EUTHANASIA AND THE DUTY TO DIE

A moral advocacy of the responsibility to end life at the right time

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Abstract

The general aim of this project is to investigate thoroughly the moral issues related to death and dying in medical contexts, focusing on those cases where patients seek help to die on their own terms. The focus of the debate in society at large tends to focus on the question of whether it is morally *permissible* for a patient to ask for help to die, and whether it is morally *permissible* for a doctor to provide that aid. This issue will be thoroughly discussed in the course of this study. But the primary aim of this project is to approach this debate from a different and hitherto neglected angle. If there is a moral *duty* to die in certain circumstances, then the traditional debate needs to be recast. Put another way, if there is a moral *duty* to die in certain circumstances, then there is a related *right* to aid in carrying out this duty if such aid is required: a right which confers a moral *obligation* on those who can provide that help. This casts the familiar debate in an entirely different light. The primary aim of the project, then, is to establish that there is indeed a moral duty to die in certain circumstances, and to work out and analyse the ramifications of this claim.

The hypothesis defended in this project is the recognition of a personal moral duty to die in certain scenarios, for which active euthanasia must be among the available procedures to end one's life when one has such a duty. Timing is paramount for those who recognise their duty to die and are willing to retain control over their dying. Therefore, active euthanasia is one of the medical procedures that allows patients to retain control over the time of their dying, which further offers them the possibility to find meaning in their lives and deaths. Another integral part of our thesis is advocating for the active role that healthcare practitioners must play in actively ending the patient's life at her own request. Healthcare professionals must acknowledge their societal role as medical experts whose duties are ultimately based on a shared understanding of what is good and fair for all. Finally, although it is discussed in the first chapter, an overarching metaphysical reflection regarding the meaning of life and death, together with a consideration of the evils of dying, supports the ideas and arguments presented. Ultimately, both the duty to die and active euthanasia rest on the consideration that, sometimes, death is preferable to suffering in life and can also provide a final meaning to our existence.

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1. INTRODUCTION

You will die. I will die. Everybody has to die. The end of life makes us all equal, no matter our political, social or economic background. Furthermore, is life not a continuous act of dying? Every hour we spend alive, every time we blink, we are gradually leaving life behind us. Every breath we take, we are closer to our death. However, there is nothing we can do to avoid this inevitable fact. Despite that, there are still a lot of people for whom facing death in a complex and autonomous way would be an enormous and problematic issue. Especially so when death has become a highly medicalised process. People now tend to live longer lives due to all the scientific advances that have contributed to the improvement of medicine, although, on the other hand, chronic and terminal diseases are more common as a result of our extended lives. Consequently, death usually comes after a prolonged period of pain and suffering.

In this context, discussion should not focus on the de-medicalisation of death, for the best medical care can only be provided by healthcare professionals. The main concern lies in how to humanise an already medicalised death. It is at this point that reflection on the available means to end life and their morality becomes relevant. As autonomous individuals, some people deem it important to decide how and when to die, besides any motives they may have to make such a decision. Thus, we are, to some extent at least, responsible for our dying as part of a medicalised death that allows us to retain control and autonomy until the very last minute of our existence. Similarly, our moral responsibilities do not disappear; within them, our caring duties towards others might give rise to a duty to die.

The general aim of this project is to investigate thoroughly the moral issues related to death and dying in medical contexts, focusing on those cases where patients seek help to die on their own terms. The focus of the debate in society at large tends to focus on the question of whether it is morally *permissible* for a patient to ask for help to die, and whether it is morally *permissible* for a doctor to provide that aid. This issue will be thoroughly discussed in the course of this study. But the primary aim of this project is to approach this debate from a different and hitherto neglected angle. If there is a moral *duty* to die in certain circumstances, then the traditional debate needs to be recast. Put another way, if there is a moral *duty* to die in certain circumstances, then there is a related *right* to aid in carrying out this duty if such aid is required: a right which confers a moral *obligation* on those who can provide that help. This casts the familiar debate in an entirely different light. The primary aim of the project, then, is to establish that there is indeed a moral duty to die in certain circumstances, and to work out and analyse the ramifications of this claim.

The euthanasia debate is far from over, and there are now new demands which have given rise to even more controversial issues related to how we end our lives and the means available to do so. Death is something we will all face at some point, and the way we confront this experience, as well as the way to end it, is of decisive importance. Public opinion around end-of-life choices and physician-assisted death has wavered from its total prohibition to its moral acceptance and legalisation in some countries (e.g. euthanasia and physician-assisted suicide in the Netherlands, euthanasia in Belgium, and assisted suicide in Switzerland). Physician-assisted death includes both euthanasia (Wreen, 1988) and physician-assisted suicide, the sole difference being who is the active agent in the act of ending a life: doctors in the case of euthanasia, and the patient herself in cases of physician-assisted suicide.

In more recent times, and notably since the 1980s and 1990s, with the publication of a handful of articles (e.g. Hardwig, 1997) and books (e.g. Battin, 1994) on the subject, there has arisen a new topic related to death within medical and familial contexts that requires attention: the duty to die. This can also be understood as the responsibility to die at the right time in a world where resources are scarce in our contemporary health care systems (Margaret Pabst Battin, 2005); and where the risks of becoming a burden to our loved ones due to a terminal illness (Hardwig, 1990, 1997b) are increasingly high. Thus a thorough review of doctors' duties in helping patients die will be needed, as well as addressing to what extent these duties must be performed (Varelius, 2006; Veatch, 2000).

Besides those who, as already mentioned, advocate in one way or another a duty to die, there is a widespread reluctance to accept the existence of such a duty. No consensus has yet been reached regarding the moral character of the duty to die and whether it truly exists. Adding to these difficulties, active euthanasia is illegal in most countries, which thwarts many people's right to have their autonomy protected and respected also at the end of their lives. After all, the illegalisation of active euthanasia imposes on many people the obligation to die in ways they regard as undesirable.

Those topics have all been addressed separately, but until now nobody has considered them all together, examining and discussing their interrelation. Our current research offers a unifying perspective where the duty to die and euthanasia are both seen as legitimate and morally defensible proposals within an already medicalised death, because they are together a better alternative, for many people, than spending their last days in pain and suffering. Is there a duty to die? Is active euthanasia a morally defensible alternative for those people who recognise their duty to die? Who should perform active euthanasia? Why doctors? The originality of this project thus lies in developing and analysing the ethical notion of a duty to die. In particular, it will be argued that this approach can help to reappraise the controversial issue of physician assisted-dying from a new perspective and allow established ideas of patient autonomy to be challenged by a new bioethical conception of justice and individual obligation. Ultimately, this will offer a more profound understanding of death in medical contexts and the ethics underlying those debates.

The hypothesis defended in this project is the recognition of a personal moral duty to die in certain scenarios, for which active euthanasia must be among the available procedures to end one's life when one has such a duty. Timing is paramount for those who recognise their duty to die and are willing to retain control over their dying. Therefore, active euthanasia is one of the medical procedures that allows patients to retain control over the time of their dying, which further offers them the possibility to find meaning in their lives and deaths. Another integral part of our thesis is advocating for the active role that healthcare practitioners must play in actively ending the patient's life at her own request. Healthcare professionals must acknowledge their societal role as medical experts whose duties are ultimately based on a shared understanding of what is good and fair for all. Finally, although it is discussed in the first chapter, an overarching metaphysical reflection regarding the meaning of life and death, together with a consideration of the evils of dying, supports the ideas and arguments presented. Ultimately, both the duty to die and active euthanasia rest on the consideration that, sometimes, death is preferable to suffering in life and can also provide a final meaning to our existence.

This thesis is divided into five chapters. Chapter 1 initially examines metaphysical considerations about death and its relation to the possibility of finding meaning in life. Different perspectives on giving value to and finding meaning in our lives are thoroughly examined and discussed, focusing on the crucial role that death plays within those views. Later, a variety of approaches to addressing whether death is bad and, if so, what its evil is, are discussed. In relation to this, we will consider and examine the possibility that other evils in life are worse than death, which will confront us with the question of what to do in cases where one's life will be full of evils worse than death.

Chapter 2 aims to offer a response to that last question, examining the morality of active euthanasia as an alternative to ending life when all that remains is pain and suffering. This second chapter will initially address the clarification of key concepts, and later on different arguments for and against euthanasia will be assessed. The main thesis of this chapter is to defend the moral acceptability of voluntary euthanasia in certain circumstances, and to examine the relevant reasons and situations where that would be the case. A final analysis of the wish to die is offered, in order to gain a more thorough understanding of patients' situations when they request that their lives be ended.

Chapter 3 thoroughly examines the moral justifiability of the existence of a duty to die. Any such duty will be understood as the responsibility to end one's life at the right time in order to avoid becoming a burden to others, mainly family and loved ones. Initially, the focus lies on the definition and complete understanding of the duty to die and its implications, paying close attention to the notion of being a burden and its relevance for the main argument. Later, the principal argument in defence of the duty to die is explained, and further clarification is provided in relation to other general implications the duty to die might have, i.e. whether it applies to incompetent patients, its impact on finding meaning in life, and also the likelihood of its existence. Third, different understandings of the duty to die are explored in order to establish the shared moral features that allow us to (re)affirm its existence. Finally, objections to the duty to die will be answered.

Chapter 4 attempts to provide a metaethical foundation for the duty to die, against those detractors who point to the lack of a normatively supporting ethical theory. These chapters will show that it is not necessary to include the duty to die in any specific normative theory, for the predominant reflective equilibrium methodology in medical ethics sustains and validates it. A preliminary metaethical reflection for situating our reflection will initially be offered. Later, the emphasis will shift to the metaethical roots of the duty to die and their defence.

Finally, chapter 5 offers a clarification on healthcare professionals' role, especially physicians, in the newly defined context where voluntary active euthanasia is permissible and there is a duty to die. The chapter starts by thoroughly examining the traditional medical approach where the prohibition on ending a patient's life was regarded as the fundamental, unbendable rule that could not be trespassed. Secondly, this traditional approach is questioned in relation to the moral permissibility of ending a patient's life at her own request, which is proven to be compatible with physicians' duties and the main biomedical principles. As a result, a new model of healthcare practice is proposed, where the focus lies on three main issues. First, palliative care and end-of-life decision-making are shown to be complementary, and not exclusionary, procedures for guaranteeing optimal care for patients at the end of their lives. Second, conscientious objection is analysed in moral terms in order to understand whether it should be always permitted or, on the contrary, whether there are limitations to situations where healthcare professionals can object to performing euthanasia. Finally, further explanation is provided for why doctors are those who must carry out end-of-life procedures, due to their expertise and a wider societal understanding of their obligations acquired as healthcare services providers.

2. METAPHYSICS OF LIFE AND DEATH

Death has always struck human beings as one of the most important and, at the same time, difficult topics to address and deal with. The mere thought of nothingness makes some of us tremble in fear and, without us even noticing, it challenges our most deeply enrooted assumptions about life, from the significance of our daily routines to the meaning of those projects we engage so passionately in. Does anything make sense? Where and how do we find meaning within the awareness of our finitude?

However, before engaging in a journey to explore the relationships between death and meaning, it is worth noting how human perception of death has changed and evolved historically. Following Pabst Battin (2005, Chapter 17), there have been three transformations in the way Western societies have faced death. First, we find an epidemiological transition (Olshansky & Ault, 1986), as the result of medical and technological advances in medicine and public health. Not so many centuries ago, diseases that have a known and easy solution nowadays were the main cause of death. However, those illnesses would occur early in their lives, impeding people from aging and having the opportunity to live longer. Consequently, they would not reach what is consider today the average life expectancy, which has been furtherly increasing with the passage of time. The result of those improvements has been the postponement of death to later years of age, and, when death comes, it is usually under completely new appearances, unimaginable for our predecessors: degenerative diseases. A second major variation in our perception of death consists in the secularization of society and the abandonment of very old and deep-rooted religious attitudes towards death. Gradually, persons have been developing a stronger sense of possession of their own life and body, not considering it sinful to dispose of them as they please, regardless of what a deity could think, blame, or punish them for. Together with that, people are less likely to see death as a divine punishment for sin, or to consider suffering a prerequisite for afterlife; also, suicide is now mainly regarded as an issue caused by mental illness and depression, rather than a stigmatized and serious sin (Margaret Pabst Battin, 2005, Chapters 7 & 17). A final decisive change led us to our present situation, where individuals are empowered to decide upon their own deaths. People are now entitled and able to adopt, within certain boundaries, variating from one legislation to another, different attitudes and resolutions towards their deaths. Death is no more something that happens to us, but something we can decide when, where, and how to bring about. It is easy to appreciate the clear emphasis in the notion of individual rights of self-determination that goes together with this last alteration. Like most historical transitions, taking over our own deaths has been an ongoing process. Withdrawal of medical treatment[1] was the first practice to be legalised, hence bestowing more autonomy at the end of life. Later, other procedures would follow, as the cases of terminal sedation, physician-assisted suicide (PAS), and active euthanasia[2]. Although this last one is only legal in certain jurisdictions[3]. This shows how individuals have been gaining control over many dying's features, for these procedures do give patients more alternatives about when, how, and even why they will end their lives.

Closely related to this evolution of our perception of death, but in a different domain, there is the necessity of conceptual clarification for the upcoming sections apropos of what we are talking about when we speak about/of death. Three are the ideas that need elucidation: the process of dying, the moment of death, and being dead. We will consider the *process of dying* as the period from where a person knows that life is coming inevitably to an end in a short period of time to the moment of death (e.g., those patients with terminal illnesses). The second concept could be defined as the precise moment, a thin line were we to draw it, when a person gives her last breath and ceases to exist. It is the instant where our existence comes to an end, the separatory moment between being alive and being dead, and could be named as *the moment of death*[4]. The last of our notions, *being dead*, can be understood as all the time following that precise moment of death, the time when a person no more exists after her death.

1.1. Death, meaning, and value in life

Death and meaning in life are closely related and mutually affected by each other. Some[5] affirm that death can help us find meaning in our lives, furthermore that we can find meaning in death, while others[6] assume the opposite, even when acknowledging that death itself does not remove any meaning that life could have, they think that a longer existence would permit us enjoy lengthier the good facets of life. There are still others who affirm that it is of extreme urgency to find meaning in aging and death itself[7]. We will analyse and

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[1] The withdrawal of treatment is widely considered and regarded as passive euthanasia.

[2] Detailed definitions and a clarification of all those notions, as well as their differences, will be offer later in chapter 2.

[3] Among them we find, in Europe, The Netherlands, Belgium, Luxemburg, and, most recently, Spain. PAS is legal in Germany and Switzerland.

[4] The expression is commonly use within the medical context to establish and delimit the precise time when a patient dies.

[5] See (Schenck & Roscoe, 2009), (Nussbaum, 1994, Chapter 4), (Williams, 1993), (Hardwig, 1997b), (Callahan, 1993).

[6] See (John Martin Fischer, 2009, Chapter 7), (Thomas Nagel, 1979, Chapter *Death*).

[7] See (Williams, 1993), (Schenck & Roscoe, 2009).

comment on those different perspectives later within this section, but we shall now offer some introductory ideas that will aid us when discussing them.

Paradoxically, two of the most important features that we need to address when we start thinking thoroughly about death have their origin in birth (Nagel, 1986, Chapter 11), and the fact that we exist at all. So, when a profound reflection about our existence begins, these two main characteristics significantly arise above others less important: the contingency and the unimportance of our lives. By contingency we refer to the fact that we are here by luck, no right or necessity, and that removes an unnoticed but important support, i.e., the sense of security and confidence with which we go on living day after day. On the other hand, the unimportance of our lives reflects the fact that there are no specific reasons for any of us to exist at all, our existence is entirely gratuitous. Certainly, the insignificance of our lives does not mean that finding meaning and value in them is unreachable or impossible, but simply that we are an irrelevant part in the world, with insignificant impact on it when considered from a bigger scale perspective. Those two factors inevitably take us to the problem of meaning, the challenging task of regaining certainty about life and finding something that makes it worth living, even when death is the unescapable end.

However, before focusing on different attempts to give content, value, and meaning to life, there is a structural difficulty that needs attention. In what follows, we need to have present the all-embracing dilemma of two conflicting perspectives that seize us when pondering and assimilating our own mortal condition and finitude (Nagel, 1986, Chapter 11). There is an internal fight within us between two outlooks, an objective one, so called *philosophical*, and a subjective one, considered more *personal*, both trying to stablish themselves as the predominant one. On the one side, the objective perspective powerfully indicates us to find meaning in viewing ourselves as part of the universe, in harmony with it. On the other side, our subjective perspective demands that we find the meaning of our lives within our current social and historical setting. The subtle philosophical problem is that objective meaninglessness threatens human life even at its subjective best. Sadly, there is no integration possible of the two views, at least for Nagel, but we can still try to accommodate both, finding a tolerable level of harmony which does not frozen us and impede us carrying on with our lives. What is worth saving and having present in the forthcoming discussion, as Nagel adequately points out, is the fact that every person has the two conflicting and opposing attitudes, leading a life towards which she feels simultaneously engaged with and detached to. We think this is what really generates the subjective necessity of looking for meaning while an internal thought is always whispering to remind us about the objective true of our deathly condition. But death is personal, it happens to each of us and thus the way every person embraces it depends entirely on her worldview.

Seneca says, on his *Letter LXX*[8], as if foretelling the previously mentioned changes in our attitudes towards death, that dying well means escaping from the dangers of living badly. And although Seneca referred mostly to suicide, his thought becomes highly relevant to our discussion. For, what is a bad life and what a good one? Both, *good* and *bad*, are moral terms that we employ to evaluate a person's life. Yet, value is not an attribute life is originated with, it is an external and complementary element that can be adhered to it. So, how do we give value to a life? It would be risky to assert that there is an exclusive and unique way of doing so. Thus, it is worth examining various theories that present diverse ways of doing so and trying to find the best manner of implementing them together. The focus will be on their compatibilities and strengths, rather than exclusively on their incongruencies and irreconcilabilities.

We will address the topic always bearing in mind whether death could deprive a life completely of meaning or, on the other hand, whether it would be the main feature that gives value to it. Our position, despite this previous overarching consideration, will be the defence of the essential and irrevocable intertwinement of life and death, their mutual necessity in shaping life and providing it with meaning (Callahan, 1993, Chapter 5). Life needs to be interpreted as providing a central and integral role to death. For, what is life if not the continuous waiting for death? What is death if not the permanent losing of life, a wearing away that goes on all the time? Death is a necessary compliment to life, it is always with us, constantly reminding that one day everything will be over, that one day, for the individual, there will be nothing. However, this view is not contrary to Fischer's (2009, Chapter 7) defence of the possibility of immortality and the reflection on the value of life that it invites us to do. Martin Fischer defends that temporality, or time extension, is only one dimension of our lives and therefore finitude is not essential to the narrative structure of our lives. There are other dangers, different from death, which can give value to and shape life; among them we find physical and emotional features that give worth to our experiences and contribute to the overall value of life. As expressed before, the fact that value can be adhered to life from various sources does not imply that they are necessarily exclusive. For, Fischer's reflection summons us to consider different aspects that might coexist with and be complimentary to temporality as an intrinsic value of life.

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[8] See (Seneca, 2010).

At this point, it is important to note that we are approaching life from a narrative perspective; following Allan H. Goldman, “meaningfulness in life is a matter of narrative intelligibility” (2018, p. 127). This meaning in our lives will emerge from the internal coherence within different life events, together with their pointing outside themselves, becoming intelligible in terms of their relations to future and past events, and our overall plans and goals. It is important to highlight the three-folded relation of the meaning of events. That is, something means something else to someone[9]. That stresses the relevance of events when they are acknowledged by the subject, recognised as significant for her, and she is able to stablish relations to preceding and following events (Goldman, 2018).

So, if we are going to approach life as a story, it comes clear to our minds that death is the (happy?) end of it. But, like all stories, we cannot fully tell the value of it, what we can learn from or despise in it, until its very end. Applying this idea of value, we will not be able to wholly evaluate a life until the moment of the individual’s death. That means, following Velleman (1993), that wellbeing is not additive because the value of a period of time has global features, i.e. the same increment in one’s momentary well-being has a different effect depending on when and how it occurs within the individual’s life. On the other side, the value of a moment is a temporally local matter that needs fitting in a major timeline to be given a more appropriate meaning. We can see then that later events modify the meaning and value of earlier events in life, shaping them, and altering the contribution to one’s life. The value of a particular moment is determined by its position in the larger trend, and by its relation to other events in the same life. Given a specific moment, e.g., meeting what will become your best friend later, it acquires full significance and value within your life depending on the time the meeting occurs and other relevant surrounding, but defining, conditions of your life that will let you accommodate the value of this new friendship within your existence. Presumably, meeting your best friend sooner than later would increase the overall value and meaning of your life, but engaging with that is not necessary for our argument and thus cannot be address here.

Equally important to the previously mentioned Fischer’s consideration of death for the meaning of life, and not necessarily exclusive, we find Nussbaum’s (1994, Chapter 6) affirmation that mortality gives value to human experience, and thus it is a constitutive factor in all valuable things. She presents death as having a central and determinant role in life, where many of the values we have now would not be such in a deathless experience.

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[9] In a more formal way, the sentence would be: “x means y for z”. This way of presenting it might highlight more clearly all the different possibilities for a given life event to have a specific meaning for certain person.

Those values are only comprehensive within a temporary conception of life. But, it could be thought, our fear of death can paralyse us and stop us from having a valuable life and enjoy the process of living. However, Nussbaum balances this fear with reflections that diminish its immobilizing power, reflections that treats that fear from a better comprehension of mortality, its acceptance, and the positive role it has in our lives. Among the good aspects of our mortal condition, we find that our awareness of death help us develop an instinct of self-preservation. Contrary to Lucretius[10], Nussbaum's therapy to combat the fear of death, does not leave aside the full enjoyment of diverse pleasures and joy, but it integrates them offering a deeper understanding of the connections between them and the fear of death[11]. She accepts one's mortal condition and limits, as well as one's desires in life, not fleeing to *ataraxia*, like epicureans propose.

However, despite this apparent contradiction with epicureans' conception of pleasure and desires, Nussbaum's seemingly irreconcilable position can be reunited with a new approach to epicureanism offered by Luper-Foy (1993) and his conception and definition of "Neo-epicureans". His position begins with a similar standpoint of that presented by Nussbaum, the acceptance of death, more precise and updated to nowadays time: the acceptance of an average life-expectancy determined by technology and medical advances. So, we basically need to accept that dead will come to us when doctors, with all the means available, will not be able to save our lives. But, how to live in the meantime? Luper-Foy, following many epicureans before him, propose an existence where the individual squeezes out of life as much as it is possible, as much as a lifetime can hold. When doing so, she needs to have very present that she must not allow her happiness to require more than what is rationally extractable from life. To do so, it becomes of chief importance the way we, as individuals, approach our deaths and the future that will follow when we will not be there anymore. Luper-Foy's proposed strategy to do so rests on two main aspects. Firstly, we must work our way through to be completely dispensable at the very end of our lives. This means that we must eliminate all those desires that we rationally comprehend are unachievable by that time. It is true that some desires will be impossible to remove, but they are just a few that we need to adequately identify and discard the rest. A second, and closely related, aspect is the importance of leaving every matter solved by the time of our deaths, so they will not be thwarted. Put in different words, we shall avoid forming new aspirations that death is certain to defeat.

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[10] See (Lucretius Carus & Stallings, 2007) and section B of this chapter for more information about Lucretius' position against the fear of death.

[11] It must be specified that what Lucretius is referring to is the 'fear of dying'. More will be added later in section B of this chapter.

We have just seen how the satisfaction of our pleasures can be a relevant component in our efforts to provide life with value. Evidently, it would be enough for epicureans, or neo-epicureans, to live what would be defined by them as a happy and pleasant life, yet many others would argue that the fulfilment of your most basic desires is not sufficient to qualify life as valuable. Of special interest at this point we find Susan Wolf's (1997, 2007) attempt to provide us with a more complex and holistic theory of the features that give value to life. Besides happiness and morality, she suggests a third defining characteristic of the value of life: meaningfulness. But what does she mean by that term? Wolf understands *meaningfulness* as the active engagement in projects of worth[12]. Before examining in depth this notion and its implications, it is important to highlight that happiness, morality, and meaningfulness are, all three, necessary to live a good life. A good life needs to have moments of enjoyment, entertainment and pleasure, situations that are only valuable because we are satisfying our desires, physical or intellectual; in other words, moments of doing plainly what we want. However, living a life exclusively centred in our wants would not be completely satisfactory and whole without a sense of duty, provided by morality, a notion of what is right and wrong. There is a more or less objective morality towards which we can judge and define our actions in order to comprehend their correctness. This is not the place to develop a thorough theory of morality, but it should be enough to point that most moral theories define or supply the individual with the tools to do so, what is right or wrong, good or bad, within its own limits. A third, and last, component is the concept of *meaningfulness*. This feature rests upon the philosophical assumption that there exists a distinction in worth of different actions and activities. And Wolf follows stating that it is undeniable that we do believe that some projects are worthwhile whereas others are a waste of time. It should not be difficult for any of us to think about routine actions or fully valueless projects that individuals around us are engaged with. A very good example for that is offered by Rawls when presenting the case of a happy grass-counter. Imagine the case of a Harvard professor whose only source of happiness in her life is to count blades of grass in the University lawns. We are inclined to regards her life as meaningless, despite the personal active engagement the professor has obtained with her purposeless activity. It is also true that some of those projects, like the case of the grass-counter, would need a careful specification, and especial attention to detail and nuances would be required; nevertheless, we could be able to objectively find projects which worth is inexistent. In saying so, we must

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[12] There is room for critique to this affirmation questioning who has the authority to decide which projects are worthy and/or valuable, therefore, the risks of elitism. However, the only necessary assumption lies in accepting that there exists an unspecified socio-cultural consensus that determines the worth of some projects above others, and this unspoken consensus does not exclusively arise from the elites of a particular society, but from each and every of the groups within it.

notice the objective component of meaningfulness, considering that meaningful activities have valued independently of our interests. For example, composing a classic music masterpiece has objective value despite our total distaste or incapability to appreciate its magnitude and beauty, or our lack of musical knowledge.

Now that we have outlined the defining characteristics of those features that give life value, we must add some considerations about what motivates individuals to pursue a valuable life. Happiness, morality, and meaningfulness are not enough on their own to create the necessary stimulus on individuals to make them pursue a life full of value. It has been generally thought that there is only one reason that initiates the mechanisms of motivations in persons: self-interest. And this is normally deconstructed in terms of duties (deontological ethics) or pleasure (hedonistic ethics). However, once we consider meaningfulness as a crucial part in our considerations about value, we find the necessity to ponder other reasons, or at least a justifying explanation, to elucidate what motivates us. Those are the reasons of love (Wolf, 1997, 2007), which accept that the fact that an activity contributes to the meaningfulness of one's life is sufficient to motivate people to engage in projects that include that specific activity, even when they are not fully in accordance with duty or provide instant pleasure.

But, if that were the case, would that not mean that we are changing the topic of our discussion? If the above-mentioned reasons of love are the source of our motivation, would that not mean that we first value our projects and relationships within our lives and afterwards, just because of that, the events that happen or the projects we engage in contribute to the meaningfulness of our lives? That is the objection presented by Alan H. Goldman (2018), who would reject the idea of an objective theory of value, providing instead an account of the meaningfulness in life based on the narrative intelligibility of the events that happen within that life. He sustains that there are problems of possible misinterpretation of that supposed objective value with merely social and culturally constructed preferences or personal liking. Instead, he defends that the importance of meaning in life lays in the internal coherence of events, as well as their pointing outside themselves to configurate a higher narrative. Under this perspective, there are two clear sources of meaning (Goldman, 2018, pp. 136–139): 1) long-term goals: the broader the intentional context in which actions are embedded, the greater and deeper the meaning life has; 2) success: our life achievements matters to give our lives meaning, although it does not necessarily means success from a social, cultural or economic perspective, but in a much deeper sense of fulfilment of one's goals and roles in relation to others.

So far, a lot has been said about finding meaning and value in life. However, regardless of the metaethical considerations we sympathise with, either the objectivity of morals and its relevance to provide value in life, or the idea that meaning in life is subjective and based on an intelligible narrative, the role of death will be crucial. For, in the first case, it would mean the impossibility to engage in any other project of worth, also depriving us of any other objectively valuable thing in life and will necessarily be an issue to consider when engaging in our last days projects. On the other hand, from the point of view of a narrative, it would be equally important to consider whether it has any sense to ask about the possibility to seek meaning and value in death. Even though many will find counterintuitive this statement, even contradictory with what have just been held, a complete understanding of death will make us realise clearly that dying is only another happening, another event, yet an unavoidable one, in our lives. But it is precisely the certainty of our unescapable fate that enlightens and emphasise the relevance of finding meaning in death. The fact that we will all die, sooner or later, make us equal, and in that same sense, generates inside us the obligation to shape our last moments in order to close appropriately and coherently the story of our lives. One defining trait of a peaceful death, as pointed by Callahan (1993, Chapter 7), is its acceptance. We need to make peace with the fact that one day we will die, and we must do so in a personal manner, independently, finding the meaning that *our* deaths will have within *our* life. However, we are not likely to find it exclusively inside us or entirely by ourselves, we will construct the meaning with the help of others, within a community with which we interact and to which we contribute.

It is important to clarify, firstly, that those two factors are not contradictory; for, I, and I alone, am the one to search for meaning and give it to my own death, but that does not exclude my using the affective bonds created throughout my life with other persons. To exemplify our point with a writing metaphor can be clarifying. If our life were a book whose only author is oneself, nobody apart from ourselves would be entitled to write that final chapter, but nothing stops us from getting the useful help of the stories narrated by others about our existence and its impact in their lives. Secondly, the relevance that our own death has for those we love and care about is also a decisive feature to advocate for the recognition of a moral duty to die, as we will later do in Chapter 3[13]. For, the duty to die might help us recover meaning in death and does remember us of our moral responsibilities and bonds generated from our interactions within family and society.

In addition to individual attempts to find meaning in death, it is worth noting that there is an extended trend to do so with the help of our most-at-hand technological and medical

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[13] See section 3.4.

advances. We face and combat death with an arsenal of weapons that most likely will only make us gain a few more hours, days, months, but never will we obtain a final victory against it. At this point, we must be cautious not to naively believe that we can master our medical possibilities in response to the threats of death (Callahan, 1993, Chapter 1), which makes us aware of our fragility (e.g. accidents and illnesses), of the process of aging and the fact that one day we will all be dead. There exists what Callahan calls the 'idea of technological brinkmanship', which refers to our gambling effort to go as close as possible to the line where treatment is futile before cessation. This way, our initial illusion of mastering our medical choices divide itself into two illusions of mastery. First, we believe that we can seize control of the medical technology and find the right time to die. Secondly, we believe that we can manage ourselves with the same precision we control technology. The alternative to that is the return to a tame death, characterized by its familiar simplicity and its public character. However, it might be too late, there might be no way back with technology (Margaret Pabst Battin, 2005, Chapter 12) and our only alternative will become accepting it as part of our deaths, as we already do in relation to our lives. Technology has brought to our knowledge an increasingly informative possibility of genetic prognostication about the size of an individual's life. Inevitably, a considerably improved awareness of how long our life is likely to last will entail several changes in the human experience of death. Whether or not it will help us with our acceptance of it is something we will need to figure out in the upcoming decades. Despite that, we can foresee and acknowledge a positive instrumental side of knowing the size of our lives, which has to do with prevention and treatment options available, which can be a huge help in planning and communicating the end of our existence.

1.2. The evil of death

On a considerable majority of cases, if we were asked about whether death is an evil, the most common response would be affirmative. Most people would probably argue that it is common sense, it is of course better to be alive and experience the goods things of life. There would be as well some other people trying to find cases where death is not the worst of evils, situations when life becomes unbearable, and we would be better off dead. However, became the questions more accurate, some puzzles would arise that would trouble us before providing a definitive answer.

There are, at least, four identifiable puzzles about death (Feldman, 1993) that are worth considering. First of all, we find the problem of misfortune and the existence condition. Briefly explained, it refers to the problem of identifying a subject who is the recipient of the misfortune of death, because the person who dies no longer exists, thus she cannot suffer that misfortune. Closely related to that, and alsomhaving to do with the existence condition, we find a second puzzle. A common approach to consider death an evil consists of pondering those things death deprives us of and conclude that it is an evil to lose them when we die. However, there is no second term in the comparison, there is no person after death with whom we could compare what death has deprived us of. In the third place, there is a troublesome consideration of temporality. Were we to assume that death is a misfortune (letting our initial puzzle pass), when does the misfortune happens?[14] Finally, one of the most frequently addressed puzzles related to the evil of death, the problem of the asymmetry of posthumous and prenatal existence, first suggested by Lucretius (2007). This is a problematic issue that will occupy some of our upcoming discussion, but as a matter of brief explanation we can summon the puzzle in the form of a question: why do we consider an evil our non-existence after death, but we do not regard as equally evil our prenatal non-existence?

We will shortly address this and other quandaries, but first, it is necessary to pinpoint two basic initial and unquestioned assumptions underlying the already presented puzzles about death, as well as our following discussion. In first place, it is assumed and accepted that being alive is generally good. There are various counterexamples and thought experiments that argue against it in determined conditions, but it is enough to admit that, in normal circumstances, it is the case that life is good. Secondly, we will be working with the assumption that when one dies, one ceases to exist, and that non-existence is so in an important and closing sense, not giving room to possible religious or mystic approaches to life after death in any ontologically relevant sense[15].

Apart from, but closely related to, all the already mentioned puzzles about death, which could initially seem philosophically overwhelming, we find a much more sensitive matter: the fear of death. It could have been this fear which truly triggered the posterior debate about the evil of death, the puzzle regarding the subject of the misfortune and all debates about the non-existence condition. So that, we will now move on to this topic with the purpose of disentangling and comprehending it thoroughly. Its first appearance and originality take us back in history to the IV-III BC, time when Epicurus wrote his well-known and controversial argument against the fear of death:

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[14] At this point, it becomes relevant our initial distinction and clarification of 'the process of dying', 'the moment of death' and 'being death'. See page 8.

[15] It is interesting to note Yourgran's (1993) solution to the problem of non-existence. His ontological approach distinguishes between: a) being something, b) being an object, c) being an existing object (where existence is understood as a property). Using the language of Logics: b) $\exists x$, and c) $E!x$. Based on that, we can affirm that 'some objects do not exist' = $(\exists x)\neg(E!x)$; which allows Yourgran defend the admission of other non-existent beings apart from the dead, e.g., unborn people, possible worlds, past and future.

> *"Grow accustomed to the belief that death is nothing to us, since every good and evil lie in sensation. However, death is the deprivation of sensation. Therefore, correct understanding that death is nothing to us makes a mortal life enjoyable, not by adding an endless span of time but by taking away the longing for immortality For, there is nothing dreadful in life for the man who has truly comprehended that there is nothing terrible in not living. Therefore, foolish is the man who says that the fears death, not because it will cause pain when it arrives but because anticipation of it is painful. What is no trouble when it arrives is an idle worry in anticipation. Death, therefore – the most dreadful of evils – is nothing to us, since while we exist, death is not present, and whenever death is present, we do not exist. It is nothing either to the living or the dead, since it does not exist for the living, and the dead no longer are."*
> (Epicurus, 1993, p. 63)

Despite our consideration of this argument, it must be said that Lucretius[16], following Epicurus, argued in an analogous manner. So, in the following, both arguments will be considered, examined, and addressed as if it were the same. There have been two main approaches to the argument, one that interprets it as arguing against the human fear of death, and another one that focuses on whether death is an evil, for whom, when… At this point, it is important to notice that both perspectives are challengingly intertwined and generally misunderstood as one and not two different problems to examine. But before analysing in depth both issues, it would be clarifying to separate the different parts of the argument for a better understanding. For this purpose, we will consider Rosenbaum's (1993b, pp. 121-122) presentation of the argument:

A. A State of affairs (S) is bad for a person P only if P can experience it at some time.
B. P's being dead is bad for P only if it is a S that P can experience some time.
C. P can experience S only if it begins before P's death.
D. P's being dead is not a S that begins before P's death.
E. P's being dead is not a S that P can experience.
F. **Conclusion:** P's being dead is not bad for P.

As we can see, especially on B, Rosenbaum's reconstruction of the argument is an approach focusing on sentience[17], on the subject's capability of experience. And, since there is no subject that can experience anything after her own death, being dead cannot be a bad

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[16] See (Lucretius Carus, 2007).
[17] See (Rosenbaum, 1993a)

state of affairs for that person. As we just noticed in the paragraph above, this way of presenting the argument only attends to one of the two inherent problems, i.e., the evil of death. But that is only half of Epicurus' original argument, so something must be also said about the fear of death. Martha Nussbaum (1994, Chapter 6) provides us with an enlightening perspective when developing further the conclusions of death not being an evil and thus not being bad for the person who suffers it. The beginning of her reconstruction of the Epicurus' argument is like Rosenbaum's, the subject's existence and capability of experience are necessary for an event to be bad or good for that subject. Likewise, death is equal to nonexistence, thus there is no subject possible of experiences. We can conclude that, by *Modus Ponens* of the previous two assertions, being dead is not bad for the person who dies. It is at this point when Nussbaum develops its conclusions further and rescue the other half of Epicurus' argument, being it that it is irrational to fear events that will not be bad for us. And, therefore, it is irrational to fear death.

It is important to understand all the implications that result from Epicurus' argument, without leaving aside any of the two key features that shape it. However, historically, arguments have been presented separately for or against each part, so we will also initially tackle both issues distinctively for a later and final reunion that will help us gain a better and overall understating of it. This approach will allow a more profound reflection on its influences and relevance for the topics of euthanasia and the duty to die that follow in next chapters.

We are all familiar with the feeling of fearing death. In our lives we have experienced, or will do, that persistent anguish in our guts that unpleasantly remind us of our mortal condition. Different from other kind of fears, the fear of death has a unique characteristic which makes it remain in our minds and defuses our hopes of finding good tools to fight against it and win the battle: the difficulty of admitting that there is nothing after death, or at least that we are unable to ascertain what awaits us once we have died[18], that death is the infinite state of affairs mainly characterized by our non-existence[19]. This makes it difficult for most of us to calmly accept the fact that one day everything will be over, that we *will not*

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[18] It is worth noticing that, putting it in different words, our lack of knowledge of what happens or not after death also generates this unique feature of the fear of death.

[19] It could be argued here that no attention is given to alternative religious perspectives of afterlife, which are prevalent both across cultures and time. There to two alternatives to respond to that objection. On one side, religious belief should not be considered too relevantly within our thesis due to its prevalent moral status, where morality is above the particularities of specific religions. On the other side, our focus is on sustaining a neutral religious standpoint; because, at best, religions are only able to offer predictions about what they wish to believe it could/should happen after death. So, they are unable to rationally justify those beliefs. Furthermore, their offering of viable solutions to alleviate the pain and suffering caused by our acknowledgment of death does nothing but proves the existence of that fear of dying.

be, in the strong ontological meaning of the verb. Nonetheless, when we talk about the fear of death, we are not merely describing an exclusive feature that wholly defines that fear. Moreover, our fear of death is multi-layered (Callahan, 1993, Chapter 5), and we normally refer to different aspects, or a blend of them, when describing it. Often, what we really fear is not death itself, but the extreme, obliterating pain and discomfort that we will have to endure for some time before dying. A second kind of fear of death is the dread of the self's dissolving and the body's coming apart. Thirdly, we imagine with horror what will be the losing of our social world, all our bonds and connections disappearing forever due to our deletion from life. Finally, in most of the cases, we also experience anguish because we do not understand why dying and its meaning. As noted above, all of those are instances of what we refer to in our daily lives when we speak about our fear of death, and we must be aware of the source of this fear, i.e., the subject's nonexistence, to fully comprehend and accept its presence.

The existence of the mentioned fear of death is indisputable but, is there anything that could explain it? And, if it really is irrational as defended by Epicurus, what role should we concede it within our lives? An interesting response to our first question can be reached by examining the role that time has in our existence (P. Yourgran, 1993). Our existence is time-based and future-oriented which explain quite simply our fear of death. We live necessarily in the direction of the future and at the very end of it, patiently, awaits our death. Thus, the existence of this fear is completely normal and has a simple elucidation. Similarly, our concerns about suffering are biased towards the nearer and towards the future, rendering our fear to death as rational (Parfit, 1993). Finally, to complete our position, we must add that what death deprives us of is approached from a subjective standpoint and regarded, thus, as worse to any previous evil we could have experienced in life (Nagel, 1986, Chapter 11) [20]. To recover Nagel's considerations on the previous section about death and meaning becomes relevant at this point because, when pondering death, there is no way of eliminating the radical clash of standpoints (objective and subjective) in relation to it. We can only mitigate the effects of that collision by externalizing our own interests when death approaches, e.g., worrying for the welfare of others, or working for the success of causes and projects that do not depend on our being around[21].

In answering the first question, we have also, in a sense, provided a response for the second, since we have just defended the rationality of fearing death. However, this position

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[20] This part of the argument will also be relevant when considering later the asymmetry in our attitudes towards prenatal and posthumous nonexistence.

[21] Note similarities with Luper Foy's argument about 'epicureanising' our desires, in section 1.1.

needs nuancing. Despite its being rational, we can also argue about the irrationality of the way a person handles it, i.e., the role we let that fear play in our lives (Jeffrie G. Murphy, 1993). Therefore, having a prudent fear of death is completely rational, when it is kept in its appropriate place, because it helps people lead the kind of lives they regard as meaningful. However, there is a truly thin line that stops us from letting fear make us its prisoners, which irremediably happens when that dread of death becomes irrational, and it cannot serve a legitimate purpose in our lives. This whole situation makes us aware of a paradox: although we consider death as bad because it represents lost opportunity, we need to keep generating new projects to engage in. To be sure, the fear we feel about death, that dread that on many occasions overcomes our willingness to further develop new projects, to keep on living fully, is something rational to experience. But we cannot allow that fear to immobilize us permanently, we should not let it stop us from engaging in projects of worth, in caring and love relationships, in other words, we cannot accept that this fear paralyses our lives totally; that would be irrational.

At this point, it is relevant to note very briefly the implications of our fear of death, on its multi-layered approach, for the upcoming topics in following chapters. In order to face and combat the horror that thinking about our own death sometimes generates on us, there are various tools that we could use to find an appropriate and rational place for that fear. For now, we will only confront the reader with a question worth bearing in mind while addressing the forthcoming arguments about the evil of death, euthanasia, and the duty to die. That question is: could physician-assisted suicide and euthanasia, either in its passive or active form, be morally (and even legally) acceptable options to consider with the intention of providing persons with powerful tools to fight the fear of becoming someone they do not want to be due to their illness?

We must now move to the second aspect of the epicurean argument, the considerations about the evil of death. What makes death an evil and why? If death really is an evil, who suffers it and when? Without long consideration, were we appealed to provide an answer for those questions, we all would probably agree that the person who suffers death is the one who dies, that death is bad because it deprives us of life; and we would consider the time of it being an evil from the precise moment of death. However, it is also simple to foresee possible questions (how can death be bad for the one who dies if he no longer exists? Is life necessarily something good to experience under any circumstance?) to those answer that would take us in a deeper analysis of the subject. We will dedicate the remainder of the chapter to the enterprise of examining possible responses to those questions and the relevance of the enquiries themselves.

Why is death an evil? As noted above, the main argument (Thomas Nagel, 1979, Chapter *Death*) to answer that question is presented from the approach that considers death as the deprivation of the good things in life. Utterly, this reflexion rests upon a basic assumption from the subject's perspective, the fact that more life is always better than less, because we have more time available to experience more things. An early objection can be formulated at this point, what if among the experiences left ahead there are more bad ones that good ones, and the balance on the overall summation is negative? Nagel defends that experience always adds something genuinely positive to life, rendering the overall result of the balance irrelevant. We will argue and sustain, later in this chapter and in chapter two, the possibility of finding different situations where the overall remainder of life has more evils than goods; so, even if Nagel were right, that would not be enough to affirm that experiencing always adds something valuable to life. Besides that, there is another important feature which needs to be added in this widely held understanding of the evil of death. The latter must be understood as a loss of life, and never treated as a positive state, because it has no positive characteristics of its own. We cannot experience death, neither imagine it as something we will go through. Death is an unimaginable experiential blank.

However appealing and intuitive, this proposal faces three main difficulties that are on their own challenges to the consideration of death as an evil. To begin with, we confront the problem of sentience[22], can anything be bad to a person without being positively unpleasant to her? Nagel argues that some things are evils *per se*, and not all goods and evils are temporally assignable states of the person. This means that there are some states of affairs, death among them, that can be morally evaluated independently of their being experienced as bad for the individual. To exemplify that, Nagel presents us with a case where a person dies without knowing about her partner's infidelity, the failure and bankruptcy of her company, and the lack of love from her children. However, we could examine this example in detail an observe that, even though the subject does not find out about the lie of her life before dying, there exists her possibility of doing so, by a good and regretful friend telling her everything about the truth of her life. Imagine now, following Fischer (2009, Chapter 3), that we can add to the story a new character, the 'counterfactual intervener', someone who will always with total security impede our initial person, whose life is a lie, find out the truth. That new feature in the example makes it stronger, since it does not give any room to the possibility of the subject finding out about the unpleasant experiences. Therefore, leaving sentience and experience aside, this novel approach focuses on the badness of death

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[22] The problem of sentience has been previously, on this chapter, brought to our attention when explaining Rosenbaum's (1993b) reconstruction of the epicurean argument.

understood in an ontological/metaphysical sense, rather than an epistemological (sensory unpleasantness) one. We could, then, rephrase our opening query as 'does any metaphysical harm remain even when the subject has no epistemological access to that harm?'.

We will answer the previous question affirmatively and will move on now to explain the badness of death by a better understanding of the loss and deprivation involved in death. On his 'revised possible good account', McMahan (1993a) defends the measurement of the badness of death in terms of the quantity and quality of life that the subject would have enjoyed[23]. In the same sense, death is worse to the extent that there has been an investment in the future, investment that will become nothing and will not pay back because of the subject's death. Here, the badness of death lies on two features. On one side, the frustration of the subject's desires and sacrifices. On the other, death will be worse when there is a high degree of psychological connectedness with the person the subject would have been by the time of achieving those desires. Similarly, persons care about what their lives stories are like, and death can harm persons in spoiling the story of their lives (Velleman, 1993).

The second problem that we face, when considering death as an evil because it deprives us of the good things in life, has to do with the problem of existence mentioned at the beginning of this section. How is the supposed misfortune to be assigned to a subject at all? Nagel (1979, Chapter *Death*) offers the first response to this question, defending a conception of misfortune broader than the happenings within the subject's life. On this view, there are many things in a person's life, among them some harms, which occur outside the boundaries of their lives. This argument is more like the previously presented metaphysical approach offered by McMahan. We can also consider the person she was and the person she could be now. However, the latter reason would be more appropriate for cases of premature death, where we can easily imagine the possible development of the deceased's life, but it is less likely to occur when the person is older. Besides that, this second attempt to answer our initial question by Nagel does not truly eliminate the problematic, it merely rearranges it into a more comprehensible case. The person-that-could-have-been does not exist either, even when we can picture her in our minds and imagine the kind of life she could lead. A more compelling argument is offered by Pitcher (1993), who also defends that the death can be harmed, grounding his argument on the distinction *ante-mortem* and *post-mortem* when describing the dead person. On this position, all the wrongs committed against the

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[23] This view supports our beliefs that death is worse when it comes earlier and that it cannot be bad in some cases (euthanasia, physician-assisted suicide, rational suicide…).

dead are committed against their *ante-mortem* selves[24]. Thus, death is a harm that happens to the *ante-mortem* self of the subject who dies. But how could this occur? Death can sometimes be bad for the one who dies by defeating their surviving interests (Feinberg, 1993), so the person who is dead is harmed by their own death and there is no necessity of their awareness/knowledge of that harm, neither of their experience of it. To clarify, this harm to an interest is better defined in terms of the objective blocking of goals and thwarting of desires[25]. Overall, we only need to admit the objectivity of the badness of death in certain cases by putting an end to all the projects the subject has actively engaged in in life, which means that the one harmed is the subject who dies before she was dead[26].

Our third, and final, problem to analyse refers to our asymmetric attitudes towards prenatal and posthumous non-existence. the main relevant aspect of this objection pinpoints the differences in the manner persons regard their non-existence before being born and after their deaths. And it follows arguing that there are no significant differences between those two periods of non-existence and, thus, we cannot consider the time after our death as a deprivation of the good things in life without regarding our pre-natal non-existence equally bad. Nagel (1979, Chapter *Death*) offers an interesting answer, pinpointing the differences in the causational effect that birth and death have in our lives. Whereas birth indicates the beginning of our life and does not have any casual relation to the previous time when we were nothing, death causes the deprivation of time that we could have otherwise experienced, had we not died. Another possible, and complementary, explanation is the one offered by Brueckner and Fischer (1986) who defend that our asymmetric attitudes towards pre-natal and post-humous non-existence is explained by the temporal asymmetry in our attitudes towards certain goods. The importance we assigned to past events, experiences, or goods, is inferior to those we have not lived yet, even when future goods could be overall less enjoyable and pleasant than previous ones. In this sense,

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[24] Pitcher goes even further, though it is not so relevant for our argument here, defending that a person can be harmed after her death. How could an *ante-mortem* person be harmed after dying? The occurrence of the event (after the subject's death) that is considered harmful makes it true that during the time before the person's death, she was harmed.

[25] The area of a person's good or harm is necessarily wider than her subjective experience and longer than her biological life.

[26] An alternative way of responding to this objection is by criticising the Epicurean argument, arguing that it rests on an incorrect temporality assumption. That is Silverstein's (1993) position when defending a four-dimensional framework to solve the problem of the subject of harm. A spatiotemporal view of the universe would allow us to see post-humous events as coexisting with us, though temporally distant from us. This way the subject's death co-exists with the subject, and it is a possible object of the subject's suffering, and therefore and intelligible subject-relative evil. However, we consider this explanation highly troublesome, since, as rightly pinpointed by Rosenbaum (1993b), there is an important distinction between the existence and occurrence of a state of affairs. So, even if we accepted the fact that our death co-exists with us, it would be its occurrence which would matters.

dying later means that the possibility of experiencing future goods is still open. However, it is important to indicate that this argument also justifies the possibility to seek a good death when there are no more future goods to experience, or those do not weight more than the possible bad experiences when balancing them. That leaves the door open for our future advocacy for euthanasia and a duty to die when the situation and circumstances are appropriate[27].

1.3. The possibility of a good, and preferable, death

Despite all the considerations already presented and all the arguments defended, we can appreciate that we are facing a tough topic with no definitive answers. We have in front of us a subject whose essence has always been present in philosophical discussions and will continue being so meanwhile the mortal condition of persons prevails. That turns our debate about death in a dialectical stalemate (Fischer, 2009, Chapter 7), since it cannot be definitively shown in the arguments offered above that death is bad for the individual who dies. But that does not mean we must stop seeking alternative principles or show that the initial claim was not so philosophically relevant. Our compromise is with the first of these alternatives, since for the shake of our overarching argument we only need to accept that death is bad in a huge majority of cases, and we will focus on the exceptions, where in the final balance of goods and evils that life can offer the negative side outweighs the positive one, making death the best alternative. In other words, even under the consideration of death as an evil, there are circumstances which make it the lesser one, being sometimes the most appropriate course of action to put an end to that specific life. Does it mean that there could be a *good death*? It initially seems that we are dealing with a philosophical oxymoron (Scarre, 2012), for we have defended that death is the loss of a valuable and that can never be good[28]. However, we have also analysed different approaches that enlighten us about some deaths being better than others and, like we just noted above, death can sometimes be the most desirable outcome to expect from a life full of suffering or other substantial evils. Evidently, death is, or at least can be in most cases, a moment of maximum existential anxiety, because it does not merely complete the story of our lives but eliminates it completely, yet that consideration does not imply that it is always wrong to bring death about or to permit it occurs sooner than it otherwise would have done.

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[27] A detailed argument of this affirmation will be offered lately in chapters two and three. For now, it is enough to accept that in the final balance between the good and the bad left to experience, death might be preferable in scenarios where only evil awaits us.

[28] It is important to notice that this affirmation does not imply that there cannot be better deaths than others.

It is sometimes difficult to accept the previously mentioned *goodness of death*, for we have a profoundly enrooted and instinctive desire to remain alive and go on living to delight ourselves with the goods life can bring about, even when it often carries the same number of evils. It could be said that we, as human beings, have a general biased to life (Brock, 1996), which could be gathered in two main claims. The first support for that bias rests upon the supreme importance and value of human life. Here is not the appropriate place to address whether human life has intrinsic value, but it is enough to admit that it is a widely accepted view, despite all the possible room for nuances. Still, we can also easily imagine cases where life is deprived of its intrinsic value, e.g., cases of persistent vegetative state, and can become a burden when on balance with a chronic or terminal disease. Secondly, an even more controversial argument to maintain the bias towards life, the irreversibility of the decision to take life. The argument basically defends that it is wrong to take life from a person because we would have no way of correcting and reversing it in circumstances where we would find a mistake in our previous judgement or a cure for the illness that was tormenting the subject, to mention two common examples offered by defenders of that thinking. However, we can counterargue that the affirmation is misleading, since we also confront irreversibility when addressing the suffering and pain tolerated by the subject, those wrongs caused by preserving life cannot be undone either. The argument concludes that life, thus, can be mistakenly continued causing irreversible pain. To this point, some of the questions introduced by Philippa Foot (1977) are highly relevant. When life is said to be a benefit, on what grounds is the assertion made? Is balancing goods and evils the best procedure we have available? When are we to say that life is a good or a benefit to a person? Addressing these enquiries would be a topic for another occasion, for now, what is relevant to our discussion is the joint dilemma that they all present. Even if we accepted that life as such is a good, and that it is so at least as a condition for other goods to be obtained, this is clearly not always the case, for how can it be good when it brings more evils than benefits? Foot's answer consists in a defence that what makes life good is it coming up to a standard of normality, which is specified as a life containing some minimum of basic goods. Whether we accept Foot's proposal or any other theory that gives an account of the value of life, we only need to admit that they would have in common a situation in which the evils of life outweigh its goods, becoming death the better, or less bad, alternative.

A different approach about what a good death consists in could be offered, whose focus would be to make meaningful and valuable the last weeks of life, and not merely the last days or hours (Emanuel & Emanuel, 1998). The underlying motivation for this new perspective, which is medically oriented, is the acknowledgement that a good death is still far from becoming a standard medical practice for all patients. The reason to explain the lack of capacity to elaborate and develop an appropriate practice for a good death in medical contexts has a strong societal component. That is, Western societies have not been able to elaborate narratives that help individuals find meaning in death and dying (Verkerk, 2015, pp. 144–145); which, together with a resolute social attitude that celebrate youth and denies death, creates a paradox we as society inevitably face. On one side, technological and scientific development have made possible the adequate alleviation of symptoms of an illness, as well as the physical pain it causes, which also helps improve care. Similarly, there is an increasing concern about death and the way of dying and the worry that not all physical pain is controllable and alleviable, hence the persistent suffering of dying patients. On the other side, we find the continual denial of death, on a cultural and societal level, which influences individuals. There could be a way out of this apparent contradiction by offering a framework for a good death (Emanuel & Emanuel, 1998), which could help develop narratives to give meaning to death and dying. This framework distinguishes three main components that contribute to the final outcome of a dying experience: a) the fixed characteristics of the patient (clinical status and sociodemographic characteristics); b) the modifiable dimensions of the patients' experience (hopes, physical and psychological status, social relationships, economic demands…); and c) the care-system interventions (social, family and friends, medical-provider, health-care-institution, and social interventions)[29]. The only relevant feature for our purpose here are the patients' dimensions, for more research is needed to fully comprehend and appropriately address those varying facets of their lives, which together would help individuals construct their own life narratives to incorporate and accept death and dying, and it would also help them find value within those narratives.

To conclude, we have thoroughly examined different alternatives explaining the badness and evil of death, as well as analysed various arguments defending whom is the person harmed by death, how this damage occurs, and why it is defensible that we address our future non-existence as worse than our prenatal nothingness. It should be clear by now that even though society and individuals fear and perceive death as an evil, it is unlikely that a concluding and final rejection of the admissibility and goodness of death could be defended on moral grounds, especially when life has more suffering and pain than joyful and worthy experiences to provide. For, every author above mentioned accepts the burden that life can become, hence they consider rational and morally justifiable to have the option of abandoning life when regarded as necessary. This commonplace from different metaphysical approaches is all we need to defend the relevance of incorporating and

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[29] See appendix.

legalising alternatives like voluntary active euthanasia to our societies, since its moral permissibility and advocacy can be defended, as we will show in next chapter.

3. EUTHANASIA

Dealing with death, from facing it and losing our fear of it to accepting its final consequences, is not an easy task to accomplish, as we have already seen in the previous chapter. Discussions about the evil of death are far from finished, the debate can be approached from different perspectives, but no matter which one we decide to align with, it has been shown how and when people sometimes deal with instances where pain and suffering are unbearable and impossible to cope with, transforming the Epicurean argument about death in a possible advocacy for euthanasia. This position can be defended departing from the core of the argument, the absence of sentience, which will be used now to defend its preferability to the suffering sometimes endured by patients at their final stage of life. In other words, opting for death might be the morally adequate alternative for those whose suffering is unbearable and impossible to manage. On those cases, thus, putting an end to life becomes the ethically preferable outcome and the only way to create coherence with the rest of our life preferences and ideas. Gaining control over the last period of one's life empowers us to acquire a more morally significant closure.

On the contrary, being unable to take active part in the decisions that will drastically shape our last moments could cause unnecessary and unwanted stress and emotional suffering, and the additional loss of meaning. For, the purpose of all the previous narrative could be destroyed by an incoherent last chapter. However, even for different philosophical approaches to medicine, like the phenomenological one offered by Havi Carel (2011), where the perception of our body has a central role in the way we interpret and live our illnesses, euthanasia would still be the preferable means to abandon life and put an end to unnecessarily endured suffering. That is because, even when assuming the central position of our bodily perception and the repercussion that illness has on it, death could be a morally valid and preferable option when it is known that this perception will not change due to the irreversibility of our condition, and also because first person reports would have a major impact on medical procedures[30]. We can all easily think of persons for whom being left defenceless and vulnerable confronting an illness, whose only outcome is a foreseeable and unavoidable death, would be outraging and would opt, if possible, to end their lives by more active means, i.e., voluntary active euthanasia.

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[30] That does not mean that death would be the only moral alternative in all cases. For, different people would still have different reactions to the same self-perception and distinct life values to address and confront their illnesses with. For a detailed phenomenological approach on the possibility of being healthy within illness, see (Carel, 2007).

In the following, we will argue and advocate that euthanasia is a morally defensible course of action. Similarly, we will show and prove how and why this procedure can be the best alternative in cases where the end of life is at sight and inevitable, especially in those problematic situations where patients are unable to put an end to their life more actively[31]. We will start defining the concept and clarifying its differences to others with which it is commonly mistaken. Afterwards, we will explain the different types of euthanasia there exist. Finally, we will examine, in two different and separate sections, various arguments offered against and for it, being especially attentive to their argumentative strengths and weaknesses. We will then conclude with the assertion that euthanasia is a morally justifiable and desirable alternative to end life providing it with meaning and coherence.

3.1. Definition

Euthanasia is often mistakenly defined, and the lines that separate it from other similar concepts are thought to be blurry. It is common to hear public debates that use interchangeably the notions of euthanasia, withdrawal of treatment and physician-assisted suicide (PAS from now on), assuming that there are moral differences between those terms, and that such differentiations are presupposed and shared by the totality of the social community where the distinction is so deeply rooted in. It is necessary, then, to clarify the meaning of those notions for a better understanding and an appropriate moral evaluation of them. For example, the expression ‘withdrawal of treatment’ is frequently used to avoid the public opinion’s criticism when using its other label, ‘passive euthanasia’, as we will define it. The idea of euthanasia has been so mistreated and misuse that people normally avoid its usage on the speech to prevent their contribution to the debate from being directly unconsidered. However, we do advocate for its correct use, striping off all those layers of meaning that have been inadequately attached to it. There is no reason to believe that the term is morally charged with negative features, but it simply is a morally neutral concept that will need further moral assessment when taking it to practice[32].

Bearing that in mind, euthanasia can be defined here as the intentional termination of an individual’s life by or with assistance of other person. It is important to notice the broad character of this definition, since it will allow us to later specify, on section 2.2., the various

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[31] We are talking here about cases where patients cannot opt for physician-assisted suicide due to the restraints their illnesses have left them with; in other words, their condition is so severe that they are unable to act for the lethal dose to be inoculated into their bodies.

[32] Concepts are not objects for moral evaluation. For what we can morally evaluate is the action where an instance of the concept occurs. For example, in the euthanasia case, what is relevant is whether the action we performed when supplying a lethal dose did the patient good or bad, not the fact that euthanasia is defined in one way or another.

kinds of euthanasia that can be found. Besides that, we must notice and clarify that, despite it being possible to receive assistance from practically anyone, by definition, it is most common that doctors, and not a friend or a family member, take over the role of assistants in dying, because they are the most qualified to do so (Brock, 1992, p. 21)[33]. Leaving momentarily aside all the possible nuances and clarifications that the initial and general definition needs, it is necessary to mention another defining feature of euthanasia: suffering and its evidence are necessary conditions to perform euthanasia. It could be questioned what kind of suffering matters[34], whether this must be physical, emotional, or both, but it is undeniable that some sort of suffering is necessary for a person to request assistance in dying (Beauchamp & Davidson, 1979). Now, to be more specific and clarify what our definition of euthanasia is, we follow Wreen (1988) and state that a person A carried out an act of euthanasia if and only if

1. A killed B or let her die.
2. A intended to kill B.
3. The intention to kill B must be casually efficacious in bringing about B's death.
4. The casual journey from the intention (2) to action (1) is in accordance with A's plan of action.
5. A's killing of B is a voluntary action.
6. The motive for action (1) and behind intention (2) is the good of the person killed.
7. The good is/includes the avoidance of evil.

We can see how this definition of euthanasia is a broad one and will allow us to include within it the defence of euthanasia in cases where persons have a duty to die. But it is not time yet to discuss this matter, we will do so in next chapter. What is more relevant now is to explain the absence of the notion of 'suffering' in our offered definition. To clarify where the idea of suffering would be relevant, explanation is needed to nuance the sixth step in our argument, which is more enlightening if we add to it that the good of the person will necessarily include the termination of her suffering by ending life. The same specification is also needed on 7, where the avoidance of evil conveys within it the evasion of suffering, to the extent of what could be possibly done[35]. Equally important it is to notice that the first

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[33] In chapter 5 we will explain and justify why it must be that way.

[34] Physical suffering would be a necessary condition in non-autonomous psychiatric patients to defend their right to have euthanasia. See (Varelius, 2016) for a further discussion on the topic.

[35] For a more detailed explanation of the types of suffering that matters, as well as the relevance of emotional suffering to request euthanasia, see section 2.5.1. of this chapter.

premise of the argument makes no moral distinction between killing and letting die, which will be defended thoroughly later in section 2.2. of this chapter.

On another hand, PAS can be defined as an instance of suicide where the need of a doctor is required to control any unexpected course of events and prevent it from harming and causing more suffering to the patient. Thus, the only discernible difference between PAS and euthanasia lies on the causal agency, i.e., the person who administers the lethal dose[36]. Their similarities are, however, more important. First, the physician plays in both alternatives an active and necessary causal role. In the case of euthanasia, the doctor will be the one injecting the lethal dose to the patient, whereas in PAS, a doctor is equally needed to supply the lethal dose, even though she need not be the one administering it, and to supervise the process. A second common feature is the person upon whom the choices rest, being it the patient. Both in euthanasia and PAS, the patient will request aid in putting an end to her life through a well-informed, consented, and autonomous request. Finally, both alternatives share the fact that the patient retains control until the very last moment, when things become irreversible, and can revoke her consent any time before that happens. Following Brock (1992), we will sustain that the only depicted difference between these two alternatives to end life when suffering becomes unbearable is of no moral significance, thus our choosing one over the other will exclusively rest on a contextual decision[37].

To illustrate this, we could use an example. A clear instance of PAS would be the case of a patient who decides to put an end to her life before the situation incapacitates her and the suffering becomes unbearable. The patient request aid in dying; accordingly, a doctor provides the lethal dose and sets everything for the patient to act letting the dose enter her body and dying because of it. So, the patient is the active agent who performs the action that puts an end to her life by, for example, pressing the button that allows the drug into her body. In similar circumstances, we could speak of an instance of euthanasia if the doctor acted to end the patient's life by active means, e.g., injecting a lethal dose of a drug, or passive ones, e.g., letting the patient die by not pursuing further treatment at the patient's request.[38]

Overall, euthanasia and PAS are both instances conveying the termination of one's life and thus they share some defining constituents (Vink, 2016). Firstly, we need to consider

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[36] Some advocate for the moral preference of PAS due to the not burdening doctor with a supposedly inalienable responsibility; the duty not to kill. See (Vink, 2016) for a defence of this position and his notion of self-euthanasia.

[37] It is important to notice that this affirmation does not imply that we make a moral judgement of the preferability of one or other method depending on the situation. For the moral validity of the argument for euthanasia or PAS rests in the underlying reasons offered to prove its ethical rightness.

[38] See next section for a clarification of the active and passive euthanasia concepts.

the large individual's role over the process, where the person retains control over her decision throughout the course of events, being able to change her mind and abandon the procedure before it is too late. In second place, whichever the method, it must be self-chosen, being this choice clear and achieved after careful consideration. Thus, we can pinpoint two defining features shared by them, their being self-requested and self-determined. Next, both euthanasia and PAS must always be conducted with due care, which means that no extra suffering should be caused to the patient. Further, it would be important for patients to have contact with their loved ones, since the event will also have a significant impact on their lives. Finally, the chosen way of exiting life would normally be accepted in calm and quietness, since it is the person's election to put an end to her life, as we defended in chapter 1. This reference to quietness and calmness should not be understood as a kind of moral imperative that explicitly states how the process must be experienced, lived, by the patient, but it rather is the expected attitude in a person who has rationally decided, after careful and long consideration, what the end of her life will be. It is also worth mentioning that it neither precludes the person from feeling the initial fear or anxiety which is to be expected when the end of our existence is near. Although, because of it being the patient's decision, those feelings would presumably be easier to overcome. After all, both euthanasia and PAS must be understood as a process that takes places over time, rather than the result of that same process (Vink, 2016), which makes the before mentioned overcoming apprehensible.

3.2. Classification

Once an initial definition of euthanasia has been presented, some features of it need further explanation to gain a more thorough understanding of this notion, as well as to be able to offer a strong defence of those cases where euthanasia is the morally acceptable and preferable action. There are two major classification of euthanasia (B. Hooker, 2006). The first one is based on the patient's voluntariness, ranging from explicit opposition to expressed consent and acceptance of the procedure. Within this spectrum we find three clearly distinctive types of euthanasia: 1) involuntary, when the person explicitly rejects it; 2) non-voluntary, for those cases where neither consent nor rejection for the procedures has been expressed; and 3) voluntary, when euthanasia has been accepted and expressed as the chosen way of exiting life. At this point, we must indicate that cases of involuntary euthanasia will not be considered morally defensible instances of euthanasia under any circumstances and must be regarded as clear cases of murder. So, even when involuntary euthanasia has been typified as a category within euthanasia by Hooker, we will not consider it as an acceptable instance, since the lack of consent makes it clearly a case of unjustifiable murder. It is also important to notice that the lines distinguishing the last two types are not always clear and some contexts blur them. Understanding the distinctions between them as a scale of greys would be the appropriate approach. A second classification cuts across the first one to distinguish between distinct types of euthanasia based on the means employed to conduct the action. There are only two kinds of euthanasia within this classification: 1) passive, consistent in the withdrawal or withholding of medical treatment; and 2) active, where a lethal dose is injected to the person requesting it with the purpose of ending her life. As we briefly mentioned above, instances of passive euthanasia are commonly referred to as withdrawal or withholding of treatment by the media/public with the intention to avoid the concept of euthanasia, thought to be negatively morally charged. A possible explanation of this phenomenon is the linkage of active euthanasia with acts of killing, whereas passive euthanasia is typically understood as an instance of letting a person die; for example, the non-intervention to fight a disease that will naturally end the patient life. However, when we refer to "letting someone die", we mean only that a person knowingly refrains from preventing someone else's death which they alone could prevent (J. Bennett, 1966, p. 93).

However, at this point, asking what the moral significance of the distinction is becomes crucial for the rest of the ideas hereupon defended. Therefore, is there any morally relevant line to draw between active and passive euthanasia? At first sight, it seems obvious that relevant distinctions can be found between both instances, but a deeper analysis will be necessary to discern whether those differences are morally relevant. We will start by presenting arguments that advocate for maintaining the distinction as a relevant matter.

First, Phillipa Foot (1977) defends the moral importance of the distinction grounding her argument on the idea of the right to life. She offers an initial assertion where the right to life is considered a cluster of claim-rights, which are those rights that generate duties/obligations on others. Among them we find the right of non-interference and the right of positive service (which correspond within our argumentation to passive and active euthanasia, respectively). Considering that, Foot sustains that the right to life creates a duty of non-interference more widespread than the duties of positive service. Thus, passive euthanasia, i.e., non-interfering on an ongoing illness and letting the patient die, is less morally blameable than active euthanasia, i.e., positively serving the patient's desire to die and end her life by active means. A similar argumentation is offered by Brody (1996), though it is presented this time from the standpoint of the priority of obligations and the causal responsibility linked to an agent's action. It is argued that, in cases of obligations' conflict, the one not to kill precedes over the obligation not to let someone die. It is important to clarify that, in this terminology, active euthanasia is identified with killing and passive euthanasia with letting die. The distinction can also be drawn from intention, where the death of the patient is only a foreseen but unwanted outcome in cases of passive euthanasia, but an intentional and sought result in cases of active euthanasia; and from causation, where active euthanasia is the direct cause of the patient's death, whereas passive euthanasia is merely refraining from doing anything that interferes with the natural course of events that will eventually end with the patient's death. In other words, in cases of active euthanasia, the patient is killed by the lethal dose injected by the doctor, whilst in passive euthanasia the patient dies because of an underlying necessary condition, i.e., her terminal disease.

Despite how convincing the previous explanations seem, in the following paragraphs we will maintain that those arguments exhibit multiple flaws, which will be first spotted and then counterargued.

To begin with we shall address Foot's argumentation. Our objection will not question her notion of the right to life as a cluster of claim rights which generate duties on others, neither we will examine whether the right of non-interference and the right of positive service are among them. However, the correspondence Foot establishes between passive euthanasia and duties of non-interference, on one side, and active euthanasia and duties of positive service, on the other, is not obvious and it furthermore lacks moral relevance. As we will discuss below, the causal explanatory power of omissions is morally significant in cases where non-interfering with an ongoing disease might cause the patient's death. However, focusing more specifically on Foot's argumentation, it is difficult to appreciate how, in some euthanasia scenarios, the duty of non-interference on the patient's condition might be preferable to taking more active steps towards her ailment. Medicine can be understood as a continuous interference to restore patients' health, which is morally justifiable from the avoidance of harm and the patient's autonomy. Providing treatment is interfering in the patient's life; and withholding or withdrawing of treatment at the end of life does not imply a total abandonment of the patient, for she will be nevertheless treated respecting her decision, albeit differently, and palliative care would be provided until death came. Similarly, there are cases where not positively serving the patient's decision to end her life is more morally blameable than non-interfering. First, because it would go against the patient's autonomous decision and, second, because it could extend the patient's suffering, either physical or emotional, unnecessarily.

We turn now to disentangling the causal accountability of the permissibility of passive euthanasia. To do so, it is enough to show that the act-omission distinction employed to differentiate between morally acceptable or blameworthy course of events lacks moral force and it is morally untenable. First, the act-omission distinction does not directly correspond with the distinction between active and passive euthanasia. For, we can think of cases where an action causes the patient death and must be considered a case of passive euthanasia, e.g., switching off a ventilator connected to a patient as their only life support. We have here a clear instance of an action that causes the patient's death (Orentlicher, 1998). Secondly, we can also argue against the intentionality of the doer pinpointing the existence of some cases where the withdrawal/withholding of life-support or treatment, i.e., passive euthanasia, is an intentional action, where death is the foreseen, desirable and sought outcome (Buchanan, 1996). For example, we could easily imagine a patient who does not want to live any further and suffer from their terminal condition and decides that, in the event of an additional infectious disease, e.g., pneumonia, new treatment to combat it must not be started, accepting death as the necessary result of that decision. In this case, the withholding of treatment is an intentional action clearly seeking the death of the patient, thus a case of passive euthanasia where death is the desirable outcome. Lastly, advocates of the act-omission distinction defend those omissions cannot have explanatory power; however, we routinely attribute causal explanatory power to many omissions, e.g., the car accident happened because the driver failed to signal before turning left, or the students failed the exam because they did not bother to revise for it. Furthermore, in medical contexts, there are multiple cases of omissions that can end up in death (Garrard & Wilkinson, 2005). For example, the case of a patient with a severe infection on her lungs that could be easily treated and completely cured with antibiotics, the doctor's negligence (or malevolence) not to prescribe the appropriate treatment would mean the death of the patient. We can now see how the causal responsibility linked to the agent's action is not enough to support the full moral significance attributed to the distinction. Similarly, it renders any mention to the physician's intentions morally irrelevant.

To conclude, we notice how the apparently simple, basic distinctions turn out to be complex and multifaceted. There are multiple instances where, for example, withdrawing aid counts as killing and others where it is considered letting die. The importance we attribute to the mere causal responsibility for a death seems excessive. The central issue at stake is the value of the human life, of all the goods that life contains (McMahan, 1993b).

Once we have proved the irrelevance of the distinction, and it has been showed that it only matters as a factual, technical explanation of the means employed, we need now to emphasise the underlying moral relevance of the euthanasia cases that renders the distinction inadequate. Thus, what is actually morally relevant is the consideration about whether someone can be better off death in some circumstances (Rachels, 1979, 1986). In other words, the means and procedures employed to put an end to the patient's life are not so important, what matters are the reasons offered to defend and justify the euthanasia case. The rightness or wrongness depends on the merit of the justification underlying the action, not on whether it is an instance of killing or letting die, active or passive euthanasia. The relevant features to judge an instance of euthanasia are the actor's motive, the patient's preference, and the act's consequences (Beauchamp & Childress, 2009, Chapter 5). So, if a doctor is acting following the patient will to end her life, where the patient has been adequately informed, has expressed her consent, is autonomous and competent, and the act's consequence will be the end of the patient's suffering by the patient's death, the means employed do not matter to the moral evaluation of the action, which will be the right one to perform. Again, it is clear now that the critical issue is the underlying moral consideration about the patient's situation and what would be best for her. We cannot forget either the patient's central role in the discussion, since it is her life which is at stake, so of equal moral relevance will be the voluntary agreement reached together by the physician and the patient to decide about the time to carry out the procedures, the best means that could be employed, and many more similar technical and personal arrangements, in order to ease the remaining time before death (Orentlicher, 1998).

3.3. Arguments against euthanasia

First, it is important to clarify, once the moral distinction between active and passive euthanasia has been debunked, that the following arguments are, unless indicated otherwise, presented against voluntary active euthanasia, since passive euthanasia is an extended and accepted practice within the majority of Western healthcare systems (Emanuel et al., 2016). Cases of involuntary euthanasia will not be addressed because they are morally equal to killing someone against their expressed desire not to die. Meanwhile, the considerations and arguments that will be offered on the following pages address instances of non-voluntary euthanasia and will provide general reflections and reasons to evaluate those cases as valid options of euthanasia.

Among the variety of arguments offered against euthanasia, it is not difficult to differentiate three overarching categories from which slightly different reasons will be offered to prove the wrongness of active euthanasia: 1) arguments from the sanctity of human life and the intrinsic wrongness of killing; 2) slippery-slope, or risks of abuse, arguments; and 3) concerns about the physician's role.

3.3.1. The sanctity of life and the intrinsic wrongness of killing

We will start addressing the first of those categories of arguments, the one pleading to the sanctity of human life and the intrinsic wrongness of killing (Margaret Pabst Battin, 1994, Chapter 5). Firstly, when appealing to the sanctity of human life, detractors of active euthanasia argue that there is an essential characteristic on human individuals that make them different, unique, a feature that define them as humans and helps differentiate them from other individuals (e.g., the idea of 'human dignity'). In other words, defenders of this position believe that human life possesses intrinsic value, consisting in an indecipherable mixture of dignity and the mysterious power of human life itself. On the other side, the argument from the intrinsic wrongness of killing has a major standpoint to argue against active euthanasia. It consists in the so-called doctrine of innocence, which condemns the intrinsic wrongness of killing innocent people and, since the individual requesting euthanasia is an innocent being, there are no moral reasons to defend her killing.

Secondly, it is also possible to question the circumstances in which the requisites for active euthanasia are met. A critique in that same direction is offered by Kass (1989), who questions the possibility of truly autonomy and informed consent, both necessary requirements to request voluntary euthanasia. The argument goes on questioning the debilitating condition the patient finds herself in, the position from which the patient will have to provide her consent. That makes us wonder whether manipulation could be a predominant aspect that would render the discussion about voluntary euthanasia a dangerous topic, due to the impossibility of guessing whether the patient is offering her sincere desire and thus consenting to the procedure that is about to happen. After all, how free and informed is a choice in those conditions? Similarly, Kass continues questioning the real number of patients undergoing unbearable and intractable pain, to conclude that the medical technologies and means available to treat and alleviate physical suffering allow for the relieve of those symptoms in a clear majority of cases, where adequate analgesia is provided.

Finally, Callahan (1993, Chapter 3) offers a two-folded argument that includes social and individual features. On one side, the concept of human sovereignty, understood as the individual control and capacity to decide within the realm of her own life, has a central role. Callahan defends that the acceptance of voluntary euthanasia would erode our understanding of this notion rendering it inoperable, for we cannot transfer our sovereignty to another individual without contradicting the meaning of it. That is the same to say that our right to life is unwaivable, and that there is no argument strong enough to counter that claim. On the other side, the introduction of consenting-adult killing, i.e., voluntary active euthanasia, to relieve suffering also harms the community. For, society's trust on the health care system and practitioners within it would significantly decrease due to a fear of abuses and malpractices that could end in the community's acceptance of non-voluntary and/or involuntary euthanasia cases.

Before moving on to the next type of arguments against euthanasia, considerations and comments regarding the first kind of them are necessary. For, those arguments are far from conclusive, being it necessary to specify and counter their claims. First, when it comes to consider the sanctity of human life and its intrinsic value, there are at least two alternatives at hand. At first glance, the assumption of a necessary and sufficient feature, shared by all human beings and which makes them irrefutably humans, is a bold one, and it allows within it plenty of room for doubt and scepticism about the notion itself. In other words, there might not be such '*intrinsic dignity*' necessarily attached to human existence, being then our capacity to provide a morally justifiable argumentation to defend the rightness of ending someone's life at her own request the only relevant matter. Besides that, it would neither be philosophically appropriate nor rigorous to base our assessment of euthanasia on a notion whose existence is out of the justifiability boundaries. On the other side, it would be possible to argue that the consideration of intrinsic value as necessarily attached to human life is a position that exclusively belongs to religious beliefs, which are not shared by the totality of the community. Thus, in democratic societies, where laicism is a defining feature, no concrete religion can impose its own views over the totality of the citizens. It is important to note that the moral, and legal, permissibility of active euthanasia by no means obliges people to opt for this kind of procedure when bringing their life to an end. In the second place, regarding the doctrine of innocence, decisive nuances must be pinpointed. When addressing cases of euthanasia, what truly matters is not the innocence attributed to the patients, but the underlying moral judgement concerning the appropriateness of ending a life where unbearable suffering and pain are its definitory features, and considering what would be best for the patient. In other words, innocence is not a moral feature to be considered and weighed when discussing the moral justifiability of active euthanasia. Besides that, appealing to the patient's innocence is fallacious, especially considering that we live in societies where other forms of killing are socially and politically accepted (e.g., killing in self-defence) (Rachels, 1986, Chapter 1).

Secondly, addressing now those problems presented by Kass, we can begin pinpointing the unnecessariness of his claims. By that I mean that it is dangerous and fallacious to assume, first, that the appropriate informed consent and an autonomous decision could not be provided by the patient. The fact that the patient is suffering and is in a debilitating condition does not necessarily mean that she is unable to choose freely. Furthermore, it is precisely her condition which makes mandatory for the patient to express her will; and having at hand the possibility to end her suffering by means of active/passive euthanasia does nothing but to improve the range of options available, transforming that election in a more liberating and freer one. Besides that, Kass' additional argument appealing to the real number of patients who truly are undergoing an unbearable condition of pain and suffering misses the relevant moral matter. It is not a question of numbers, but rather a qualitative and thorough examination that considers the patient's time left before death, the way one wants to spend it, and a question of being able to choose among the major number of morally permissible possibilities. Even when accepting Kass' premises, we would still have to face cases where pain and suffering are intractable. Shall we admit then that, for those cases, undergoing such a condition must be accepted and regarded as morally right just because of irrational and socially shared fears about euthanasia? The answer is no, because we, as a society, have the means available to provide effective safeguards and guidelines to establish voluntary active euthanasia as a choice. Nevertheless, we could also go along Kass' argument when considering the importance of the number of patients suffering unbearably. As pointed by Emanuel & Emanuel (1998), there are numerous cases of patients where pain remains inadequately treated (between 20% and 70%). Hence, from a practical perspective, the real number of patients unnecessarily suffering remains high because, despite the available technologies and means to alleviate the symptoms, they are not being properly and effectively implemented to achieve their intended aim. But even if an optimal care were provided and the percentages above showed diminished, our previous counterargument for those remaining cases of intolerable suffering would still be applicable and valid.

Finally, Callahan's argument appealing to individual sovereignty presents an internal flaw due to a poor understanding of voluntary active euthanasia. It can be questioned that there exists a loss of control over our own lives when opting for euthanasia, for there is no erosion of the above-mentioned sovereignty but an enhancement of it. The patient widens the range of alternatives at hand, increasing the dominion of things in life she can control and consolidating her freedom to freely choose the best alternative based on her worldview. Callahan's argument regarding the social features of implementing euthanasia will be commented together with the next type of arguments against euthanasia due to their similarities[39].

3.3.2.Down the slippery slope

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[39] The social features of his argument constitute a clear case of slippery-slope argument.

As noted above, the second type of arguments offered against voluntary euthanasia are concerned with the risks of abuse, generally under the form of slippery-slope arguments (Margaret Pabst Battin, 1998, Chapter 8). A common reasoning and structure are shared by this type of arguments, which consists in the prediction of catastrophic consequences that will follow from a presumably neutral moral concession. In other words, using the euthanasia case as example, were we to accept active voluntary euthanasia as a morally permissible action, there would be nothing afterwards to stop us from conceding increasingly dangerous practices within our health care systems, to the extent of accepting cases of involuntary euthanasia as permissible[40]. But there are more types of undesirable outcomes that could permeate into our societies because of the moral acceptance of practices like euthanasia and its effective implementation. Among the most common situations to be avoided we find those presented by Philippa Foot (1977): risks of abuse would take us to the killing of the elderly and handicapped infants, persuasion of people in a terminal condition to give their consent, or changes in the social scene (i.e., a trust decrease on the doctor-patient relationship). Before thoroughly addressing the effective consequences of the presented catastrophic scenarios, we need to bear in mind two overarching questions that both opponents and defenders need to answer when discussing about slippery-slope arguments. The first of them addresses the actual possibilities of real abuse, as well as making explicit what type of abuse occurs. The second question asks about the available means that could be used to prevent the possible sorts of abuse, and whether they would be effective.

Detractors of active voluntary euthanasia would argue that risks will always be there and would advise to avoid giving the first step down the slope to prevent later cases of mere killing under the name of involuntary euthanasia. However, when furtherly asked about the possibility to establish appropriate safeguards and guidelines to prevent and avoid abuse, they cannot offer any reasonable argument and face serious problems to demonstrate their catastrophic predictions. First of all, it is possible to develop appropriate policies to prevent abuse and its risks, as well as good safeguards and adequate professional and institutional guidelines (Margaret Pabst Battin, 1998). Among the different possibilities of safeguards to protect against abuse, the ones offered by Beauchamp and Childress (2009, Chapter 5) are worth mentioning: 1) protecting the quality of the patient's choice by means of

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[40] I do not mention here cases of non-voluntary euthanasia because the discussion about its permissibility in certain cases is open to debate and far from concluded. See (Varelius, 2016).

psychological evaluation, counselling and the continuity requirement[41]; 2) protecting against professional and institutional distortion of patient's choices: prohibition of fees and no advertising, documentation of all the process, reports to an external agency; 3) developing objective indices of abuse: possibility of retroactive action; and 4) protecting against vulnerable patients using advance directives: living wills or durable power of attorney. In the latest safeguard, we can observe how it evidently stops physicians from perpetrating euthanasia instances where the patient has not expressed her will (non-voluntary euthanasia) or explicitly opposes it (involuntary euthanasia), for documents like living wills dictate the patient's desire of how to proceed in case she become incompetent. Of relevance is the retroactive character of safeguard number 3, for it facilitates to keep a summary of situations where abuse was committed and make the necessary changes for them not to occur again. Finally, the first two safeguards provide an exceptional example of measures that must be implemented by medical institutions and hospitals at a patient-centred level.

Despite the guidelines that have just been offered, there might still be scepticism on a social level about the permissibility of voluntary active euthanasia[42]. Evidently, opponents could nonetheless maintain that the safeguards presented are purely theoretical and its practical implementation would be flawed and deficient. However, a recent series of studies realised in the Netherlands (Rietjens et al., 2009) over a period of 20 years to evaluate the actual changes and progress on euthanasia can clarify the matter. These studies show the absence of signs that indicate abuses from cases of voluntary active euthanasia to others of non-voluntary or involuntary euthanasia; in fact, the number of non-voluntary euthanasia cases has decreased from 0.8% to 0.4%. Likely, there are no signs of an increment in the number of cases of voluntary active euthanasia over that period, which has never increased over the 2.6%. Besides that, there is neither higher frequency of euthanasia nor direct impact over 'vulnerable' groups[43] (Margaret P. Battin et al., 2007). Among the main

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[41] The patient needs to express the same choice over an established period to probe that her decision was not made impulsively and without considerations of all the available alternatives and the totality of prospects for every of them.

[42] It is worth noticing that we are referring to western countries with only slightly different socioeconomic standards, a similar cultural background and a legislation that shares the conviction to defend basic Human Rights. However, we need to be aware that discussions on euthanasia legislation need to consider the workability and ethical acceptability of a euthanasia-law under various and changing socio-economic circumstances. That concerns especially least wealthy countries, where there might appear an economic pressure for euthanasia. For example, the case of China would be especially relevant, where the elderly usually depends on their offspring and would become a burden for them (Sleeboom-Faulkner, 2006).

[43] Among the groups included under the label of 'vulnerable' are women, uninsured people, people with low educational status, racial and ethnic minorities, the poor, people with non-terminal physical disabilities or chronic non-terminal illness, minors and mature minors.

conclusions of the research we find: 1) frequent choice of euthanasia over PAS, because physicians can control the symptoms and aid in case of unforeseen difficulties; 2) forgoing life-sustaining treatment and alleviation of symptoms is preferred over euthanasia and PAS; 3) fewer cases of ending life without the explicit request of the patient; 4) the alternative of euthanasia and PAS was always discussed with the patient; and 5) public control and transparency of the practice of euthanasia are at large extent possible.

Thus, voluntary active euthanasia can be effectively implemented in society without venturing the risks of abuse and other disastrous consequences. Furthermore, we can appreciate, paying close attention especially to 3 and 4, how the effective implementation of active euthanasia would suppose the reduction of cases where euthanasia might be done without consent due to the stricter control over all cases, as well as an increase on the patient's control over her own death. Similarly, there must be highlighted that passive euthanasia has been the preferred way of exiting life, as the second point shows, which enlightens us on a general presupposition and extended fear of the risks of abuse about applying active euthanasia, thought to drastically increase the number of patients opting for it, which the study proves wrong. A similar study was realised in Belgium to compare the euthanasia situation prior and after the law legalising it passed in 2002 (Deliens & Smets, 2015). Likewise, findings and conclusions match with those obtained in the Netherlands. It is of special relevance to highlight the direct impact that legalisation has on a better implementation of the required procedures and criteria to conduct euthanasia requests. Although active euthanasia was already performed both in the Netherlands and Belgium prior to its legalisation, its legalisation resulted in quite the opposite outcome that had been foreseen by the euthanasia detractors. For, the practice of euthanasia became subject of strict guidelines and safeguards that would guarantee the patient's autonomy on their decision, as well as the physicians meeting the criteria of due care, reporting, and the correct use of drugs to end the patient's life. Thus, it is possible to satisfactorily implement voluntary active euthanasia and protecting patient from the potential risks of abuse. Furthermore, outlining the legal, medical, and ethical aspects of euthanasia does provide a better understanding of the end-of-life situation of patients and a safe framework from which good medical practice can be developed.

3.3.3. The physician´s role

There is also a third type of arguments against active euthanasia which addresses those concerns about the physician's role in ending the patient's life. Detractors of euthanasia would commonly argue that actively provoking the patient's death is contrary to physicians' duties and obligations. The ethical code of our medical tradition, the argument follows, explicitly condemns the termination of the patients' life by their doctors, and thus forbids active euthanasia. We will carefully address the matter of physicians' duties later, on Chapter 5, but there are at least two general ideas that must be mentioned to counter the defenders' claim. First, if our previously offered argument against the moral distinction between active and passive euthanasia is correct, doctors are currently employing passive means, i.e., withdrawing or withholding their treatments provided the patient's informed consent, to terminate their patients' lives and consider it morally right; thus, it cannot be claimed that it is against their duties to end their patients' life when passive euthanasia is already an accepted and largely established practice. In any case, the conclusion to be obtained from this argument is not the condemnation of passive euthanasia, but the recognition of active euthanasia as a morally equal means of ending life to be offered as an option to any patient who could benefit from it. In second place, a rapid contemplation of medical practices nowadays makes us aware of the traditional medical ethics code's unworkability since its original boundaries have been furtherly extended or surpassed. In our days, the role of medicine has gone far beyond the mere prescription of drugs and preserving life (Rachels, 1986, Chapter 7). In other words, what is the code physicians rely on to defend their duty not to kill? Could it be redefined? A thorough examination of those questions and their answers will be offered on Chapter 5.

3.4. Arguments for euthanasia

On the opposite side of the debate, arguments from advocates of active euthanasia will rest upon two major principles of bioethics: the principle of autonomy and the principle of beneficence (Margaret Pabst Battin, 1994, Chapter 5).

3.4.1. Mercy

In the first place, arguments from mercy are based on the importance of the patient´s pain and suffering alleviation to avoid it from becoming an unbearable condition[44]. Therefore, it is claimed that euthanasia is morally justifiable because it puts an end to the

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[44] This idea is reflected on the conditions for voluntary active euthanasia (Young, 2015):
"Advocates of voluntary euthanasia typically contend that if a person

- a. *is suffering from a terminal illness;*
- b. *is unlikely to benefit from the discovery of a cure for that illness during what remains of her life expectancy;*
- c. *is, as a direct result of the illness, either suffering intolerable pain, or only has available a life that is unacceptably burdensome (e.g., because the illness has to be treated in ways that lead to her being unacceptably dependent on others or on technological means of life support);*
- d. *has an enduring, voluntary and competent wish to die (or has, prior to losing the competence to do so, expressed a wish to be assisted to die in the event that conditions (a)-(c) are satisfied); and*
- e. *is unable without assistance to end her life,*

then there should be legal and medical provision to facilitate her being allowed to die or assisted to die."

excruciating suffering of terminally ill patients (Rachels, 1986, Chapter 9). The underlying assumption of the argument seems obvious, for it tries to put an end to the unnecessary suffering of a person who does not want to undergo it and decides instead to finish her life. The patient autonomously consents to have euthanasia after having been informed of her medical condition and the possible prospects of it, weighing the benefits and detriments of doing so, and concluding that death is preferable to her actual suffering. Thus, the moral justification of the permissibility of euthanasia, from a merciful point of view, rests on the alleviation of unbearable suffering. To clarify, this affirmation does not imply that we can willingly avoid or forget about the rest of means available to ease physical pain and suffering[45]; neither it conveys physicians' oversight of the application of those above-mentioned means. Even when choosing euthanasia, patients have the right to have their suffering lessened until the very last moment of their existence.

However, there are at least two relevant questions that could be asked to the proponents of this argument, regarding, in first place, incompetent patients, those who are not capable of expressing their readiness to undergo euthanasia, and secondly, the consideration of the kind of suffering that matters to permit those patients opt for euthanasia, i.e., should physical pain be exclusively considered or shall emotional suffering also be taken into account? The argument from mercy becomes morally truly relevant when addressing the first of our enquires. In cases of competent patients, autonomy can be appealed to and regarded as a decisive factor, even when also having to consider the patient's suffering, because patients can informedly consent to the procedure after morally weighing what they consider best for them. However, in cases where we deal with incompetent patients, the argument from mercy becomes of the highest moral relevance, for it would be the only available resource to justify euthanasia. But how could we justify an instance of euthanasia for a patient who has not expressed her determination to undergo it? To suffer unbearable pain will be the first unbending condition[46], followed by a thorough consideration of the patient's biographical life: continued life could be against the patient's interests, because a merely biological existence can be considered bad for some (Dworkin, 1998). It is important to emphasise the unlikeliness of this situation, for there are means

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[45] A detailed discussion on the compatibility between assisted dying procedure and palliative care will be offered later in chapter 5. See section 5.3.1.

[46] The kind of suffering that matters for incompetent patients has also been recently questioned by authors as Jukka Varelius, who defends that the prohibition of euthanasia for those psychiatric patients mentally suffering is incoherent with other end-of-life practices commonly accepted in current medical ethics and law. See (Varelius, 2016).

available, such as advance directives[47], that could anticipately express the patient's desire of how to proceed after the moment when they lose their competence, so physicians would know whether euthanasia was regarded as a wanted outcome. Besides, we must explain that non-voluntary euthanasia cases are considered so when, by the time of requesting euthanasia, the patient is unable to do so, even in situations where patients have already stated in a previously written document of living wills how they would like their lives to be taken care of in specific circumstances.

Our second problem, regarding the kind of suffering that matters, needs careful consideration as well. The current position relating to suffering in those countries where active euthanasia is legal is to consider physical pain and suffering a necessary condition for the moral justification and permissibility of the procedure (Young, 2015). Indeed, it seems plausible to establish physical suffering as a required condition effectively functioning also as a strict safeguard that prevents society from sliding down the slope into other morally condemnable cases of euthanasia, especially instances of non-voluntary euthanasia where the patient has not previously expressed her will on how to proceed, and suffering is inexistent or easily alleviable; so, there would not be moral justification for euthanasia. But, we can similarly think of cases where patients experience existential suffering, where they are merely tired of living (Varelius, 2014), or simply decide to opt for euthanasia due to the burden their lives impose over them now that they are at the end of their existences, which is also regarded as 'life fatigue' (Huxtable & Möller, 2007). Would forcing those persons to continue living and enduring their *existential* suffering longer not be unfair and morally wrong? It seems, from this new perspective, that only those people suffering from a terminal condition conveying physical pain are *lucky enough* to be able to opt for euthanasia; for, they have the underlying fatal disease that stands as a necessary condition to put an end to their suffering. Would those people not be trapped in an existence that only makes them suffer? Our claim rests on the assumption that there are other things than physical suffering that can make an autonomous person's life bad for her, for example, dissatisfaction of desires or deprivation of the kind of life the person used to enjoy before[48]. Besides that, we need to acknowledge that life fatigue can constitute suffering, especially unbearable in the elderly,

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[47] We could distinguish three types of advance directives: 1) living wills, where patients can specify their preferences to opt or reject specific treatment; 2) proxy-designation forms, where patients designate a surrogate who has the authority to make medical decisions in the event of patient´s incompetency; and 3) values histories, where patients indicate their values and what gives meaning to their lives (Emanuel & Emanuel, 1998).

[48] To consider whether becoming a burden to their loved ones could be regarded as a moral justification for requesting euthanasia would be of special interest here, which links with our idea of having a duty to die that will be defended on chapter 3.

thus we must admit the difficulty to relieve pain and psycho-geriatric conditions that are notoriously chronic.

A good example, although controversial, was the case of Brongersma, an 86 years-old man with life fatigue and existential suffering, but no other somatic or medical condition, who was aided to commit suicide by his doctor in 1997[49]. The fact that a patient does not suffer from any medical condition, somatic or psychiatric, does not imply that there is a lack of argumentative tools to defend the moral permissibility of assisted dying in those cases, for it would still be possible to discriminate between good and bad requests. The former type of requests would be based on the patient's autonomous and informed consent to the procedure, considering thoroughly her values, preferences, and attitudes towards life. Once again, as it happened when we defended the moral equivalence of passive and active euthanasia above, what is truly relevant from a moral perspective is the underlying ethical consideration of the appropriateness and rightness of the action that will be performed. In this sense, the arguments offered regarding the moral importance of emotional suffering counts as a decisive factor to defend the permissibility of helping those who are tired of life and want an exit.

Similarly, there is another case of existential suffering that exemplifies our arguments. We are talking about an case in 2016 where Dutch doctors practiced euthanasia on a patient in her twenties who suffered from PTSD (post-traumatic stress disorder) that was resistant to treatment (Steven Doughty, 2016). The woman had been a victim of child sex abuse and suffered from mental disorders during the 15 years following sexual abuse, which lasted from the age of five to fifteen. Besides her PTSD, the woman had other psychiatric conditions as severe anorexia, chronic depression, and hallucinations. Her psychiatrist said that there was no prospect or hope for her; and she experienced the suffering as unbearable. Reports release by the doctors on the case show that the patient was fully competent and autonomous to decide she would opt for euthanasia. It is important to emphasize her competence to autonomously choose to end her life, since detractors of euthanasia, as we saw above on section 2.3., would oppose to this type of euthanasia for considering it the end of a scary slippery slope. This is, by no means, a case of non-voluntary euthanasia, but a clear one of voluntary euthanasia. The circumstances that shape and nuance the victim's psychiatric condition will help us elucidate the rightness or wrongness of the arguments for the moral permissibility of euthanasia in her case, but they do not have any relevance in stating the kind of euthanasia with which we are dealing.

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[49] For more details of this case and its context, see (Huxtable & Möller, 2007).

3.4.2.Autonomy

A complementary argument to the one just offered from mercy rests upon the bioethical principle of autonomy, which is the pivotal standpoint within the euthanasia debate. This argument to defend euthanasia states, simply put, that competent patients can and must decide what is best for them, without the impediments of the paternalistic medical tradition, where doctors have a central role in the whole medical process, from diagnosis to healing, and patients are relegated to be mere receptors of physicians' instructions and guidelines, unable neither to be part of the restoration course nor to decide what they regard as their preferable choice.

I will assume, following Beauchamp & Childress (2009), and Gillon (2003), that the principle of autonomy is a *prima facie* principle, which means that it is binding unless there be conflict with another moral principle. The principle relies in two essential conditions that make autonomy possible: liberty and agency. In a bioethical context, those two conditions are specified and guaranteed by the necessity of the request for euthanasia to be informed, consented, and provided by a competent patient (Beauchamp & Childress, 2009). That prevents from abuses and instances of coercion that would lead to unwanted cases of involuntary euthanasia. Furthermore, respect for autonomy involves acknowledging the value and decision-making rights of persons, which encourages them to act autonomously. Following that, aid-in-dying is morally right and permissible under the autonomous request of the patient who consider death as a benefit to alleviate pain and end suffering. It is important here to notice the significant role that the principle of non-maleficence also has in the requests of euthanasia from autonomous patients, since it is their willingness to end suffering which make them eager to accept and opt for euthanasia. That implies that doctors' negative answer to euthanasia requests would be disobeying and neglecting one of their major duties, i.e., to avoid causing pain and suffering on their patients. To be clear, situations like this one would irremediably happen in cases where the entire alleviation of physical suffering is impossible, thus unjustifiably causing the extension of patient's suffering, contrary to the non-maleficence principle. We can see, then, how autonomy rights justify requests for active forms of aid-in-dying, i.e., active euthanasia (Beauchamp & Childress, 2009, Chapters 4 & 5).

There are those, however, who oppose this understanding of autonomy and its direct influence over and closeness to the advocacy for euthanasia. Materstvedt (2015) argues for the difficulty, within the medical context, to clearly draw the line between non-autonomous and autonomous expressions of the wish to die in patients with terminal illnesses and/or chronic pain. The argument goes on questioning patients' self-determination due to the difficulty for them to decide autonomously while enduring 'unbearable suffering'. Distinguishing between ethical and empirical autonomy, the right to decide and the sufficient capacity to do so, respectively, Materstvedt, following Campbell (1999)[50], questions that patients suffering unbearably are in a situation to act and choose freely; thus, euthanasia requests cannot be clearly regarded as autonomous. Besides that, there are fluctuations in terminally ill patients expressing their wish to live and, consequently, their wish to hasten death (i.e., their wish to die). As defended by other authors (Ohnsorge, 2015) (Chochinov et al., 1999), the wish to die conveys a wide variety of intentions and motivations, as well as being constitutive of different social interactions, which makes it difficult to fully comprehend what lies behind a patient uttering their desire to die or to hasten death. Bearing these remarks in mind, Materstvedt warns us about the perils of granting every request for euthanasia or identifying the expression of a wish to die with a sincere desire to hasten death. Those wishes might express something completely different; they could perfectly be a cry for help or attention, or a way to express different thoughts about death and dying, no needing to convey the will to hasten death[51].

Nevertheless, considerations like those offered by Materstvedt do not exclude the possibility and existence of a truly autonomous and persistent wish to die and/or hasten death. As discussed by Ohnsorge (2015), this type of considerations are relevant to make us fully aware of the true meanings of patients requests, and equally important, they make us mindful of the sort of care and attention that needs to be provided to patients at the end of their lives. Hence, the stability of the wish to die in terminally ill patients cannot be deemed as unproblematic. However, that only means that it needs to be fully explored and analysed on its complexity and breadth, as well as appropriately understood by well-trained medical staff; and any further claim discarding the possibility of autonomous and free choice regarding euthanasia falls behind the scope of those considerations.

The societal recognition of rational suicide provides defenders of euthanasia with another argument: the acceptance of rational suicide must imply the acceptance of euthanasia. Despite its having been rejected for so much time, rational suicide[52] has become a morally acceptable and understandable practice. For a person could choose to exit live

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[50] *"If the pain and suffering are by definition unbearable, then it seems clear enough that the decision to die is not freely chosen but is compelled by the pain. (…) The natural conclusion to draw from this is that there can be no such thing as voluntary euthanasia, or, at the very least, that we have no means to ensure that the patient´s request to die was not compelled."* (Campbell, 1999, p. 243).

[51] A thorough examination of the wish to die will be offered in next section.

[52] Although there is no need to consider the cases of irrational suicide for the purposes of our argument in here, it is worth mentioning that some authors also defend its moral permissibility. See (Hardcastle & Stewart, 2002).

after careful consideration of all the possibilities the future could bring and rationally decide that being dead is the best alternative. Following Benatar's (2013) arguments against the irrationality of every case of suicide, it can be argued that our way to regard suicide will vary depending on the sense of rationality we adopt; however, no matter which meaning we consider more appropriate, there will always be room for rational suicide. If we accept a position that understands irrationality as adopting means of action that do not, and should be known do not, secure their ends, we can easily see that sometimes suicide is not only *a* rational action, but *the* rational course of action. For example, when the only way of avoiding the burdens of life is by the cessation of one's life, suicide is rational an considered morally acceptable (Benatar, 2013, p. 228). Another possibility to explain the irrationality of suicide would be to argue that no action whose end is the death of the person can be regarded as rational, being the end itself irrational in this different approach. The claim is, again, difficult to maintain. For, it is simple to imagine situations where an individual would want to die, would prefer death over the pain and suffering life has awaiting her (Benatar, 2013, p. 228). Examples of them have already been provided when describing different unbearable situations experienced by people who opt for euthanasia.

Regardless of the number of instances where there is a rational component among the cases of suicide, and the person herself has done a thorough consideration and examination of her life before deciding to end it, there is enough for our discussion to accept that it is possible, and morally justifiable (Humphrey, 1998). The idea of suicide does not suddenly appear on the person's mind, but it slowly grows within her, becoming another considerable alternative that the subject could choose, after weighing the pros and cons of each of them.

Back to the relation between rational suicide and voluntary euthanasia, it can be argued that if we have the right to end our lives, we must also have the right to solicit assistance to do so (Rachels, 1986, Chapter 5). The fundamental aspect of the argument is to apply justice to those patients who are unable to commit suicide on their own due to the incapacitation caused by their illnesses. It would not only be unfair, but even more paradoxical, that patients suffering terribly from a terminal condition that thwarts their capacity from ending their lives by themselves are not given any alternative to put an end to the suffering others can easily end. Active euthanasia, then, would be the best alternative to do justice to all those persons who have autonomously decided that they would be better off dead and are unable to do so because of their medical condition. The case is similar to the one presented in section 2.2. to debunk the differences between passive and active euthanasia, since it seems that only patients suffering from a terminal condition, from whom treatment can be withdrawn or withheld, could escape from an existence full of suffering; whereas those undergoing other chronic illnesses are condemned to remain endlessly suffering because actively ending someone's life is considered morally wrong, illegal, and contrary to physicians' duties.

Imagine Melissa. Melissa is a 40 years-old woman whose life has evolved accordingly to her plans and prospects, time throughout which she has regarded her existence as happy and full of great life experiences. She has also had tough times, but she has been able to positively overcome them so far. Melissa has a decent job that pays enough for the kind of life she always wanted to have, and she spends most of her spare time doing physical activity, interacting with friends, or rather watching TV series and reading. After a tragic car accident where she lost her partner, Melissa became quadriplegic and unable to achieve all her future plans, at least to some relevant extent of utter significance to her. Besides that, the loss of her partner hurts her badly, making nearly impossible to completely recover emotionally from the accident. Being unable to do after the accident most of the things she regards as valuable and providers of happiness, she decides to put an end to her life. That happens months after the accident, so the shock suffered after the disaster cannot be considered a relevant factor that made her decide that. However, Melissa is not suffering from any other somatic or medical condition that could end her life, so withdrawing or withholding treatment are not options available for her. Similarly, her condition makes impossible for her to commit suicide, not even with the assistance of a doctor (PAS), for she would not be able to act to administer the drug herself[53]. It is obvious, therefore, that active euthanasia is the only alternative to put an end to Melissa's suffering, complying with her wishes and respecting her decision, as well as doing justice, since the rest of alternatives are impossible for her.

Before analysing the implications of the previous example in our argument for euthanasia, we must carefully consider possible objections that could be presented from people with disabilities who would never opt for euthanasia despite the changes their new situations have supposed in their live. Following Elizabeth Barnes' argument about disability on '*Valuing disability, causing disability*' (2014), we agree that the right approach to address disability is the one which defends that "having disability makes you nonstandard or different, but it doesn't by itself make you worse off" (Barnes, 2014, p. 89). According to that, there could exist the case of Melissa$_2$, who would adapt to her new situation and discover new ways of enjoying life to the fullest with her different capacities

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[53] It is important to remember here, that in physician-assisted suicide (PAS), the doctor is present during the procedure to provide the patient with the right amount of the lethal dose and to supervise the process and intervene only if necessary because the situation becomes painful for the patient.

and abilities after the accident. The truly relevant aspect of disability for our argumentation on euthanasia is to state clearly that by no means the moral acceptance of euthanasia would render every case of disabled people a more likely, or highly-potential, candidate for euthanasia. Once again, euthanasia is a personal and autonomous choice that depends exclusively on the personal evaluation of one's situation, and thus it equally affects people regardless of their disabled or nondisabled condition. Similarly, we cannot forget the enormous impact that society has in a person's consideration of her own disabled condition. That is to say that in our nowadays ableist societies, where there is plenty of room for improvement on the life conditions of people with different abilities, they can struggle to fully enjoy life due to the inconveniences and problems they must constantly face and go through. As stated by Barnes, the mere-difference view on disability is associated with other claims about disability, for example, "a principal source of the bad effects on disability is society's treatment of disabled people, rather than disability itself"[54] (2014, p. 93). However, this situation being a condition to opt for euthanasia cannot be regarded as an argument against our position, for it does not affect the moral permissibility of euthanasia. The furthest an argument of that type could get would be to assert that our ableist society makes it more likely for disabled people to choose euthanasia over continuing their lives; however, this would be a socio-political argument against our current society's organization and could never blame euthanasia as the cause of its wrongness.

Consequently, active euthanasia must be considered the appropriate and morally justifiable alternative in cases like Melissa's because, grounding our argument in the principle of autonomy, it is the only alternative at hand to respect the patient's autonomous decision. Finally, it is important to notice that accepting euthanasia as a morally valid alternative does not mean that the rest of them are not offered, or that it must be always regarded as the preferable choice. Deciding that our own life has come to its end, that it is time to finish it, is a difficult enough process to add external pressure about the means of doing so. Each person will have to carefully consider which of the alternatives suit them better, amidst the ones they have as effective options, and both family and loved ones' support, and adequate medical care and treatment must be guaranteed throughout all the process, making their time as bearable and free of suffering as possible. Otherwise, "*making someone die in a way that others approve, but that he believes contradicts his own dignity, is a serious, unjustified, unnecessary form of tyranny*" (Dworkin, 1998, p. 93).

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[54] Also, "it is perfectly consistent with the mere-difference view that the actual well-being of disabled people is, on average, lower than that of non-disabled people, simply because of how society treats disabled people" (2014, p. 90).

To conclude, it is of utter importance to state and establish that the euthanasia debate is about principles and world views, as we could just see in the example of Melissa, and that it must move into greater liberalization (Parker, 2005). There are groups among euthanasia detractors who repeatedly appeal to increasingly obtaining empirical data before finally deciding what is best to do regarding the legalisation of active euthanasia, believing that the bigger the amount of data is gathered, the better the moral conclusions about the permissibility of legalising active euthanasia would be. However, claiming for the need of more empirical data amounts to deferring tactics. Data, like facts, only contributes to the debate with description and clarification, whereas the euthanasia debate is about the underlying values, which requires justification and assessment. All the data collected would be of an immense help to draft new guidelines and safeguards that make the practice of euthanasia safer, as well as to improve or change the present ones. However, such data are not legitimate candidates for the purpose of modifying or establishing moral conclusions, for they do not qualify as moral principle, and will only be useful after debates of principles have occurred. The important issue, as I have attempted to do along this chapter, is to offer arguments for or against euthanasia, achieving a better understanding of the moral quandary and deciding why some reasons are better and more justifiable than the rest to corroborate the moral rightness of euthanasia.

3.5. The wish to die

There is a final concern that might be still alleged at this point, a preoccupation about the true nature of the wish to die when expressed by a patient. In other words, how could we be sure that a person genuinely wants to die? After all, multiple situations could be encountered where people regret an initial choice or desire, changing their minds about it. This is of special relevance when addressing such a delicate topic as euthanasia because the irreversibility of death makes it mandatory that the wish is validated by healthcare specialists. To be sure about what the patient is trying to make explicit when asserting their wish to die, it is necessary to offer an initial reflection on the main factors that serve as a motivation for the wish to die. Secondly, a schematic context of the wish to die anatomy will be offered, which intends to make us aware of the big picture, allowing us to fully grasp the meaning of the expressed wish to die. The section will finish with a discussion on the relevant aspects of the wish to die for euthanasia, together with its direct impact on the overarching medical care context.

3.5.1. Main factors motivating a wish to die

The first question that usually comes to our minds when dealing with death requests is to ask ourselves, and maybe sometimes the person asking, about the reasons behind such a strong (at least apparently) desire. Why did patients want to die? Schroepfer (2015) offers an interesting list of factors as a result of a thorough analysis and study. Among the predominant reasons presented by patients we find: a) loss of autonomy; b) loss of dignity; and c) a decreased ability to participate in activities that make life enjoyable. No further comments will be made about those, for I hope they are self-evident and have no major impact on the argument we are trying to present. However, there is a key remark to specify, for it is important to note that factors such as physical pain or suffering are not predominant among those offered by patients to explain the motivation behind their wish to die and their idea of a good death (Emanuel & Emanuel, 1998). That supports our previously stated arguments defending the moral justification of euthanasia. For if pain and suffering cannot be listed among the most common reasons offered by people who want to die, the alleviation of those symptoms by strong drugs cannot be presented as a counterargument to defend that euthanasia is not needed, because there are more compelling reasons to consider when one explicitly states their wish to die.

There are still another two sources of motivation which become of special relevance for our overall thesis. The first of them serves as a link with our previous chapter about the relations between death and finding meaning in life. For, the loss of meaning in life is regarded by plenty of patients as one of the decisive factors to have a wish to die. So, when someone explicitly states that they desire to die, sometimes, in many of those cases, voluntary active euthanasia would be the chosen path to put an end to life and will likely help patients find a last opportunity to create meaning in their dying. As examples of this aspect, we find: to let death put an end to severe suffering, to spare others from the burdens of oneself, to not have to wait until death arrives, to end a life that is now without value[55].

Similarly, among the reasons motivating a wish to die there is the feeling that one is a burden. This will be of crucial importance to understand why and how those people who feel a burden for their loved ones will believe that they have a duty to end their lives, a duty to die. In chapter 3, arguments for and against the existence of such duty will be analysed, and it will become clearer if people having a duty to die are right to think so, the existence of a duty to die will be defended.

3.5.2. Contextual anatomy of the wish to die

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[55] See more examples in Ohnsorge (2015, pp. 88–89).

It is our purpose now, following Ohnsorge (2015), to clearly depict what the wish to die consists on. To do that, it will be necessary to start comprehending what are the underlying intentions of a person who specifies a wish to die. First, it might be that the person is not truly considering hastening their death, but simply looking forward to dying, hoping that it happens quicker. Secondly, others could be simply considering hastening their death, but not undertaking any active action that leads to it. For example, someone could only consider hastening their death later if and only if the situation worsens. Finally, there are still other patients whom by their wish to die entail a thoughtful consideration of hastening death and would act to bring it about. The last includes cases where the patient explicitly requests it, refuses life-sustaining treatment, or acts towards dying, e.g., assisted dying.

> *"It might be helpful in the clinical context (for overcoming reluctance to deal with such statements) to bear in mind that wish to die statements do not necessarily mean a person also intends to hasten death, and that a patient with a wish to hasten death does not always intend to carry out this wish" (Ohnsorge, 2015, p. 86).*

A second distinctive feature of this anatomy of the wish to die is its motivation. Even though we have already, in the previous subsection, analysed the main factors motivation the wish to die, we have not enumerated all of them, which becomes necessary to fully gain a coherent and overarching understanding of the patients' desires. Firstly, it will suffice to list some of the subjective reasons held by people wishing to die: a) physical (acute or chronic pain, respiratory distress, drowsiness…) and psychological (anxiety, hopelessness, fear of becoming dependent); b) social reasons (the most important ones are fear of being a burden to others, experience of loneliness or abandonment by loved ones, social isolation, lack of financial support); and c) spiritual issues (loss of dignity, uncertainty of the dying process, loss of a sense of life). This is not a hierarchy based on its relevance or commonness, but a simple enumeration of them. Accompanying the motivation of the wish to die expression, and interrelated with it, there is a function the patient hopes their wish to die will have on others. Many patients hope, consciously or not, their wish to die to have a particular effect, on themselves or their relationships.

Finally, the wish to die becomes a constitutive aspect of social interactions. To begin, patients sometimes wish with respect to others, that is, the expressions of the wish to die are conditioned by interdependence, voluntary or non-voluntary responsibilities, and obligations towards others. This would be a clear case of the familial responsibilities from which a duty to die can and will be defended in the upcoming chapter. Equally important is the moral interpretation that others make of the patient's expression of their wish to die, for it varies depending on the way it is understood by those around them and their constitutive preconceptions about death, its plausibility, the means to be employed… There is also a performative aspect of the wish to die, i.e., its explicit expression often changes something in the relationship between people. A final but crucial aspect of the social interactions that the wish to die faces us with is the master narrative from within it is stated. Determined dominant cultural schemes make individuals order and frame their wishes, desires, thoughts, experiences in a certain perspective. For example, the meaning of not becoming a burden to others (thus of acknowledging having a duty to die) might be influenced by dominant societal schemes (being independent, having a task, being a productive member of the community, are all regarded as virtuous and positive for the configuration of individuals' identities by the dominant conception in our societies).

3.5.3. Discussion

A vast number of considerations could be obtained from our previous reflection about the wish to die. The first among them must necessarily point into the direction of precaution; for, the patient's situation near death is, most of the time, ambivalent due to the variety of intentions they have, which might be contradictory amidst them. Thus, it cannot be doubtlessly assured that the patient's wish to die is unproblematically stable. Moreover, a thorough examination of the wish to die as expressed by a specific patient seems necessary, because it is not always closely related to the patient's desire to hasten death. However, this does not preclude from the existence of a persistent wish to die in some patients (Ohnsorge, 2015; Schroepfer, 2015); which is all we need for the euthanasia argument's sake to be morally pertinent, relevant, and necessary. Moreover, following Nissim, Lo & Rodin (2015), patients whose desire to hasten death is contemplated and understood as a hypothetical ´exit plan´[56] are better able to cope with the fears regarding their future due to the sense of having a safety net. Thus, the legalization of PAS and euthanasia would provide them with such a safety net, for they could count on either of the procedures to put an end to their lives in a more dignified manner.

In addition, there are many patients who are able, and do, express their intentions behind the wish to die; fully competent patients who are aware of the implications resulting

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[56] In their study, this alternative, i.e., the expression of a Desire to Hasten Death (DHD) as a hypothetical ´exit plan´, is the most common form of DHD. So, extrapolating the figures proportionally from their percentages, the number of people who would opt for PAS and euthanasia as the preferred way of ending their lives must not be disregarded or overlooked.

from expressing their wish, capable of explaining what it means for them within a personal wider framework of moral ideas and identities. So, even though close attention should be put to interpret and fully comprehend the real wish behind the expression of the wish to die, that could never impede us from seeing the possibility of a coherent and well-structured desire to die, which entails the hastening of the patient's death. The possibility to opt for active euthanasia in those cases must be granted for justice reasons, as earlier defended in preluding sections of the present chapter. Finally, because of the previously stated, wishes to die must be understood as communicative acts, instead of mere declarations, or simple messages, for they are situated in a particular time, setting, and in the relations between people.

There is, however, a final legit question to consider, what can be done from medical institutions to make sure that the expressed wish to die conveys a sincere desire to hasten death and, thus, choose active euthanasia? What is the approach healthcare professionals should attach to when accompanying a patient who has expressed a wish to die on their journey to death? More will be said in chapter five regarding physicians' and nurses' medical and bioethical duties towards those patients; but, for now, it should be enough to sketch a preliminary approach. Hence it should be obvious that caring for these specific patients implies a unique type of engagement with and understanding of the underlying narrative structure, within which their intentions, meanings, and social interactions must be located and are explained.

3.6. Conclusions

This chapter has discussed the moral justifiability of euthanasia, in both its active and passive instances, furtherly offering a moral defence of this medical procedure from mercy and autonomy. Initially, the clarification of concepts helped us support our later arguments on solid grounds. By now the difference between the variety of assisted-dying methods should be clear. For, it allowed debunking the existence of a morally relevant distinction between active and passive euthanasia, thus unveiling the paradox of the extended practice of the withdrawal or withholding of treatment whereas more active means to end the patient's life at her own request was deemed morally wrong. It has been argued that the relevant matter to morally advocate for euthanasia rests on the reasons we are able to provide to justify its practice, not on the means employed to perform the procedure. So, when a patient autonomously gives her (informed) consent to end her life because she is suffering due to a chronic and/or terminal condition, there are no moral grounds to reject her petition, we shall ultimately respect the patient's values and decision.

Close attention has been put to analysing the arguments from detractors and defenders of euthanasia, concluding that reasons presented against active euthanasia are not sufficient to morally condemn the procedure. We have seen how the risk of slippery-slope instances can be effectively impeded by the implementation of strong guidelines and safeguards to largely protect the patients' rights. In a like manner, the difficulties of defending the intrinsic value of human life and the intrinsic wrongness of killing have been shown, and they have been demonstrated not to be morally relevant enough to counter the justification of euthanasia. This defence of active euthanasia is grounded on mercy, avoiding the unnecessary patient's suffering, and autonomy, respect for the patient's free and informed decision regarding her medical condition and, ultimately, her life and how to put an end to it.

Finally, close attention has been given to gain a thorough understanding of patients' expressions of their wish to die, which facilitates the implementation of euthanasia in healthcare settings and helps practitioners gain a better understanding of death requests. This analysis, however, has not left out of the discussion the possibility of a truthful desire to hasten death and do so by active means, as in euthanasia. Moreover, we have showed how active instances of assisted dying are the best alternative for some people who wish to die and want to hasten their deaths. Ultimately, the desire not to be a burden to others has appeared as one of the motivations for the wish to die expressed by some patients, which takes us directly to tackle the problematic of the existence of a duty to die when one feels she is such a burden.

4. IS THERE A DUTY TO DIE?[57]

4.1. Context

Our mortal condition has always been the eternal, unescapable companion, and fate of human beings since the beginning of their existence. As a result, diverse ways of facing, fighting and, finally, accepting death have been offered by different societies along the passage of time. Contemporary western societies are currently facing the challenge of providing successful answers to a new shift in the way of dying. The irruption of highly-developed technologies employed in medicine and the improvement of the efficiency of treatments, which together convey the ability to postpone the moment of death and transform the waiting time before it into a more comfortable one, have shaped a characteristic new way of dying (Hardwig, 2009). Nowadays, death is more likely to happen after a prolonged period of physical and mental debilitation, where our life is gradually fading away until its final disappearance. This shift from a more traditional conception of death, typically defined and socially understood as unexpected, quick, and coming too soon in most cases, implies the appearance of a corresponding new fear of death, the fear of dying too late and after the endurance of an unnecessary extended period of suffering (regardless of it being psychological or physical). This change has taken place in such a brief period that cultural adjustment has not been feasible; in other words, society is still incapable of a profound understanding of this new way of dying, its consequences, and direct impact in the different spheres of life.

Western societies' response to this alteration in the traditional conception of death can be synthesised in the idea of the 'medicalization of death' (Hardwig, 2006). Death, both as a process and as clearly delimited moment, has progressively abandoned the premises of our homes to move into the more aseptic atmosphere of hospital rooms. Its new location, in a place where death can be almost *treated*, as if it were a disease, involves direct consequences both to the dying person and those around them. In first place, the person facing death within a medicalized context often tries to postpone it, in a venturing attempt and effort to get as close as possible to the dividing line beyond which treatment if futile before its cessation; this is the idea of *technological brinkmanship* proposed by Callahan (1993, Chapter 1)[58]. The difficulty to clearly draw a defining line between life and death, in terms of where and when we must set it, includes tough decisions and moral peril when

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[57] Sections of this chapter will be published in the forthcoming issue of Revista Portuguesa de Filosofia.

[58] The notion of technological brinkmanship has been already furtherly discussed in chapter 1. See page 18.

considering the different options at hand to escape from an unnecessary delayed death. Similarly, a medicalized death lacks its personal traits, it is a kind of death snatched from the subject and turned into an object of medical analysis and scrutiny. This new layout makes us forget about the human tasks of dying (Hardwig, 2006): the wisdom to recognise and accept that our life is over; the skill of wrapping up and get ready for the end; and the ability to make peace with our past. Secondly, the medicalization of death profoundly affects those around the dying person, their loved ones. On one side, families are burdened by the costs of treatments and the emotional impact this belated death has on them. On the other side, considering the big picture, society is also affected to the extent that it must decide on the difficult moral task of what lives are worth preserving[59], which will inevitably affect the medical profession, for physicians will have to decide when to stop saving a life.

As the result of the previously mentioned changes, both the medicalization of death and the high costs of new treatments and technologies employed for them, societies are not prepared to confront the new economic challenges presented by them. Assuming the right to a decent minimum of health care as an unquestionable and defining characteristic of Western societies, the problem of a just allocation of scarce resources remains as one of the biggest ordeals to solve. Bearing in mind the principle of justice within the field of bioethics, and considering the factual budget limitations, priorities must be clearly stablished about determining what ought to be done when resources are inadequate to provide all the healthcare benefits that is technically possible to provide (Beauchamp & Childress, 2009, Chapter 7). Different responses have been offered regarding the fairer method to allocate resources justly; some argue for a rationing by age[60], whereas others regard as more appropriate to also consider the excessive costs of some treatments as a determining factor[61]. Both approaches will be properly discussed and examined in section 3.3.

Due to this described new way of dying, learning how to die becomes one of the most important tasks of our times. The shift from a death that would usually come too soon and unexpectedly, before most of our life goals and expectations could be fulfilled and/or successfully achieved, into a death that comes too late and after an unnecessarily lengthy period of suffering, in a majority of cases, has created a widespread fear of the later type of death. Within this context, the idea that death may often be worth pursuing gains strength and becomes a powerful tool to face and overcome the widespread fear of a late dying.

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[59] Needless to say, it will not happen on a case-by-case basis, but as the result of discussing and deciding about the allocation of resources and the investment in healthcare.

[60] See (Daniels, 2008).

[61] See (Margaret Pabst Battin, 1994, Chapter 3).

Hardwig (2009) chooses the language of art to talk about *the art of dying*, understood as the ability to pursue and accept death prior to entering the feared process of dying too late. The main elements in this *art of dying* are wisdom, skill, and prudential virtues, which function together to determine the key factors to unfold our desired way of exiting our existence. The first element to consider is the acknowledgement of one's life trajectory, the various stages a person has lived, endured, enjoyed… throughout their lives, identifying ups and downs, success and failure, reflecting on every and each of them and their individual meaning contribution to the whole. When doing so, the remembrance of our past will unveil events that we may regret, thus bringing life to an end will require from us self-forgiveness regarding those past incidents were our actions could have been different. Secondly, but closely related to the previous one, there is the acceptance of death, the recognition that our life is finite, and it will necessarily end. Finally, interwoven with the other two, there is the relevance of timing. The subject will need to identify the right moment for their death wisely and skilfully, where the recognition of their life's trajectory and the meaning of events within it will play a crucial role to ascertain the adequate time to die. It is also worth mentioning the interpersonal dimension of the art of dying. Our decision will affect our family and loved ones, thus it must be made considering them as key elements within our lives, so we must prepare them for our deaths as well.

4.2. Definition

The notion of a duty to die first appeared, though not explicitly, in *Death: right or duty?* by Lamm (1997). His argument started with the consideration that there was (and there still is) a concentration of health care resources on the sickest 1%, whereas other people are going without primary basic health care and kids without vaccinations. Lamm considers that framing the discussion around death in terms of 'rights' entails a misunderstanding in our perception and beliefs about the impact our decision has in society. Believing that death is a right, or merely an option that we can postpone if we wish, creates in us the irrational fiction that we can spend as much government or insurance money as we want to delay death. This misinterpretation of our present health care context, already described in the previous section, has as a result the high expenditure of resources and money on the last generation at the expense of the next one. In words of Lamm, "*our aging bodies can bankrupt our children and grandchildren*" (1997, p. 112).

The philosophical problem that appears behind Lamm's reflection is clear: in a context where resources are scarce, a reduced percentage of very sick people are concentrating most of the resources, whereas a more just distribution of those same resources could be implemented to improve and lengthen other people's lives. Among the plausible causes for this situation, people's belief that they can prolong their lives as much as they wish without considering the arising bigger picture is one of the most relevant. Thus, the proposal of a duty to die. A duty to accept that our lives necessarily and irremediably end, to assimilate that irrationally clinging to it will only cause unjust procedures in the allocation of resources affecting others negatively.

However, its social side and repercussions is only one of the features, or arguments, to defend a duty to die. For John Hardwig (Hardwig, 1997b, 1997a) digs deeper into the notion and its further implications. First, the true sense of *duty* as employed by Hardwig needs to be clarified, for him it is a pretheoretical concept, interchangeable with other notions, such as *responsibility* or *obligation*. Thus, despite the moral weight that could be assigned to those concepts, the truly relevant matter is to understand the idea behind them, that is, the idea of not becoming a burden for those who we love and love us. The underlying intuition behind all that is clear: it is sometimes needed to prioritise the needs of others before our own, even when dealing with situations where our own death plays a significant role, and our final decision lies in choosing our own death over our loved ones' suffering. Secondly, the notion of burden employed in the definition of the duty to die becomes troublesome; even more significantly in Western societies where the influence of Christianity still casts a big shadow over our ways of addressing morally problematic issues. However, simply understood, following its dictionary definition, 'burden', as a noun, is defined as something which is difficult to bear, and as a verb, it means to load oppressively, to trouble. Far from pretending or defending the meaning of a word purely by its dictionary definition, but because we consider it is also the common usage of it in our day-to-day life, the notion of 'burden' within the duty to die shall be understood in this uncomplicated way. Furthermore, Hardwig (1997a, 1997b) plainly states that the burden imposed over their loved ones when a person does not accept their duty to die could have an emotional or financial impact, even both. Finally, it must be clarified that the duty to die is a *prima facie* duty, that is, it can be outweighed by countervailing moral forces (Menzel, 2000). In other words, the duty to die will only be an element to consider when weighing the different alternatives that a person has when deciding how to proceed about their medical treatment and/or condition.

Before moving on to its philosophical grounds, we shall furtherly develop the idea of the duty to die, addressing more carefully its structure and the implications of becoming a burden. Difficult as it might be to assimilate and accept, there are situations where the family would be better off if the patient were dead. The circumstances could be that the economical, physical, and/or emotional costs of the patient's condition were too high, thus becoming a burden to their loved ones, since their lives could be seriously compromised by caring for the patient (Hardwig, 1997b). Undoubtedly, not every patient's situation would be equally burdensome for their loved ones, but there are cases where those burdens can decisively and drastically shape the lives of a person's loved ones. A reasonable question may arise at this point, why can we not, or should we not, become a burden to our loved ones? Callahan (1993, Chapter 4) defends that human beings are and must be a burden to one another; he furtherly states that the flight from dependency is a departure from humanity, which creates the illusion of self-sufficiency. However, the duty to die is rooted in quite the opposite insight. For it is precisely due to our bonds to those who we love and love us which creates and develops certain responsibilities within us towards them. Precisely because there are dependency strings attached to each person and connected to their loved ones, the duty to die is a reminder that we are not sufficient on our own and constantly need to care about others' necessities. We cannot reduce our loved ones to means for our well-being (Hardwig, 1997b). Accordingly, in that same paper, Hardwig attempts to debunk what he calls 'the individualistic fantasy', which consists in an atomistic conception of the self, where there is no consideration of the others and their interests. There is the assumption, his argument goes, within the health care context, that the patient's opinion is the only one that matters, since they are thought to be the ones exclusively affected by the impact and consequences on their choice in the treatment decision. Quite the contrary, there is a moral obligation to consider the impact of our decisions in our family members and loved ones. It is precisely this conception from which the duty to die arises.

Having clarified the key defining elements of the duty to die and becoming a burden in the previous paragraph, a more significant insight on the structure of such duty is necessary. The main foundation of the duty to die is the idea of dying in order that other might live (Narveson, 2000), because staying alive would impose unbearable burdens upon them, ruining their lives. Having said that, it is a duty which emerges in an interrelational context, within a family, and thus considering everyone involved. However, that does not mean that deciding whether one has a duty to die is a group/family decision, but a personal one where the person who might have the duty to die must consider everyone involved. Hence, our duty to die is a duty towards others, based on the interaction of people in society, and the bonds created as the result of such process. In a sense, then, the duty to die can be comprehended as an implicit agreement between family and friends by the ties created by love and will.

4.3. Being a burden

The problematic associated to the notion of *burden* has been already discussed, albeit briefly, in the preceding section and the appropriateness of its usage within our argumentation justified based on its meaning. However, it is necessary to delve, not into the linguistic features[62] of the notion, but into the medical context where it appears and its significance at the end of life.

Regardless of whether the existence of a duty to die is considered as morally defensible or not, the avoidance or reluctance to burden others is one of the prominent values for a good death among those patients at the end of life who are deciding between different life-prolonging treatment alternatives (Singer et al., 1999; Steinhauser, Christakis, et al., 2000; Steinhauser, Clipp, et al., 2000; Winter & Parks, 2012). Moreover, it is a desire frequent enough not to be overlooked. Thus, patients at the end of life are concerned with not burdening those people they love and care about, which is one of the premises to defend the existence of a moral duty to die. Their worry not to burden others is also one of the main reasons offered to justify their willingness to die, so the causal connection between the patients' feeling of being a burden and their desire to die (which sometimes includes the explicit request to doing so by hastening death) is obvious and cannot be ignored.

However, even when the feeling of being a burden could be perceived as a misfit between the patient's perception and the reality of their situation, the shift on the ways we die nowadays, where death and dying had been medicalized and thus required specialised care during the end of life, demands more resources, both financial and of personnel. As a result, caregivers, family members mainly, highly admit being overburdened, either physically, emotionally and/or financially:

> *"The rising number of deaths from cancer and other life-limiting illnesses confronts society with growing difficulties in terms of care organization. As a result, considerable responsibilities for long-lasting care, including end-of-life care[63], are taken on by family members."* (Pivodic et al., 2013, p. 825).

The variations and the extent to which caregivers carry those burdens depends substantially on the organization and funding of the healthcare structure. But it is important to highlight that even in countries where a strong public healthcare system is in place, e.g., Spain and Italy, caring responsibilities are not completely covered, therefore delegating to

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[62] Even when acknowledging that the metaphor of the 'burden' is not free from assumptions; for, there is a generalised negative understanding of it.

[63] The last three months of life are widely accepted as the period of end-of-life care.

family carers (Pivodic et al., 2013). In other words, formal care, that is, the one provided by healthcare institutions, is unable to provide care, and it bears the needs of patients at the end of their lives who need palliative and end-of-life treatment over extended time periods.

We come to a halt at this point, where further clarification in relation to caring responsibilities must be offered. The defence of the existence of a moral duty to die by no means should be argued in favour of cutting back the necessary state's investments in healthcare and palliative care at the end of life. Furthermore, adequate health and social care policies should be implemented to maximally reduce and alleviate the burdens carried by family members due to the end-of-life care. However, there may remain situations where, even when optimal policies and redistribution strategies had been implemented, burdening others occurs as the inevitable outcome of limited resources scenarios. And it is in those cases where the duty to die could still appear and needs to be properly addressed.

Once that we have acknowledged the existence of patients' wishes to end their lives, even to hasten their death in countries where it is possible, motivated by their reluctance to (over)burden others who they love and care about, it is necessary to gain a more thorough insight on what being a burden to others means for those who express such desire to die. The main salient feature of the feeling of being a burden to others is its complexity; for, it is a moral emotion where the ill person cares about the caregiver's burdens imposed by the patient's own illness (Rehmann-Sutter, 2019). That makes evident the relational character of feeling a burden, and points us in the direction of how difficult it is to estimate the perception of the burden from both the patient and the caregiver, for it may significantly differ. However, it does not mean that it is impossible to apprehend the existing burden and comprehend the extent to which it is felt by both persons concerned.

Following Rehmann-Sutter (2019), phenomenology can help us gain a more complete understanding of the self-perceived burden to others, which has two key features if addressed from this perspective. On one side, the patient finds herself in a situation where the feeling of being a burden is experienced as a form of existential suffering, and her plight could be only relieved by dying. The direct connection between the burden and the subject's life can be clearly seen. On the other side, the feeling of being a burden is the connection the patient has with those caring, and the patient also feels burdened by the burden that her situation is causing others she cares about. In this setting, the patient puts their needs about her own, even when this imposes on her the acceptance (and wishing) of dying to relieve those she cares about from the burdens caused by their caring[64]. It would indeed be difficult to qualitative and quantitative analyse the burdensomeness imposed on others and felt by both the patient and the caregiver due to the relational structure of being a burden, and the inherent interexperience of the self-perceived burdensomeness on others. Although, at the same time, and precisely due to the relational character of the burdensomeness feeling, the shared stories and life experiences by both patient and caregivers are intertwined in a way that creates common knots from where open dialogue about the situation should begin. Woefully, this kind of conversation is often lacked, as Hardwig also lamented on his articles[65].

To conclude, the feeling of being a burden to others taking care of her is frequent enough in patients at the end of their lives to be overlooked. The willingness to free others who the patient loves from the burdens her condition imposes on them is also common. There is nothing wrong with such reluctance of being burdensome and the desire to die associated to it, which both need to be properly understood to comprehend the reasons behind patients' wishes to die so they can be accommodated within a specific healthcare context. The existence of an extended reluctance of patients at the end of their lives to burden those people caring for them and whom patients love provides evidence of existence of an acknowledged responsibility on people to end their lives to take care of others. In other words, there already exists a duty to die whose moral defence seems legit.

4.4. Main argument

The argument to defend the duty to die was presented and defended by Hardwig on his paper *Is there a duty to die?* (1997b), although Hardwig's first mention of such a duty appeared as part of an Ethics anthology on a chapter titled *Dying at the right time: reflections on (un)assisted suicide* (1997a). Despite it being presented throughout those articles, it will be exposed here by the usage of bullet points, for the sake of clarity and a better understanding, as Hardwig himself did years later in another paper (2013). The argument rests on three main premises, from which the existence of a duty to die will be deduced. Those premises are:

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[64] Rehmann-Sutter avoids providing a moral defence and/or justification of the situation just described, and he concerns himself only with employing phenomenology to better understand what is occurring. However, it seems evident that the depicted situation is a clear example of patients acknowledging their duty to die. We will, later in this chapter, provide justification for a moral defence of such duty.

[65] Cf. Hardwig (1990, 1997b, 1997a).

I. Our medical decisions do not exclusively affect ourselves but have a direct impact on the lives of those we love, which will affect them in important and long-lasting ways.

That is especially true in societies[66] where medical treatment costs are sometimes too high, economically speaking, to be afforded, with no further significant impact on the lives of those taking care of the expenses. However, in societies where health care is of a public character and all the treatment costs are covered, the emotional and physical burdens imposed in some cases by certain illnesses shall be considered weighty enough to contemplate the possibility of the existence of a duty to die[67].

The relevance and role of the family when addressing the duty to die is well-known by now, which takes us directly to the second premise Hardwig defends:

II. Medical decisions must be made considering what is best for all concerned, that is, the patient cannot, and should not, only measure their own interests and well-being when deciding for the treatment course to follow. Again, the interests of family and loved ones must be considered.

Modest as it might seem, premise II involves a significant shift from the predominant approach to bioethics, which is a patient-centred one. In this case, patient-centred bioethics should be abandoned, moving to a family-centred one. Similarly, this change would require the redefinition of the concept of autonomy, which has a central role in Bioethics. Those issues were previously addressed by Hardwig in a paper considering the family role in medicine (1990). In there, he questions the extent to which the family interests can and should be sacrificed when taking medical decisions. There is a paradox and an anomaly in medical decision-making, he states, because the process excludes those around us (family and loved ones) from the consequences of our actions/decisions about treatment or other medical procedures. That is of foremost importance because an understanding of bioethics so centred on the patient forgets about the family dynamics, where sometimes the weakest member is not the patient, thus not the one most in need of protection.

As a result, the notion of autonomy needs rethinking, since patients also have moral responsibilities towards others; without question, the right course of action to take might not always be the one that promotes the patient's own interests. However, autonomy is understood in biomedical ethics contexts as having two essential conditions, liberty and

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[66] Take as a paradigmatic example the US private health care insurance context.

[67] Cf. section 3.3. above for documented scenarios where, within public healthcare systems, patients report a reluctance to burden others among the main reasons why they wish to die and/or are willing to hasten their death.

agency, which acknowledges the value and decision-making rights of persons. Similarly, when speaking about autonomous choices in bioethics, what is implied is the patient's competence and informed consent (Beauchamp & Childress, 2009). Autonomy is understood as a *prima facie* principle which plays an important role to define and comprehend the rest of the bioethical principles (Beauchamp & Childress, 2009; Gillon, 2003). Hence, what would be necessary is not so much a complete redefinition of the notion of autonomy, but the inclusion of the family interests when patients consider all the treatment options available. For, the autonomy of all members of the family, and especially those whose autonomy would be significantly compromised, must be considered. The most significant consequence of those changes would be the increased weight that fairness and justice have in medical ethics. Equality must be the guiding principle when weighing interests; medical and non-medical, personal, and family members' interests must be similarly considered, and balanced when they conflict.

Despite the radical appearance of this shift, it is simply a specification and an amend to the notion of autonomy as currently considered in Bioethics, which would not necessarily have a significant impact, nor will it create the need of redefinition, on the concept of autonomy. We do not believe, as Hardwig does, that a complete change into family-centred bioethics is necessary. Autonomy will retain its relevance within biomedical ethics, but it is important to remember that, as a *prima facie* principle, there might be situations where it could be outweighed. To conclude, ideally, on a day-to-day basis, patients would consider their family and loved ones´ perspectives and would together decide what the best course of action to follow is.

All that leads to our third premise:

III. The elderly also has responsibilities to their loved ones, among which the protection of the well-being of the family must be included. It is important to note that those responsibilities and obligations remain despite their illnesses. Counterintuitive as it might seem, moral agency cannot be obliterated by chronic illness and/or debility.

It would be inadequate to deduce from this premise that duties of care are removed completely from discussion. Loving relationships are a two-way street where reciprocal care and responsibilities arise. This third premise attempts to highlight a commonly oversight perspective. Indeed, the moral duties of an ill person vary significantly when they are sick, some of them might totally disappear; but new ones could also arise and need to be addressed with caution.

Once we accept the already presented premises, the rest of the argument goes as follows:

IV. Some burdens are too great to legitimately expect, ask, or even allow others in one's family to bear.

V. In some cases, there is no way to go on living without imposing those burdens upon others.

VI. In those cases, we still have a duty to try to protect our family and loved ones from those burdens. That duty might sometimes be a duty to die, for death would be the only, more appropriate, and/or morally preferable, option at hand to avoid imposing unnecessarily onerous emotional, physical, or financial, burdens on a person's loved ones.

It is important to note that the relevant philosophical issue here is not the number or percentage of cases where a duty to die may arise. It is enough for the sake of the argument to find at least few situations, regardless of how seldom they might be, where the duty to die can be clearly defended. However, to appreciate the surprisingly common and familiar character of cases where a duty to die might arise, consider Hardwig's example:

> *"An 87-year-old woman was dying of congestive heart failure. Her APACHE score predicted that she had less than a 50 percent chance to live for another six months. She was lucid, assertive, and terrified of death. She very much wanted to live and kept opting for rehospitalization and the most aggressive life-prolonging treatment possible. That treatment successfully prolonged her life (though with increasing debility) for nearly two years. Her 55-year-old daughter was her only remaining family, her caregiver, and the main source of her financial support. The daughter duly cared for her mother. But before her mother died, her illness had cost the daughter all of her savings, her home, her job, and her career."* (1997b, p. 37).

The question now is: what is the greater burden/evil? On one side, the mother is solely giving up a 50% chance of another six months of life; whereas her daughter, on the other side, has compromised and lost everything, savings, home, and career, at age 55. More cases like this one could be created, where the person bearing the greatest burden could be undoubtedly pointed to. The truly relevant issue lying here to defend that there exists a duty to die is the consideration of the moral importance of the daughter's burdens to bear in her mother's final decision (Hardwig, 1997b, pp. 37–38). Death, or ending one's own life, is not always the greatest burden, as we have already seen in the previous chapter when addressing euthanasia and physician-assisted suicide; moreover, it is sometimes preferable to a life full of pain and suffering. When we add to this consideration the idea of a family-centred bioethics, advocate for by Hardwig, we can clearly elucidate the main motivation he has to defend the existence of a duty to die.

4.5. Implications and other considerations

4.5.1. Who has a duty to die and when?

Once the definition and main argument for the duty to die have been presented and thoroughly examined, there is a question that unavoidably needs answering: who has a duty to die and when? Despite there being the right questions to be asked to ascertain situations where the duty to die would need consideration, there are two main reasons why supplying specific answers is not possible (Hardwig, 1997b). First, answers to the question of who has a duty to die and when are necessarily very particular and contextual. Secondly, duties cannot, or at least should not, be defined unilaterally in the context of family and loving relationships. Those around us must be allowed to express their feelings about the burdens our life impose upon them and their willingness to bear those burdens. However, deciding about whether one has a duty to die must be a personal matter after careful consideration; it cannot be expected from a loved one to tell us about our duty, because it would be difficult to say and would cause a heavy load of guilt on them (Hardwig, 1997b, p. 38).

Nevertheless, the fundamental insight of the duty to die could work as a guideline to identify when someone has or could have a duty to die: "*a duty to die is more likely when continuing to live will impose significant burdens –emotional burdens, extensive caregiving, destruction of life plans, and, yes, financial hardship– on your family and loved ones*." (Hardwig, 1997b, p. 38). Similarly, Hardwig (1997b, p. 39) offers some features that can help us elucidate the presence of a duty to die. For example, one is more likely to have a duty to die when has lived a lavish life without worrying much about saving for the future, or when one has lived a full and rich life; the duty to die also becomes greater when one grows older, or when the lives of one's loved ones have been largely impoverished or made more difficult, and also when they have done already significant efforts and contributions towards making one's life better. On the other side, there is less likely to be a duty to die if one can still make significant contributions to one's family and loved ones' lives; or to the extent that one can make a good adjustment to their illness or handicapping condition.

The conditions that make a duty to die more or less likely are factual, that is, they depend on the social, economic, and legislative, characteristics of a given society. Obviously then, there are policies that could be changed, created, and implemented, to reshape the social landscape and significantly reduce the incidence of the duty to die. However, just as clearly, our reflections and considerations regarding the duty to die arise in a predetermined and given context, emanate from within it, and must not be neglected. For, any philosophical reflection in the field of bioethics which does not address the pragmatic conditions could be appropriately regarded as losing contact with the reality it problematises. Unquestionably, the acknowledgment of a duty to die cannot be presented and/or understood as a solution to all those above-mentioned societal problems, which will need of the adequate policies to be solved.

4.5.2. Duty do die and incompetent patients

Issues regarding a person's competence to autonomously decide what it is on their interest frequently arise in the field of bioethics, as we saw on the previous chapter when addressing euthanasia. One of the first troublesome situations that must be clarified is that only those who were formerly competent, i.e., capable of making moral decisions could have such a duty. For, an infant could never have a duty to die, or anyone with severe cognitive impairment, for example. However, cases of dementia or Alzheimer come inevitably to our minds when considering incompetence and medical end-of-life decisions. Contrary to what happens in instances of advanced directives where euthanasia could be the desired procedure to perform, especial care must be taken when claiming than a formerly competent person would have acknowledged their duty to die in the present situation. The differences with euthanasia or physician-assisted dying are clear. For one's suffering is among the fundamental criteria when considering the moral rightness of euthanasia requests but has no explicit role in the recognition of a duty to die. However, that does not remove completely the duty to die from reflection. For practical matters, among which we find the avoidance of being in a future situation where we cannot relieve our loved ones from the burdens of our life, the duty to die could appear as an obligation to die before becoming incompetent. Otherwise, the evasion of our moral duties by waiting until one escapes into incompetency would be irresponsible (Hardwig, 1997b, p. 39). Hence, one can have a duty to die when mental incapacity awaits in the horizon.

However, we cannot forget that the duty to die emerges from within a context of a reshaped bioethical landscape, where the family have a more significant role in medical decisions. That is of special importance when considering cases of incompetent patients and their possible duty to die, for the interests of all the affected by the medical decision must be considered. Hence, the interests of the incompetent patient are constrained by what is morally appropriate in each specific situation, whether or not the patient would have been sensitive to those issues (Hardwig, 2000, Chapter The problems of proxies with interests of their own). Thus, a theory of proxy decisions should include the interests of everyone involved, even when they could initially conflict with those of the patient. Similarly, Narveson (2000) defends that we do not have a duty to keep them alive at the costs of our own expenses. It would be, then, a matter of weighing one against each other and see what would be the morally best, or at least most appropriate, course of action and/or decision to make.

4.5.3. Means of dying when one has a duty to die

How should a person, once they have acknowledged their duty to die, end their life? Shall there be any assistance allowed or should the patient end their life on their own? Those are relevant questions when considering the existence of a duty to die, because it requires the elucidation of the available means to perform it. Hardwig (2013, p. 116) defends the inclusion of passive, and even active, means within the duty to die. He defends that withdrawing or withholding of treatment could be required to fulfil one's duty to die. Similarly, in the absence of a terminal illness, more active steps could be necessary to end one's life and comply with such duty to die. Despite Hardwig's avoidance of using terms, in that paper, such as euthanasia or physician-assisted dying among those more active means to end one's life, elsewhere (1997a) he advocates for them. In that later paper he carefully addresses the three different alternatives available to end one's life, weighing their pros and cons: 1) unassisted suicide; 2) family-assisted dying; and 3) physician-assisted dying. A closer look at their strengths and weaknesses becomes necessary now.

First, despite what could be our initial intuitions, i.e., the person suffering and having a duty to die should be the one putting an end to their own life, instances where that is impossible and not desirable come rapidly to our minds. Shall we consider, for example, those cases where one is physically unable to take their own life. There are others who lack the knowledge and/or means to perform it; these situations are known to end up in failed suicide attempts where people are left with permanent brain damage or irreversible conditions. But there are two crucial issues to reject unassisted suicide as a means to comply with one's duty to die. On one hand, we must remember the importance of loving bonds built between one and one's family and loved people, performing unassisted suicide in those cases would be extremely isolating and would significantly weaken our connections with our loved ones. On the other hand, but intricately linked to our previous point, if one must be the one to kill themselves, that may make one take their life earlier that would otherwise be necessary. Facing a lack of other alternatives, a person having to end their own life would mean not waiting until one becomes inevitably incompetent or debilitated, thus one must end their own life when suffering for their loved ones appears on the horizon, instead of waiting until it effectively arrives.

Secondly, the relevant role that the family have in the duty to die is clear now, it arises from our responsibility towards the lives of our loved ones. Hence the implication of the family in our decision to die and the means employed to do so are out of the question. Moreover, they could even have a significantly active role to help one find the best methods to die, to comfort one until the very end and, obviously enough, to play a key role when discussing the burdens that one's life poses on others. Likewise, it could be said that the preparation for dying is clearly family-assisted[68]. However, there are two related pragmatical reasons to reject any possible advocacy for family-assisted dying. First, ending the life of a loved one would be extremely difficult. We cannot ask a family member or a person we love to end our life because of the feelings of guilt and remorse that person may experience after performing the action. Furthermore, and of especial significance, it would be much harder considering that the loved one would be fulfilling our duty to die, i.e., our responsibility to end our life because of the burdens it imposes on people we love, among which that person helping us would be. It would be too great a burden for that person. The second reason concerns the legal status of family-assisted dying, for the person assisting would not be legally protected from their actions. The risks are too high to ask a family member to subject.

Finally, everything points towards euthanasia and physician-assisted dying as the only and best alternatives at hand to end one's life when they have a duty to die. Hardwig focuses and mentions only physician-assisted dying. However, as we previously saw in chapter 2 when defending the equal moral status of passive and active euthanasia, the truly important matter is the underlying moral justification to defend that someone is better off death[69], regardless of it being due to their terminal condition, unbearable suffering, and/or having a duty to die. Once that has been clarified, we shall address the arguments to defend physician-assisted dying. The main argument rests upon physicians' extensive knowledge of diseases and dying. Similarly, they also know best the drugs and have access to them. Both reasons put physicians in the best position to help a person die at the right time. A second argument arises from the physicians greater experience with death and dying. They know what to expect and thus are a rich source of information and resources on how to minimise the negative aspects of it for the patient and their family. Thirdly, a very society-

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[68] For a longer dwelling into the role one's family can and should have in one's death, see (Hardwig, 1997a).

[69] See section 2.2.

imbricated reason, physician-assisted dying does not carry the same social stigma that suicide, it is widely accepted, and physicians would not be exposed to the same risks that family would be to face, at least they would not in a society where physician assisted dying and euthanasia are legally permitted. Finally, physicians ought not abandon their patients, especially when death is about to come. That would significantly strengthen the patient-physician relationship and the trust within it[70].

4.5.4. Duty to die and meaning in life

There is a final consideration that needs to be pondered before we move forward to examine the different situations where the duty to die might arise. That consists in the thorough inspection of whether there exists a relation between the duty to die and finding meaning in live. What is the impact of acknowledging the existence of a personal duty to die in our search for meaning? Would it, or could it, have a positive effect on us? Despite the initial counterintuitive negative response that probably come to the minds of many when confronted with such questions, it is worth dwelling thoroughly on the issue and carefully examining some of the arguments presented to justify it.

The first of them presents the close relation, and direct influence, of recognising the possibility of having a duty to die and how it could help us recover meaning in death. The argument was first presented by Hardwig (1997b) and rests upon three main considerations. On the one side, the duty to die affirms our moral agency, for it makes explicit and evident that, even though the end of our lives is near, we still have the opportunity and can do things for others. The closeness of death does not make our moral responsibilities disappear; quite the opposite, it might become the perfect opportunity to reaffirm ourselves in them, as we had done previously during our lives. This takes us to the second foundation of the argument: the affirmation of connections. The assumption of a duty to die therefore becomes an instance to acknowledge that we are not alone and isolated but live together embedded in a myriad of family and loving connections and relationships with others to whom we have moral responsibilities. Death cannot become an excuse to avoid fulfilling our duties towards them. Quite the contrary, the inevitable approach of death makes it imperative that we accept the new duties emerging from the new situation, those duties could help us find new meanings in death. Finally, in a moment of history when people tend to isolate themselves and live alone, only establishing few and weak social, familial, and communal interactions and bonds, which all together weakens our sense of

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[70] Chapter 5 offers more arguments to defend the appropriateness of healthcare practitioners as the professionals in a better position to deal with assisted-dying request and perform them.

community, death becomes more difficult without the support of a big community which could help the individual find meaning in it. Accepting our duty to die, when there is so, then, provides us with the opportunity to die for those we love, to improve their lives as our last life decision.

The second argument is grounded on the idea of coherence. For Churchill (2000), the way we die is an opportunity to honour and preserve the self, maintaining coherence with one's life values. At a minimum, for a person whose main life value has been caring for those she loved the acceptance of a duty to die would be the avoidance of a demeaning or humiliating death, for it should be the final opportunity to embody the values that one had during her life[71]. Moreover, this coherence would significantly contribute to increase our sense of ownership over our death. That is, the acknowledgment of the duty to die, together with the acceptance and moral defence of euthanasia, as done in the previous chapter, would allow us to gain autonomy, for we could decide when and how to die; choosing the right time becomes easier under this conception. Lastly, in a more optimistic approach, Churchill argues that this coherence when ending one's life could be understood as a fulfilment of a duty to oneself, i.e., the duty to be coherent with the rest of one's life. As a possible objection to this last idea, it seems dubious to assign the term 'duty' to that necessity of coherence with one's previous life actions. It could be interpreted as too demanding, for the duty to die rests upon our responsibilities towards others, a ground where it can be more solidly defended.

A final argument for establishing a correlation between the duty to die and finding meaning in death (and life) starts from Hardwig characterization of the former. For him, the duty to die is self-recognised, self-imposed, and self-enforced (2000, Chapter Dying responsibly). Those three features help us understand, following Scarre (2012), that death is an action, and a decision we make, not something that simply happens to us. So, even though we might not fully control the circumstances of our dying, we can substantially influence its meaning. The individual is thus confronted with the possibility of a good death where caring for others would be an appropriate character of the closure of one's own life. In other words, the acceptance of a duty to die provides one's life with a new insight and the opportunity to create or discover new sources of meaning in death.

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[71] Consider the example of Carola, widow for more than 7 years, whose main role in the community was helping others and taking care of them. Such personal trait was a core value in her self-understanding (even when it coexisted with other morally different narratives), thus the duty to die arose naturally on her (Ohnsorge et al., 2012).

Whether or not we fully agree with the arguments presented above, not all of them are necessary to accept the existence of a relation between the duty to die and finding meaning in death. To accept the validity and plausibility of just one of them is sufficient, for the purpose of our argument, to confirm our initial, although for many counterintuitive, claim.

4.6. Different approaches to a duty to die

Once the key features of a duty to die have been exposed, together with its definition and the relevant explanation of the main argument presented by Hardwig, it is necessary to gain a wider insight of the duty to die by thoroughly examining the different approaches under which it has been addressed by a variety of authors. These wide-ranging understandings of the duty to die will, however, share the core intuition presented by Hardwig, that is, there are situations where one has the duty to die not to become a burden to others. Who those others are might vary from one perspective to another, as well as one's closeness to them.

4.6.1. A passive duty to die

The idea of a '*passive duty*' to die was first introduced by Callahan (1993) and finds its underlying justification in a societal context, where resources are scarce and limited. For Callahan, then, the passive duty to die consists in finding the way to a low cost, non-technological death. His assumption is that no culture can allow health care to pre-empt all other societal needs totally; doing so would be morally wrong and blameworthy. However, the most common way of dying in Western societies nowadays is that of an extended period where unlimited money and resources are thrown to delay the process of dying, which sometimes entails unnecessary suffering and wait for the unavoidable outcome.

Despite what could be initially thought, Callahan is quite conservative when considering the appropriateness of death and, thus, of the duty to die. For, death would be only considered acceptable when further efforts would be likely to deform the process of dying, and when there is a good fit between the inevitability of death and the timing and circumstances of that death in the life of that individual. That is, only when further treatment is futile based on the patient's prognosis, and death comes at the right time for that person, can one have a duty to die by withholding or withdrawing treatment. It is worth mentioning that Callahan does not consider active steps towards the end of a patient's life.

A quite similar argument is defended by Ehman (2000) and Menzel (2000) in response to Hardwig's argument for a duty to die. For the first, the duty to die in medical contexts is a duty not to accept, claim or purchase medical care necessary to prolong our lives. For the second, the duty to die is a duty to let death come relatively cheaply, but by no active means. Evidently, the emphasis in these notions of a duty to die does not rest on the duty to die itself, but on the idea of a passive dying; for, there are no reasons presented to defend the motives that could create such a duty in someone, it being caring for our loved ones or something similar, for example. The focus seems to be on the idea of dying by passive means, what we analysed previously as passive euthanasia, the withdrawal or withholding of treatment, and whose moral differences with more active means to end life, i.e., active euthanasia, have been debunked. Thus, Ehman's and Menzel's proposals of a duty to die are only relevant for our main argument to the extent of their contribution to an insight where the duty to die arises in a context of economic scarcity of resources and one has a duty to die in order not to pre-empt all other societal goods – in other words, to the extent they align with Callahan's argument[72].

A much stronger reason to support Callahan's argumentation is offered by Corlett (2000), who also defends the duty to die inexpensively in medical contexts. He pinpoints to three main conditions in his analysis of a duty to die in that 'passive' sense. First, the agency condition, which dwells in the agent's capacity to know, intend, and act freely; that is, the person must be a moral agent. Secondly, the ability condition points to the agent's capability to perform an action to die at a given time and place. Finally, the moral liability condition states that one has a stronger duty to die when one has caused enough harm to others to justify one's death[73]. Unlike Corlett's understanding of a duty to die, Hardwig's is broader in the sense that it also considers future harm, or burdens, to use his own words, imposed on others. Nevertheless, for Hardwig, Corlett's proposal would be an acceptable instance of a possible situation when one has a duty to die.

4.6.2. Decent minimum of health care and just distribution of scarce resources

A second, and much sounder in the bioethical field, approach to the duty to die can be defended from the principle of justice and two interrelated perspectives within it: 1) the right to a decent minimum of health care (Buchanan, 1984); and 2) the just allocation of scarce resources (Margaret Pabst Battin, 2005, Chapter 14). However, our moral responsibility to die arises due to the socioeconomic situation and context of our healthcare

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[72] However, Ehman also considers a contractarian approach that will be examined later in section 3.5.4.

[73] It does not apply exclusively to Hardwig's notion of a duty to die, but to a much broader one including the moral duty to die in criminal contexts (i.e., committing suicide).

system[74]. Here, the duty to die is a duty towards others, a duty that appears when acknowledging how unfair it would be to expect our healthcare system to provide limitless resources and money to treat us, whereas others in higher need would be deprived of a fairer allocation of resources for them. But one could ask, what is the moral relevance of health? To justify its moral importance, we need to extend the principle of justice outside the context of medicine. The main idea is that meeting health needs protects opportunity (Daniels, 2008, Chapter 2). Our health needs are those things required to maintain, provide and reinstate functional equivalents to normal species functioning, Thus, giving us a 'normal opportunity range' within which an array of life plans reasonable people are likely to choose for themselves could be developed (Daniels, 2008, Chapter 2).

The argument to defend the duty to die from this view is two-folded.

It needs, on one side, to explain what the implications of recognizing a right to a decent minimum of health care are. Buchanan (1984) points to four main features of this right. First, the right of a decent minimum of health care is a right in the proper sense, not a mere ought judgement. When saying that, we mean that if a person A is entitled to X, i.e., has the right to X, X is due to A. The X in our context is a decent minimum of health care. A second characteristic of this right is its enforceability. By that, Buchanan means that we are all equally compelled to obey the right, and societies must guarantee that everybody receives such a decent minimum. Thirdly, and probably the most problematic, valid right-claims for health care trump appeals to maximization of utility. Thus, we could not speak of improvement of treatment for a few on utilitarian grounds when the number of resources used to achieve that would cause a failure to provide decent minimum care and/or treatment for others. Only once this right is guaranteed, utilitarian moral weighing could be considered. Finally, and based on what has been just explained, this right is universal.

On the other hand, once that right has been safeguarded, we need to provide a just way of allocating resources when those are limited and scarce. That ought to be done, following Battin (2005, Chapter 14), by allocating more resources in the early stages of life to guarantee a higher life expectancy and quality of life for most. Thus, when reaching our last stages of life, the duty to die might well appear to us justified by others' needs to enjoy the

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[74] It is important to note that Hardwig himself later addresses the likelihood of the duty to die in societies where healthcare systems are public. There are four factors that might increase the duty to die in a European context (Hardwig, 2013): a) the new kind of medicalised death; b) the ability to invent new life-prolonging medical technologies faster than we can grow the economy to pay for them; c) the relevance to remember that patient autonomy necessarily comes with patient responsibility; and d) outsourcing more care to families. Due to the scarce resources, patients are sent home before they should in order to save some money, where families become mere patients support, being used as means.

same goods in life we have already experienced. It is important to note an underlying assumption for the duty to die and the allocation of resources to be effective, that is there ought to exist redistributive mechanisms that effectively move the saved resources to a place where its use would be efficient. Similarly, the institutions need to be capable of accomplishing such an enterprise.

Yet, a reasonable issue arises questioning the way of distributing and allocating those scarce resources, and its justification to do so. Battin (1994, Chapter 3) and Daniels (2008, Chapter 6) have both advocate for age-rationing to defend the just allocation of resources. Battin's argument sustains that the treatment elder people require is commonly the most expensive and it would only serve to prolong a life of poor quality, which is also likely to be shorter when compared to the time left for younger generations – who would more efficiently enjoy the benefits of allocating resources at those stages of life. Besides that, the elderly has already lived full lifespans and claimed a fair share of societal resources. Daniel's justification is based on what he calls the 'prudential lifespan account'. The main feature of this account is the protection of the normal functioning (health needs) at every stage of life and within an age-relative normal opportunity range. Our needs vary from one life stage to the next one and so do, correspondingly, our opportunities; thus, we need institutions which can protect us and respond to these changes. That is the justification to defend the unequal treatment at different stages of life. However, contrary to what could be thought, this account does not treat persons unequally over the lifespan. Quite the opposite, the unequal treatment based on age may have effects that benefit everyone. Finally, it is necessary to state the main objective of both defences of age-rationing, for they seek the maximization of the chances to reach a normal life expectancy.

The recognition of a duty to die in this context plays a significant role to improve the overall situation of a just resources' allocation. One must accept, when the time comes, that it is immoral to use resources limitlessly merely to postpone an already known death. In other words, one has a duty to die in situations when, while awaiting death due to a terminal illness, their use of resources would deprive someone else of their fair share and thus it would impede that person enjoy an average lifespan. Furthermore, such a duty to die ought to be pursued by active means, i.e., active euthanasia, and not by merely passive euthanasia or physician-assisted dying, because the higher number of resources saved by active euthanasia could be given a better use.

4.6.3. Contractarian approach

On a still new perspective, Ehman (2000) approaches the idea of a duty to die from a different angle, focusing on the hypothetical consent that moral agents would give to the duty to die proven its rational acceptability on a societal level. To fully comprehend his argument, Ehman's initial reluctance towards the notion of a duty to die as presented by Hardwig must be explained. For him, the duty to die cannot be defended on grounds of self-sacrifice that might benefit others significantly. When talking about duties in the moral sense, Ehman assumes that it is always in the rational interest of each agent to accept the duties. However, ending their own life to protect others could never be in the rational interest of a moral agent. Thus, he denies the moral legitimacy of such duties that require that much from agents. Why would someone do that? It would be completely irrational to accept a duty that imposes a moral weight that does not promise a benefit worth that cost.

There is, however, on Ehmans´account a situation where the duty to die could be defended, but on different grounds. If we, as individuals, were required to think about the totality of our lifespan and make decisions bearing always in mind this big picture perspective, could we find a moral justifiable situation where the duty to die became acceptable because the benefit provided by it would be worth the cost (i.e., our lives) it imposes on us? Under this new light, the duty to die appears as a more rational idea to comply with and consent to. For, when considering the consequences of compliance with the duty over the course of one's whole life, an individual could rightly accept the decision-making[75] procedures that led to such duty; because it would be on their benefit and interest to accept the restrictions on life-saving medical care as a general practice. Our compliance with the duty to die would increase our survival and enjoyment of a higher-quality life when considering a life-span perspective; even though it could not be in our interest in particular cases. Using Rawlsian terminology, it is in the individual's best interest to accept and comply with a duty to die from a veil of ignorance position. For, that would guarantee a better overall care and resource destination across different life-stages, increasing our chances to live better and longer, even when that would eventually mean that we, as individuals, could also have to recognise our own duty to die. The costs saved in a moral context where the duty to die is recognised and thoroughly accepted would be used to improve medical care and increase resources in earlier stages of life[76].

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[75] Those decisions are made in the context of the invariably scarcity of medical resources, which constrains our capability to decide what the optimal morally right course of action could be.

[76] Note the similarities with the argument previously offered in section 3.5.2. regarding the reallocation of resources.

Now, for the duty to die to be morally defensible and accepted in a societal scale, the above-mentioned reallocation of resources must occur; it would be the sole guarantee which supports that it is in the prospective interest of individuals to comply with the principle.

4.7. Objections to a duty to die

Multiple worries have been raised against the moral permissibility, or mere existence, of a duty to die as understood primarily by Hardwig. The arguments offered to counter his claim vary from proposing a different terminology which would alter the moral strength of the claim, to an ethical examination of the correlation between rights and duties, also addressing the notion of 'family' and the implications that the possibility to die could produce within it. This section aims to offer a clear and thorough examination of all the different objections presented to the notion of a duty to die, presenting counterarguments to ultimately advocate for the moral justifiability of the existence of such duty.

4.7.1. Three initial difficulties

It seems appropriate to start tackling three objections that Hardwig already considered, and gave an answer to, on his paper *Is there a duty to die* (1997b). First, it could be thought that there is always a duty that takes precedent over the duty to die, so there will always be a most relevant moral obligation that would prevent us from acquiring such duty. We could, for example, think of a higher duty of preserving life because it was God-given; or, in a more secular scenario, we could consider the duty not to impose over our loved ones the additional weigh of guilt in thinking they are responsible for our decision to end our lives. However, should we always preserve life at any costs? Based on what has been explained so far regarding the duty to die, circumstances where it may arise seem undisputable, especially when someone's illness would drastically affect the lives of their loved ones, turning their existence into a living nightmare. Furthermore, Bennett (2000) questions whether we would have an obligation to keep providing health care resources when a person chooses not to do their duty. An attempt to provide a resolute answer for those questions exceeds the purpose of this work; but, at least initially, it seems plausible that in some scenarios the duty to keep providing medical care resources would be rendered as morally inadequate.

A second objection focuses on the existence of an incompatibility between the duty to die and the recognition of human dignity or the intrinsic value of a person. Hardwig's response to this concern is convincing enough. For him, such critique is clearly biased by our traditional Western conception of personhood and the rejection of death, regardless of the context where it is considered. As a result of this prejudice, death is thought to be the worst evil or burden one can face. Yet, as showed in chapter 2 when considering euthanasia, there are situations where death seems the morally preferable choice, rather than living with adamant suffering. Similarly, as exemplified in section 3.3., there are cases where the burden our staying alive could impose on others might be heavier than the burden rejecting a couple of months of life would be for the ill person.

Finally, detractors of the duty to die could defend the wrongness of putting on the dying person the additional burden of having a duty to die, besides all of those which come along with the illness. Acceptance that one is dying is a sufficiently difficult matter to confront, thus no further burden should be imposed on those about to die. Similarly, Drebushenko (2000) defends that patients are free from a duty to die when the burdens of an illness are unforeseen and unintended. For, feelings, such as fear and/or anxiety, can impede us to comply with a duty to die. However, the presence of an illness does not remove every other of the patient's responsibilities (Hardwig, 1990, pp. 8–9), among which the duty to die could be present. To the extent that the patient's medical decisions will affect not only them but also the lives of their loved ones and their interests, the impact of the patient's decision over their life must be considered. Hence, different duties of care, among which the duty to die could be present as a final and inevitable resort to protect other family members of an impoverished life, might arise even when the situation for the patient is difficult enough due to their facing death and accepting it. Consequently, the need of weighing burdens arises, which should be based on fairness and justice to decide the best course of action. When doing this assessment of the burdens that the apparent duty to die might impose in all affected parties, Hardwig (1997b, pp. 38–39) advices that a 'lifetime perspective' must be employed, i.e., the amount of life different persons affected by the decision can still enjoy and how it could be shortened or worsened. For, it is the crucial aspect since it would be immoral to ruin a loved one´s lives so they can live two, three or a few more months before the inescapable and already known fate of dying occurs.

4.7.2. The notion of 'duty'

A second type of objections can be clustered under the criticism of the notion of duty that Hardwig employs. For Drebushenko (2000), Hardwig's notion of duty is highly morally charged, that is, it is morally impermissible to refrain from it. As a result, an act of dying under this understanding of duty should be categorised as heroic, supererogatory. However, it needs not be so, for the duty/obligation to die simply consists in considering and weighing the interests and impact of one's decision in the life of all affected by it, thus there is no heroism in acknowledging as the morally correct and preferable course of action the one requiring from someone to put others' interests ahead of hers.

A similar argument is presented by Tong (2000), who defends that it would be better to avoid the language of duty because it is considered too heroic for morals; for that same reason, neither should it be understood as an obligation. Tong opts for putting the emphasis on the notion of *care*, which, in his opinion, should be substitutive of the one of *duty*. Care is understood as a deliberate choice that promotes empathy. The focus ought to be on the idea that the last action of dying creates/gives meaning to life, so the decision to end our lives sooner than otherwise would be expected should not be understood as an obligation, but a choice, a gift that we might give others because we love them. We are now, after the thorough examination of Hardwig's argument presented in the previous pages, in a situation to question whether Tong's critique is truly an objection. Would it not be more appropriate to consider it as a suggestion to rename the idea behind the duty to die so it does not appear to be so highly morally charged? It could be argued that both positions are not that far from each other, for they share common argumentative ground in defending the idea of a close relationship that might require from us to die in order to protect others from the negative effects that our continuing to live a life, whose end is unavoidable, could have upon them.

We will argue that, despite and against the previously offered objections presented to lessen the moral implications of the concept of 'duty', its usage is the most appropriate from an ethical perspective when talking about the duty to die. The following ideas are based on Brandt's (1964) distinction and reflection about duties and obligations, which starts with some grammar considerations regarding both terms, followed by a thorough reflection on its usage in moral and non-moral contexts, and a final conclusion addressing his own approach to explain their usages based on a distinction between a paradigm use and an extensive use.

The term 'duty' normally, but not exclusively, appears in the context of morals referring to a person's engagement or commitment to do something, and therefore it also points to what other people expect and require that person to do[77]. Admittedly, this a general understanding of the concept, lacking any further moral nuance on its usage. This is one of the main considerations to bear in mind when defending the appropriateness of the term 'duty' usage when talking about the duty to die, for we cannot forget that "language is

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[77] For a further discussion about the existence of a correlation between rights and duties, see section 3.6.4. below.

continuously accommodating itself to new problems" (Brandt, 1964, p. 375). This apparently naïve, from a philosophical standpoint, distinction has a crucial role when applied to the problem of a duty to die. Prior to Hardwig's argument in defence of a duty to die, and Lamm before him[78], language had not been required to describe a reality thus far inexistent. However, when the situation first arose of a person feeling committed to, required to, end their life to save the quality of their loved ones´ lives, in the specific context of medical ethics, it brought with it the compelling necessity to create a new terminology by which it could be appropriately defined and understood. Hardwig's choice was to employ the terminology of 'duty'. Was it the right choice? Is there any other more appropriate term to define what Hardwig had in mind when defending the duty to die?

I will defend an affirmative response to the first question; and hence a negative one to the second. Talking about duty is better and preferable, not only in a regular use of the term, but even within the ethical discourse, than the alternative terms of 'responsibility' or 'obligation'. Brandt (1964, pp. 380–384) advocates for a non-distinctive consideration of the term 'duty' when used together with the modifier 'moral'. For him, the truly relevant aspect of its various uses is its core standard meaning and sense, deployed by us when employing the term 'duty'. He admits that the modifier 'moral' give expression to these uses; however, the relevant factor are the common features shared in all the different usages and contexts where the term appears and can be used correctly.

Yet, some detractors could still maintain the relevance of the modifier and argue for a significant ethical distinction between generic duties and moral duties. Could our argumentation endure this objection? To offer a consistent and well-argued response, we must consider the peculiarities of the term 'moral' when used as a modifier. What does it add to the concept of duty? Brandt (1964, p. 381) offers a list of five considerations to prove that our duty is a moral one. I will first cite those considerations and then see whether the notion of a duty to die successfully meet those requirements.

1) "*It must be a matter of conscience. (…) Failure to perform will (…) arouse guilt feelings in the agent and moral disapproval in observers.*"
2) "*The requirement must command roughly community-wide support.*"
3) "*Failure to perform, without excuse, will reflect on character -this being spelled out by reference to traits like (…) respect for the rights of others.*"
4) "*The requirement is (…) a matter of principle.*"

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[78] See section 3.2. for a contextualization of the concept's origins.

5) “*The requirement must be construed (…) to have superior stringency to that of claims of manners, customs, taste, law, and courtesy.*”

First, it should be clear by now that one of the main motives that makes a person consider the possibility of having a duty to die is the matter of conscience mentioned on the first point. Those having a duty to die would feel guilty if they are not allowed to do so or are obliged to stay alive against their will; they will unavoidably feel the fact of their mere existence as a burden imposed upon their loved ones. Secondly, whether we agree with the private character of healthcare systems in the USA, the context of Hardwig’s argument defending a duty to die, we must admit the relatively high acceptance that the duty could have. For, it is based on the financial and emotional burdens that caring for a loved one in the context of a private health insure have. It is not difficult to imagine other families, likely or not to shortly endure an analogous situation, to accept as correct the arousal of a duty to die in such contexts described by Hardwig. Similarly, all other approaches explained in section 3.6. advocate for a collective acceptance of the duty to die to protect equal access to healthcare resources and to guarantee their fairer allocation and distribution. In respect to consideration 3, it is obvious that it appeals to one of the pillars of the duty to die’s reasoning, i.e., the respect for the right of others, more specifically of their right to have a rich and full life. The person failing to acknowledge their duty to die could be regarded as a bad-character person, a person who is unable to comply with their commitments, because they make their desires prevail over others’ right (e.g., the right to a life free of economic debts acquired by others’ failure to acknowledge their duty). Fourthly, the recognition of duty to die is obviously a matter of principle, it is not a requirement of prudence or convenience, but a true conviction of putting others’ rights ahead of one desires or fears. Finally, the duty to die is moral in the final consideration indicated above because its stringency is clearly superior to that of an act of courtesy or a well-adopted custom. To die so others can live should be, beyond question, a stringent moral requirement, because it is a matter concerning the wellbeing of many.

4.7.3. Concerns about the family

Hardwig’s notion of a duty to die is rooted in the role the individual has within a family, emerging from the love bonds generated in it. It is his understanding of the familial dynamics, which must be based in respect of everyone’s interests, what supports his argument. Conversely, there are others who insists that this characterization of families fails to fully comprehend and capture the sort of relationships that are created and stablished within them.

On the one side, it could be argued that the idea of a duty to die trivializes the notion of 'family', which begins to be judged by some benefit-burden calculus (Specelly, 2000). Under this view, the consideration that a family member could have a duty to die would erode the principles upon which the family relationships were initiated and forged. Furthermore, it would be profoundly wrong to inform and demand a family member that they have a duty to die so the rest of the family could live. Similarly, following Drebushenko (2000), relatives can effectively decide how much they want to be burdened and also have duties to protect their welfare, not necessarily existing any impediment to do both at the same time, and not letting those burdens overcome them.

Secondly, a much stronger argument is presented by Govert den Hartogh, who sustains that "*there cannot be any proper duty to die, because it is inconsistent to attribute at the same time an unlimited duty of care, and a claim-right to be freed from its burden by the elimination of its recipient*" (2018, p. 404). In other words, if there were a duty to die which should be openly discussed within families, duties of care could not exist, for it would be contradictory to defend, at the same time, that we need to care for the person whose duty to die we have previously acknowledged. Hence, den Hartogh focuses on the apparent incompatibility of the recognition of a duty to die with the duties to care that family members and loved ones acquire in relation to that person. Nonetheless, he also recognizes that the duties of care also have their own limits, which are defined by the history of familial relationships. For him, there should be no place within families for talks about duties of care and their upper limits, nor about burdens being too heavy. "However huge the burden of care, the burden of failing to provide it will be greater" (den Hartogh, 2018, p. 408). In a common scenario where the duty to die might arise, i.e., the case described in section 3.4.[79], a detailed analysis of it would show that there are two decisions behind the acceptance of the duty to die. On one hand, the patient would refuse care from their loved ones; on the other, she will decide to end their life due to their medical condition. This distinction is important, for den Hartogh's main claim is that there is no causal connection, with explicative power, between them: the patient would not end her life to relieve her relatives from the burdens of care. The relevance of the distinction between the two decisions lies in the possibility to opt for a different path, instead of putting an end to your life, once you have decided to relieve your family from the burdens of care (i.e., going to a nursing house). That explains why his alternative to acknowledging the existence of a duty to die would be withholding care and leaving the consequences to the ill patient, since it would be perverse to require them to die. The offered justification for his claim is that the burden imposed to

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[79] See page 71.

family members, if they attribute the reason for the patient's dying to the burden their care poses on family members and loved ones, would be even greater.

Finally, Felicia Ackerman (2000) accuses Hardwig of having profoundly misinterpreted the duties emerging from family and loving relationships. She offers a criticism of the type of loving relationships Hardwig implicitly depicts by arguing for the duty to die. What sort of value and love would they indicate? The answer to this question would be, on Ackerman's view, an emphatic no. To begin with, conversations about the duty to die would destroy family relationships ("*cruelty of telling a sick and vulnerable person that you would welcome his death*" (2000, p. 178)) or marriage ("*cold-blooded and destructive to the loving spirit of marriage*" (2000, p. 178)), due to the implicit assumption that our relative's life is worthless and must be ended to relieve ourselves from the burden that our relative's staying alive would suppose. Moreover, Ackerman emphasizes that, on her view, Hardwig magnifies the burdens of illness, making death seem preferable, which also subtly conveys a bias against the systematic devaluation of the ill and old, whose life are worth less than those around them. Similarly, Ackerman states that in the uncommon scenario where the duty to die could arise, if so, the situation would be paradoxical on its own terms. On the one side, we could face a situation where the patient's loved ones do not want them to die quickly to make their lives easier, to relieve them from the burden of their care. In that possible situation, the patient's acknowledgement of their duty to die together with their active pursuing death would not be respectful to their loved one's wishes to continuing providing care. On the other side, the patient's loved ones might want them to die quickly so they are relieved from the burdens of caring and their lives become easier. If that was the case, why should the patient sacrifice their live for people who love them so little that they value the patient's life less that money or freedom from burdens?

Despite her strong disagreement with the notion of a duty to die, Felicia Ackerman acknowledges that there are limits to the duties of care: "(…) *it is unreasonable to suppose there are no limits to what a loving family can be expected to do for a sick member*" (2000, p. 179). However, she focuses on the problem's reconceptualization, focusing on the sacrifices that family members and loving carers might do to extend the life of a burdensomely ill person, which she defines as 'a duty to aid'[80].

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[80] 80 In page 181 of her article, Ackerman offers a list of conditions that make the duty to aid more likely, emulating Hardwig's list addressing the situations where the duty to die would be more likely.

Now, we shall pay close attention to whether these two last objections truly present problems to Hardwig's argument and are accurate when they point to different flaws in the concept of family.

Neither of the first two objections, presented jointly at the beginning of the section, can be seriously considered an impediment to Hardwig's claim. First, we need to remember the relevance Hardwig gives to the decision-making process when deciding who has a duty to die and when. Such conversation must be initiated by the person who might have the duty, who will have considered the different possibilities, and decide to discuss it furtherly with the rest of their family. From there, a dialogue starts which does not necessarily have to end concluding that someone has a duty to die. However, regardless of the possible outcome, having that conversation needs not weaken family bonds but strengthen them if sincerity and humility are present, so everyone can express their opinion and comment on the possible burdens ahead. Likewise, Drebushenko's counterargument does not exclude the possibility of, in that individual balance of burdens and duties to protect one's welfare, deciding that the burdens imposed by the person who has a duty to die are too high to be imposed upon them. In those cases, it would be unjust to oblige those whom we love to carry the burden of our medical care to the extent that their lives will be forever ruined.

With regards to the second objection, it seems that den Hartogh acknowledges the existence of those upper limits of the duties of care and of burdens being extremely heavy to ask a loved one to bear them, but simply fails to argue why such discussion should not occur in a family. He offers no justification of that assumption, which is simply accepted as common sense. And then, when he refers to the moral acceptability, and preferability, of withdrawing care, we shall question whether it would be even more perverse to withdraw our care and leave our loved relative in a circumstance where, besides dealing with a terminal illness, they would also need to comprehend why we left. The apparent distinction between actively accepting that the patient might have a duty to die, or the passive withholding of our care, mirrors the one debunked in the previous chapter concerning the differences between active and passive euthanasia when discussing their moral permissibility[81]. The truly important moral issue at stake is to elucidate the possibility of acknowledging that one has the responsibility to die sooner than they would wish to protect their loved one's lives and interests, action that must be understood as a final act of love, not an external imposition due to economic factors.

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[81] See pages 37-39 .

At last, a possible direct answer to Ackerman paradoxical situation where the duty to die would arise, presented few paragraphs above, consists in providing a more thorough understanding of the motivation and intention behind the duty to die. For, she seems to forget that the duty to die appears in a vast majority of cases in situations where someone is suffering and enduring a terminal condition and their death is the only safeguard available for them to provide for their relatives, by doing a final act of care and love, even when it might be the most definitive one: dying. The fact that the patients among which the duty to die is likely to arise are terminally ill or suffering from other types of chronic conditions is decisive to morally assess the burdens imposed upon both parts (patient and loved ones) and decide about the existence, likeliness, and moral justification of the duty to die.

4.7.4. The correlation between rights and duties

The existence of a correlation between rights and duties is one of the strongest ethical theses when discussing and considering different perspectives within the moral realm. The initial intuition from which anyone making their first steps in the field departs is the existence of an obvious correspondence between moral duties and rights. In other words, if we can unmistakably claim that a person A has the duty to do X for another one B, then B has the right to claim to A that they do X. Applied to our discussion regarding the duty to die, if a person A has the duty to die to protect B from the burdens that A´s staying alive would unjustly impose upon B, the B has the right to end A´s life (i.e. the right to kill A) to protect himself from those burdens.

The first philosopher to attack Hardwig's notion of duty from its above-mentioned understanding was Callahan (2000), for whom the notion of 'duty' entails a right on the side of others. In the case of a duty to die, it would be the right to kill the person thought to have such duty if they become a burden. If the discussion concerning the duty to die is simply framed considering its terminological aspects, we could initially reply to Callahan's objection by referring to Hardwig's original clarification of the term 'duty'. For, if we understand the concept of 'duty' in a pretheoretical sense of the term, as he suggests we shall do (Hardwig, 1997b, 1997a), it would not necessarily generate, morally speaking, a right on others; in other words, the suppose correlation between rights and duties would disappear. Yet, we could be accused of sidestepping our argumentation and eluding a direct reply to the objection originally presented. To address, then, more straightforwardly the correlation between rights and duties, we need to show whether it would be possible for a duty not -at least in certain circumstances- to be correlated with a right on others to claim what our duty has generated. Are there types of duties not necessarily correlated with other people's rights? Feinberg (1966, pp. 140–141) answers that question affirmatively. Among those duties without correlative rights we can find duties of status, what a person ought to do in virtue of their status, their role/position within a specific institution or the larger society; duties of obedience, which are duties owed to a commanding authority, that might be represented by a person (e.g. police officer) but are nevertheless owed to the status that person impersonates; and, finally, duties of compelling appropriateness, when a person believes that an action ought to be done because they regard it as the convincingly fitting deed in an specific situation. In a further attempt to provide examples of this latter category of duties, which "*are perhaps only duties in an extended sense*" (Feinberg, 1966, p. 141), he mentions 'duties of love' and 'duties of self-sacrifice'. Now, it is clear how a impeccable fit Hardwig's idea of a duty to die is within this category of duties of compelling appropriateness. For, what is the duty to die, as we have previously defined, if not the perfect blend between love and self-sacrifice in a final act of caring for those we love to free them from the unnecessary burdens our remaining existence would impose upon them?

Similarly, Cholbi (2010) frames the question of the correlative right that emerges from the duty to die in terms of killing in self-defence. He argues that the duty to die necessarily correlates with a right on others to kill the person imposing the burden on them in self-defence. For Cholbi, then, the underlying truly important ethical question is: "*Does the person pose a threat to the lives of others?*" (2010, p. 419). He proceeds from that starting point arguing that what is needed, thus, would be to check whether the conditions of self-defence are met if we were to kill someone who impose a weighty burden on us. There are three main criteria to consider our action as an act in self-defence: 1) necessity, the existence alternative courses of action to protect that right; 2) imminence, how near in time the harm is likely to occur; and 3) proportionality, the balance of good and harms caused by the action. So, does our killing a loved one because they impose a burden on us meet those conditions? Cholbi´s answer is negative. On one side, it is not necessary because there is an alternative course of action available. We could opt for relieving ourselves from the burdens by no longer supporting economically, emotionally, or medically the ill person. On the other side, it does not meet the proportionality criteria, because the financial and emotional burden that a person can impose on us because of their illness is not comparable, it is disproportionate to killing a person for that reason. Therefore, there exists an incommensurability between the emotional and financial burdens that the patient's family and loved ones must endure because of the patient's condition/illness, and the burdens of dying that the patient would have upon them.

A first objection to the above-mentioned incommensurability of burdens consists in pointing to the underlying assumption that death is always the worst outcome. As we saw in chapters 1 and 2, specifically when we explained the kind of strong suffering that patients might have to endure before requesting euthanasia, there are sometimes evils worse than death. Cholbi seems to implicitly defend a medical vitalist perspective, the idea that prolonging life is always the highest personal value. Nonetheless, the critical aspect when considering the existence of a duty to die is the acknowledgement that more than one life is needed to be accounted for, that is, the lives of patient's relatives and loved ones, and not simply the one of the person who has a duty to die. Secondly, Cholbi frames the discussion of weighing burdens in terms of low quality of life versus death. However, it is important to notice that, in Hardwig's example, death would inevitably happen, which shifts the questions to whether the extension of one's life that is irremediably condemned to death shall be allowed to compromise so drastically another person's life, depriving it from many good things that could be still experienced.

4.7.5. Social repercussions of its acceptance

As we saw when examining the possible objections to euthanasia, there is a social worry presented by some authors regarding the conceivable impacts that a duty to die could have on certain population groups, i.e. those already dying (Cohn & Lynn, 2000) or in women (Tong, 2000)[82]. In the view of those authors, the defence of a duty to die could lead to a slippery slope situation where we could not, at certain point, distinguish between cases where the duty to die exists and others where it would be masking a moral consideration that some lives are worth less than others. Bennett (2000) warns us that the consequences of anticipated abuse and the misconstruction of the duty to die could be devastating in a particular social climate, like nowadays in many Western countries, where some population groups are at risk of being their lives considered less worthy. Likewise, Cohn and Lynn (2000) argue that the existence of a duty to die preclude us from finding meaning in suffering and dying.

To respond firstly to the latest objection, it could be said that it is not necessarily the case, for meaning in dying can be also found in the recognition and acceptance of a duty to die[83]. Now, regarding those cases where some 'vulnerable' groups would be more likely, or even have the pressure to act, to end their lives after the recognition of a moral duty to die, we must acknowledge the lack of data to support any, for or against, definitive conclusion.

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[82] Tong's conjecture that there is a male-female difference regarding the way they understand rights and duties, assuming that women's ethical focus is care (understood as a sum of relationships and responsibilities) whereas men value more justice (understood as the cluster of rights and rules), will not be assessed nor criticized here due to its controversial character, which would take us to a different moral realm.

[83] See section 3.4.4. for a more detailed explanation.

However, we have no reason to think that the situation would differ considerably from what occurred with a similar concern regarding the possible risk of abuse of physician-assisted dying when it became legal in some countries or states. As shown by Batting et al. (2007), there is no evidence of abuse of the impact that assisted dying had on 'vulnerable' patients' groups.

4.8. An actual example: the Covid-19 pandemic situation and our duty to die

The Covid-19 pandemic stroke us as a medical emergency never experienced before in recent times. Its rapid spread together with its novel character significantly worsen the global situation. For, it was a new type of coronavirus for which no effective treatment or a vaccine had yet been developed, and neither scientific knowledge of the virus had been obtained. Healthcare systems were strained due to the limited character of the available resources to provide appropriate care to the unexpected increase of people needing treatment[84]. Intensive care units were rationed and could not be offered to everyone, even when an increased number of patients were suffering the Covid-19 acutest symptoms and the risk of death increased(Farrell et al., 2020). As an unavoidable consequence, many people were barred from receiving treatment that could have improved their condition because it had been previously offered to someone who caught the virus earlier on, maybe when resources were enough to be justly distributed and thus the situation was not ethically problematic. In a like manner, healthcare professionals were physical and mentally exhausted due to the intense conditions on which their job was being performed. Adding to that, they had to deal with the unavoidable decision to let some people die, which had a significant psychological impact on them(Wu et al., 2020). Finally, there is still another feature of Healthcare Systems worth mentioning for the sake of our argument, that is, the pandemic emergency emphasised the closed character of medical institutions where the allocation of resources occurs(Warner, 2020). As a result, all saved, or unemployed, resources could be destined to another person who would benefit from them. For example, if a patient refuses an intensive care bed unit and thus the treatment she would receive, that same unit would be assigned to another Covid-19 patient who also needs it. Contrary to what it could be intuitively thought, resource redistribution and reallocation of resources do not necessarily occur in the described closed ways in "normal" circumstances, i.e., in non-

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[84] Although the focus will be put exclusively on the reallocation of resources from Covid patient who acknowledge their duty to die to other patients who would benefit better from the same treatment, we are aware of the Covid-19 impact on other relevant healthcare procedures, as the treatment of chronic diseases, transplantation, or the earlier diagnosis of cardiopathies. Cf. (Chudasama et al., 2020; Doná et al., 2020; Pessoa-Amorim et al., 2020)
Thanks to an anonymous reviewer for bringing my attention to this issue.

pandemic medical scenarios; sometimes the saved resources could be reallocated to a different medical unit or be saved for future projects.

Once the new medical situation has been adequately depicted, what is the new context's incidence in our moral responsibilities? How ought we to act were we in a position where our treatment decisions might have a direct impact on the lives of others? If we were at the end of our lives and had made peace with the unavoidability of death and its proximity, would we have a responsibility to refuse treatment so others could benefit from it? In other words, would we have a duty to die? An initial objection could be offered to impede our argumentation from the beginning. It can be argued that medical triage is already in place to decide how to (re)allocate and distribute the scarce resources that any specific healthcare setting has. Triage is a medical procedure to decide who would benefit more from a limited set of resources, offering treatment based on the severity of their illness, their likelihood to benefit from it, and the available resources. The procedure becomes especially difficult during medical emergency situations[85], where the ethical challenges increase due to a higher number of people in need of help and the impossibility to aid them all, some of which may irremediably die as a result.

So, if appropriate and ethically just triage is on place -therefore deciding who receives treatment based on how likely the person is to benefit from it- why would a person have a duty to die in a health emergency context? Our thesis defends that acknowledgment of the existence of a personal duty to die is necessary despite the effective implementation of medical triage, since it would be complementary, facilitating healthcare personnel to make decisions and releasing more medical resources. The underlying moral justification for our thesis rests on the principle of autonomy, central in contemporary bioethics[86]. The patient's recognition of her duty to die, in other words, her autonomous decision to let herself die, either by rejecting treatment or access to intensive care, or hastening death, were this were legally permissible, would ease the triage procedures, facilitating the reallocation and redistribution of saved resources, which would thereby be more effectively employed. Triage decision-making is amidst the most challenging procedures in medical settings because the bioethical principle of justice outweighs those normally paramount of respect for autonomy and non-maleficence. Decisions of this kind, especially during emergency situations like the Covid-19 pandemic, irremediably result in patients to whom the necessary treatment that improves their condition will not be provided. That means, failure to respect the autonomy of those patients, and thus the harm caused on them, which could

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[85] Cf. (Kuschner et al., 2007)

[86] Cf. (Beauchamp & Childress, 2009, Chapter 4. Respect for Autonomy; Gillon, 2003)

even mean their death, is morally justified based on a more just allocation of those saved resources on others who are more likely to benefit from them.

The above-depicted triage procedure is overly simplified. For there are numerous features and defining characteristics of the patients' condition, available treatment, and patient's prognosis, which must be considered when making decisions regarding who will have access to the available resources and why[87]. However, the underlying moral justification to apply the bioethical principle of justice[88] in those cases remains the same. Then, the incidence of the duty to die here is of a complementary and facilitating character. Autonomously recognising our duty to die, therefore the acceptance that our own life has come to an end, so no further treatment will be required and could be employed to save and/or improve another's lives, would have a major impact on easing the triage procedure, removing alternatives to evaluate and consider. Objectors could argue that we are not merely "removing alternatives", for that is a euphemistic way of referring to our own lives, so the matter should not be so lightly examined. However, extraordinary healthcare emergencies make uncommon moral responsibilities arise, or even become mandatory due to the exceptional character of those same circumstances. Discussion here does not revolve around saving everybody's life. The crucial matter in this kind of moral quandary is to dilucidated who will receive treatment and why, accepting the unavoidability of a worsening condition or the consequence of death for those who will not. Moreover, acknowledgment of those deaths, bearing them as the inevitable outcome of our medical decisions, does not impede our moral justification from being right. In other words, there are good moral reasons to justify the triage decision-making procedure, based on the just allocation of resources and the possibility to save lives by doing so, and the fact that some people will die as a result is not a counterargument. The relevant issue is who will die and why. So, if someone who is among the people who will die has autonomously accepted it, as a result of the recognition of her own duty to die, our moral justification for leaving her out of the resources allocation is more solid.

4.9. Conclusion

This chapter has discussed the reasons for the existence of a moral duty to die. We have showed how the duty to die is far more common than initially expected, appearing not only in family situations but also on a societal level where it is paramount to remember that we do not live isolated. The consequences of our medical choices will have an impact on the

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[87] It became especially difficult due to the novel characteristics of the Covid-19. Cf. (Jaziri & Alnahdi, 2020)

[88] Cf. (Beauchamp & Childress, 2009, pp. 279–292)

lives of other people with whom we share the same healthcare setting. Despite of its likelihood, the main finding of this chapter is the existence of a moral duty to die that arises in scenarios where a person must acknowledge her death and avoid during the last time of her life to become a burden to others, them being family members, loving people, or, also, other members of society. In general, therefore, it seems that more attention should be given to a thorough consideration of the duty to die and its implications, instead of being directly discarded from discussion.

The scope of our research is limited to the ethical implications of the duty to die; however, we are aware of the contextual shaping of the duty to die in specific situations. It might indeed be difficult to examine and determine whether the duty to die is present in a concrete scenario, where specific features will appear on both the patient's and the family/society side. Nevertheless, this practical difficulty alone does not suffice to object to the existence of the duty to die. In a like manner, albeit briefly, this chapter has stablished a strong and direct relation between the duty to die and euthanasia, which has a major importance for our overall argument. For, more active means of assisted dying than those widely practised and morally accepted in most western countries are necessary when a person acknowledges her duty to die. Active aid in dying becomes a key factor to guarantee that people can fulfil their duty to die. This claim will be tightened up in chapter 5 when healthcare professionals' duties to aid in dying be discussed.

5. METAETHICS OF THE DUTY TO DIE

This chapter straightforwardly addresses one of the strongest, from an ethical perspective, objection presented to the duty to die, the one concerned with the lack of a normative theory to support it. Our aim here is to provide strong metaethical grounds to support the duty to die without the need of a moral normative theory. First, the objection will be presented and clearly explained. Second, our metaphysical assumptions and a preliminary metaethical discussion will be offered to situate and understand the context. Finally, we will show how the duty to die can be integrated within the metaethical approach previously presented, defending that there is no need of a normative theory to provide good justification and strong ethical grounds for the duty to die, because they are already provided by our metaethical arguments.

5.1. Need of a normative theory?

A major objection to Hardwig´s argument defending the duty to die points to the lack of a normative theory which could provide ethical support of his claim[89]. For Seay (2002), Hardwig would need such normative theory to protect his argument from objections that might be offered against it; however, it seems that Hardwig rejects any kind of normative ethical theory because it would depersonalize relationships. It is important to recall now the relevance that family and loving relationships have in the advocacy for a duty to die. For, they are precisely those types of relationships which are situated at the core of Hardwig's argument and provide the ethical foundation and justification of the duty to die: dying so others we love might live better lives, free of the burdens that our staying alive would impose upon them.

What are, then, the consequences of missing a normative ethical theory? Seay (2002) argues that Hardwig's argument thus lack the capacity to offer a proper moral justification of his claim. Moral justification, Seay follows, consists in offering reasons to support our conclusions in arguments about the right thing to do. For reasons of logical consistency, similar judgments need to be made about similar cases, and to do that we need normative and evaluative principles that make our moral reasoning possible. Otherwise, we would be lost without the guidance of a theory which could help us apply the same principles to similar specific situations. More specifically, in the medical care context, those universalistic principles are required to provide solutions in concrete clinical cases.

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[89] This objection was not discussed in the previous chapter because it needed to be properly addressed here.

This absence of a normative theory takes us to two critiques Hardwig seems unable to accommodate in his defence of a family-based model of bioethics[90]. First, how can we defend personal rights in a family-centred model when interests conflict within the family? Hardwig has no alternatives to defend his argument from objections of this sort. For, family interests could sometimes impose themselves over the patient's medical decision, even if the latter is to be generally accepted as the right thing to do. Seay (2002, p. 269) presents the example of a 16 years-old girl within an ultra-catholic family who is secretly pregnant and wants to abort. In a family-centred model, the girl's decision would be stopped and his right to privacy violated, for the family would need to be informed and their interests considered prior reaching any agreement regarding the medical alternatives and final decision. This case is a clear situation where the patient's autonomy would be left unconsidered in detriment of their family. Secondly, and furthermore, physicians must never permit patients to make decisions autonomously because the interests of any family member involved should be equally considered and they would be violated in cases of exclusive patients' decisions. That would imply a return to a doctor's paternalistic attitude towards patients and could involve a violation of their fiduciary duty to their patients, which would ultimately make people lose trust on their physicians and withhold information from them.

5.2. Metaethical preliminary reflection

The main objective of this section consists in offering a metaethical foundation for the duty to die. The only purpose is to find justifiable grounds for the duty to die to be properly supported and well-founded. The intention is to show how the duty to die might appear in a variety of moral situations where action is required, and thorough consideration is needed, before offering a final response to the quandary posed by that specific situation. To provide further moral justification principles will be necessary. The metaethical debate about moral properties is far from concluded, consensus has not been reached regarding the 'nature' of moral properties, whether they aim to describe the world, thus could be true or false, and neither about the means there are available for us to gain knowledge of those

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[90] We have already tried to argue for the necessity to nuance Hardwig's understanding of the family-centred bioethical proposal, see section 3.3. for a fully developed explanation of Hardwig's family-centred model of bioethics.

moral properties[91]. As a preliminary discussion, the metaphysical assumptions my argumentation will rest upon must be clearly stated.

5.2.1. Moral cognitivism

When debating about the origins[92] of moral beliefs, there are at least three predominant options available, based on the answer they provide to the question: 'do moral judgements express moral beliefs?'. First, reason can be the sought origin of our moral beliefs, implying that empirical or rational intuitions are appropriate means of justifying our moral beliefs. This position is called 'cognitivism', it defends that ethical claims can be true or false and it implies that ethical language aims to describe the world. On the opposite side, as a second possible answer, non-cognitivism argues that ethical claims/judgements, do not express a cognitive mental state, but simply state a personal attitude or feeling towards a specific situation or action. As a result, ethical claims cannot, and do not aim to, describe the world, nor can they be true or false. Accordingly, moral judgements would simply serve as a guide of action based on what we feel compelled to do or sanction in determined circumstances. There is yet another alternative, third and final, moral relativism and the acceptance of the absence to find any possible form of justification for our moral judgements. On this view, society is the unique source of moral judgements, so morality is the equivalent of a record of different codes of behaviour that different groups of people have accepted and shared throughout history.

Inversely to the exposition order offered in the paragraph above, I will briefly try to show the flaws of the last two approaches and, consequently, the strengths of the cognitivist view that I will adopt as a metaethical support for the duty to die and its relevance in the field of bioethics. There are three quick arguments that clearly settle the strengths of moral cognitivism, while expose the deficiencies of the other two options[93]. First, the possibility of being mistaken about morality is widely intuitively accepted. That is, persons usually fail when judging a given situation, maybe because they have not been aware of all the morally relevant features of it or due to a lack of development on their moral character. For example, we could initially judge as wrong the act of stealing and later, when a thorough insight has

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[91] Authors, as Robert L. Holmes, question the relevance of metaethics, normative, and applied ethics for what he calls 'substantive morality', understood as "the ongoing process of making moral judgements that all of us engage in during the course of living" (1990, p. 145).

[92] It is important to specify that the word "origins" here means the justificational source of our beliefs, and not a mere causal initial relation.

[93] The arguments are so quickly exposed for the sake of brevity, they just intend to show the plausibility of moral cognitivism as a sufficiently robust theory to ground the further practical ethical claim of the existence of a duty to die.

been obtained (i.e., about the fact that such person needs the stolen money to buy food for their children), change our judgement to the acceptance and moral justifiability of the action itself. On a second instance, and maybe more controversial, morality feels as a demand from outside. When behaving in a morally sanctionable way or weighing the alternatives before choosing a specific course of action, we feel compelled to do the right thing, or at least avoid doing the clearly wrong alternative. The 'demand' to choose correctly, to do the right thing, feels weighty every time we face a situation with moral features. Finally, the idea of moral progress also supports cognitivism, for the possibility to offer justification of our moral claims appealing to something 'real', to a property our actions have, together with the possibility of them being validated with the way the world is, is only plausible and arguable under cognitivism; because mistakes in moral reasoning would be thus explained by an erroneous attempt to identify those properties when justifying our claims and judgements. For these reasons, moral cognitivism will be accepted and assumed in the following.

5.2.2. Moral intuition, foundationalism, and Wide Reflective Equilibrium

The duty to die can be understood as a moral intuition when a person encounters a situation where letting themselves die or actively hastening their deaths is morally required and the morally right thing to do. By moral intuition I mean "a pre-theoretical ethical belief or attitude, where this may include anything from a pre-cognitive 'gut reaction' on the one hand, to a considered ethical judgement on the other." (Lillehammer, 2011, p. 185). That definition includes the idea that moral intuitions need not be the result of inferential reasoning; however, it is important to add that moral intuitions do not need to be reached immediately, like sensitive perception (McMahan, 2013, pp. 104–105); that is, they might be acknowledge after a period of reflection. This epistemological conception of the moral duty to die is compatible with any of the different understandings of it that have been offered from a variety of perspectives to defend its existence. It can perfectly accommodate Lamm's[94] and Hardwig's[95] personal understanding of the notion, as well as other approaches like the right to a decent minimum of health care[96], the just distribution of scarce resources[97], the less discussed ideas of the duty to die understood as a passive duty[98], or based in the justice and equal access to health care resources[99]. However, this

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[94] Cf. (Lamm, 1997).

[95] Cf. (Hardwig, 1990, 1997b, 1997a, 2000, 2009).

[96] Cf. (Buchanan, 1984).

[97] Cf. (Margaret Pabst Battin, 2005, Chapter 14).

[98] Cf. (Callahan, 1993; Corlett, 2000; Ehman, 2000; Menzel, 2000).

[99] Cf. (Daniels, 2008, Chapter 2)

understanding of moral intuition does not suffice as a valid form of moral justification on its own, it needs a more robust ethical structure to support it.

Our metaethical approach here follows McMahan (2013), for although intuitions are discovered first, when we encounter an ethical situation which needs solving, they take us to general moral principles which will furtherly help us justify those initial intuitions. The main idea is that intuitions are a reliable guide for moral knowledge, they are epistemically knowable; but further reflection in seek of moral justification will take us to moral principles. Are principles morally required? Yes, in two separate ways. First, in the sense we have just stated because they are the foundations of morality, since they serve as moral justification of our intuitions, as it was previously indicated, which are nevertheless reliable sources of moral knowledge. Principles help us identify the morally salient features of the moral problems we have intuitions about, facilitating the appropriate moral approach and examination of them. But there is still a second way in which principles are needed: they provide/enhance intuitions with higher credibility. For, in that way the latter can be subsumed under plausible moral principles also applicable to other similar situations. In this sense, our claim is principlist, because accordance to principles will serve as a criterion of justifiability, and as a source of epistemological robustness. To the defence of principles as the foundation of moral justification, we must add a coherentist methodology. The coherence method adopted here is Wide Reflective Equilibrium (WRE), which requires principles to be tested for coherence and consistency with other intuitions and principles (Rawls, 1975). The methodological requirement of WRE helps show that our intuitions are presumptively credible not because they have some special property, but due to the good evidence that if they survive in a state of wide reflective equilibrium they are not relying in ethically irrelevant claims/principles/intuitions, for the latter would have exposed and eliminated discreditable criteria of assessment (Lillehammer, 2011, pp. 188–189). Finally, it is important to specify the three main commitments that, following Nichols (2012), WRE has. First, universal revisability. Every considered moral judgement, principle, or background theory in WRE is apt for constant scrutiny and possible rejection. It is important, having reached that point, to anticipate an objection regarding the viability of our version of WRE with an intuitionist foundation, for it could be objected that if intuitions can be revised, they are not self-evident. However, we shall bear in mind, before presenting such concern, that the self-evidence of moral intuitions does not entail infallibility, incorrigibility, or indubitability. Second, restricted epistemic priority, that is, cases, principles and background theories have all the same epistemic status/preference. Third, and last, the method of coherence, where holism is the methodology of discovery in bioethics, thus no linear model, bottom-up or top-down, of moral beliefs discovery would be appropriate to describe what we do in the field of bioethics.

5.2.3. Possible objections

a) Ethical particularism

The first objection to our metaethical considerations previously explained could be observed in ethical particularism, which postulates the non-existence of moral principles[100]. Its most imminent consequence for our purposes is the impossibility to appeal to bioethical principles to justify and ground the notion of the duty to die. For particularism, morality must be approached on a case-by-case basis, where specific moral features of a concrete scenario cannot be extrapolated to others, independently of how similar the two could be. For, moral properties can make a difference in some cases but be completely irrelevant in other. Thus, the rightness, or wrongness, of individual acts can be discerned without the need to appealing to moral principles. The particularist alternative is to consider the specificities of a case, identifying the salient moral aspects of it, and judging them accordingly. In Dancy's words: "we discern directly that individual acts are right without needing any detour through principles" (1983, p. 543).

Three are the problems pointed by particularism to be wrong about the defence and necessity of moral principles to justify our morality. Firstly, there is a problem of consistency, for conflicts of duties seems unsolvable. Retaining clashing principles appears impossible after disagreements on which one must prevail in a determined moral quandary. How could a moral subject keep both and apply them in a different situation once the conflict has been elucidated? The second problem concerns the epistemology of moral principles; in other words, the means to acquire knowledge of those principles. For particularists, moral principles are not self-evident and cannot be proved so[101]. And, finally, there is the difficulty to account for the moral relevance of principles in distinct situations: "why should we admit that if a property 'makes a difference' in a particular case, then it generally 'makes a difference'?" (Dancy, 1983, p. 534).

However, the possibility to offer a robust moral justification without pointing to principles into which our claims can be grounded, even if they simply serve as an initial guideline, seems difficult. To begin with, it is simply not the way we behave and operate in

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[100] See (Dancy, 1983).

[101] We have already argued for the self-evident character of moral intuitions, such as the duty to die, so discussion will not be furtherly offered here.

our moral life. The identification of morally relevant and salient features on specific situations is not enough to justify our moral actions, for it would be empty without the justificatory power of principles. The epistemological strength of our argumentation would be severely weakened if there is nothing else to tie our moral justification to than the identified features; it could perfectly be the case that we misinterpreted the scenario and, with it, the morally significant elements to be considered. Thus, how could anyone rest assured that the chosen features serve as justification if there is nothing else to appeal to than themselves? Principles provide us with a starting point from which we can begin reasoning and seeking moral justification in diverse situations, 'playing' with different arguments, previously employed with success, which seems initially applicable to new scenarios. That is not to say, as considered by Dancy, that we are truly switching arguments in a strict sense, for it is not the case that we take a moral argument and apply it, without further consideration, to a new situation with similar but not identical relevant moral features. What we in fact do when we reason ethically is to flexibly apply principles we have learned from previous experience to new circumstances. Those principles are admittedly quite elastic and might perfectly adapt to a variety of cases, as if they were a regular sock which can fit three consecutive feet sizes. Continuing with the sock analogy, the fact that our principles sometimes fit quite tightly does not mean that they are the wrong match for our moral situation, it might just be that we have encountered a quite rare scenario (or just an unusual foot size for our socks). So, it would be a mistake to think that in such situation any piece of cloth would be completely useless; for it could be simply the case that we misinterpreted the moral relevant characteristic of the situation and we are truly dealing with a hand instead of a foot, thus we would need a glove or, in a more appropriate moral terminology, another principle under which the scenario could be subsumed.

Similarly, as an answer to Dancy's questions previously offered, Hooker (2000, pp. 7–11) points to some possible counterexamples to particularism, where moral properties that 'make a difference' in a determined situation also 'make a difference' in general; in other words, there are moral properties that are always on the same side of the moral problematic. Amidst the examples offered that can be place on the side of rightness we find seeking non-sadistic pleasure, benefiting others, and promoting justice. Examples of properties that count always on the wrongness side are promise-breaking and stealing. Those considerations need to be taken cautiously, for there are just understood as general moral pluses or minuses in specific situations. That means that, for example, even when promoting non-sadistic pleasure is always a moral plus, there could be a situation where it could be outweighed by opposing moral minuses, such as promise breaking. There are situations where moral pluses are not justified or opposite ones where moral minuses are justified. Imagine that someone needs to steal a drug to save a close friend's life. Stealing in that case is morally right and justifiable when weighing other relevant features, but that does not make stealing in general neutral, much less a moral plus to extrapolate to other circumstances (Brad Hooker, 2000, p. 10). Moral cases like that help us fine-tune our principles.

There is still a final argument against particularism offered again by Hooker, who indicates the absence of any predictability in particularism. A particularist defence of moral justification makes impossible to predict how others will behave in the future, there could be no sureness that a particularist would not attack us, rob us, or break their promises to us. Trust seems impossible. Appeal to principles as a means of justification gives morality with the share commitment needed to provide people with the assurance that nobody will attack them, rob them… Widespread acceptance of particularism would have bad net effects on human well-being. To conclude, "the overall plausibility of a moral view is seriously impaired if it denies that one of the points of morality is to increase the probability of conformity with certain mutually beneficial practices" (Brad Hooker, 2000, p. 22).

b) A critique of Reflective Equilibrium

The second set of objections worth mentioning and considering focuses on Reflective Equilibrium, on its wide version, as an appropriate methodology for bioethics. In fact, this criticism questions the viability of Wide Reflective Equilibrium (WRE) and the idea that coherence could provide sufficient justificatory power for our moral claims and principles. On that line of argumentation, Arras (2007) also points to some concerns linked to the one just mentioned that are more likely to appear in the field of bioethics. First, he questions whether WRE is truly practicable, for there are, on his view, difficulties of justification due to the need to constantly check our moral beliefs with the entire network of beliefs. Closely related to this, as a direct consequence, WRE would not provide a precise guide for action, which is imperiously necessary in current bioethical decisions. The endless enterprise of checking our moral beliefs against the rest of cases, principles, and background theories to reach an equilibria situation seems inadequate to proceed in healthcare settings where time is a crucial factor making medical decisions. Secondly, and going back to the problem of the justificatory power of WRE, Arras criticises the absence of epistemologically privileged moral beliefs and principles in WRE, which does inevitably convey that anything is equally susceptible of being expelled from the equilibrium. Moreover, coherence between elements in reflective equilibrium on its own is not sufficient to provide justification for our judgements. This is the result of a wrong analogy with the scientific methodology, where observation statements provide 'datum' for further theorising in physical sciences, guaranteeing a sufficiently stable support in which justification can be firmly grounded. Besides that, the scientific model also provides mutually supporting beliefs or 'credibility transfers' across disciplines, raising the epistemological status of the whole set of beliefs (Arras, 2007, pp. 51, 57–62). Hence, coherence alone is unable to provide justification for our moral beliefs.

It is now time to clarify the misunderstandings that led to the previously offered objections and, also, to offer counterarguments in defence of a more precise comprehension of WRE, its possibilities, and limitations. First, regarding the lack of practicability of WRE, it is important to note that equilibria shall not be understood as a final reachable stage where all of our moral judgements, principles, and background theories do harmoniously cohere. As Nichols empathises, the method of WRE is never finished, nobody will ever be in that state, which means that we should never stop to employ the methodology and to subject our moral beliefs to scrutiny and revision: "all we can do is to use our best judgement in determining when we have subjected our beliefs to enough scrutiny to be able to justifiably use them as the basis for moral action" (Nichols, 2012, p. 334). Second, in relation to the justificatory power of WRE, an initial misunderstanding on Arras's side needs to be clarify, which is the same that Nichols unveils in Strong's (2010) argument against WRE as a valid methodology in bioethics. The confusion rests on an inappropriate conception of WRE, for both Arras and Strong consider that the methodology of WRE entails coherentism for epistemic justification. However, the role coherence plays in the above defended version of WRE is methodological, playing a justificatory role as well in our beliefs system, but merely contributing to it. Coherence is necessary for justification, but not sufficient. What coherence can do is to elevate the epistemic credentials of a moral belief. The foundationalist WRE, together with the intuitionist nuances that have been specified and defended before in section 4.2.2., avoids the criticism relative to the lack of justificatory power of reflective equilibrium by presenting a set of reliable principles that will be called upon when justification for particular cases is needed. Moral intuitions could serve as the *observation statements* we find in sciences, providing support and epistemological justification to our claims, which will later be included in reflective equilibrium to be finally evaluated against previously accepted moral statements.

5.3. Metaethics of the duty to die

How, thus, is the duty to die to be metaethically supported in this approach? As stated above, the duty to die could be considered a moral intuition; that is, specific morally salient features can be identified in a situation where a person might have the responsibility to end their life as a way of preventing becoming a burden for their family and loved ones. The frequency of such duty is irrelevant for the purposes of moral justification, for, even if seldom, the duty to die might appear and thus deserves moral consideration. However, it might be the case that the duty to end one´s life before one would have otherwise initially thought is more common than usually believed. Even when Hardwig (1997a, 1997b) first presented his advocacy for the duty to die in a medical care context, the USA´s one, where most services respond to the economic interests of private companies, i.e., a private medical insurance scenery, morally similar situations could be encountered in public healthcare contexts, where resources are nevertheless scarce and a just distribution of them could never suffice to cover everyone´s needs[102]. Similarly, we must not forget that the existence of a right to a decent minimum of healthcare[103] in those same public healthcare setups would inevitably generate scenarios where resources should be allocated fairly based on people's needs, most likely making the duty to die arise in other people. This approach could be understood as a passively letting oneself die inexpensively[104], thus facilitating the just allocation of those saved resources on cases where they are more needed. However, the existence of situations where more active steps should be undertaken when one has acknowledged their duty to die cannot be completely discarded from discussion. To conclude, following what we have just seen about how more often than expected the duty to die might emerge in different contexts, the identification of the duty to die with a moral intuition seems appropriate, for it does have its own specific and characteristic moral features. Situations where we might have responsibilities to those we love are often experienced by anyone with sufficiently strong affective bonds. Truth be told, those duties are not always equally demanding from us, but it is not difficult to picture a scenario where the circumstances could be so extreme that require from us to give up some of our lifetime, even more in situations where the end is inevitably near (e.g., terminal illness with a prognosis of two months of life) to ensure a better life for those we care about and love.

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[102] See (Margaret Pabst Battin, 2005, Chapter 14). Cf. also later Hardwig´s considerations regarding the likelihood of a duty to die in Europe (Hardwig, 2013).

[103] See (Buchanan, 1984).

[104] The main argument for the passive character of the duty to die is defended by Callahan (1993); see also (Ehman, 2000; Menzel, 2000).

To avoid any possible confusion or misunderstanding of the moral advocacy of the duty to die, it must be clear that even though the socioeconomic circumstances of countries/nations is a crucial factor which will determine the possibilities that such duty arises, a lack of funding in healthcare institutions, where they are supported with taxpayers' money, could be never justified by the existence of such a duty. For, the duty to die is a personal one, so political ineptitude, when distributing resources and giving public institutions their due importance for the general interest and citizens' wellbeing, should never be evoked as a counterargument to justify that the duty to die is more common than it truly is. In other words, the fact that the duty to die arises in socioeconomic and political contexts where resources are inevitably scarce and a just distribution of the is difficult is just that, a factual determinant, therefore it could not be appealed to as a moral argument, or else a fallacy would appear.

Returning to previous metaethical reflections, once we have stablished, and argued for, the duty to die as a moral intuition, accordance to moral bioethical principles should be proven to provide our intuition with a more robust moral justification. In the field of bioethics, principlism is embodied in Beauchamp's and Childress' (2009) theory of the four ethical principles to justify medical practices, which also employs WRE as a method to integrate those principles and provide them with greater coherence, and thus epistemological strength. Within that bioethical framework, the duty to die as a moral intuition can be subsumed under the principles of beneficence and justice; however, there might happen to be extraordinary circumstances which could make appealing to the principle of non-maleficence necessary[105].

The principle of beneficence is rooted in the idea that morality shall not merely consist in avoiding to harm others, but also taking positive steps to help them. As a principle, it focuses on the moral obligation to act for the benefit of others (Beauchamp & Childress, 2009, pp. 202–203). Regardless of who the 'other' is, the duty to die rests precisely on that assumption; that is, sometimes it is our moral duty, or responsibility, to weigh all possible available alternatives, considering other people's interests and wellbeing as well as our own, when making medical decisions. It could be argued that moral obligations emerging from beneficence would be extremely demanding, thus beneficence requests would be rendered as ideals that cannot be enforced. However, there are a number of prima facie rules of obligation, or duties, justifiable from bioethical principles that serve as a support to

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[105] There are so few cases that it is not even worthy to mention and seriously consider them. For moral obligations subsumed under the principle of non-maleficence are stated negatively, as prohibitions of actions, they must be impartially applied.

morally defend the duty to die. Beauchamp and Childress (2009, p. 204) mention some of them: a) protect and defend the rights of others; b) prevent harm from occurring to others; and c) remove conditions that will cause harm to others. Presumably, nobody would deny that situations are far more common than initially thought where a terminal illness with a death prognosis could endanger other family members' or loved ones' chances to have access to education or would suppose a great burden due to the care needed, putting at risk their life goals and/or projects. That is not to say that everyone should have to do it, nor that a third-party could occasionally enforce it, for the duty to die must be understood as a *prima facie* moral obligation that must be weighed against other salient moral features in each specific case, which could perfectly leave it off the ethical considerations to consider before making any important medical decision. On the other side, it does not mean that situations where the duty to die is unavoidable, from a moral perspective, could be encountered. I would like to emphasise that what seems troublesome for most people when faced with the possibility of having a duty to die is not at all different to the fear of dying itself, regardless of the means employed or the reasons to do it. I do not intend to deny the extremely arduous process that the acceptance of the duty to die might be, coming to terms to the idea that one is going to die would likely make us all cling to life and seek any possible reason to stay around for a little longer. But it would be morally irresponsible and unjustifiable to let our fear ruin our loved ones' lives. If we focus on the beneficence rule c) stated above, we could easily picture a situation where our staying alive for a couple of months more, when already suffering from a terminal illness that would nevertheless end our life within that period, became the removable condition that could prevent harm of others[106]. It is also important to pinpoint the distinctive character of the bonds created with our family and loved ones, for they generate specific benevolence, creating a more demanding moral behaviour towards them.

Attending now to the principle of justice, it normally addresses bioethical problems concerning the distribution of scarce resources in the context of limited funding and expensive treatments and medical technologies. So the term justice is commonly associated to its societal perspective, for when talking about distributive justice we refer to "the fair, equitable, and appropriate distribution of benefit and burdens determined by norms that structure the terms of social cooperation" (Beauchamp & Childress, 2009, p. 250). Thus, it might appear to be a decision which must be determined on a politico-social level, not on a personal one. Justice is concerned, in the biomedical discussion, with the equal treatment of

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[106] That is precisely what Hardwig tries to show on his work advocating for the duty to die. Cf. (Hardwig, 1997a, 1997b, 2000, 2009).

persons attending to their material differences, pursuing to guarantee the same opportunities to access medical services. Societies are morally obliged to treat every citizen in the same way, protecting everyone´s right to healthcare, and assuring a decent minimum of services which cover their fundamental needs. How is the duty to die then related in any significant way to the principle of justice, where they appear to be implemented at different tiers, individual and societal, respectively? Well, let me show it with an example. A person has a remaining period of between two to three weeks left before a terminal disease ends their life. The technologies and treatment necessary to maintaining that person alive during that period amounts to a sum of money that could be redistributed to significatively improve the chances to life of other patients. Provided that such redistribution of the saved resources be possible, should the referred person desperately cling to life or accept its end therefore saving others? Trying to escape one's responsibilities towards others in a situation like the one presented seems unfair, unjust, to those in need of those medical resources. Especially so in cases where one has accepted their death, left everyone settled and has provided for their loved ones; once again, one's incapability to come to terms and accept death cannot be sustained as a morally sufficient reason to stay alive. Just to clarify, it is enough to defend the argument for the duty to die to accept that there could be some cases where this *prima facie* duty would arise, even when in most other situations there would be heavier moral considerations which would tip the scales in favour of staying alive.

5.4. Conclusion

Notwithstanding the relatively limited metaethical considerations, for implications have not been thoroughly discussed and some assumptions have been made, this chapter offers a valuable insight into the possibility of moral justification of the duty to die in perfect harmony with the mainstream bioethical principles and methodology. Similarly, the argument presented satisfactorily solves the objection that pointed to the necessity of a normative theory to support the duty to die.

The chapter defends that the duty to die can be understood as a moral intuition arising in specific medical context where a person might have to acknowledge it to avoid becoming a financial and/or emotional burden for their family or to society by making an unfair use of scarce resources. As a moral intuition, its moral characteristic features are first identified in a given scenario to be later on supported by strongest biomedical principles. In the case of the duty to die, those principles are beneficence, for the person who has a duty to die must consider the wellbeing of others whose life could be ruined if the patient fails to recognise her duty; and the principle of justice, for healthcare resources must be justly distributed amidst all members of society to guarantee equal access to health opportunities, thus the duty to die can require from a person to stop employing medical resources that could be better use to save others' lives.

The metaethical approach of the duty to die offered in this chapter makes a substantial contribution to the discussion, for it provides a more robust ethical ground where it can be established. The scope of our metaethical reflection is limited to the assumption of moral cognitivism as the preferred alternative to support our arguments, but it nevertheless points to the possibility to justify and argue for the existence of a duty to die within a strong, well established ethical paradigm.

6. PHYSICIANS' ROLE IN HELPING TO DIE

Euthanasia and the duty to die have both been defended in the preceding chapters as morally justifiable practices within medical healthcare contexts. The existence of a narrow connection between both has also been clarified, for people having a duty to die should be allowed to actively hasten their death by the active means offered by euthanasia. Choosing the right time to end one's own life is a decisive factor to retain autonomy at the end of our lives. It can also help us give meaning to death, especially in those scenarios where the duty to die arises, for our dying would bestow life upon others. However, no argument has been yet offered to justify why physicians should be the ones performing the medical procedure to end a person's life. The moral problems arising from such assertion are not to be taken lightly, for medical tradition has long regarded the duty not to kill, not to actively end a patient's life, as the core moral obligation that gives meaning to their profession. Despite the debunking reasons offered in chapter 2 to expose the lack of a morally relevant distinction between passive and active euthanasia, we are now occupied with the moral reasons that can be presented on more practical grounds from healthcare professionals. Thus, our concern is to question the moral justifiability of the arguments offered by physicians not to actively help patients die.

This chapter reflects on physicians' duties towards patients at the end of their lives. Firstly, the traditional approach to medicine and physicians' obligations will be carefully examined to comprehend the reasons behind doctors' refusal to provide active euthanasia, grounded on their alleged duty not to kill. Second, the just-mentioned argumentation to defend such traditional approach to medicine will be questioned. Different counterarguments and objections will unveil the internal inconsistencies of the arguments and the lack of a connection with other current practices physicians perform. As a result, physicians' duties will need to be redefined and new arguments will become necessary to explain the paradigm shift and the justifiability of the novel medical practice. Finally, the focus will put on the specific duties of healthcare professionals at the end of patients' life. The right of a person to be aided by a physician when she has acknowledged her duty to die will be defended; that argument will effectively encompass both notions previously upheld, i.e., voluntary active euthanasia and the duty to die, linking them with the idea defended on the present chapter apropos doctors' obligations to help patients die.

6.1. Traditional approach

Mainstream medicine has traditionally defended, at least until recent times, the existence of an intrinsic ethics to the medical profession, under which certain duties and restraints are inviolable. Above all, the duty not to harm a patient, funded on the Hippocratic Oath: *primum non nocere* (first, do no harm). Kass (1989) defended medicine as an inherently ethical activity pursuing an overarching good: the naturally given end of health, understood as the wholeness and well-working of the body. But how is this abstract idea of *human wholeness* to be understood? It presupposes an underlying natural and universal subject, an *Anthropos* where body and person are self-identical, thus the correct functioning of the body becomes a sufficient and necessary condition to guarantee the person characteristic development. Another closely related reason, on the same arguing foundations, understands the body as the living ground for the higher, characteristically and defining, human functions. So, annihilation of the body would unavoidably imply the extinction of the person. As a result, since medicine pursues health, understood as body wholeness, killing, i.e., the destruction of the body, is contrary to medicine's objectives; for, "to bring nothingness is incompatible with serving wholeness" (Kass, 1989, p. 41).

According to the previous reasoning, the duty not to kill appears as one of the adamant obligations that physicians must comply with to maintain the medical profession intact. The limits of medicine are fixed, firm, and non-negotiable under this perspective, so the dispensation of deadly drugs is utterly forbidden. Although we might think that some extreme medical circumstances would render such prohibition inhumane due to the caused suffering, either physical or mental, i.e., cases where we have previously advocated for euthanasia, the traditional approach would reject any alternatives. When body's wholeness cannot be restored, doctors need to focus all their efforts to ease pain and suffering, checking the patient's comfort and providing support, and lastly avoiding any futile treatment that would unnecessarily extend the agony. Similarly, the traditional view goes on, courage to face the evil of death and ability to stand against the fear it creates in us is praiseworthy. This final macabre twist implies an ideological imposition on people, for there is only one accepted manner to cope with pain and suffering, so any other alternative is morally condemned as wrong. Consequently, liberty and autonomy at the end of life are significantly reduced, directly harming people based on their previous life choices and their understanding of existence.

A more recent defence of physicians' duty not to kill has been offered by Garcia (2007). His argument rest on a previous understanding of human nature, which assumes that patients, as any other human animal, have an inherent interest in being alive. For, it is the precondition to enjoying all other possible goods and benefits that life might bring upon a person. Under this approach, there are no conditions whatsoever that render life value-deprived. Instances of suffering, either physical or emotional, could never overcome that instinctive willingness to survive at all costs. Garcia goes even further to assert that life itself retains value even when it no longer produces satisfaction (2007, p. 10). No attention is given to the fact that patients willing to actively hasten their death by euthanasia are autonomously deciding so, after competence is confirmed and informed consent is provided. This lack of regard is due to the assumption that certain rights are unwaivable, autonomy among them. Hence, the underlying human-animal *instinct* to continue being alive is conceived as the natural limit to our moral and intellectual capacity to decide how much suffering we are willing to endure, as well as how, when, and why we would want to put an end to our existence.

Since every human animal has that irrevocable interest in being alive, doctors' defining duty is to maintain or restore health. For, keeping the body alive fulfils such necessary condition. Conceiving this as their main obligation, all other physicians' duties need to be consistent, compatible, and coherent with it and will keep it as the base of their justifications. Cases of active euthanasia and/or physician aid in dying become instances that wreck internal coherency of doctors' obligations. Mercy killing is contrary to maintaining and restoring health, because it halts suffering by ending the patient's life, whereas pain and suffering relief are amidst their prominent duties because its aim is to keep the person alive avoiding the harm caused by physical and emotional distress. But what if the alleviation of suffering requires a high dose of drugs that would foreseeably end the patient's life? The traditional approach embraces here the doctrine of double effect, in an intention-sensitive understanding of morals. Providing drugs that knowingly terminate the patient's life is morally justifiable when the first, and foremost, physician's intention is to alleviate the suffering experienced by the patient. In such cases, death, although foreseen, is considered the unavoidable and unintended collateral effect of drugs supply. As a result, terminal sedation is considered coherent with doctor's duties to avoid suffering and thus morally and professionally permitted.

Similarly, Pellegrino (2001) presents an argument against physicians' help in dying grounded on the unnecessariness of active euthanasia and physician-assisted suicide due to the available methods of pain relief and palliative care. In other words, technological advances on the medical field regarding the alleviation of suffering at the final stages of life is deemed sufficient to render any other alternative, such as active euthanasia, as unnecessary. However, what about emotional/mental distress? Can it be equally properly addressed and removed? If so, would it not imply the loss of the patient's consciousness due to the high drug dose needed? Life would be void, meaningless in such state where experience, both physical and intellectual, have been rendered impossible for the patient[107]. Furthermore, legalisation and wide moral acceptance of physician-assisted dying within the medical community could significantly erode the physician-patient relationship. Patients' fears that their doctors could suggest euthanasia as an available option would be exacerbated. Therefore, patients' trust on physicians would diminish, for it could be thought that not all treatment options are being considered and physicians are not doing everything they can to help them. If patients believe that physicians are not trustworthy, they could withhold relevant medical information; for, when doctors are perceived as potential ending life agents, sensitive medical issues could be hidden from them if patients feel their life is at risk. As a result, doctors could not completely rely on the patients' provided information regarding their condition, which would significantly impede an appropriate development of their work. For example, patients suffering from a terminal condition who are experiencing considerable physical pain could avoid talking to their physician about it due to their fear that she might consider such suffering unbearable and thus ending the patient's life if necessary. On the other side, lack of information would inevitably lead physicians to treat patients in an inadequate manner, furtherly increasing the potential suffering and pain experienced.

6.2. Objections to the traditional approach

The above depicted understanding of medicine is regarded as teleological essentialism (Seay, 2001), that is, medicine is essentially devoted to healing the sick and preserving and extend life, thus helping a patient die is not permitted. This section will offer objections to the arguments presented to defend such traditional approach to medicine.

First, attention will be given to Hippocratic Fundamentalism, the idea that medicine is committed to healing and the conservation of life, thus physician-assisted dying is not permissible. It is difficult to comprehend how defenders of this type of arguments are keen to also sustain doctors' obligation to prevent futile treatment to avoid extending agony unnecessarily. As we have previously defended in chapter 2, when debunking the distinction between passive and active euthanasia, there seems to be only one identical underlying moral reason to justify both instances of either letting a patient die or actively hastening the process. That is, what truly matters from a moral standpoint is the patient's regard about her life and her autonomous decision that it has come to an end. Doctors implicitly agree, and rightly do so, with such argumentation when rejecting further futile

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[107] Compatibility between palliative care at the end of life and physician-assisted dying would be furtherly discussed on section 5.3.1.

treatment; their acceptance of the patient’s death seems obvious, so all that is at stake are the means that will be employed to avoid suffering. Arguments for the moral permissibility of active euthanasia have been offered before[108], so there will not be furtherly discussed here. If rejection of futile treatment is an exception, morally justifiable, to the conservation of life at the core of doctors’ duties, on what grounds could the inappropriateness of aiding to die not be considered another exception? Especially when autonomous patients competently decide so, but even more when palliative care is incapable of alleviating all pain and suffering. In those instances, would physicians not be neglecting their duty not to harm patients by refusing to provide active euthanasia, for it is the only alternative that puts an end to that agony? This kind of situation exemplifies that there are times where alleviating pain can be more important and overriding to physicians’ duty not to end a patient’s life. Hence, doctors’ non-maleficence duty needs to be properly understood. Every alternative needs to be weighed and especial attention given to those described cases where ending life is the unique option to end pain and suffering.

Evidently, opponents of physician aid in dying argue that terminal sedation would still be an available option to provide adequate care for the patient and is not contrary to the Hippocratic Oath. In cases where patients require such a high dose of morphine, or similar, to alleviate their pain that will irremediably also end their lives, it is sustained that hastening the patient´s death is not intended but merely accepted as an unavoidable consequence of treatment. However, it is difficult to defend an intention-sensitive approach to morality in scenarios like the one just depicted. Even though there might be instances where our moral actions can be justified by merely considering our good intentions, especially when among its consequences some were not foreseen, it seems we would be sidestepping doctors´ moral responsibilities by defending terminal sedation as one of those cases. As stated before, the patient´s death is not the unforeseen consequence of the chosen treatment to ease her suffering and pain; quite the opposite, the selected drug is supplied in a dose high enough to also cause the patient’s heart to stop, which implies her death. It appears that doctrine of double effect proponents would be hiding behind this faulty reasoning to avoid accepting the true moral reasoning justifying their intervention. It could be that using the label of ‘foreseen but unintentional consequence’ is easier that abandoning their previous medicine paradigm to embrace a new redefined one.

By no means, a devaluation of the duty not to actively and intentionally help a patient die is intended with the objections presented. The duty not to harm is reflected in one of the

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[108] Cf. chapter 2, esp. section 2.5.

prominent bioethical principles, non-maleficence, but needs to be regarded as a *prima facie* obligation, that is, it needs to be weighed against other physician specific duties, which might render it defeasible. Respect for patient's autonomy and the relief of suffering are also professional duties doctors have, grounded on the principles of autonomy and non-maleficence, respectively. When a patient autonomously requests hastening her own death due to the unbearable suffering experienced, the physician's duty to fulfil this right prevails over their obligation not to help a patient die[109].

The other main cluster of arguments defended by the teleological understanding of medicine is concerned with the loss of trust that patients could feel towards their doctors[110]. As a result, it is thought, risk of abuse might considerably increase or, at least, the possibility of its appearance is higher. However, recent research shows the opposite[111]. It is not the case that an erosion of trust on the patient-physician relationship occurred in any of the countries where physician-assisted dying is legal. Findings of the study show that palliative care was furthered as the result of physician-assisted dying in those countries[112], so the fear that abuse might happen is ungrounded. If anything, it seems that patients' trust on their physicians could improve when they foreknow that their dying choices will be respected and multiple means to exit life are available. Going back to the example at the end of the previous section, a terminal patient would be confident to inform physicians about her suffering and her decision regarding the chosen means to put an end to her life. Knowing that her doctor respects her decision and will do what she can to help the patient increases patients' trust and contributes to strengthen the patient-physician relationship.

There is still a second, complementary, objection that can be offered against the loss of trust between patient and doctor, it concerns patients' expectations from healthcare systems and professionals. It is unrealistic to expect limitless treatment to be provided to only one person or small group of people, even less at the end of life. That is not to say that the elderly be neglected on their treatment options, for adequate care should be provided at every stage of life. However, there are other morally biding imperatives that healthcare professionals must comply with to guarantee everyone in society their fair share of healthcare resources. This just allocation of resources rests on the recognition that we are all equally from a moral standpoint, thus we all deserve to have the same opportunities in

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[109] For a more detailed explanation between correlative and noncorrelative doctors' duties, see (Seay, 2005), who sustains that doctors' duty no to end a patient's life cannot be unconditional.

[110] See also in (Pellegrino, 2001) and (Kass, 1989).

[111] See (Chambaere & Bernheim, 2015).

[112] The Netherlands, Belgium, and Luxemburg.

life, which are, at least to a significant extent, determined by our health condition. Age-rationing, where allocation of scarce healthcare resources corresponds to earlier stages in life, ensures a just distribution of them, which allows every person to enjoy a higher life expectancy and quality of life for most[113].

Finally, the above-mentioned risk of abuse on the physicians' part could be considered among the slippery-slope scenarios and arguments to object to euthanasia and other types of physician-aid in dying. The possibility of slippery-slope situations where nothing can prevent irrational killing to people regardless of their medical situation and autonomous consent was discussed and rejected in chapter two[114].

6.3. A novel approach to medicine and doctors' duties

Identification of medicine goals and physicians' duties is fundamental to providing high quality and adequate health care to society. So far, the traditional approach to medicine, whose ultimate maxim was to avoid harm and promote health, has been questioned by different arguments which debunk the inviolability of doctors' duty not to end a patient's life. However, our notion of common-sense changes rapidly in medical ethics with all the scientific and technological advances, which results in new challenges to our thinking patterns about life and death[115]. What counts as a legitimate part of medicine has changed over time, consider for example cosmetic surgery as a common accepted medical practice nowadays that would not have had a place within the definition of medicine few centuries ago.

The proposal for a new medical practice, to the extent of the possibilities within this thesis, is to defend that aid in dying should be included amidst physicians' duties. It is, as Jonsen (1996) puts it, the inauguration of a new social practice, where medical support to help patients' end their lives in the chosen way becomes a procedure integral to the practice of medicine. That is not to utterly reject the principle 'do no harm', but to understand that it needs nuancing, and it has exceptions. Respect for the patient's autonomy, where she decides when and how to end her life, becomes the pivotal bioethical principle to support our claim. However, there is still a further underlying objective: the humanization of medicine in a healthcare environment where scientific and technological medical

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[113] Arguments for this thesis have been offered when different approaches to the duty to die where presented, see chapter 3, section 3.6.2. Cf. (Margaret Pabst Battin, 2005, Chapter 14; Buchanan, 1984; Daniels, 2008).

[114] See section 2.4.2.

[115] Cf. (Seay, 2011).

improvements prolong and extent life to the limits of the morally defensible. That intention to keep a person alive until just before treatment becomes futile[116] rests on, and is morally supported by, the assumption that life has intrinsic value, and is furtherly defended as the core medical principle of ‘first, do no harm’. Thus, the promotion of health, as well as the relief of pain and suffering, must be understood in a broader sense. Suffering and pain relief is a physicians´ duty equally fundamental to their duty to conserve life (Seay, 2001), and many situations will require from them to hasten death, grounded on the patient´s autonomous request not to endure any more suffering.

Reflecting on the objectives of medicine, Hardwig (2000, Chapter Dying responsibly) argues against medical vitalism, that is, the idea that being alive is itself valuable despite further medical or moral considerations, thus prolonging life is the highest valued within medical practice. As we have already tried to show when discussing the existence of a duty to die, there are more important goals for healthcare than endlessly fighting death, e.g., the fair allocation and distribution of resources to treat everyone justly. We should also consider, as Hardwig suggests, the impact on families that medical vitalism has; for, families are reduced to mere “patient-support” systems and the impact on the lives of others is not to be left unconsidered. Longer life, the simple fact of remaining biologically alive for a lengthier period, is not valuable by itself. What matters is what we do with the time left, how we autonomously decide to spend it based on personal values and life trajectory. The traditional medical account, which rejects physicians aid in dying, fails to respect autonomous decisions by patients who opt for the earlier termination of their lives, choosing assisted death as the appropriate and meaningful personal way to end their lives.

Varelius (2006) offers further criticism regarding the goals of medicine. There are two main approaches to defining the goals of medicine: subjective and objective. Among the later, we find considerations closely related to the preservation of life, as the promotion of health and the patients’ wellbeing, together with the avoidance of harm. Those are the ones traditionally defended and incorporated by medical practice as exceptionless. However, further reflection will lead us to question such assumptions. For example, what is the role of the quality of life on the traditional approach? Should it matter at all what we consider as harm or benefit for the patients? It is not difficult to imagine situations where the same treatment might be beneficial for a person, based on her personal beliefs, and harmful for another. End of life process is exemplary to this regard: prolongation of life for further two

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[116] This is the idea of technological brinkmanship defended by Callahan (1993, Chapter 1), which has been previously discussed in chapter one.

weeks might be regarded as necessary for a patient who is waiting for a loved one to arrive and say goodbye, and the same extent of time can easily become a nightmare for another patient who has made peace with her death and does not want it to be delayed any longer. Similarly, end-of-life choices demonstrate that the promotion of health is not self-evident regardless of the patient's personal circumstances. These considerations should make us consider the subjective approach to the ends and goals of medicine, where they should be determined by the autonomous decisions of patients.

It seems evident that some of the questions posed before to challenge the objective perspective, are easier to answer from a subjective patient's approach. There are two main reasons for valuing autonomy. First, it is an instrument for promoting the patients' well-being. Patient must be adequately informed about their condition, prognosis, and treatment options, so they can be in a position to independently decide what is best for them, considering their own life values and trajectories. Second, it is intrinsically valuable, independently of its role promoting the patient's well-being. In other words, autonomous decisions that could not contribute to the patient's good retain value when they are freely and informedly consenting[117].

Overall, it seems obvious that medicine should not concern itself with promoting whatever enhances the patient's well-being regardless of the patient's autonomous considerations and decisions. Despite of its origins, medicine has developed as a profession committed with the alleviation of pain and suffering, and not simply dedicated to healing and conserving life. This shift makes physicians' duty to alleviate suffering override, on some occasions, their duty not to end life (Seay, 2001, 2005).

6.3.1. Compatibility between palliative care and euthanasia

One of the greatest challenges when discussing physician-aid in dying is its apparent incompatibility with palliative care. Especially, active euthanasia, the objection goes, seems contrary to the goals and main objectives of the medical care provided at the end of life. Furthermore, the legalisation of diverse types of physician-assisted death would negatively affect palliative care for two main reasons. First, patients would feel that having the possibility to choose over their own death makes them vulnerable not to receive appropriate end of life care. In other words, having active euthanasia, for example, as a medical option at the end of life could make patients think that their physicians would

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[117] Further discussion on whether there is such intrinsic value on autonomy cannot be offered here. Cf. (Gillon, 2003; Varelius, 2006, pp. 123–125).

encourage them to elect this path instead of the expensive treatments necessary in palliative care. Second, the purposefulness of palliative care would significantly diminish, for considerations of more active procedures to end the patient's life would make it the chosen and preferable option in many cases. And, if death is deemed as an acceptable alternative, the importance of end-of-life care could be rendered less practical and appropriate. As consequence of both, palliative care would presumably suffer from a lack of the resources, both material and in personnel, by making alternative decisions at the end of life available to patients.

However, it is far from evident that the offered concerns regarding palliative care truly arise by the moral and legal acceptance of different physician-assisted dying procedures. I will try to show how palliative care and physician-assisted dying can be compatible, and in fact are in countries where these procedures are legal. As part of doing so, the main common assumptions of the incompatibility between palliative care and euthanasia will be debunked.

Palliative care and euthanasia are related and compatible, they are treatment alternatives, procedures that do not exclude each other, which can also be mutually beneficial and complementary. My claim here does not pretend to establish a reciprocal necessity and close relation between palliative care and active euthanasia, it is sufficient for the purpose of our argument to show how the relations between both is a two-way street where the procedures support each other in certain cases. As already discussed throughout this work, especially in chapter 1, death in contemporary Western societies is more likely to happen after a prolonged period of deterioration and suffering. This fact is paramount to understand that palliative care is, in many cases, the best alternative, the adequate medical procedure before euthanasia can become acceptable. In the process of dying, physicians' duties of not harming and being beneficial to patients necessarily convey their obligation to provide the best care available before death occurs. Moreover, it might perfectly happen that for many people dying palliative care does effectively prevent the need of euthanasia by the mentioned alleviation of pain and suffering. However, "*this does not mean that all requests for and cases of euthanasia or PAS can be prevented; neither can it be claimed that such requests and cases are indications of a lack (or of a low quality) of palliative care.*" (Widdershoven et al., 2015, p. 152). Even when the best palliative care is provided, patients might still opt for a more active means of dying because they autonomously decide that waiting any longer is needless. Although some of the main principles and goals of palliative care are irreconcilable with euthanasia, i.e., the acceleration of death is not an aim of palliative care; they share other objectives, i.e., the recognition that dying is an intrinsic part of life and that palliative care is designed to make patients as autonomous and active as possible (Widdershoven et al., 2015).

Research by Michael Gill (2009) also supports the thesis of the compatibility between physician-assisted dying and palliative care. Even though the research undertaken by Gill focuses only on debunking common assumptions regarding the incompatibility of physician-assisted suicide, and good palliative care, I see no reasons to think that significant differences would appear in cases of active euthanasia, for what truly matters is the underlying moral ground to support the justifiability of physician-assisted death, regardless of the employed means to perform the procedure[118].

The first common assumption is concerned with suffering, more specifically, with the complete elimination of pain when palliative care is provided. It is commonly argued that appropriate palliative care would render physician-assisted dying unnecessary; for, if suffering is the prominent feature that determine patients' wish to die, its effective alleviation would make people reconsider and lastly reject their willingness to end their lives. However, the ability to control pain does not make instances of physician-assisted dying illegitimate. First, it is not always possible to utterly eliminate physical pain. Some people suffering from terminal conditions continue experiencing extreme pain even when the best palliative care is provided. Furthermore, 12% to 20% of patients receiving excellent end-of-life care keep their desire to hasten their deaths, which indicates that better palliative care does not utterly eliminate physician-assisted deaths' requests. Second, other physical conditions, such as nausea, extreme fatigue and weakness, or diarrhoea, can be an obstacle that impede patients' from having a comfortable and good death. Third, and last, people hold different attitudes and beliefs towards death, as well as have different pain and suffering thresholds. That implies that the exact same medical situation and its associated conditions, if it comparing different cases were at all possible, could be tolerable for one person and palliative care would suffice to ease her last days, but it could be unbearable for another patient who cannot endure that suffering and would prefer to end it by taking more active steps, i.e., requesting active euthanasia. Once again, justifications offered to defend why physical or psychological suffering are good reasons to provide help in dying are the truly important moral features to consider and discuss.

Another related and frequent assumption points to the incompatibility of hospice care and physician-assisted dying. Hospices have always been places where people went to

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[118] For a detailed discussion on this topic, see chapter 2, section 2.2.

receive adequate care throughout the final stage of their lives. Respect for life was the paramount principle guiding hospice practice, which seems contrary to help someone die. However, the principle not to abandon patients at the end of their lives and respect their wishes conflicts with another hospice principle, that is, the one against postponing or hastening death. It seems obvious that in instances of patient requesting her death to be hastened, hospice carers face a conflict of obligations, for they must respect the patient's wish and not abandon them on suffering but providing help in dying is forbidden. We advocate for an inclusive understanding of both principles that makes help in dying, thus respecting the patients' autonomous wishes, compatible with providing the best care available, so people are not abandoned to their suffering. The end of a person's life must be understood as a continuum where respecting their death wishes can be compatible with providing the best care until just before the time comes. In addition to that, hospice personnel have the expertise to deal with death requests and physician-assisted dying procedures. Different studies show how hospice care-givers have not experienced any greater difficulty combining both (Gill, 2009, p. 15).

Now we shall address a final assumption. Physician-assisted dying requests, where the hopelessness of prospective life is presented as an argument to hasten death, are thought to be possibly erased by providing adequate end-of-life care. The type of care provided is viewed as sufficient to give suffering patients hope for the remaining days of their lives. Whereas different justifications could be offered from patients as to which extent their regarded hopelessness for life is due to bleak prospects in the expected end-of-life care, we believe that the determinant features that trigger such feeling have more to do with the patient's awareness of her factual medical condition. For example, in patients with a terminal condition, hopelessness is more likely to be associated with the imminence of death and its unavoidability. Thus, better end of life care could not change their previous decision and offered reasons to their wish to die due to their hopeless condition and future. Adequate palliative care could indeed make the remaining time bearable and will surely easy pain and suffering, but it cannot alter the features that make the patients' lives hopeless.

In short, either palliative or end-of-life care are compatible with physician-aid in dying requests, for they must be understood as distinct stages within the same process. Respect for patients' autonomy is the prominent aspect to consider and accommodate in healthcare settings or hospices. Doctors, nurses, and hospice carers must accompany patients during their final time alive, providing the best care possible until death comes, regardless of whether the time to die is natural, as it is commonly described in traditional literature, or chosen by the patient by a request to actively hasten their death.

6.3.2. Conscientious objection

One major issue to carefully consider when including physician-aid in dying as customary practice in healthcare settings is the impact conscientious objection might have in the effective implementation of such procedures. Medical professionals might appeal to their scruples to avoid performing assistance in dying, thus patients' autonomy might be seriously compromised and even disrespected on various occasions. Is conscientious objection a sufficiently robust moral appeal to avoid performing euthanasia or other dying procedures that need the help of a physician/nurse? Are there any exceptions? Traditional medical ethics have long regarded the appeal to scruples as a legit excuse to perform specific procedures that were legally and morally demanded from patients, such are the cases of abortion or euthanasia. The justification offered in defence of conscientious objection was the right to freedom of conscience, protected by the United Nations Universal Declaration of Human Rights, which reads: "Everyone has the right to freedom of thought, conscience and religion" (art. 18). However, there could be limits to this right within specific contexts, such as healthcare, where professional duties rests on other citizens' rights, establishing limits to physicians' right to conscientious objection. That will be the thesis we will advocate for in the following. Especially enlightening are Savulescu's words to that regard:

> *"A doctors' conscience has little place in the delivery of modern medical care. What should be provided to patients is defined by the law and consideration of the just distribution of finite medical resources, which requires a reasonable conception of the patient's goods and the patient's informed desires."* (Savulescu, 2006, p. 294)

These words might appear to many as contrary to the predominant understanding of medicine goals. However, we have advocated for a change of paradigm that is more adequate to present challenges within current modern societies. Healthcare is a service provided to citizens by society, where the main objective of healthcare systems is to protect the health of their recipients. The focus when addressing conscientious objection must shift from healthcare practitioners (doctors, nurses, and pharmacists) to the rights patients are entitled to. Therefore, if a healthcare practitioner presents a conscientious objection not to do a specific procedure, and such objection compromises the quality, efficiency or equitable delivery of a service, there are not reasons to tolerate it (Savulescu, 2006). It may be thought that a possible solution would be to refer the patient to another doctor willing to perform whatever procedure objected to by the first physician. But there are several objections to this alternative, both philosophical and practical, that questions the tolerability of conscientious objection in healthcare settings.

The previous discussion relates to our first objection: the commitments of healthcare practitioners. The latter are required to deliver healthcare services based on what is legal, beneficial, and desired by patients, and part of a just healthcare system. “Doctors are first and foremost providers of healthcare services. Society has every right to determine what kinds of services they ought to deliver” (Schuklenk, 2015, p. iii). Healthcare professionals are not different from others who perform fundamental societal services. It might be difficult to fully grasp the implications of such assertion, for physicians have long retained a deontological moral code upon which their practices are substantiated. But why should such medical values override their obligations as a certain type of professionals within society? To be a doctor has implications based on what society requires from the profession grounded on their expertise and skills. Those requirements cannot be personally adopted by practitioners at will regardless of their fellow citizens’ rights (Giubilini, 2014, pp. 173–174). We shall try to clarify the point with an example from another profession where the goals are established by society: teachers within a public educational setting. The knowledge and skills that teachers must provide to their pupils is established by society and enforced by governmental educational laws. Teachers cannot select specific parts within the national curriculum of their subject to impart and others to avoid based on their personal, either moral or religious, beliefs. A biology teacher cannot skip the Darwinist theory of evolution on grounds of her personal religious belief from the creation of the world by God. Then, why should we allow doctors to perform euthanasia, where it is legal and citizens are entitled to receive such healthcare service, based on practitioners’ beliefs and convictions?

The second objection points to the consequences of permitting conscientious objection, for it may lead to an inefficient waste of resources in cases where patients are unable to find an appropriate practitioner to deliver the service[119]. Similarly, it is not difficult to imagine patients who are not connoisseurs, or are simply less informed, of their right to the specific service their regular practitioner is conscientiously objecting to. As a result, they will fail to receive the service they are entitled to, which generates a morally and legally unjustifiable situation of inequity. Following Schuklenk (2015), patients are entitled to receive an

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[119] That is the situation face by many women in the South of Italy, where a majority of doctors conscientiously object to abortion, seriously compromising the women reproductive rights. Cf. (Minerva, 2015).

uniform healthcare service from practitioners, not subjected to today's lottery of conscientious objectors. Furthermore, even in scenarios where we could accept conscientious objection on grounds that there would be sufficient professionals to help patients, healthcare practitioners who fail to state initially their scruples to perform a specific medical procedure acquire positive obligations towards their patients[120]. This is especially relevant in physician-assisted dying. A doctor who knows her patient and is fully aware of her willingness to hasten death when she decides so cannot wait just until the last days before the procedure will be performed to present her conscientious objection. The patient-doctor relationship is fundamental in medical procedures such as euthanasia and a strong relationship facilitates the patient's readiness and it eases their psychological suffering at the end of life, for they know that a familiar caring person will be assisting and fulfilling their wish.

A third argument points to the inconsistency of permitting healthcare practitioners object to perform and deliver specific services based on their moral and/or religious beliefs. If society does not, rightly, accept other forms of objection on self-preservation or self-interest grounds[121], it would be inconsistent to accept other types of objections (Savulescu, 2006). It might be initially believed that moral or religious claims are somehow more solid or consistent, but it is easy to show how we would never permit practices which would be plainly discriminatory just because they would have moral or religious grounding. Giubilini (2014) brilliantly exemplifies the case stating that we would not, and should not, permit healthcare practitioners reject treating a patient based on her gender just because her religion prohibits so. The underlying reason is the existence of a moral justification to argue that persons´ healthcare rights and entitlements have nothing to do with their gender. Similarly, in cases of physician-aid in dying, healthcare practitioners cannot avoid fulfilling their obligations as professionals by sidestepping them presenting a conscientious objection. There are solid moral grounds to defend the justifiability to grant plenty of requests –depending on whether they meet the established criteria– for a hastened death in countries where the procedure is legal, thus doctors' duties involve the delivering of the service safely. Furthermore, an increase in the risk of abuse is not to be taken lightly. Healthcare professionals could appeal to their right to conscientiously object in situations

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[120] Cf. (Margaret Pabst Battin, 1998) (Margaret Pabst Battin, 2005, Chapter 4).

[121] For example, physicians rejecting to provide a service in a public healthcare setting because she could benefit more from that same procedure if conducted on her private surgery.

where the true reason is different. How could we know that theirs are genuine moral objections and not mere inconveniences? (Giubilini, 2014; Schuklenk, 2015)

The above offered arguments provide support against the permissibility of conscientious objection in healthcare settings, grounded in an understanding of healthcare practitioners as professionals within society from which the delivery of specific services is expected. However, we are aware of the practical difficulties in attempting to implement such a huge change in societies where physician-assisted dying is not yet legal or has been recently legalised. It can surely be too much for society to fully comprehend and rationally accept. We thus believe that intermediate steps might be necessary to ease the transition and thorough understanding of euthanasia and assisted suicide as morally justifiable healthcare services. It might be possible then for physicians, nurses, and pharmacist to initially object to these practices on moral grounds, even though some of objections would remain in scenarios where the patients' rights would be compromised. For example, conscientious objection would only be permissible when there are enough doctors willing to take over their colleagues' responsibilities, guaranteeing an equitable and efficient service provision (Margaret Pabst Battin, 1998, 2005).

6.3.3. Why doctors?

Having discussed how to redefine doctors' duties and the goals of medicine, always giving special attention to the impact both have on physician-assisted dying, it is now necessary to explain why doctors must be the ones amidst other healthcare practitioners to perform euthanasia, and be present, having previously prepared all that is needed, in assisted suicide. Advocates of a traditional approach to medicine, where ending a life is regarded contrary to doctors' main duty not to harm, could argue that even where assisted death could be legalised and morally defensible physicians should not be the ones performing it[122]. Our thesis here is that doctors must oversee assisted dying because they are the best professionally qualified to do so.

As previously stated, respect for the patients' autonomy and the relief of pain and suffering are two fundamental duties of doctors, which might sometimes collide with their duty not to harm, not to end a life (Seay, 2005). We have proven that the first two together might override the latter, especially when we also consider physicians' duties as established by their professional expertise within society. Thus doctors' duty to help patients die will arise, in this new scenario, from the expectations patients have regarding standard care

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[122] Confront with the idea of self-euthanasia proposed by Vink (2016).

(Seay, 2001). Besides these morally grounded arguments presented from a new understanding of healthcare practitioners' duties, there are other reasons to defend our thesis.

First of all, physicians are currently laying their professional knowledge to serve other interests far from strictly medical issues, or where the restoration of health and preservation of life is not the main goal of their work (Huxtable & Möller, 2007). There are, in those countries where there is still legal, physicians providing lethal injections for inmates in the death row, only because they have the knowledge to do so. This example by no means defends the moral permissibility of the death penalty, but it only focuses on the non-traditionally understood role of physicians. Another example is cosmetic surgery, where physicians use their expertise and knowledge about human bodies to modify it attending to purely aesthetic intentions dictated by capitalist societies. There are, indeed, cases where cosmetic surgery is necessary to restore mental and societal health, facilitating the patients' return to their normal life, i.e., cases where doctors perform breast reconstruction surgery due to cancer. Therefore, if doctors can use their knowledge in those situations, why should they not employ it to help people die when there are strong moral reasons that justify their requests?

Secondly, the main reason to defend our thesis is that physicians are the most appropriately qualified, possess the best knowledge of the patient, and have control of the medication employed in assisted-dying (Huxtable & Möller, 2007; Seay, 2001). Delegating the responsibility into less qualified professionals would most likely inflict harm or would unnecessarily put patients in a dangerous position. Good medical practice at the end of life requires that the dying person leaves in a state of maximum physical and mental comfort (Scarre, 2012), and the only professionals within society to guarantee that are healthcare practitioners. Moreover, due to the medicalization of death, whose main consequence has been a significant shift from people dying at home to people spending their last weeks or months in healthcare facilities, "*only healthcare professionals today develop sufficient experience and familiarity with death and dying*" (Emanuel & Emanuel, 1998). Furtherly, these practices should be restricted to physicians because of the inevitable involvement with safeguards, specific healthcare guidelines, the discharge of medical information that justify the procedure,… Societies that acknowledge and approve aid-in-dying medical procedures would require from their healthcare professionals to include help in dying as a good medical practice, for it honours the autonomous decisions of patients (Brock, 1992) and guarantees their right to healthcare within which euthanasia is offered as fundamental service.

Finally, as a way of summarising what has been so far discussed in this chapter, physicians' role could be understood under a different lens. Veatch (2000) proposes regarding physicians as patients' helpers, assistants, thus shifting the medical focus from doctors' duties to patients' rights. This perspective could help rebuild and strengthen the patient-doctor relationship, where dialogue becomes a secure place for mutual understanding, make possible that patients discover their best interest from a comprehension of their practitioners' knowledge. It can be seen as an educational process where patients learn how to proceed with specific illness, giving them an increase informed autonomy to reach their own conclusions and decide which is their preferable treatment or procedure. This proposal emerges from the recognition that patients are the only ones who know what benefit them holistically speaking, whereas doctors are only concern about the medical well-being. Moreover, doctors must accept that protecting patients' rights is more important than seeking their benefit; in other words, patients have the right to choose a treatment that is less likely to benefit them than other available alternatives. In the same way, the core duty of healthcare practitioners would be respect for the patient's autonomy, the recognition of their right to decline a beneficial treatment even when they could be mistaken. Consequently, two other duties become significantly relevant, their duty to tell the truth, that is, patients must be well informed and in an optimal position to decide what is best for them, and their duty to keep promises, that is, the information share between patients and physicians would remain confidential.

6.4. Conclusions

The present chapter provides arguments to defend the implementation of physician-aid in dying among the duties that healthcare practitioners must perform. Healthcare should be understood as a cluster of services to which the whole citizenship is entitled to. The suitability of the procedures offered as part of the healthcare agenda depends on the justification we can present to defend their aptness to be considered fundamental services. Our reasons should be grounded on the core bioethical and medical principles: respect for autonomy, avoidance of harm, beneficence, and justice. Within such theorical-practical framework, we have questioned the traditional medical rejection to end a patient's life due to doctors' ultimate duty not to kill. Our main argument against the traditional view of physicians' duties points to a paradigm shift where there are other obligations that doctors must fulfil, which emerge from the patient's right to have her autonomous decision respected and her suffering and/or pain ended.

At this point, we have clarified why and how end-of-life and palliative care are compatible with euthanasia or other help-in-dying medical procedures. For, the total alleviation of suffering it is not always possible, patients may have different suffering and pain thresholds, and end-of-life care must be also always present until the performance of euthanasia or physician-aid in dying. Later, the possibility conscientious objection refusals to perform euthanasia has been addressed, analysing the inconsistencies of those objections and the practical negative implications they might have. However, more cautiously, we have accepted some instances where it could be possible to assume them as a transitional stage towards a new understanding of physicians' duties and responsibilities. Finally, healthcare practitioners' suitability, and further obligation, to be the ones responsible to perform end-of-life practices has been defended. For they are the ones best qualified and have the necessary knowledge to perform hastening death procedures, and they are already familiar with death and dying in medical settings.

Healthcare practitioners must perform end-of-life practices as part of their job on a new understanding of them as professionals from which society requires specific services, grounded on people's rights to healthcare.

7. CONCLUSIONS

Despite the generalised initial reluctance to conceive death as having good features, defensible from a moral standpoint, it has been shown how certain circumstances might make it preferable to live. The focus has been put on situations where pain and suffering are extreme and unlikely to remit due to the terminal or chronic character of some illnesses. Furthermore, the way in which we die plays a key role in finding meaning in life, and how to end it, for many people. Thus, widening the liberties that people have to decide how and when to end their lives is morally preferable to making people die in a way they do not considered appropriate due to a lack of alternatives available.

The path to achieving that complete freedom rests on considering the different means to end a person's life as equally available. Opting for one or other of the medical assisted deaths available is only a matter of personal choice. Morality becomes important to explain and provide arguments to justify the preference of death on certain medical scenarios. Respect for the patient's autonomy, when deciding what she considers what is best for her and how she wants to proceed after being informed of her prognosis, is the key moral feature to assess the defensibility of hastening death. Hence, in situations where suffering is inevitable and will remain with the patient until the moment of death, granting the patient's wish to hasten their death is morally justifiable based on avoiding to further harming her and respecting her autonomous consent to have her life ended in whatever way she has chosen. Needless to say, reassurance regarding what the expression of the patients' wishes to die needs to be obtained prior to permitting the procedure to be performed. Notice that ending the live of another person is generally deemed as morally wrong on grounds of the person´s autonomy and avoidance of harm, which are precisely the same moral roots on which the defence of euthanasia lies.

The questioning of the existence of a moral duty to die emerges from within the above presented medical death scenario. Could there be situations where the patient, in deciding how to proceed with her end-of-life treatment, should consider the impact her decision would have on their lives? An affirmative response has already been argued for. There are situations where our staying a life for some extra time, when death is known to be the inescapable outcome of our illness, would have such a significant impact on the lives of people we love and care about that it is morally preferable to hasten it and avoid that unnecessary (financial, emotional, and/or physical) harm on them. Moreover, in countries where healthcare is funded with tax-payers money, we all belong to the same medical network, where our decisions will have an impact on the lives of others. Thus, the existence of a duty to end one´s life as a final act of care for those we love, or even to protect and improve the lives of others with whom we share societal goods, is defensible on moral grounds.

The effective integration of our initial metaphysical reflection concerning life, the advocacy for active euthanasia, and the moral defence of a duty to die occurs when considering the current medicalisation of death in western societies. Death has been moved to the sphere of medical knowledge and practical expertise, where healthcare professionals are highly qualified to retain some control regarding the timing and circumstances of a patient's dying. Thus, when a person has recognised her moral duty to die and decides to actively bring her life to an end, it would be justifiable to hasten her death by any of the assisted-dying procedures, including active euthanasia. The later might be, in certain scenarios the only morally defensible alternative to avoid the patient becoming a burden for her loved ones, which is the moral root of the duty to die.

It is indeed difficult to deal with our finitude, with the ineludible fact of our own death. However, we need to develop strategies and tools to be able to overcome that fear, because our moral responsibilities do not disappear at the end of our lives. I do believe that thinking about death, endeavouring to gain a better understanding of it from different (ethical, metaphysical, epistemological, political…) standpoints might lead us to live a meaningful life where death has a well-defined place and our fear to it can be overcome. After consideration, the impact that our death might have on the lives of others is clearly acknowledged. In certain cases, hastening our death might be the only path available to avoid, directly (in the case of family members) or indirectly (from a societal perspective), harming others. Accepting that can help us find meaning in dying, which can be now comprehended as a final act of love and care.

I recognise the difficulty to fully comprehend the existence of a duty to die in our liquid times (Bauman, 2000), where interpersonal loving and caring bonds are so fragile, volatile, and thought to be easily replaceable. It might be that we are unable to think of dying for others because throughout life we have been incapable of building sufficiently strong bonds with other persons. However, even in those circumstances where the payoff might be the possibility that the duty to die arises, it is worth working on building strong caring and loving bonds with others. For, what relevance and meaning could life have without them? We are not alone, isolated from other persons, we need and depend on them to live a fulfilling life. Even though it might hurt to experience the shattering of one of those relationships, it is impossible to live meaningfully if they are absent.

Surely many would think that the elderly lives are not deemed valuable for society and thus they should be kindly *invited* to acknowledge their duty to die. However, the existence of a duty to die should never imply that the elderly has their caring rights trumped by an insistent society that somehow compels them to die. The duty to die is an ethical obligation that must be recognised individually after long and careful reflection on our life and the kind of relationships we have built throughout our existence. As with other moral duties, e.g., the duty to keep promises, we can by no means force the person to comply with it. But, equally important, the duty does not disappear just because we have not identified it or because we are unable or unwilling to act in accordance with it.

What could be done then? I firmly believe in the importance to develop the necessary moral sensibility to appreciate when our personal duty to die arises, if it ever does, and try to fully comprehend why and how we are morally bound to it. This takes us inevitably to the beginning of our dissertation, when discussing the fear to death. The recognition of a moral duty to die that emerges from our love to others, from the recognition that other persons in society have the same right to a decent minimum of healthcare, might help us overcome that fear by giving meaning to our last life choice.

The attempt to provide an overarching argument across different philosophical disciplines made it impossible to dwell into the topics that necessarily had to be explained only to the extent that they were needed for the main argument. Being that the main limitation of the current thesis, it must be also added that the implications of the possible legalisation of active euthanasia have not been discussed; for, its legal ramifications significantly vary from one country to another. Similarly, when discussing in the concluding chapter healthcare professionals´ duties when performing assisted-dying procedures, we have not delved into all the scenarios where their right to conscientious objection could be appealed to. It was enough, for the purpose of the main argument, to state that there are circumstances under which conscientious objection is not morally defensible because it would violate patients' autonomy and their right to choose how to end their life.

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REFERENCES

Ackerman, F. (2000). For now have I my death: The ‘duty to die’ versus the duty to help the Ill stay alive. *Midwest Studies in Philosophy*, *24*(1), 172–185. https://doi.org/10.1111/1475-4975.00028

Arras, J. D. (2007). The way we reason now: Reflective Equilibrium in bioethics. In B. Steinbock (Ed.), *The Oxford Handbook of Bioethics* (pp. 46–71). Oxford University Press.

Barnes, E. (2014). Valuing Disability, Causing Disability. *Ethics*, *125*(1), 88–113. https://doi.org/10.1086/677021

Battin, Margaret P., van der Heide, A., Ganzini, L., van der Wal, G. & Onwuteaka-Philipsen, B. D. (2007). Legal physician-assisted dying in Oregon and the Netherlands: Evidence concerning the impact on patients in ‘vulnerable’ groups. *Journal of Medical Ethics*, *33*(10), 591–597. https://doi.org/10.1136/jme.2007.022335

Battin, Margaret Pabst. (1994). *The least worst death*. Oxford University Press.

Battin, Margaret Pabst. (1998). Ethical issues in physician-assisted suicide. In M. Uhlmann (Ed.), *Last rights?: Assisted suicide and euthanasia debated*. Grand Rapids, Mich. : Eerdmans.

Battin, Margaret Pabst. (2005). *Ending Life: Ethics and the Way We Die*. Oxford University Press.

Bauman, Z. (2000). *Liquid modernity*. Polity Press.

Beauchamp, T. L. & Childress, J. F. (2009). *Principles of biomedical ethics* (7th ed.). Oxford University Press.

Beauchamp, T. L. & Davidson, A. I. (1979). The Definition of Euthanasia. *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*, *4*(3), 294–312. https://doi.org/10.1093/jmp/4.3.294

Benatar, D. (2013). Suicide: a qualified defense. In J. S. Taylor (Ed.), *The metaphysics and ethics of death : new essays* (pp. 222–244). Oxford University Press.

Bennett, J. (1966). Whatever the consequences. *Analysis*, *26*(3), 83–102.

Bennett, M. (2000). Do we have a duty to die? In J. M. Humber & R. F. Almeder (Eds.), *Is there a duty to die?* (p. 221). Humana Press.

Brandt, R. B. (1964). The concepts of obligation and duty. *Mind*, *73*(291), 374–393. https://doi.org/10.1093/mind/lxxiii.291.374

Brock, D. W. (1992). Voluntary Active Euthanasia. *The Hastings Center Report*, *22*(2), 10–22.

Brock, D. W. (1996). Borderline cases of morally justified taking life in medicine. In T. L. Beauchamp (Ed.), *Intending death: the ethics of assisted suicide and euthanasia*. Upper Saddle River, N.J. : Prentice-Hall.

Brody. (1996). Withdrawal of treatment vs killing of patients. In T. L. Beauchamp (Ed.), *Intending death: the ethics of assisted suicide and euthanasia*. Upper Saddle River, N.J. : Prentice-Hall.

Brueckner, A. L. & Fischer, J. M. (1986). Why is death bad? *Philosophical Studies: An International Journal for Philosophy in the Analytic Tradition*, *50*(2), 213–221. http://www.jstor.org/stable/4319856

Buchanan, A. (1984). The right to a decent minimum of health care. *Philosophy & Public Affairs*, *13*(1), 55–78.

Buchanan, A. (1996). Intending death. In T. L. Beauchamp (Ed.), *Intending death: the ethics of assisted suicide and euthanasia*. Upper Saddle River, N.J. : Prentice-Hall.

Callahan, D. (1993). *The troubled dream of life: living with mortality*. Simon & Schuster.

Callahan, D. (2000). Our burden upon others: a response to J. Hardwig. In J. Hardwig (Ed.), *Is there a duty to die?* Routledge.

Campbell, N. (1999). A problem for the idea of voluntary euthanasia. *Journal of Medical Ethics*, *25*(3), 242–244. https://doi.org/10.1136/jme.25.3.242

Carel, H. (2007). Can I be ill and happy? *Philosophia*, *35*(2), 95–110. https://doi.org/10.1007/s11406-007-9085-5

Carel, H. (2011). Phenomenology and its application in medicine. *Theoretical Medicine and Bioethics*, *32*(1), 33–46. https://doi.org/10.1007/s11017-010-9161-x

Chambaere, K. & Bernheim, J. L. (2015). Does legal physician-assisted dying impede development of palliative care? The Belgian and Benelux experience. *Journal of Medical Ethics*, *41*(8). https://doi.org/10.1136/medethics-2014-102116

Chochinov, H. M., Tataryn, D., Dudgeon, D. & Clinch, J. J. (1999). Will to live in the terminally ill. *Lancet*, *354*(9181), 816–819. https://doi.org/https://doi.org/10.1016/S0140-6736(99)80011-7

Cholbi, M. (2010). The duty to die and the burdensomeness of living. *Bioethics*, *24*(8), 412–420. https://doi.org/10.1111/j.1467-8519.2008.00723.x

Chudasama, Y. V, Gillies, C. L., Zaccardi, F., Coles, B., Davies, M. J., Seidu, S. & Khunti, K. (2020). Impact of COVID-19 on routine care for chronic diseases: A global survey of views from healthcare professionals. *Diabetes & Metabolic Syndrome: Clinical Research & Reviews*, *14*(5), 965–967. https://doi.org/https://doi.org/10.1016/j.dsx.2020.06.042

Churchill, L. R. (2000). Seeking a responsible death. In J. Hardwig (Ed.), *Is there a duty to die?* Routledge.

Cohn, F. & Lynn, J. (2000). A duty to care. In J. Hardwig (Ed.), *Is there a duty to die?* Routledge.

Corlett, J. A. (2000). Analyzing the moral duty to die. In J. M. Humber & R. F. Almeder (Eds.), *Is there a duty to die?* (p. 221). Humana Press.

Dancy, J. (1983). Ethical particularism and morally relevant properties. *Mind*, *92*(368), 530–547.

Daniels, N. (2008). Just health: meeting health needs fairly. In *Bulletin of the World Health Organization* (Vol. 86, Issue 8). Cambridge University Press.

Deliens, L. & Smets, T. (2015). Euthanasia (requests) after the implementation of the euthanasia law in Belgium in 2002. Results of empirical studies in Flanders, Belgium. In C. Rehmann-Sutter, H. Gudat & K. Ohnsorge (Eds.), *The Patient's Wish to Die* (pp. 47–60). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780198713982.003.0005

den Hartogh, G. (2018). Relieving one's relatives from the burdens of care. *Medicine, Health Care and Philosophy*, *21*(3), 403–410. https://doi.org/10.1007/s11019-017-9815-9

Doná, D., Torres Canizales, J., Benetti, E., Cananzi, M., De Corti, F., Calore, E., Hierro, L., Ramos Boluda, E., Melgosa Hijosa, M., Garcia Guereta, L., Pérez Martínez, A., Barrios, M., Costa

Reis, P., Teixeira, A., Lopes, M. F., Kaliciński, P., Branchereau, S., Boyer, O., Debray, D., … Jara, P. (2020). Pediatric transplantation in Europe during the COVID-19 pandemic: Early impact on activity and healthcare. *Clinical Transplantation*, *34*(10). https://doi.org/10.1111/ctr.14063

Drebushenko, D. (2000). How could there be a duty to die. In J. M. Humber & R. F. Almeder (Eds.), *Is there a duty to die?* (p. 221). Humana Press.

Dworkin, R. (1998). Do we have a right to die? In M. Uhlmann (Ed.), *Last rights?: Assisted suicide and euthanasia debated*. Grand Rapids, Mich. : Eerdmans.

Ehman, R. E. (2000). The duty to die: a contractarian approach. In J. M. Humber & R. F. Almeder (Eds.), *Is there a duty to die?* (p. 221). Humana Press.

Emanuel, E. J. & Emanuel, L. L. (1998). The promise of a good death. *Lancet*, *351*(SUPPL.2). https://doi.org/10.1016/S0140-6736(98)90329-4

Emanuel, E. J., Onwuteaka-Philipsen, B. D., Urwin, J. W. & Cohen, J. (2016). Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe. *JAMA*, *316*(1), 79–90. https://doi.org/10.1001/jama.2016.8499

Epicurus. (1993). Letter to Menoeceus. In E. M. O'Connor (Ed.), *The essential Epicurus: letters, principal doctrines, Vatican sayings, and fragments*. Prometheus Books.

Farrell, T. W., Francis, L., Brown, T., Ferrante, L. E., Widera, E., Rhodes, R., Rosen, T., Hwang, U., Witt, L. J., Thothala, N., Liu, S. W., Vitale, C. A., Braun, U. K., Stephens, C. & Saliba, D. (2020). Rationing Limited Healthcare Resources in the COVID-19 Era and Beyond: Ethical Considerations Regarding Older Adults. *Journal of the American Geriatrics Society*, *68*(6), 1143–1149. https://doi.org/10.1111/jgs.16539

Feinberg, J. (1966). Duties, rights and claims. *American Philosophical Quarterly*, *3*(2), 137–144.

Feinberg, J. (1993). Harm to others. In John Martin Fischer (Ed.), *The metaphysics of death*. Stanford University Press.

Feldman, F. (1993). Some puzzles about the evil of death. In John Martin Fischer (Ed.), *The metaphysics of death*. Stanford University Press.

Foot, P. (1977). Euthanasia. *Philosophy & Public Affairs*, *6*(2), 85–112.

Garcia, J. L. A. (2007). Health versus harm: Euthanasia and physicians' duties. *Journal of Medicine and Philosophy*, *32*(1), 7–24. https://doi.org/10.1080/03605310601152966

Garrard, E. & Wilkinson, S. (2005). Passive euthanasia. *Journal of Medical Ethics*, *31*, 64–68.

Gill, M. B. (2009). Is the legalization of physician-assisted suicide compatible with good end-of-life care? *Journal of Applied Philosophy*, *26*(1), 27–45. https://doi.org/10.1111/j.1468-5930.2009.00407.x

Gillon, R. (2003). Ethics needs principles--four can encompass the rest--and respect for autonomy should be 'first among equals'. *Journal of Medical Ethics*, *29*(5), 307–312. https://doi.org/10.1136/jme.29.5.307

Giubilini, A. (2014). The paradox of conscientious objection and the anemic concept of 'conscience': Downplaying the role of moral integrity in health care. *Kennedy Institute of Ethics Journal*, *24*(2), 159–185. https://doi.org/10.1353/ken.2014.0011

Goldman, A. H. (2018). Meaning in life. In *Life's values. Pleasure, happiness, well-being, and meaning*. Oxford University Press.

Hardcastle, V. G. & Stewart, R. W. (2002). Supporting irrational suicide. *Bioethics*, *16*(5), 425–438. https://doi.org/10.1111/1467-8519.00300

Hardwig, J. (1990). What about the family? *Hastings Center Report*, *20*(2), 5–10. http://www.ncbi.nlm.nih.gov/pubmed/2318632

Hardwig, J. (1997a). Dying at the right time: Reflections on (un)assisted suicide. In H. LaFollete (Ed.), *Ethics in practice: An anthology* (3rd Ed.). Oxford University Press.

Hardwig, J. (1997b). Is there a duty to die? *The Hastings Center Report*, *27*(2), 34–42.

Hardwig, J. (2000). *Is there a duty to die?* Routledge.

Hardwig, J. (2006). Medicalization and death. *APA Newsletters on Philosophy and Medicine*, *6*(1), 2–9.

Hardwig, J. (2009). Going to Meet Death: the Art of Dying in the Early Part of the Twenty-First Century. *Hastings Center Report*, *39*(4), 37–45. https://doi.org/10.1353/hcr.0.0151

Hardwig, J. (2013). Is there a duty to die in Europe? If not now, when? In Y. Denier, C.

Gastmans & A. Vandevelde (Eds.), *Justice, Luck & Responsibility in Health Care: Philosophical Background and Ethical Implications for End-of-Life Care* (pp. 109–126). Springer Netherlands. https://doi.org/10.1007/978-94-007-5335-8_7

Harry S. Silverstein. (1993). The evil of death. In John Martin Fischer (Ed.), *The metaphysics of death*. Stanford University Press.

Holmes, R. L. (1990). The limited relevance of analytical ethics to the problems of bioethics. *Journal of Medicine and Philosophy*, *15*(2), 143–159. https://doi.org/10.1093/jmp/15.2.143

Hooker, B. (2006). Rule-Utilitarianism and euthanasia. In H. LaFollete (Ed.), *Ethics in practice: An anthology* (3rd Ed.). Blackwell.

Hooker, Brad. (2000). Moral particularism: wrong and bad. In Brad Hooker & M. O. Little (Eds.), *Moral particularism* (pp. 1–22). Oxford Brookes University.

Humphrey, D. (1998). The case for rational suicide. In M. Uhlmann (Ed.), *Last rights?: Assisted suicide and euthanasia debated*. Grand Rapids, Mich. : Eerdmans.

Huxtable, R. & Möller, M. (2007). 'Setting a principled boundary'? Euthanasia as a response to 'life fatigue'. *Bioethics*, *21*(3), 117–126. https://doi.org/10.1111/j.1467-8519.2007.00535.x

Jaziri, R. & Alnahdi, S. (2020). Choosing which COVID-19 patient to save? The ethical triage and rationing dilemma. *Ethics, Medicine and Public Health*, *15*. https://doi.org/10.1016/j.jemep.2020.100570

Jeffrie G. Murphy. (1993). Rationality and the fear of death. In John Martin Fischer (Ed.), *The metaphysics of death*. Stanford University Press.

John Martin Fischer. (2009). *Our Stories: essays on life, death, and free will* (John Martin Fischer (ed.)). Oxford University Press.

Jonsen, A. R. (1996). Criteria that makes intentional killing unjustified. In T. L. Beauchamp (Ed.), *Intending death: the ethics of assisted suicide and euthanasia*. Upper Saddle River, N.J. : Prentice-Hall.

Kass, L. R. (1989). Neither for love nor money: Why doctors must not kill. *Public Interest*, *94*, 25–46.

Kuschner, W. G., Pollard, J. B. & Ezeji-Okoye, S. C. (2007). Ethical triage and scarce resource allocation during public health emergencies: tenets and procedures. *Hospital Topics*, *85*(3), 16–25. https://doi.org/10.3200/HTPS.85.3.16-25

Lamm, R. D. (1997). Death: right or duty? *Cambridge Quarterly of Healthcare Ethics*, *6*, 111–112.

Lillehammer, H. (2011). The epistemology of ethical intuitions. *Philosophy*, *86*(2), 175–200. https://doi.org/10.1017/S0031819111000027

Lucretius Carus, T. & Stallings, A. E. (2007). Book III Mortality and the soul. In *The nature of things* (pp. 72–105). Penguin Books.

Luper-Foy, S. (1993). Annihilation. In John Martin Fischer (Ed.), *The metaphysics of death*. Stanford University Press.

Materstvedt, L. J. (2015). Caring and killing in the clinic: the argument of self-determination. In C. Rehmann-Sutter, H. Gudat & K. Ohnsorge (Eds.), *The Patient's Wish to Die* (pp. 125–138). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780198713982.003.0012

McMahan, J. (1993a). Death and the value of life. In John Martin Fischer (Ed.), *The metaphysics of death*. Stanford University Press.

McMahan, J. (1993b). Killing, letting die, and withdrawing aid. *Ethics*, *103*, 250–279.

McMahan, J. (2013). Moral intuition. In H. Lafollette & I. Persson (Eds.), *The Blackwell guide to ethica theory* (2nd ed.). Blackwell Publishing Ltd.

Menzel, P. T. (2000). The nature, scope, and implications of a personal duty to die. In J. M. Humber & R. F. Almeder (Eds.), *Is there a duty to die?* (p. 221). Humana Press.

Minerva, F. (2015). Conscientious objection in Italy. *Journal of Medical Ethics*, *41*(2), 170–173. https://doi.org/10.1136/medethics-2013-101656

Nagel, T. (1986). The view from nowhere. In *Tanner lectures*. Oxford University Press.

Narveson, J. (2000). Is there a duty to die? In J. M. Humber & R. F. Almeder (Eds.), *Is there a duty to die?* (p. 221). Humana Press.

Nichols, P. (2012). Wide reflective equilibrium as a method of justification in bioethics.

Theoretical Medicine and Bioethics, *33*(5), 325–341. https://doi.org/10.1007/s11017-012-9223-3

Nissim, R., Lo, C. & Rodin, G. (2015). The desire for hastened death in patients in palliative care. In C. Rehmann-Sutter, H. Gudat & K. Ohnsorge (Eds.), *The Patient's Wish to Die* (pp. 71–80). Oxford University Press.

Nussbaum, M. C. (1994). Mortal inmortals: Lucretius on Death and the voice of Nature. In *The therapy of desire*. Princeton University Press.

Ohnsorge, K. (2015). Intentions, motivations, and social interactions. In C. Rehmann-Sutter, H. Gudat & K. Ohnsorge (Eds.), *The Patient's Wish to Die*. Oxford University Press.

Ohnsorge, K., Keller, H. R. G., Widdershoven, G. A. M. & Rehmann-Sutter, C. (2012). 'Ambivalence' at the end of life: How to understand patients' wishes ethically. *Nursing Ethics*, *19*(5), 629–641. https://doi.org/10.1177/0969733011436206

Olshansky, S. J. & Ault, A. B. (1986). The fourth stage of the epidemiologic transition: the Age of Delayed Degenerative Diseases. *The Milbank Quarterly*, *64*(3), 355–391.

Orentlicher, D. (1998). The alleged distinction between euthanasia and the withdrawal of life-sustaining treatment: conceptually incoherent and impossible to maitain. *University of Illinois Law Review*, *1*.

P. Yourgran. (1993). The dead. In John Martin Fischer (Ed.), *The metaphysics of death*. Stanford University Press.

Parfit, D. (1993). Reasons and persons. In John Martin Fischer (Ed.), *The metaphysics of death*. Stanford University Press.

Parker, M. (2005). End games: euthanasia under interminable scrutiny. *Bioethics*, *19*(5–6), 523–536.

Pellegrino, E. D. (2001). Physician-assisted suicide and euthanasia: rebuttals of rebuttals - The moral prohibition remains. *The Journal of Medicine and Philosophy*, *26*(1), 93–100. https://doi.org/10.1076/jmep.26.1.93.3034

Pessoa-Amorim, G., Camm, C. F., Gajendragadkar, P., De Maria, G. L., Arsac, C., Laroche, C., Zamorano, J. L., Weidinger, F., Achenbach, S., Maggioni, A. P., Gale, C. P., Poppas, A. & Casadei, B. (2020). Admission of patients with STEMI since the outbreak of the COVID-

19 pandemic: a survey by the European Society of Cardiology. *European Heart Journal - Quality of Care and Clinical Outcomes*, *6*(3), 210–216. https://doi.org/10.1093/ehjqcco/qcaa046

Pitcher, G. (1993). The misfortunes of the dead. In John Martin Fischer (Ed.), *The metaphysics of death*. Stanford University Press.

Pivodic, L., Van Den Block, L., Pardon, K., Miccinesi, G., Alonso, T. V., Boffin, N., Donker, G. A., Cancian, M., López-Maside, A., Onwuteaka-Philipsen, B. D., Deliens, L., Zeger, D. G., Sarah, B., Augusto, C., Joachim, C., Anneke, F., Richard, H., Higginson Irene, J., Stein, K., … Sheila, P. (2013). Burden on family carers and care-related financial strain at the end of life: A cross-national population-based study. *European Journal of Public Health*, *24*(5), 819–826. https://doi.org/10.1093/eurpub/cku026

Rachels, J. (1979). Euthanasia, killing, and letting die. In J. Ladd (Ed.), *Ethical issues relating to life and death*. Oxford University Press.

Rachels, J. (1986). *The end of life*. Oxford University Press.

Rawls, J. (1975). The independence of moral theory. *Proceedings and Addresses of the American Philosophical Association*, *48*, 5 / 22. https://doi.org/10.5840/apapa2013245

Rehmann-Sutter, C. (2019). Self-perceived burden to others as a moral emotion in wishes to die. A conceptual analysis. *Bioethics*, *33*(4), 439–447. https://doi.org/10.1111/bioe.12603

Rietjens, J. A. C., van der Maas, P. J., Onwuteaka-Philipsen, B. D., van Delden, J. J. M. & van der Heide, A. (2009). Two decades of research on euthanasia from the Netherlands. What have we learnt and what questions remain? *Journal of Bioethical Inquiry*, *6*(3), 271–283. https://doi.org/10.1007/s11673-009-9172-3

Rosenbaum, S. E. (1993a). Epicurus and annihilation. In John Martin Fischer (Ed.), *The metaphysics of death*. Stanford University Press.

Rosenbaum, S. E. (1993b). How to be dead and not care: a defense of Epicurus. In John Martin Fischer (Ed.), *The metaphysics of death*. Stanford University Press.

Savulescu, J. (2006). Conscientious objection in medicine. *British Medical Journal*, *332*, 294–297. https://doi.org/10.1111/1467-8519.00191

Scarre, G. (2012). Can there be a good death? *Journal of Evaluation in Clinical Practice*. https://doi.org/10.1111/j.1365-2753.2012.01922.x

Schenck, D. P. & Roscoe, L. A. (2009). In search of a good death. *Journal of Medical Humanities*, *30*, 61–72. https://doi.org/10.1007/s10912-008-9071-3

Schroepfer, T. (2015). The journey to understanding the wish to hasten death. In C. Rehmann-Sutter, H. Gudat & K. Ohnsorge (Eds.), *The Patient's Wish to Die* (pp. 61–70). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780198713982.003.0006

Schuklenk, U. (2015). Conscientious Objection in Medicine: Private Ideological Convictions must not Supercede Public Service Obligations. *Bioethics*, *29*(5). https://doi.org/10.1111/bioe.12167

Seay, G. (2001). Do physicians have an inviolable duty not to kill? *Journal of Medicine and Philosophy*, *26*(1), 75–91.

Seay, G. (2002). Can there be a 'duty to die' without a normative theory? *Cambridge Quarterly of Healthcare Ethics*, *11*, 266–272.

Seay, G. (2005). Euthanasia and physicians' moral duties. *Journal of Medicine and Philosophy*, *30*(5), 517–533. https://doi.org/10.1080/03605310500253071

Seay, G. (2011). Euthanasia and common sense: A reply to Garcia. *Journal of Medicine and Philosophy*, *36*(3), 321–327. https://doi.org/10.1093/jmp/jhr016

Seneca, L. A. (2010). Letter 70 (Book VIII). In E. Fantham (Ed.), *Selected letters* (pp. 109–114). Oxford University Press.

Singer, P. A., Martin, D. K. & Kelner, M. (1999). Quality End-of-Life Care. *Journal of the American Medical Association*, *281*(2), 163–168.

Sleeboom-Faulkner, M. (2006). Chinese concepts of euthanasia and health care. *Bioethics*, *20*(4), 203–212. https://doi.org/10.1111/j.1467-8519.2006.00495.x

Specelly, R. (2000). Dying for others: family, altruism, and a duty to die. In J. M. Humber & R. F. Almeder (Eds.), *Is there a duty to die?* (p. 221). Humana Press.

Steinhauser, K. E., Christakis, N. A., Clipp, E. C., McNeilly, M., McIntyre, L. & Tulsky, J. A. (2000). Factors considered important at the end of life by patients, family, physicians, and other care providers. *Journal of the American Medical Association*, *284*(19), 2476–2482. https://doi.org/10.1001/jama.284.19.2476

Steinhauser, K. E., Clipp, E. C., McNeilly, M., Christakis, N. A., McIntyre, L. M. & Tulsky, J. A. (2000). In search of a good death: Observations of patients, families, and providers. *Annals of Internal Medicine*, *132*(10), 825–832. https://doi.org/10.7326/0003-4819-132-10-200005160-00011

Steven Doughty. (2016). *Sex abuse victim in her 20s allowed to choose euthanasia in Holland*. Daily Mail Online. https://www.dailymail.co.uk/news/article-3583783/Sex-abuse-victim-20s-allowed-choose-euthanasia-Holland-doctors-decided-post-traumatic-stress-conditions-uncurable.html

Strong, C. (2010). Theoretical and practical problems with wide reflective equilibrium in bioethics. *Theoretical Medicine and Bioethics*, *31*(2), 123–140. https://doi.org/10.1007/s11017-010-9140-2

Thomas Nagel. (1979). *Mortal questions*. Cambridge University Press.

Tong, R. (2000). Duty to die. In J. M. Humber & R. F. Almeder (Eds.), *Is there a duty to die?* (p. 221). Humana Press.

Varelius, J. (2006). Voluntary euthanasia, physician-assisted suicide, and the goals of medicine. *Journal of Medicine and Philosophy*, *31*(2), 121–137. https://doi.org/10.1080/03605310600588665

Varelius, J. (2014). Medical expertise, existential suffering and ending life. *Journal of Medical Ethics*, *40*(2), 104–107. https://doi.org/10.1136/medethics-2012-100812

Varelius, J. (2016). On the Moral Acceptability of Physician-Assisted Dying for Non-Autonomous Psychiatric Patients. *Bioethics*, *30*(4), 227–233. https://doi.org/10.1111/bioe.12182

Veatch, R. M. (2000). Doctor Does Not Know Best: Why in the New Century Physicians Must Stop Trying to Benefit Patients. *The Journal of Medicine and Philosophy*, *25*(6), 701–721. https://doi.org/10.1076/jmep.25.6.701.6126

Velleman, J. D. (1993). Well-being and time. In John Martin Fischer (Ed.), *The metaphysics of death*. Stanford University Press.

Verkerk, M. A. (2015). Towards responsive knowing in matters of life and death. In C. Rehmann-Sutter, H. Gudat & Kathrin Ohnsorge (Eds.), *The Patient's Wish to Die* (pp. 139–148). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780198713982.003.0013

Vink, T. (2016). Self-euthanasia, the Dutch experience: In search for the meaning of a good death or eu thanatos. *Bioethics*. https://doi.org/10.1111/bioe.12279

Warner, M. A. (2020). Stop Doing Needless Things! Saving Healthcare Resources During COVID-19 and Beyond. *Journal of General Internal Medicine*, *35*(7), 2186–2188. https://doi.org/10.1007/s11606-020-05863-6

Widdershoven, G., Stolper, M. & Molewijk, B. (2015). Dealing with dilemmas around patients' wishes to die: moral case deliberation in a Dutch hospice. In C. Rehmann-Sutter, H. Gudat & Kathrin Ohnsorge (Eds.), *The Patient's Wish to Die* (pp. 149–160). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780198713982.003.0014

Williams, B. (1993). The Makropulus case: reflections on the tedium of immortality. In John Martin Fischer (Ed.), *The metaphysics of death*. Stanford University Press.

Winter, L. & Parks, S. M. (2012). The reluctance to burden others as a value in end-of-life decision making: A source of inaccuracy in substituted judgment. *Journal of Health Psychology*, *17*(2), 179–188. https://doi.org/10.1177/1359105311414956

Wolf, S. (1997). Happiness and Meaning: Two Aspects of the Good Life. *Social Philosophy and Policy*, *14*(01), 207. https://doi.org/10.1017/S0265052500001734

Wolf, S. (2007). Meaning in Life and Why It Matters. *The Tanner Lectures on Human Values*, *May*, 71–116. https://doi.org/10.1007/s10790-011-9300-2

Wreen, M. (1988). The Definition of Euthanasia. *Philosophy and Phenomenological Recearch*, *48*(4), 637–653.

Wu, P. E., Styra, R. & Gold, W. L. (2020). Mitigating the psychological effects of COVID-19 on health care workers. *Cmaj*, *192*(17), E459–E460. https://doi.org/10.1503/cmaj.200519

Young, R. (2015). Voluntary Euthanasia. In *The Stanford Encyclopedia of Philosophy (Spring 2015 Edition)* (Fall 2016, pp. 1–13). Edward N. Zalta (ed.).

APPENDIX

Emanuel, E. J., & Emanuel, L. L. (1998). The promise of a good death. *Lancet, 351*(SUPPL.2). https://doi.org/10.1016/S0140-6736(98)90329-4

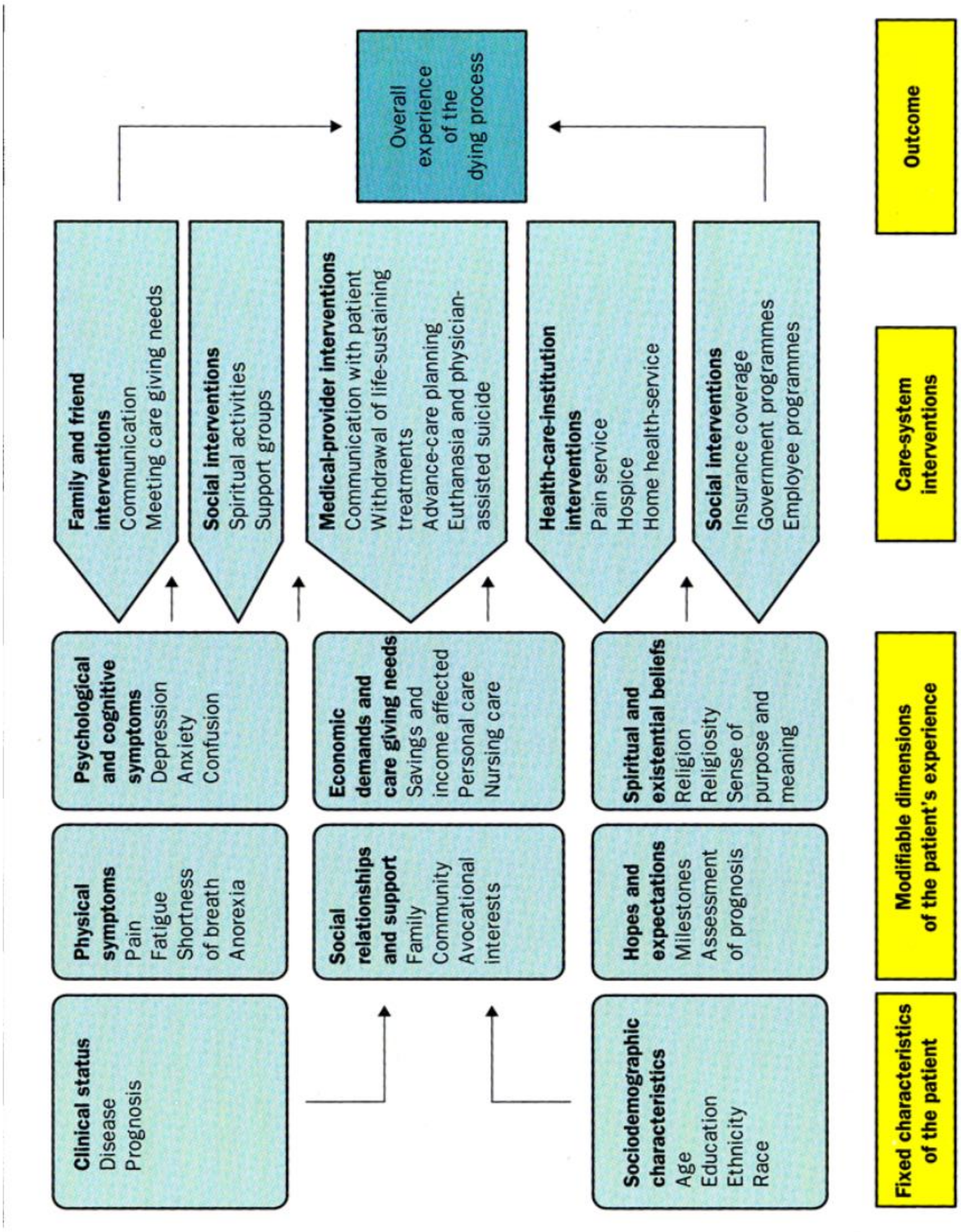

Figure: **Framework for a good death**