* standard of normative competence, a level of common sense, which I will argue is sub-optimal when it comes to the case of completed life.

For Mill, if human beings are minimally competent, their self-regarding decisions should be respected. Acting autonomously by using your own deliberative capacities leads to self-development. Even if individuals were to make mistakes, they learn and grow from these,

making them better persons with more defined individual personalities. The freedom to make autonomous decisions and autonomous mistakes is essential for individual happiness according to Mill. However, it should be obvious that suicide is a one-time decision from which there is no return. Suicide is not a mistake that one can learn and grow from. Moreover, potential happiness is lost from mistaken (assisted-)suicides. Because a minimal standard of normative competence does not sufficiently protect individuals from making mistakes and because suicide is irreversible, a minimal standard of normative competence might not be the optimal standard for maximizing individual welfare in the case of completed life.

Suicide *could* be an expression of individuality, but to ensure that individuals are not making a mistake from which there is no return, it might be beneficial, next to the mandatory waiting period, to expect that individuals possess a heightened level of rationality when considering ending their lives prematurely. Upholding a heightened standard of rationality will help explore if suicide is *really* what individuals desire. A heightened standard of rationality would entail that individuals make optimal decisions based on a full understanding of their own desires. This means that, under this standard, individuals make requests for assisted-suicide based on well-argued and firmly backed personal preferences. This heightened standard of rationality can ensure that the amount of mistaken life-ending decisions are minimized. Ensuring this heightened standard of rationality might involve soft-paternalistic interference (e.g. therapy), if individuals are not capable of deliberating to this extent individually.

Yet, while defending Mill's framework, one could argue that even if the choice for suicide is a mistaken one, it should not matter, because when life is over, one cannot regret the decision afterwards anyway. On top of that, as discussed earlier, the consequences of non-existence do not reflect the negative nature of the consequences of an unfree existence. In fact, there are no consequences that would reduce the instrumental value of liberty when one completes the act of suicide.

Still, even though one does not have any experiences (either good or bad) after passing away, and despite the fact that there are no bad consequences for liberty in non-existence, I would argue that one does have an interest in a deeper understanding of one's self *when still alive, when one can still make use of one's liberty.* In my view, until the exact moment of death, insights into one's mind are important because they can greatly influence the life-ending decision. These insights can positively change one's outlook on life, thereby increasing

individual happiness to such an extent that the individual does not desire (assisted-)suicide anymore. Therefore, temporarily interfering with the autonomy of individuals to come to a deeper understanding of their desires can be justified.

Now that the two ways are clear in which I think Mill's framework of liberty and autonomy is sub-optimal for maximizing individual welfare, I will discuss the appropriateness of Mill's framework for maximizing societal welfare in the last section of this chapter. In particular, I will discuss Mill's harm-principle in relation to completed life and what it means for societal welfare. I will argue that his conception of the harm-principle is sub-optimal for maximizing societal welfare in the case of completed life, because the principle does not include psychological harm as a legitimate reason for interfering with the self-regarding decisions of individuals.

3.6.4 Suicide and the harm-principle

The harm-principle's goal is to preserve personal liberty because liberty is the supreme value that leads to happiness. Again, the harm-principle states that interference with individuals is off-limits when the actions of individuals do not harm the rights-based interests of others. In line with the harm-principle, the life-ending decision should be an autonomous one if no rights-based interests of others are harmed in the process. Even though self-harm can do psychological harm to others, Mill does not think this should warrant interference, because psychological harm is not rights-based harm.

In my view, Mill's conception of harm and consequently the functioning of the harm-principle are too individualistic when applied to the case of completed life. Suicide has a great impact on direct family and friends that is underestimated. Typically, suicide represents a huge tragedy for bereaved relatives and, among other things, leads to a sense of grief, social isolation, feelings of guilt and depression (Feldman, 2006, p. 531), which leads to the reduction of the instrumental value of liberty. Furthermore, it is shown that suicides lead to increased levels of grief and depression compared to natural deaths (Young, Iglewicz, Glorioso, Lanouette, Seay, Ilapakurti & Zisook, 2012, p. 177). A suicide, as opposed to a natural passing, often comes as a surprise to family and friends. There is a sense of bewilderment that can overcome those close to the suicide victim. Family and friends can be left with many unanswered and lingering questions. These include: "why did they do it?" and "why didn't I prevent it?" (e.g. could I have done more to save the suicide victim?) (Jordan, 2001, p. 92). As

a result, those close to a suicide victim struggle with making sense of the victim's motives, and suffer "higher levels of feelings of guilt, blame and responsibility for the death" (Jordan, 2001, p. 92). The individualization of self-regarding decision-making in Mill's framework seems detrimental to the maximization of overall societal happiness in the case of (assisted-)suicide. Considering this insight, I argue that psychological harm to family and friends in the case of (assisted-)suicide should be seen as rights-based harm and (the prospect of it) should be sufficient warrant for interference with the autonomy of suicidal individuals in the case of completed life. But what would this interference look like in practice? Specifically, I argue that friends and family must be involved into the end-of-life process to ensure a minimization of overall societal pain.

To clarify, when I argue for the involvement of family and friends in the end-of-life process, I do not mean to say that they have a specific responsibility in the life-ending decision. What I mean to argue is that family and friends should emphatically be made aware, by external individuals who facilitate the assisted-suicide (e.g. end-of-life supervisors or physicians), of the fact that someone close to them is considering suicide, even against the will of the suicidal person in question. As a result, family and friends gain the opportunity to talk about the situation with the suicidal individual. This could ensure that family and friends can clear up any misunderstandings about the reasons for suicide, which can reduce feelings of guilt and retrospective responsibility. Furthermore, friends and family will have a chance to say goodbye, which gives them an opportunity to be more at peace with the decision to die of the suicidal individual. Feelings of grief, depression and guilt with those affected by a suicide will obviously not disappear completely. But there is a chance that the suffering of those affected by a suicide can be reduced through this minimal form of involvement.

To conclude this chapter, the analysis in this chapter has shown to what extent Mill's framework of liberty and autonomy is appropriate in the case of completed life. In essence, Mill argued that no one can fully understand another's experience of life. If one were to interfere with another's decisions, one would most likely interfere wrongly. Individuals themselves are in the best position to decide what brings them happiness (or what minimizes their pain). Mill argued that individual and societal happiness would be greatest when the autonomy of (at least minimally competent) individuals is respected.

I agreed with Mill to a certain extent. Essentially, I argued that in the case of completed life, personal autonomy should *eventually* be respected, because it can with reasonable

certainty be said that external actors can never truly understand how another individual experiences physical or mental pain. But at the same time, I argued that it is possible for external actors to aid individuals *initially* in determining their preferences through paternalistic interference. There seems to be a sensible case for a more extensive interference in the case of completed life then can be derived from Mill's framework.[13] I have argued that some paternalistic conditions for the use of autonomy in the case of completed life are necessary for maximizing individual welfare. Before individuals are allowed to make an autonomous life-ending decision, a mandatory waiting period and a heightened standard of rationality should be upheld.

Lastly, Mill argued that psychological harm is not rights-based harm and should therefore not warrant interference. I argued that the (prospect of) psychological harm caused to bereaved family and friends in the case of suicide should be sufficient warrant for interference with the autonomy of a suicidal individual. To ensure a minimization of overall societal pain, family and friends should be given the opportunity to be involved in the end-of-life process.

Now that it is clear to what extent the use of personal autonomy is appropriate in the case of completed life, I will investigate the other side of the autonomy-paternalism debate, the side of *paternalism*, in the next chapter.

[13] As mentioned throughout this chapter, this would entail soft-paternalistic interference to check if individuals are mature, minimally competent, and aware of what they are doing in case of purely self-regarding harm.

CHAPTER 4: PATERNALISM

Paternalism is a concept that is in nature antithetical to the concept of autonomy. State paternalism is defined by instances in which a government makes decisions on behalf of its citizens, without their consent, thus rivalling autonomy. There are three elements that are commonly associated with paternalism. Paternalism is generally defined as: (1) the inference with the autonomy of x (2) in the absence of x's consent (3) primarily for the good of x (Dworkin, 2017). In general, a government acts paternalistically because it thinks it needs to save citizens from the possibly damaging results of their decisions and actions (Le Grand & New, 2015, p. 1).

The goal of this chapter is to show the autonomy-paternalism debate from the side of paternalism and investigate the legitimacy of paternalistic interference in the case of completed life. In chapter three, Mill argued that paternalistic interference would do more evil than good, because paternalists do not properly understand the subjective experiences of individuals and would *mostly* interfere wrongly. But, as has become clear, there are situations in which it would be desirable to have our autonomy interfered with.[14] So, if we begin with the assumption that paternalism is permissible, under what circumstances and to what extent would it be justified for a government to act paternalistically in the case of completed life?

First, I will introduce a relevant distinction between two types of paternalism, namely soft-paternalism and hard-paternalism. Afterwards, I will discuss these types of paternalism in the context of completed life. I will try to answer the question(s): *to what extent are soft-paternalism and hard-paternalism justifiable in the case of completed life?*

I am discussing these two types of paternalism because they are the two main strands of paternalism and present the typical idea behind paternalistic interferences.[15] Making the distinction between soft- and hard-paternalism will reveal important questions and dilemmas with regards to the case of completed life. Soft-paternalism is mainly about (temporary) interference to make sure someone *does not act against one's own will*. Hard-paternalists

[14] One such example is Mill's broken bridge example, as discussed in chapter three (§3.4.2).

[15] Indeed, more distinctions can be found in the literature on paternalism (Dworkin, 2017). Because of the limited size and scope of this thesis, I will not be able to delve into all those distinctions. Furthermore, because this thesis on completed life is exploratory in nature, it would in my view be wise to apply the typical strands representing paternalism first, before moving on to other variants.

argue to interfere with certain decisions of individuals even if deemed voluntary. Hard-paternalism is mainly about safe-guarding individuals from *undesirable, bad, or irrational decisions*, overruling the voluntary decisions of individuals for their own good.

4.1 Soft-paternalism

The primary concern of soft-paternalists is that self-harming decisions are *authentic*, in other words, 'of one's own will'. Decisions are deemed authentic when made voluntarily. Concretely: "the state has the right to prevent self-regarding harmful conduct only when it is substantially nonvoluntary or when temporary interference is necessary to establish whether it is voluntary or not" (Feinberg, 1971, p. 113).

Drawing on Aristotle, Feinberg (1986, p. 104) notes that there are various levels of voluntariness. First, there are *fully voluntary* acts. These are acts that are "deliberately chosen", and are free of any misunderstanding, misinformation, intoxication (e.g. drunkenness) or compulsion (internal factors: illness such as neurotic diseases or depression or external factors: held at gunpoint).[16] Other factors that limit voluntariness are 'infancy' and 'insanity' (Feinberg, 1986, p. 153). Acts that fall short of a certain degree of these requirements are to be considered relatively *nonvoluntary* according to Feinberg (1986, p. 104). Acts that are absent of any choice whatsoever (e.g. when someone is forced by external actors at gunpoint) are to be considered *involuntary.*

Furthermore, part of a voluntary decision is that it needs to be properly informed. Individuals must be knowledgeable. In other words, individuals must be aware of the facts, circumstantiality and risks involved in the (self-harming) decisions they make (Feinberg, 1986, p. 152). If individuals are ignorant of these or have a mistaken view of the relevant facts at hand, their voluntariness is reduced. If individuals are not knowledgeable enough to perform a certain act, they can be (temporarily) restrained or denied access to something until it has become clear that they are knowledgeable enough.

Furthermore, voluntariness is where soft-paternalists draw the line regarding the extent of interference. In situations where individuals merely act in an unreasonable or irrational manner, interference is off-limits (Feinberg, 1986, p. 106). To intervene with someone's decision to commit suicide, when acknowledging that this person's decision is

[16] A full and detailed account of a fully voluntary choice can be found in Appendix A.

authentic, would not be permissible. We have to acknowledge that this unreasonableness is just 'the way the individual is'.

4.2 Soft-paternalism and completed life: building a framework

Feinberg (1986, p. 116) argues that Aristotle's account of a perfectly voluntary choice is unpractical and elusive, because it is an impossibly high standard in most everyday situations. Voluntariness should be conceived of as a sliding scale in which individuals can be 'voluntary enough' or 'not voluntary enough' to perform some type of act.[17] In light of this, he also does not think the concept of 'perfect' voluntariness is useful when thinking about euthanasia and (assisted-)suicide. Nevertheless, the riskier an act is, the higher the degree of voluntariness should be because of the likelihood of irrevocable harm. The most obvious conditions of non-voluntariness must at least be avoided. This would require "at the very least the drunk to sober up, the clinical depressive to come out of his gloom, and the small child to grow into his maturity" (Feinberg, 1986, p. 347), to make sure the life-ending decision is authentic.

Then what about the status of those individuals that suffer from depression in the case of completed life? The voluntariness of individuals can be questioned when they suffer from pains or illnesses. Those with depression might not be able to call their request for assisted-suicide voluntary enough. The question that will be addressed in the following sections on soft-paternalism is: *to what extent is soft-paternalism justifiable in the case of completed life?*

4.2.1 The voluntariness of completed life (1): depression, age, and competence

Deuter & Proctor (2015, p. 8), who have done a review of the literature on attempted suicide among elderly, show that depression and mental disorders are prevalent among suicidal elderly. Furthermore, it is shown that many of the elements that are characteristic of completed life are heavily correlated with major depression. Those who suffer from loneliness, hopelessness or social isolation have a very large chance to also be depressed (Deuter & Proctor, 2015, p. 9). Moreover, depression and the risk of a suicide attempt increase after a life-changing event occurs such as the loss of a loved one.

Generally, a sufficient degree of mental competence is needed before the choices of individuals are deemed voluntary enough. With mental competence I mean that the individual

[17] In Appendix B the reader can find a schematic overview of the sliding scale of voluntariness by Feinberg.

can make well-considered choices. Individuals need to be able to identity their own values, understand relevant information and choose between alternatives while considering the consequences of alternatives (Pickering-Francis, 1998, p. 78). A wish to die in the case of completed life is a carefully considered decision in which one weighs the pleasures and pains of life. As such, it can be argued that mental competence is of paramount importance in the case of completed life and should not be underestimated.

The mental competence of individuals is influenced by depression, as well as by the natural effects of ageing, causing them to have diminished mental capabilities (Conwell, Van Orden & Caine, 2011; Deuter & Proctor, 2015, p. 10; Pickering-Francis, 1998, p. 82). A decline in mental capability can impair memory function and the ability of individuals to process information (Cartreine, 2016). Also, problem-solving and decision-making capabilities are decreased when elderly are influenced by depression, which comes down to having decreased levels of "cognitive flexibility" (Cartreine, 2016). And lastly these cognitive impairments can lead individuals to become estranged from their self and their future interests (Allard-Levingston, 2014). Does this mean that old and depressed individuals are by definition unable to make authentic life-ending decisions because of the effects of ageing and depression?

In my view, this is not the case. Even though there are high correlations between age, depression, and a general decline in mental competence, it is shown that there is no definite causal link between age and competence and depression and competence (Pickering-Francis 1998, p. 79). There are larger differences among elderly, but this is obviously not necessarily applicable across all elderly.

Furthermore, depression does not always influence competence to such an extent that it impairs voluntary decision-making. Depression can have multiple effects. On the one hand, depression can cause individuals to become more pessimistic and focus on the negatives of their lives, which should be avoided because it is bad for optimal decision-making. On the other hand, being in a mood of sadness can also cause people to think more systematically (e.g. consider all possible options before making a decision), which is good for decision-making (Khazan, 2016). Even though depression can be a dangerous factor when it comes to decision-making in the case of suicide, it does not have to be.

As such, in my view, if one were to draw the line for taking away the opportunity for receiving life-ending medication solely when symptoms of depression are present or considering that correlations between age, depression, and a decline in mental competence

are large, one could pre-emptively, and thus unfairly, exclude sufficiently competent elderly from receiving life-ending medication. It is possible that depressed elderly are sufficiently competent to express authentic life-ending decisions.

Still, considering the supreme degree of risk involved, soft-paternalistic interference to check for sufficient levels of competence seems to be reasonable at the very least. It would be best to decide on the voluntariness of the life-ending decisions of elderly through temporary soft-paternalistic interference. This would involve independent tests or interviews, conducted by psychiatrists and physicians alike, to provide conclusive evidence on the state of mind of elderly when they are requesting life-ending medication.

Lastly, should therapy be forced on depressed elderly in an attempt to cure them as part of temporary interference? If depressed individuals contemplate attempting suicide on their own, a case could be made for forced therapy, because then they are a danger to themselves or others (Van Leeuwen & Merry, 2018, p. 10).[18] But the fact that depressed individuals can still be sane enough to take the time to discuss their death wishes and make well-considered decisions about their own lives, gives reason to think that they might also be capable of responsibly choosing their moments of death without unnecessarily endangering themselves or others. However, if one is diagnosed to be mentally unstable, being an immediate danger to oneself and others, forced therapeutic counselling is wise to uphold as a part of soft-paternalistic interference.

4.2.2 The voluntariness of completed life (2): adaptive preferences

The voluntariness of a request for assisted-suicide can be challenged beyond concerns of mental competence. A request for assisted-suicide in a completed life scenario could be the result of adaptive preferences. Adaptive preferences are a set of sub-optimal preferences that individuals (unconsciously) adapt because of the circumstances they find themselves in (Colburn, 2011, p. 53). This implies that one has not voluntarily chosen the preference for assisted-suicide. Elderly in the case of completed life could adopt a preference for assisted-suicide because of a limited number of options that they have at their disposal.

Naturally, options become more limited in the later stages of life. Elderly are no longer needed for their old jobs, their group of friends and family becomes smaller, and physically

[18] Van Leeuwen & Merry discuss forced therapy for mentally ill homeless individuals.

intensive hobbies might fall away. I think it would not be unreasonable to assume that elderly do (unconsciously) adapt their lifestyles based on the options available to them. However, I would argue that it is unfounded to think that their life-ending decisions are not sufficiently voluntary due to adaptation in these natural circumstances. Even though options become more limited, it is not obvious that the circumstances which elderly find themselves in (e.g. being old but generally healthy) specifically lead to situations in which assisted-suicide is the only, or even a directly preferable option. In extreme circumstances, where an elderly person is bedridden by physical or mental impairment, one could more strongly argue that the voluntariness of the choice for assisted-suicide is reduced because of the absence of acceptable alternatives. But this is not the case with requests for assisted-suicide in the case of completed life. In the case of completed life, the situations elderly find themselves do not reduce voluntariness because elderly are in my view dealing with naturally changing but not overly abrasive circumstances.

Finally, to conclude this section on the legitimacy of soft-paternalism in the case of completed life. Soft-paternalism is about making sure that a person makes (self-harming) decisions which represent one's own will. Internal pressures (e.g. depression) are prevalent with suicidal elderly. Soft-paternalistic interference, in terms of interviews and independent tests, seems necessary to confirm if elderly are making sufficiently voluntary life-ending decisions. Lastly, therapy should be instituted to treat illness if elderly are judged to be an immediate danger to themselves or others by supervising experts.

4.3 Hard-paternalism

Hard-paternalists argue that it is sometimes justified to interfere with the decisions of individuals even when it is confirmed that they are acting voluntarily (Feinberg, 1986, p. 12). In hard-paternalism there is a substitution of judgment present to overrule the decisions of individuals:

> "one party assumes that his judgment about what you need is superior to your own judgment as to what you need, to the point where, in coercive paternalism, he can force you to do what he thinks is best rather than what you think is best" (Conly, 2013, p. 37).

Hard-paternalists argue that it is justified to withhold a person from doing what one has decided, when they have the well-being of the coerced individual in mind. Furthermore, a useful distinction between two types of hard-paternalism is made in the literature. This is the

distinction between hard-means-paternalism and hard-ends-paternalism. This distinction is important because it highlights the different rationales that drive hard-paternalistic interferences. I will mainly be discussing hard-means-paternalism because this form of hard-paternalism is the most relevant to the completed life case. This will become clear shortly.

4.3.1 Hard-means-paternalism

Hard-means-paternalists are those who do not have issues with any specifically chosen ends of individuals but do have concerns about the way in which individuals want to achieve those ends. Hard-ends-paternalists on the other hand, have issues with the specific end-goals of individuals. They argue that some ends are undesirable and should therefore not be pursued at all.

Hard-means-paternalists want to make sure that individuals make ideal instrumental decisions that coincide with their own interests (Conly, 2013, p. 12). Individuals have their own goals. But according to hard-means-paternalists, how people actually want to reach these goals is less valuable then the ideal way to reach these goals (Le Grand & New, 2015, p. 31). Hard-means-paternalists make a judgment about what is best for individuals in reaching their own goals.

This is essentially the opposite to Mill's instrumental argument for liberty and autonomy. Mill argued that liberty and autonomy are necessary for individuals to optimally satisfy their own preferences. According to hard-means-paternalists, this is not the case. Autonomy should not be held in such high regard because individuals often make bad, irrational decisions, which are detrimental to their own ends. Individuals would be better-off when helped.

I will mainly be discussing hard-means-paternalism because hard-means-paternalism seems to be type of hard-paternalism that touches upon the essence of the concept of completed life. Elderly who consider their lives completed and no longer worth living, do not want to die merely for the sake of dying. They want to die because they want to end their suffering. Elderly cannot find happiness in their lives anymore, are unable to relieve the continuous suffering that their lives have become and *therefore* want to end their lives. The main issue with completed life is not that suicide might be wrong in and by itself. In my view, because the main goal of elderly who want to end their lives is to end their suffering, the main issue seems to be about figuring out if the option to end their lives prematurely is the ideally

correct instrumental decision to end their suffering. As such, I will be investigating hard-means-paternalism in the remaining parts of this thesis.

4.3.2 Hard-means-paternalism and reasoning failure

In general, hard-means-paternalists argue they can help individuals reach their own goals better by correcting reasoning failures made by individuals. There are multiple ways in which reasoning failures can occur. Le Grand & New (2015, pp. 83-101) outline a few. *Limited technical ability, limited imagination, limited willpower* and *limited objectivity* are all examples of reasoning failures that can occur with regards to the desires or preferences of individuals. Because limited technical ability and limited objectivity are about the ability of individuals to understand and use relevant information, and thus more akin to soft-paternalism, I will only touch upon limited imagination and limited willpower.[19]

Limited imagination refers to the failure of individuals "to imagine or predict their utility in alternative situations or at different times" (Le Grand & New, 2015, p. 90). A changed state of being might be more beneficial to individuals than they initially believe. Individuals, through their limited imagination, undervalue the possible utility of alternative preferences (Loewenstein, O'Donoghue & Rabin, 2003, p. 1212). This coincides with *projection bias,* which is also part of imaginative reasoning failure. Individuals can have difficulties estimating "how a changed state will affect their preferences" because "they falsely project their current preferences" on different states of being (Le Grand & New, 2015, p. 95). One of the reasons this type of reasoning failure persists is because individuals do not have enough experience of a multiplicity of diverging situations to be able to properly decide on their preferences (Burrows, 1993, p. 545). The hard-means-paternalist would encourage individuals to try different activities with an open mindset. This allows individuals to broaden their experiences and more accurately decide on their preferences.

Limited willpower "refers to instances where people know what they prefer in the long term and what decision is in their best interests but still make a choice that leads to a suboptimal outcome" (Le Grand & New, 2015, p. 97). This discussion on limited willpower is

[19] Limited technical ability refers to the capacity of individuals to understand and process certain types of information. Limited objectivity refers to the inability of individuals to objectively judge situations and their preferences (e.g. confirmation bias, over-optimism, and pessimism).

usually framed as a contest between two competing aspects: 'reason' and 'temptation'. Against better judgement, individuals choose short-term satisfaction over long-term satisfaction. Following temptation can be beneficial, however, for hard-means-paternalists it is key to intervene in those instances of short-term decisions based on temptation that can have severely damaging long-term consequences.

To conclude this section, hard-means-paternalism goes beyond the technical understanding of the relevant facts by individuals and aims at the preferences which individuals should ideally have should they be more rational. Now that hard-means-paternalistic interference has been discussed, I will investigate the permissibility of hard-means-paternalism in the case of completed life.

4.4 Hard-means-paternalism and completed life: building a framework

The main question that will be discussed in this next part is: *to what extent is hard-paternalism justifiable in the case of completed life?* Paternalistic interference is defined by instances where autonomy is sacrificed for well-being. To secure the well-being of individuals, their autonomy could be limited to several degrees. Because individuals in liberal societies typically attach a lot of weight to their freedom of choice and their ability to live their lives according to their own visions of the good life, a burden of proof is attached to paternalistic interference. The paternalist must show that the interference is necessary and is worth sacrificing autonomy over. Some interferences however, require more qualification than others. I would argue that paternalistic laws obligating individuals to wear seatbelts require relatively little qualification in contrast to paternalistic laws aiming to restrict the autonomy of individuals in the case of assisted-suicide. This is because interference in the case of seatbelts is local, and most importantly, does not concern a significant life-choice of individuals. Contrary to seatbelt laws, interference with assisted-suicide is a more severe interference with the autonomy of individuals in the sense that it concerns a significant and well-considered life-choice of individuals. Because interference in the case of assisted-suicide is such a severe interference with the autonomy of individuals, it must be delineated properly through heavy qualification.

Because the discussion on completed life is fairly new, my analysis on the permissibility of hard-paternalistic interference in the case of completed life will inevitably be exploratory. In what follows, I will propose a theoretical framework in which hard-means-paternalistic

interference with elderly who consider their lives completed and no longer worth living should be legitimate. I argue these four conditions need to be fulfilled to justify the interference:

(1) First, as has become clear in chapter two, elderly can have differing reasons for requesting assisted-suicide in the case of completed life. To avoid arbitrary and inconsistent interferences, the paternalist must hold all cases of completed life to the same standard. The paternalist must formulate a universal standard of interference. To achieve this, I will propose a hypothetical paternalistic contract. I will argue that all elderly, who consider their lives completed and no longer worth living, should be able to reasonably agree to this hypothetical contract. To investigate the contents of this hypothetical contract, I will, based on the general experiences of elderly who consider their lives completed and no longer worth living, investigate some of the causes of, and solutions to, completed life.
(2) Secondly, interference must have sufficient consequences for the well-being of those who consider their lives completed and no longer worth living. If well-being is negligible, the necessity of paternalistic interference can be called into question.
(3) Thirdly, the costs to autonomy must be acceptable. Paternalistic interference is not automatically justified when it yields sufficient well-being. For instance, some argue in opposition to interference when bringing about well-being brings too large costs to autonomy (Colburn, 2013, p. 76). First, I will discuss the benefits of a temporary hard-means-paternalistic interference over an absolute hard-means-paternalistic interference in the case of completed life. Secondly, the right to privacy stands in direct opposition to interference in the case of completed life. This is because the interference involves a discussion between individuals and paternalists about the reasons individuals have for requesting assisted-suicide. I will be discussing if overriding this right is acceptable.
(4) The fourth and final condition entails a positive duty. I will argue that a positive duty for the paternalist to help elderly with their specific suffering must be attached to interference if hard-means-paternalistic interference is to be justified in the case of completed life. Merely interfering negatively, by instituting barriers to the autonomous life-ending decision, is insufficient in establishing the instrumental correctness of the life-ending decision.

I will discuss these conditions in order.

4.4.1 Condition 1: a universal standard of interference

Elderly have differing reasons for requesting life-ending medication. To avoid arbitrary and inconsistent interferences the paternalist must uphold a universal standard of interference. What should this universal standard entail? To investigate this question, I will, based on the general experience of completed life, investigate some of the causes of, and solutions to, completed life. Thereafter, considering my findings, I will formulate a hypothetical paternalistic contract to which all elderly who consider their lives completed and no longer worth living can reasonably agree.

Completed life: the experience of elderly

If paternalists are to legitimately interfere with elderly in the case of completed life, it is only natural that they take into account the general experience of having a completed life. Furthermore, if the hypothetical contract is recognizable to elderly, it will enlarge the chance that they can reasonably agree with it. It is probably clear by now that completed life is not experienced by elderly as the idealized interpretation of the term implies. Elderly requesting life-ending medication are usually not persons that are happy and satisfied, wanting to end their lives on a high note. Completed life is more widely associated with suffering.

As has become clear in chapter two, elderly who consider their lives completed and no longer worth living are disconnected from life, unable to recognize themselves in their current life. It is a continual struggle between how life *is* and how it *ought* to be or "*a tangle of [the] inability and unwillingness to connect to one's actual life*" (Van Wijngaarden, et al. 2015, p. 262, emphasis in original). Again, the experience of completed life is formed through a few elements of ageing and the experiences that are paired with ageing. These are (1) loneliness, (2) the pain of not mattering, (3) not being able to express oneself, (4) multidimensional tiredness and (5) the fear of becoming dependent.

Now that the readers mind on the overall experience of having a completed life is refreshed, I will consider some of the causes of, and solutions to, completed life.

Causes of - and solutions to - completed life (1): reasoning failure

Many of the elements of the experience of having a completed life as just described, namely one through four, seem to have to do with giving meaning to life itself. The experience of

having a completed life comes down to suffering of a social and existential nature.[20] It seems there is a general loss of social connection and loss of self which elderly do not want to, or feel unable to, deal with. Elderly, when arguing they are better-off dead compared to their current state of discomfort, might "misjudge their future levels of well-being" (Le Grand & New, 2015, p. 163). As such, they might employ certain types of reasoning failure that I have outlined earlier. Even though their individual experiences cannot be disputed, the idea that life-ending decisions should be attached to these experiences seems at least to hastily concluded. I would argue that the idea that these experiences are all unsolvable, in other words 'completed', can be disputed. In the easiest of cases, life can be made purposeful or pleasurable again through meeting new people, strengthening existing bonds, or finding a new enjoyable hobby.

It has become clear that elderly who are struggling with the issue of completed life cannot relieve their suffering because of a combination of the inability and the unwillingness to connect to their actual lives. One of the reasons elderly feel like they are unable to connect to their actual lives could be because of willpower reasoning failure. Because elderly feel like they are unable to end their suffering in conventional ways, they seek to end their suffering through the short-term option of assisted-suicide. For those in great discomfort, the possibility of assisted-suicide seems easier then to hope for their suffering to end through other, more natural ways (Le Grand & New, 2015, p. 165). The hard-means-paternalist would argue that giving in to their suffering and the short-term 'temptation' of ending their lives might not be in the true interest of elderly, because living might be preferable if suffering can be alleviated through other ways.

It can also be argued that elderly suffer from reasoning failure in terms of a lack of imagination. Take the inability to express oneself for instance. It is shown that elderly are alienated from their current selves because it is different from how it used to be and different from their expectations of how their lives should be. For instance, elderly might suffer existentially because they cannot practice their previously favourite physically intensive hobbies anymore. It can be argued that they are wrongly projecting their old desires on their

[20] Element number 5 is about wanting to end life *if* one ever became dependent on caregivers. This is not something that the elderly in question are dealing with at this moment. As such it is less relevant for this thesis about the legitimacy of paternalistic interference with relatively healthy elderly. Therefore, I will not be discussing this element of completed life.

current situation. The hard-means-paternalist would argue that the expectations of elderly are too high, and that they might need to experience a wider range of activities to realize other activities can be enjoyable as well.

One might contrast the situation of healthy elderly in the case of completed life to the situation of terminally ill elderly. It could be argued that persons suffering incurably with terminal illness do not suffer from reasoning failure when requesting assisted-suicide, because there is no chance that their lives will become better. Healthy elderly in the case of completed life on the other hand might be able rejuvenate their lives. What the reader should take away from this section on reasoning failure is that, with completed life, there is sufficient reason to believe that the desire for (assisted-)suicide can be instrumentally incorrect. Consequently, when hard-means-paternalists are under the impression that elderly suffer from reasoning failure, they should require them to try to relieve their suffering through means other than assisted-suicide to avoid unnecessary and unwanted deaths.

Causes of - and solutions to - completed life (2): social inability and societal neglect

From the last the section it has become clear that reasoning failure could be a part of the reason why elderly are unable or unwilling to connect to their actual lives. Yet, the experience of completed life is not solely attributable to reasoning failures of elderly. The loss of social connection and the existential suffering that elderly experience can also be attributed to the (hyper-)individualistic practice that grounds society (Gardner, 2015; Monbiot, 2016; Van Der Mee, 2018). In what follows, I will go through the four elements of completed life mentioned earlier (e.g. loneliness, pain of not mattering, inability to express oneself and physical and mental tiredness through monotony and boredom) to see how society could be partly responsible for – but more importantly – could make efforts to help elderly overcome, these elements of completed life.

First, loneliness. Modern liberal society is mostly focused on negative freedom, self-determination and self-sufficiency. In light of Mill, these are important values. These values ensure that individuals learn to take care of themselves and ensure the formation of a tolerant society in which citizens can pursue their dreams. This has beneficial consequences for happiness, as has become clear in chapter three. But the focus on self-determination and individual responsibility can have negative consequences for community-caring. The “wall” between individuals can become too high, leading to “a less compassionate world” in general

and loneliness in particular (Dobrin, 2011, p. 340). Elderly lose their partners or long-time friends and thus become increasingly socially isolated. On top of that, elderly could be lacking the social skills and resources to build new social networks. It could be that we, as a society, do not put enough effort in supporting socially isolated elderly, who struggle to be socially self-sufficient.

If elderly have family left, the most obvious first step would be for direct family to take responsibility and pay more attention to the needs of their elderly relatives. But this might be too optimistic. This is a major responsibility that they might not be able to fulfil, because they also have their own lives to manage.[21] Third-party organizations are often invoked to combat loneliness (Fokkema & Dykstra, 2009, p. 7). They can bring elderly into contact with others, which is essential to combating loneliness. It can be beneficial to organize events in the neighbourhood where elderly can meet and participate in activities. Per example, loneliness has gotten increased attention in Dutch politics. The Dutch ministry for Societal Health, Well-being and Sports has started a community effort called 'One Against Loneliness' where lonely individuals can go to get help, where information on activities can be found and where external individuals can sign-up and volunteer to help lonely individuals (Ministerie van Volksgezondheid, Welzijn en Sport, n.d.).

But facilitating social networks is just one way of combating loneliness and is no catch-all solution to combatting loneliness. It could also be that one does not benefit from a broader network of social contact. It could be that one's loneliness is more persistent because of the loss of an irreplaceable loved-one (Fokkema & Dykstra, 2009, pp. 7-8). In this case, professional assistance to help one to cope with loneliness would be beneficial. However, this can also fall short of a persistent remedy. It should be recognized that it is likely that there are cases in which the suffering that elderly endure is not sufficiently mendable by external actors. The fact that potentially solvable circumstances, such as loneliness, are present, does not definitively mean they are solvable. Van Wijngaarden et al. (2015, p. 260) show a case in which a 94-year-old man feels incurably lonely even though he has many relationships that are dear

[21] I do not mean for this to be an excuse to not support family in need. Family relationships are usually defined by going to considerable lengths in supporting family members, even at personal expense. However, combating persistent or day-to-day loneliness could prove to be a substantial task that family members might not be able to fulfil.

to him. He has a wife and grandchildren that regularly visit, which he is content with, but he feels that he has no strong connection to them anymore and are not enough to bind him to life.

Lastly, external parties cannot actually help elderly with their loneliness if elderly do not make the first-step in seeking help with their loneliness. This is because it can be hard to see if elderly are lonely from the outside, especially if elderly are socially isolated and have no frequent or meaningful contact with others. If they do not open up about their loneliness, others might never know. Still, to try and combat this, society can facilitate an environment in which loneliness is not stigmatized (e.g. looked down upon or seen as a weakness), by publicly encouraging elderly to seek help, and by openly discussing the topic to set an example for elderly to follow. This can help elderly with making the first-step. In my view, accessible or low threshold possibilities for elderly to discuss their suffering, even without considering ending life, should be institutionalized and promoted. This could even prevent that elderly develop death wishes.

With the second element of completed life, a loss of self due to the pain of not mattering, external parties can also be of importance. Because elderly are no longer needed to perform tasks they have done their whole lives, they develop the feeling that they do not matter anymore in society. Anna McEwen argues that elderly possess valuable skills and experience which are often dismissed when they become an object of care and support (Johnson, 2015). To combat this, it might be helpful to envision a larger role for elderly in society. Elderly might get a sense of importance back when helping others with the valuable knowledge they have gathered throughout their lifetimes. They can provide wisdom and perspective corresponding to their respective talents. Furthermore, due to a surplus in time to spend, elderly are flexible in fulfilling (volunteering) jobs in their communities. Third-party organizations can facilitate a connection between elderly and a special type of labour market catered specifically to elderly, where the talents of elderly can be utilised.[22]

Thirdly, when it comes to a loss of self due to the inability to express oneself, it could be that society is not putting enough effort into creating opportunities for elderly to enjoy

[22] This could involve jobs on a smaller scale or special occasions (fewer working hours, weekends, holidays). Some of these initiatives are already in place. An example is https://www.doorwerkgever.nl/ which facilitates jobs for pensioned individuals.

their preferred activities. To help, one can think of organizations dedicated to daily catering to elderly, such as elderly sports clubs, book clubs, gardening clubs or other ways of organizing pastime activities. Third-parties can also support elderly in finding new activities that they might enjoy, possibly expanding or redefining their preferences. However, it could be that despite our doubts about the instrumental correctness of their request for assisted-suicide, external actors cannot help elderly as discussed earlier. Individuals develop a preference for a certain way of life throughout their lives. It seems reasonable to assume that at least some elderly have a good idea of what they like and do not like to do. Consequently, the task of mending the loss of self that elderly experience could be extremely difficult and should not be underestimated.

Lastly, boredom, monotony and the silence of old-age can coincide with all the other characteristics of a completed life. Opportunities for society in helping elderly to relieve them of their suffering will follow a similar pattern as outlined above. Creating opportunities for elderly to come out of their daily-routine is essential.

In conclusion, this section on the societal causes of, and societal solutions to, completed life is not meant to be complete or conclusive. Surely, one could think of other critical causes of, and viable solutions to, completed life. Still, what the reader should take away from this section, again, is that the desire for suicide *can* be instrumentally incorrect. External actors in society can help elderly with their suffering in other ways than aid-in-dying. When hard-means-paternalists are under the impression that requests for assisted-suicide by elderly are instrumentally incorrect, they should require elderly to seek other ways to relieve their suffering with the help of external parties.

A hypothetical paternalistic contract: assisted-suicide as a last resort

With the looming danger of reasoning failure and possibilities for solving the problems that elderly are dealing with through societal support, the hard-means-paternalist can deny requests for assisted-suicide by elderly. This is because their desire for assisted-suicide can be deemed instrumentally unideal by hard-means-paternalists. At first sight, this seems like an exceptionally large restriction of the autonomy of elderly. Elderly are denied the last and arguably most fundamental decision of their lives. Still, I argue that elderly should be able to agree with interference to a certain extent.

Suicide belongs to a class of decisions that has irreversible consequences. A mistake with suicide leads to a death from which individuals cannot learn retrospectively. While on the other hand, individuals *can* learn from a postponed suicide. By postponing suicide and encouraging elderly to receive help, elderly can gain important insights into their own lives. Societal support or overcoming reasoning failure can help elderly to regain confidence in the idea that life is worth continuing after all.

Taking into account that suicide is irreversible, while considering that completed life is not about death itself but about ending suffering, and being aware of the potentially solvable nature of the suffering that they are dealing with, elderly, who consider their lives completed and no longer worth living, should at least be able to reasonably agree that assisted-suicide should only be available as a last resort. As such, I argue that elderly in the case of completed life should be able to reasonably agree with the instatement of a temporary hard-means-paternalistic interference.

Considering these insights, the universal standard of interference, the hypothetical paternalistic contract to which elderly in the case of completed life can reasonably agree, is formulated as follows: *Elderly should be able to reasonably agree that, when the time comes, should they need it, life-ending medication is only available when it is with some degree of certainty established that no methods other than assisted-suicide can relieve the suffering they endure, to make sure that death is not caused unnecessarily.*[23]

To clarify, this means that temporary hard-means-paternalistic interference, in terms of the hypothetical contract, will be an inevitable step in the completed life process after establishing the choice for assisted-suicide is authentic. Elderly will not gain access to life-ending medication until it is with some degree of certainty established[24] that the life-ending

[23] This is in conjunction with my earlier recommendations in chapter three (§3.6.2 & §3.6.3) to uphold a mandatory waiting period and a heightened standard of rationality. These will be included in the final formulation of the hypothetical contract at the end of this chapter.

[24] It is important to note that I leave the phrase 'with some degree of certainty' intentionally vague. Consider this: when can the paternalist conclude that enough alternative solutions have been tried, with no avail, to allow access to the life-ending medication? In my view, it is impossible to formulate a standard to which all elderly can be held equally in this regard. I would argue it is up to the paternalist or physician, in consultation with the individual, based on the specific situation the individual is in, to determine when enough alternative solutions have been tried.

decision is the correct instrumental decision to minimizing their suffering. In the following sections, I will elaborate on the hypothetical paternalistic contract. In the section on condition 2, I will discuss the benefits of this hypothetical contract for individual well-being. Afterwards, in the section on condition 3, on the acceptability of autonomy losses, I will elaborate on my choice for a *temporary* hard-means-paternalistic interference. Thereafter, in the section on condition 4, I will argue for the adoption of a positive duty for the paternalist to help elderly with alleviating their specific suffering, to further justify interference based on the hypothetical paternalistic contract. The positive duty is necessary to establish the instrumental correctness of requests for assisted-suicide by elderly in the case of completed life. Lastly, I will present my final conclusions on the hypothetical paternalistic contract.

4.4.2 Condition 2: sufficient well-being

Suicide, without ambiguity, would do the largest amount of irreparable harm to individuals. At least in terms of directly saved physical integrity, interference would lead to the most amount of well-being possible. However, the most important question is: can paternalistic interference increase the well-being of individuals in such a way that they think life is worth living again? In other words, can the (existential) suffering of elderly be sufficiently alleviated?

In my view, the chance that this question can be answered affirmatively is present. Completed life is not about death itself, but about the suffering in life. There are possibilities for elderly to alleviate their suffering as has become clear in the sections on the causes of, and solutions to, completed life. Yet, there is always a chance that interference has no effect. But this is in my view no reason to not at least try to support this vulnerable group in society, and no reason to discount the possibility of helping those elderly that can benefit from interference.

4.4.3 Condition 3: acceptable autonomy losses

Temporary versus absolute interference

I argue that a temporary hard-means-paternalistic interference, based on the hypothetical contract proposed earlier, results in acceptable losses to the autonomy of affected elderly. This is because an important consequence of the interference is that autonomy losses are minimal. Given, there will always be a basic loss of autonomy for elderly, because the interference will restrict them in their freedom of choice initially. But the severity of the

interference will be lessened if they change their mind about suicide. If the hard-means-paternalist is correct about the instrumental incorrectness of an elderly person's preference for suicide, it is likely that this person will consent to the interference retrospectively, which diminishes the gravity of the interference with the elderly person's autonomy.

Furthermore, I purposely argue for a temporary interference and not an absolute interference because, absolute interferences, when instated wrongly, would bring too large costs to the autonomy and well-being of individuals. Just as elderly can make instrumentally incorrect life-ending decisions, one cannot exclude the possibility that paternalists mistakenly deny requests for assisted-suicide based on reasoning failure or societal neglect. There can be instances where suicide is the true desire of elderly despite the possible instrumental incorrectness of this desire. This seems to be true in the case of the 94-year-old man who felt incurably lonely as mentioned earlier. Elderly who are wrongly affected by an absolute interference would not only suffer great consequences to their autonomy, because their ability to self-rule is obstructed indefinitely, but also to their well-being, because they would be condemned to endure their suffering for the rest of their lives.[25] To emphasize this point, if someone must live a life of continuous suffering, given the fact that one's suffering is so intolerable that one prefers ending life over living life, this fate is for this person "quite literally - a fate worse than death" (Le Grand & New, 2015, p. 165). The possibility that no gratitude is expressed subsequent to the interference must be taken into consideration. A temporary interference would take this possibility into account and is therefore preferable over an absolute interference.

Privacy and autonomy

Next, there is a cost to autonomy that cannot be overlooked when discussing paternalistic interference in the case of completed life. In order to confirm if elderly are voluntarily requesting life-ending medication, and in order to confirm if their preference for suicide is instrumentally correct, the paternalist must thoroughly investigate the motivations elderly have for wanting to end their lives prematurely. It can be argued that this is a major interference with the autonomy of individuals in terms of privacy. A loss in privacy is a loss in autonomy because privacy is about the way in which individuals are in control of information

[25] Given elderly do not try, or are unable to try, to end their lives on their own, of course.

about themselves (Kupfer, 1987, p. 81). Privacy, it is argued, is essential for personhood, because it builds and maintains the self (Kupfer, 1987, p. 82; Reiman, 1976, p. 41). Being able to control who certain thoughts and experiences are shared with is important in this conception of the autonomous self. Ben Colburn (2013, p. 76) argues individuals should not be obligated to discuss their death wishes, because it brings too large costs to privacy. Does the right to privacy invoke reasons to oppose discussing a death wish as a part of paternalistic interference in the case of completed life?

Having to discuss your motivations for wanting to end your life could indeed feel like an intrusion. Sharing intimate thoughts and feelings, without being allowed to withhold information you might not be comfortable with sharing, might devalue autonomy to a certain extent. Yet, I would argue that discussing a death wish as a part of paternalistic interference in the case of completed life, results in acceptable losses to the autonomy of elderly in terms of privacy. This is because I argue that discussing a death wish in the case of completed life is comparable to sharing intimate facts about oneself in a regular medical situation. For instance, individuals might be dealing with problems that they perceive as embarrassing, which they rather not share with anyone. Despite this, individuals go to the doctor's office with the intention to relieve the suffering that plagues them. They visit a doctor fully aware that they might have to share intimate physical or mental facts about themselves. Because individuals are generally willing to go through this shows that they value ending their suffering over maintaining their (right to) privacy. Therefore, the fact that some privacy is lost in a confidential setting, cannot, in my view, be enough reason to oppose discussing a death wish as a part of paternalistic interference in the case of completed life. Sacrificing privacy, by explaining one's motivations for assisted-suicide, can only be a small price to pay for alleviating suffering. Based on the reasons elderly have for requesting assisted-suicide, paternalists can, together with elderly, figure out the best way to end their suffering.

4.4.4 Condition 4: a positive duty

Usually, paternalism is practiced in a negative sense. Restrictions on individual behaviour (e.g. wearing seatbelts) are instituted to *protect individuals from harm*. But paternalism can also be practiced in a positive sense. Paternalism is practiced in a positive sense when it enables individuals to do something *more* (Kleinig, 1983, p. 13, emphasis added). In my view, the paternalist should, next to instituting barriers, also act paternalistically in the positive sense

to justify temporary hard-means-paternalistic interference based on the hypothetical contract.

The hypothetical contract stated that elderly are only allowed to receive life-ending medication when it is with some degree of certainty established that no methods other than assisted-suicide can relieve the suffering they endure. Only when alternative solutions have been exhausted can elderly escape the doubts of the hard-means-paternalist on the instrumental correctness of their preference for assisted-suicide. But as has become clear, there are two intertwined reasons why elderly continuously suffer from the symptoms of completed life. *Elderly feel they are unable and unwilling to connect to their actual lives*. Considering this, elderly will most likely not make (decent) efforts to try to alleviate their suffering on their own. Therefore, to give elderly a fair chance at receiving life-ending medication, the paternalist must put elderly in a position in which they can utilise opportunities for life-improvement.

Temporary interference creates windows of opportunity to improve the lives of elderly. To make sure elderly make decent efforts to try to relieve their suffering, it seems that a positive duty to address the specific problems that elderly are dealing with, through individually tailored interference, is necessary. Indeed, this also means that elderly who have requested assisted-suicide will not be able to receive life-ending medication when they refuse to partake in this positive programme by the paternalist. Actively helping to alleviate suffering, through the possibilities mentioned earlier, will lead to greater success in separating those that are helped by interference from those that are not helped by it. Lastly, it could be that individuals who request life-ending medication have already tried virtually anything useful that the paternalist can come up with without success. If the paternalist confirms this to be the case, then the positive duty I am proposing here would probably be short-lived.

In conclusion of this part of the thesis on the legitimacy of hard-paternalistic interference in the case of completed life. When the request for assisted-suicide has been deemed authentic, the hypothetical paternalistic contract comes into force. This contract prescribes a temporary hard-means-paternalistic interference. In accordance with the findings in chapters three and four of this thesis, life-ending medication should only be available to elderly when (in other words, hard-paternalistic inference is legitimate to the extent that) it is with some degree of certainty established, through the heightened standard of rationality and the positive duty for the paternalist during the mandatory waiting period, that no methods

other than assisted-suicide can relieve the suffering that they endure. This is to make sure elderly do not make an instrumentally incorrect life-ending decision resulting in unnecessary and unwanted deaths.

CHAPTER 5: CONCLUSION

5.1 Main findings

This thesis has investigated the autonomy-paternalism debate with regards to the medical-ethical issue of completed life. Specifically, the moral appropriateness of the 'respect for autonomy', 'soft-paternalistic' and 'hard-paternalistic' positions have been investigated to answer the main question: *to what extent, or under what circumstances, does the state have a right or duty to interfere with the autonomy of its citizens regarding the medical-ethical issue of completed life?*

In chapter three I have reflected on one side of the autonomy-paternalism debate, namely the side of autonomy defended by John Stuart Mill, to investigate the 'respect for autonomy' position. I have discussed Mill's moral and theoretical framework of liberty and autonomy outlined in his seminal work *On Liberty* (1859/2001) to answer the question: *to what extent is Mill's framework of liberty and autonomy appropriate in the case of completed life?*

I have come to conclude, based on Mill's insights about the subjectivity of the human experiences, that ultimately, autonomy should be respected in the case of completed life because one's understanding of another individual's experience of life can *eventually* be lacking. Furthermore, contrary to Mill, I argued that, *initially*, regarding life-ending decisions, external actors can play a pivotal role in helping individuals decide what is valuable to them through paternalistic interference. As such, I argued that Mill's framework of liberty and autonomy is sub-optimal for maximizing individual welfare in two ways.

First, based on Mill's theoretical framework, Mill would most likely have argued that if one thinks that one's freedom cannot be put to sufficient use anymore, by calculation of utility, and in light of personal judgement, that there is sufficient cause for a premature life-ending decision. The life-ending decision would be the ultimate and final use of liberty as a tool for minimizing pain by way of non-existence. I argued that Mill's framework rationalizes the short-term commitment to (assisted-)suicide in the case of completed life and does not protect individuals from episodic preferences for (assisted-)suicide. One should be wary of conceiving of suicide as, what Mill would call, a vital expression of individuality, because suicide might not be a true reflection of the individuality of elderly, but an expression based on temporary circumstances. To shield individuals from acting on episodic short-term

preferences that do not reflect their true desires, I argued for the instatement of a mandatory waiting period in the end-of-life process.

Secondly, I argued that Mill's minimalistic conception of normative competence for the use of autonomy is sub-optimal for maximizing individual welfare, because it does not sufficiently protect individuals from possibly mistaken preferences for (assisted-)suicide. I suggested a heightened standard of rationality should be upheld for individuals who want to end their lives in the case of completed life, because providing individuals with a deeper understanding of their self and their desires when still alive, can have beneficial consequences for their outlook on life (e.g. influence their preference for suicide).

Finally, in the last part of chapter three, I argued that the extent of the harm-principle should be broadened to include psychological harm to family and friends in cases of (assisted-)suicide as a sufficient warrant for interference, because it would benefit the maximization of societal welfare. External individuals who facilitate the assisted-suicide (e.g. end-of-life supervisors or physicians), should be allowed to make family and friends of the suicidal individual aware of the fact that someone close to them is considering suicide, even against the will of the suicidal individual. This gives family and friends an opportunity to talk about the situation with the suicidal individual. Moreover, it gives them the opportunity to say goodbye and clear up any misunderstandings. This can lead to a reduction of feelings of grief, guilt, and retrospective responsibility that bereaved family and friends experience, thereby minimizing overall societal pain.

In chapter four I have discussed the other side of the autonomy-paternalism debate, which is the side of paternalism. In this chapter I discussed two questions. The first is: *to what extent is soft-paternalism justifiable in the case of completed life?* Soft-paternalism is about ensuring that one makes sufficiently voluntary self-harming decisions, to make sure one's decisions represent one's own will. I discussed if requests for assisted-suicide by elderly could be considered insufficiently voluntary due to adaptive preferences in the later stages of life. Given, elderly do need to adapt their preferences because of naturally changing circumstances that come with ageing. For instance, old jobs and physically intensive hobbies fall away requiring elderly to redefine their preferences. However, even though options become more limited, I argued it is unfounded to think that the circumstances of being an old, but generally healthy elderly person, leads to a situation in which assisted-suicide is the only or even directly

preferable option. Therefore, I concluded that requests for assisted-suicide cannot be deemed insufficiently voluntary because of adaptive preferences.

Furthermore, I discussed the voluntariness of the life-ending decision with regards to age and depression. There is a chance that the mental competence of individuals, and thus their ability to make voluntary decisions, is influenced negatively due to the natural effects of ageing as well as cognitively distortive illnesses such as depression. It is shown that elderly who are contemplating suicide are often suffering from depression. As such, I have concluded that (temporary) soft-paternalistic interference, in terms of independent tests and interviews, is necessary to filter out requests for assisted-suicide that are insufficiently voluntary from those that are sufficiently voluntary. Furthermore, if suicidal elderly are judged to be an immediate danger to themselves and others by supervising experts because of autonomy-impairing elements such as depression, forced therapy should be attached to soft-paternalistic interference.

The second question I discussed in chapter four is: *to what extent is hard-paternalism justifiable in the case of completed life?* I proposed and discussed four conditions that need to be fulfilled to justify hard-means-paternalistic interference with the voluntary decisions of elderly to end their lives in the case of completed life. The conditions are (1) a universal standard of interference, (2) sufficient beneficence, (3) acceptable costs to autonomy, (4) and lastly, the duty for the paternalist to positively aid elderly in relieving their suffering.

(1) First, regarding the universal standard, I formulated a hypothetical paternalistic contract that I argued all elderly in the case of completed life should be able to reasonably agree to. The contract prescribes a temporary hard-means-paternalistic interference. Given the irreversible nature of suicide, while considering the fact that completed life is not about death itself but about ending suffering, and being aware of the potentially solvable nature of the suffering that elderly endure in the case of completed life, I think elderly can reasonably agree that, when the time comes, should they need it, life-ending medication is only available when it is with some degree of certainty established that no methods other than assisted-suicide can relieve the suffering they endure, to make sure that death is not caused unnecessarily. (2) Secondly, I concluded that interference can yield sufficient beneficence in terms of direct physical integrity and indirect mental well-being. (3) Thirdly, I argued that temporary hard-means-paternalistic interference results in acceptable costs to the autonomy of elderly. I concluded that autonomy losses are minimized if the hard-means-paternalist is

correct about the instrumental incorrectness of a request for assisted-suicide. This is because it is likely that the coerced individual can consent to the interference afterwards. Cases in which gratitude is not subsequently expressed are also taken into consideration due to the temporality of the interference. Furthermore, I argued that discussing a death wish as a part of paternalistic interference in the case of completed life results in acceptable losses to the autonomy of elderly in terms of privacy. I concluded that individuals are generally willing to relieve their suffering over maintaining their (right to) privacy. Sacrificing privacy, by discussing a death wish in a confidential setting, can only be a small price to pay for alleviating suffering. Based on the reasons elderly have for requesting assisted-suicide, paternalists can, together with elderly, figure out the best way to end their suffering. (4) Lastly, I argued for the adoption of a positive duty for the paternalist to help elderly with alleviating their specific suffering, to further justify interference based on the hypothetical contract. The positive duty is necessary to establish the instrumental correctness of requests for assisted-suicide by elderly in the case of completed life.

Finally, in conclusion with regards to the main question: *To what extent, or under what circumstances, does the state have a right or duty to interfere with the autonomy of its citizens regarding the medical-ethical issue of completed life?* In a high-risk area like completed life, paternalistic interference should be the primary guideline. In accordance with my conclusions, the state should have the right to protect elderly, through temporary soft-paternalistic interference, from making insufficiently voluntary life-ending decisions. Furthermore, the state should have the right to protect elderly, through temporary hard-means-paternalistic interference, from their own instrumentally bad decisions, to make sure that elderly do not request life-ending medication based on a false desire for assisted-suicide. Moreover, I argued that the state even has a duty to help elderly explore alternative solutions to their suffering, before making life-ending medication available, to ensure that any doubts about the instrumental correctness of requests for assisted-suicide by elderly are minimized.

Accordingly, I argued for the institution of a hypothetical paternalistic contract. After the request for assisted-suicide has been deemed authentic, the hypothetical contract comes into force. Life-ending medication should only be available to elderly when it is with some degree of certainty established, through the heightened standard of rationality and the positive duty during the mandatory waiting period, that no methods other than assisted-suicide can relieve the suffering that they endure. Yet, if the suffering of a mentally competent

elderly person cannot be sufficiently alleviated through positive interference, respect for autonomy must ultimately take precedence over further paternalistic interference, because in the end, it must be concluded that external actors can never fully understand the pain that another individual experiences. If all has been tried, the individual is the only one who can decide if life is worth continuing.

5.2 Societal implications: reflecting on D66's completed life bill

Considering the findings in this thesis, my judgement of D66's completed life bill is mainly negative.

When it comes to safeguards, D66 argued for elderly to have two conversations with an end-of-life supervisor, over a course of at least two months, to ensure that requests for assisted-suicide are voluntarily made, well-considered (e.g. informed) and durable (e.g. enduring). Following my conclusions, I would agree that it is important to ensure the voluntariness and durability of end-of-life requests. Voluntariness can be lacking because cognitively distortive illnesses such as depression are prevalent with elderly who consider suicide. And ensuring durability by way of a temporal-requirement is important to make sure that individuals do not base their decision to die on temporary preferences as discussed in §3.6.2. However, considering my conclusions, a closer look at the bill reveals important flaws.

First, I have reservations about D66's *universal* two-month waiting period to test durability. Even though D66 has the right idea in mind by suggesting a waiting period to test durability, it might be better if the duration of the waiting period were to be determined *individually,* as explained in §3.6.2. This is because the time it takes to determine if a preference for (assisted-)suicide is temporary or not can differ from person to person based on the personalities of individuals and the circumstances individuals find themselves in.

Secondly, D66's safeguards of two mandatory conversations and a two-month waiting period are insufficient to protect the well-being of elderly during the end-of-life process. Conversations and a waiting period could be enough to ensure the authenticity and durability of an end-of-life request but are not enough to ensure that a preference for assisted-suicide is instrumentally correct. Mere conversations and a waiting period do not place elderly in different states of being. For elderly to be able to properly explore the instrumental correctness of their death wish, they need to be put in a situation where they can utilise possibilities for life-improvement, as explained in §4.4.4 on a positive duty for the paternalist.

Thirdly, in this legislative proposal, assisted-suicide is seen as an acceptable first solution to the problems elderly are dealing with. This is because after clearing the safety conditions, options for life-improvement are explored only when the individual desires this (Dijkstra, 2016, p. 25). I would argue that because the legislative proposal offers life-ending medication as an acceptable first solution, the pressing issues that elderly are increasingly dealing with in society are not sufficiently addressed. Showing respect for a vulnerable group in society by taking their problems seriously starts with searching for, and exercising, viable solutions to those problems. Offering assisted-suicide as an acceptable first solution under the veil of 'respecting autonomy' after becoming aware of the potentially solvable nature of the problems elderly are facing, is in my view a twisted form of respect. Life-improvement must be the priority with completed life to ensure societal commitment to caring for its citizens. Societal commitment to care for elderly decreases when suicide is seen as an acceptable first solution.[26] I would urge legislators to emphatically include temporary hard-means-paternalistic interference in the legislative proposal to make sure *solving* the issues that elderly are dealing with is seen as the only acceptable first option.

Lastly, the bill fails to consider the societal impact of the autonomous life-ending decision. Especially the impact on direct family and friends is neglected. In the bill, family and friends are only involved in the end-of-life process when elderly considering suicide explicitly want this (Dijkstra, 2016, p. 25). In accordance with my conclusions in chapter three, the involvement of family and friends should be instituted in the end-of-life process to ensure a minimization of societal pain.

5.3 Disadvantages and merits

In this thesis I have made the choice to limit the discussion regarding completed life to the secular theoretical framework surrounding paternalism, and thus have not reviewed religious perspectives on completed life. I have also not discussed ends-paternalistic views on (assisted-)suicide. Even though less relevant to the current discussion, these perspectives might yield

[26] For empirical support of this worry for a slippery slope, one can refer to recent developments regarding the existing medical euthanasia law. In recent years, regular medical euthanasia has been offered in an increasing range of cases. On top of that, physicians have been increasingly more willing to help with euthanasia, without changes of the law (ANP, 2017).

valuable knowledge about the concept of completed life. Not including them has helped me to limit the scope of this thesis but has consequences for the comprehensiveness of this thesis.

To answer the main research question posed at the start of this thesis, I have used the methods of analytical political philosophy. A method of analysis in which I have tried to answer the main question by reflecting on the main values in the debate through moral arguments, analogy and empirical evidence. This method lead to a clear structure guiding this research project.

Finally, the research findings presented in this thesis yield value beyond strict academic merit. By applying the political theory on autonomy and paternalism to the practical ethical context of completed life, I have constructed a moral framework that provides valuable argumentation in guiding policy-making on completed life.

5.4 Further research

Next to religious and ends-paternalistic views mentioned in the previous section, more topics concerning completed life are still open to further research that I have not been able to touch upon here. Two come to mind specifically.

First, in this thesis I have primarily discussed the issue of what restrictions can legitimately be put on autonomous decision-making in the case of completed life and what societal duties might come with these restrictions. Based on the arguments presented, one would be right to assume that if these restrictions are off-limits, individuals should automatically gain the right to an autonomous life-ending decision. However, I have not discussed the perspective from those who are to specifically *provide* the life-ending medication. From the conclusion that the life-ending decision should be autonomous under certain conditions, does not necessarily follow that life-ending medication should also be provided. Paternalists and physicians can also make use of their autonomy and might have reservations with regards to helping to end the lives of healthy individuals. As such, the specific duties of paternalists and physicians towards individuals who want to end their lives, and the validity of the healing ethic that grounds medical practice, should be researched.[27]

[27] The term 'healing ethic' refers to the obligation of physicians, grounded in medical practice through the Hippocratic oath, to always heal and never harm (read: end the lives of) their patients (Cholbi, 2011, p. 146).

Second and lastly, the age-barrier as a condition for aid-in-dying comes to mind. Even in the bill by D66, concerns were expressed over the arbitrariness of an age-barrier (Dijkstra, 2016, p. 24). Further research should be conducted to see if this discriminatory rule is justified.

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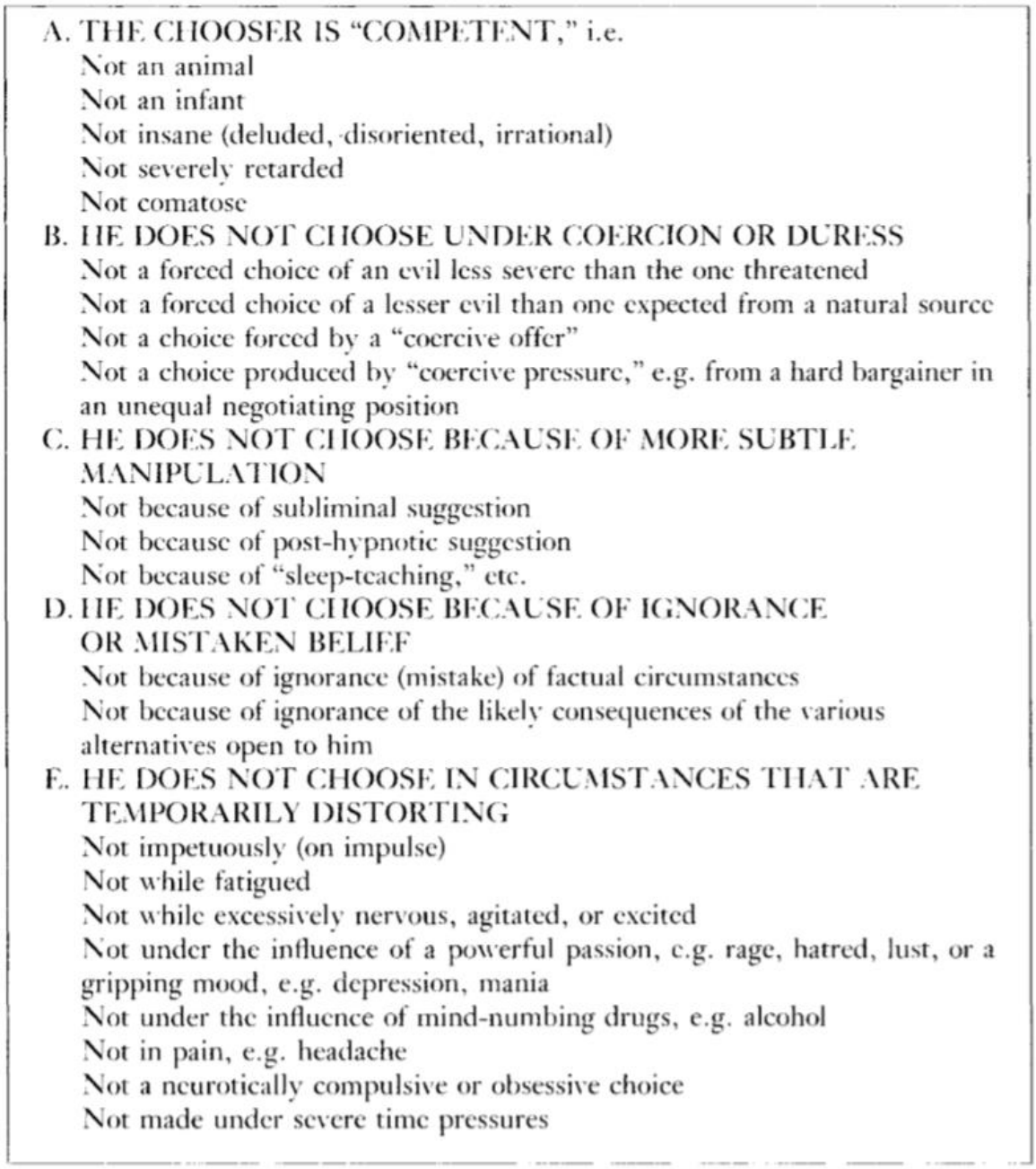
APPENDIX A



A. THE CHOOSER IS "COMPETENT," i.e.
Not an animal
Not an infant
Not insane (deluded, disoriented, irrational)
Not severely retarded
Not comatose

B. HE DOES NOT CHOOSE UNDER COERCION OR DURESS
Not a forced choice of an evil less severe than the one threatened
Not a forced choice of a lesser evil than one expected from a natural source
Not a choice forced by a "coercive offer"
Not a choice produced by "coercive pressure," e.g. from a hard bargainer in an unequal negotiating position

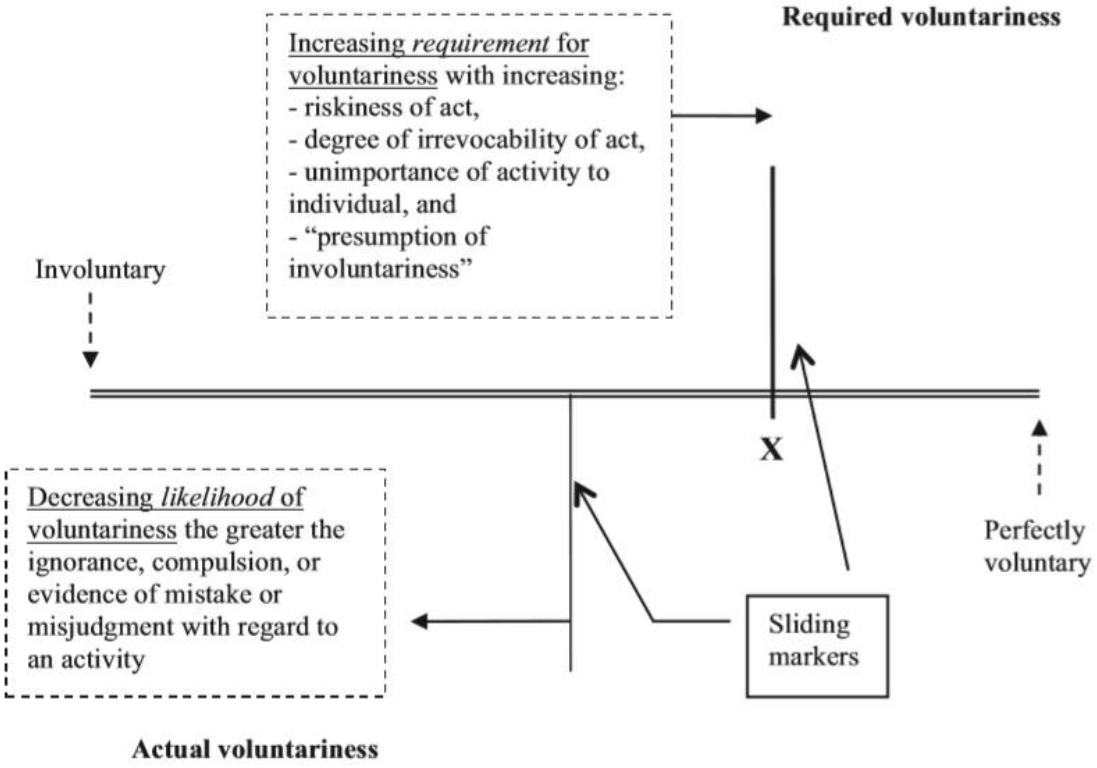
C. HE DOES NOT CHOOSE BECAUSE OF MORE SUBTLE MANIPULATION
Not because of subliminal suggestion
Not because of post-hypnotic suggestion
Not because of "sleep-teaching," etc.

D. HE DOES NOT CHOOSE BECAUSE OF IGNORANCE OR MISTAKEN BELIEF
Not because of ignorance (mistake) of factual circumstances
Not because of ignorance of the likely consequences of the various alternatives open to him

E. HE DOES NOT CHOOSE IN CIRCUMSTANCES THAT ARE TEMPORARILY DISTORTING
Not impetuously (on impulse)
Not while fatigued
Not while excessively nervous, agitated, or excited
Not under the influence of a powerful passion, e.g. rage, hatred, lust, or a gripping mood, e.g. depression, mania
Not under the influence of mind-numbing drugs, e.g. alcohol
Not in pain, e.g. headache
Not a neurotically compulsive or obsessive choice
Not made under severe time pressures

Model of a perfectly voluntary choice according to Joel Feinberg (Feinberg, 1986, p. 115).

APPENDIX B



Sliding scale of voluntariness in Feinberg's soft-paternalism (Le Grand & New, 2015, p. 120).