UTRECHT UNIVERSITY

A Lifelong Prisoner's Choice of Death

Ethical Issues Involved in Considering Dutch Prisoners Serving Life Sentences for Physician Assisted Death

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Abstract

Prisoners serving life sentences who wish to lodge a request for physician assisted death face a range of responses from the general public, politicians, medical professionals, criminologists, lawyers, and many others. In this thesis I focus on the ethical issues involved in considering these requests, creating a broad context that shows the interconnectedness of the many considerations involved, and where and why they collide.

The two main topics I discuss are the autonomy required of prisoners to request physician assisted death, and the possibility of meeting the requirements of the Dutch euthanasia law with regards to suffering, within the context of the prison. In this thesis I discuss the area of tension created when ethical issues are joined by issues from other relevant disciplines, in the process of finding out whether physician assisted death should belong to the choices of prisoners serving life sentences.

Keywords

Autonomy, Competence, Dignity, Physician Assisted Death, Prison, Life Sentence, Suffering

Introduction

The media coverage of the euthanasia request by Belgian prisoner Frank van den Bleeken peaked late 2014 and early 2015, so much so, that it was hard to miss. This prisoner's request was first refused, then granted, and following a storm of worldwide commotion it was again refused at the very last moment. The main topic of discussion: Should the option of assisted suicide or euthanasia belong to the choices of prisoners? A great variety of arguments have been made by a great variety of people. Ethical arguments concerning a 'right to die,' legal issues concerning the goal of punishments, political arguments concerning the responsibility of the state; the diversity of responses was and still is great. Not simply joining in but instead hitting pause and thoroughly considering the repercussions of this debate for the situation in the Netherlands is what I aim to do in this thesis. My focus will be on prisoners serving life sentences. Contrary to popular belief, and contrary to the situation in the other EU countries, to this day lifelong actually means lifelong in the Netherlands and this sentence is therefore prone to (inter)national scrutiny.[1]

Even outside of the prison walls assisted suicide and euthanasia are considered to be controversial topics, requiring careful consideration of a wide range of conditions. In the Netherlands we agree that free individuals are at least legally allowed to take their own lives at any moment, for whatever reason they may have. It may upset many people, cause moral concerns and cause grieve for those left behind, but it is not strictly prohibited. We agree: if no assistance is required in performing this act, it poses no problem. However, this option is not available to those who cannot perform this act without the help of another, for instance because of a physical disability or other conditions. Attempts to assist others in ending their lives are regulated by a law, which imposes several conditions that need to be fulfilled in order for such assistance not to be illegal. The *Wet Toetsing Levenseinde* provides requirements that must be met in order for assistance to die to be justified and the assisting party not to be liable to prosecution.[2] Its contents are considered to be open norms, the meaning of which are to be worked out in practice over time. Varying from the paradigmatic cases of for instance patients suffering from terminal cancer, to the marginal cases of for instance patients suffering from mental illness, a scale of cases is created that serves as a background for encounters with new situations.

The discussion about providing assistance to die in cases of long-term prison sentences or TBS has not yet been settled (or perhaps it has not even really begun) in the Netherlands. The fact that suicide rates among prisoners serving life sentences are high, along with the observation that utterances of death wishes are frequent, creates a stringency to formulate an opinion and possibly even create a policy concerning this issue.[3] I argue that this topic should

[1] Tjalling van der Goot, "Column Van der Goot: Levenslang…..en nog vele jaren!," November 24, 2014, accessed May 10, 2016, http://www.ankerenanker.nl/nieuws/archief/529_column-van-der-goot-levenslang-en-nog-vele-jaren.
[2] The Dutch Termination of Life on Request and Assisted Suicide Act, which came into force in 2002.
[3] Hilbert Meijer and Aaldert van Soest, "Doodsverlangen achter de tralies," *Nederlands Dagblad,* January 10, 2015.

be addressed sooner rather than later: after the widespread attention for Van Den Bleeken's case it could only be a matter of time before the first euthanasia request of a long-term prisoner or TBS patient in the Netherlands is filed. Just like we are confronted with the debate through all possible channels of media, so too will this information reach prisoners serving long-term sentences in the Netherlands.

Some readers might wonder why exactly this is so important. Since only a relatively small number of prisoners are serving life sentences, why does this subject matter? My answer is twofold. First, and foremost, it matters because we need to take these prisoners seriously, as human beings. We must not take their request to end their lives lightly and must consider in what context these requests arose. Second, it matters because of the open character of the *Wet Toetsing Levenseinde*. On the one hand, its openness causes it to grow and change with legal, medical, ethical and other related developments. On the other hand, its openness demands an individual approach backed only by a sliding scale of related cases. What happens if a hitherto unknown situation presents itself – some possible situation that has not yet been exhaustively researched and is yet to be placed on the 'casuistry scale'? It is such a new encounter I recognize in cases of 'lifers' requesting physician assisted death. A diversity of ethical considerations joins and collides, creating an extremely interesting area of tension. What would be a morally appropriate response to these requests? This dilemma is significant because it demonstrates the flexibility of a casuistry-based law and makes us as a society wonder and discuss whether this is always desirable.

This thesis discusses the ethical issues that surface when considering requests to physician assisted death by prisoners serving life sentences. It is a philosophical thesis, but is written for anyone interested in any one of the areas it covers. Arguably some topics up for discussion could be better handled by people more experienced in these fields. Physicians, for example, will have more knowledge and experience with regards to assessment and the actual decision to provide assistance. Lawyers and judges will undoubtedly know more about the legal framework that makes these decisions possible. Criminologists are better equipped to discuss the goals of punishment and the reasons for sentencing. And sociologists and psychologists will be far more knowledgeable about suicides and people's inner workings of leading up to it. On the one hand no one person is 'qualified' to discuss all of these issues as an expert – but on the other hand it seems like a missed opportunity to merely discuss them separately. Something valuable can be found in considering these issues within context of the others and I believe philosophy can take up this challenge. These issues are not isolated, they are interconnected and it is this relatedness that is important in understanding where conflict arises. The starting point for this discussion is the public debate and the diversity of opinions it contains. By considering the opinions that followed Van Den Bleeken's case I hope to identify where exactly there is friction, and why.

Chapter 1: The Debate and Ethical Concepts

1.1 The Belgian Case and the Dutch WTL

Frank van den Bleeken is a Belgian murderer and serial rapist who has been serving time for over thirty years. Having been declared insane (because of his alleged inability to control his impulses) and not criminally responsible he was initially sent to a prison psychiatric ward, from which he was released after seven years. Shortly after that he attacked three more victims and was ordered to be detained indefinitely. He claims to suffer hopelessly and unbearably, all the while having no prospect of cure nor appropriate care. His first request for euthanasia was denied. After years of procedural conflict and repeated contact with physicians and psychologists, it was groundbreaking news when his request was finally granted. Van Den Bleeken claimed rather to die than spend the rest of his life in jail and it seemed like he would get his wish, until his physician backed out of the procedure at the last moment, without disclosing why.

The Dutch initially responded with shock and were dismissive of discussing this case, the most obvious reason for which being that this case was deemed not 'equally probable' in The Netherlands and therefore simply not relevant. Doubts about Van Den Bleeken's mental competence as well as doubts about the standard of care in Belgian prisons make it difficult to imagine such a case occurring in The Netherlands. However, I do not find this a convincing reason not to consider and discuss its very possibility; a possibility that moves beyond case-specific details. This possibility is relevant for The Netherlands, because the execution of life sentences is in itself often deemed problematic and because our law on euthanasia is arguably even more liberal than that in Belgium.[4] To illustrate this relevance, I will now sketch an abstract and hypothetical case of a prisoner requesting physician assisted death (henceforth: PAD) that will form a recurring theme throughout this thesis. Details of this case will be further specified and tweaked in the relevant chapters, in order to discover when and why certain decisions regarding this request seem justified.

> **The case of Eric:** *Eric, aged 55, has been found guilty of murdering his wife and children, amongst several other terrible crimes, and has been sentenced to life in prison. He has been serving time for 25 years now – having been convicted when he was 30. At that time, he was not diagnosed with any mental problems and was deemed criminally responsible for his actions. Now, at age 55, Eric requests Physician Assisted Death.*

Many arguments in the debate that followed the Belgian case are also relevant for, or even directly applicable to, the hypothetical case of Eric. Before turning to an overview of this

[4] On this sentence: Wim Anker, "Wim Anker: wetsvoorstel levenslang, een gemiste kans," June 3, 2016, accessed on June 4, 2016, http://www.ankerenanker.nl/nieuws/2763_wim-anker-wetsvoorstel-levenslang-een-gemiste-kans; on the Dutch law: Theo Boer, in: Amber Dujardin, "Zonder behandeling liever dood," *Trouw,* January 28, 2014, accessed May 23, 2016, http://www.trouw.nl/tr/nl/5009/Archief/article/detail/3584948/2014/01/28/Zonder-behandeling-liever-dood.dhtml.

debate, it is important to at least succinctly sketch an image of the regulations regarding euthanasia in the Netherlands, because this serves as necessary background knowledge in considering the quality of the arguments made.

In 2002 the act that decriminalized euthanasia and physician assisted suicide under certain circumstances came into force. This act, the *Wet Toetsing Levenseinde* (henceforth: WTL), allowed a practice that beforehand was not strictly legal, but tolerated in some cases. The requirements of due care a physician must meet to be exempted from criminal liability, as mentioned in the WTL, are as follows:

a. The physician is convinced that there has been a voluntary and well-considered request by the patient;
b. The physician is convinced that the patient is suffering unbearably without the prospect of recovery;
c. The physician has informed the patient about his situation and outlook;
d. The physician is convinced, as is the patient, that there is no other reasonable solution to the situation in which the latter finds himself;
e. The patient has been seen by at least one other independent physician, who has given his opinion, in writing, regarding the due care requirements listed in a-d above;
f. The termination of life on request has been carried out with due care from the medical perspective.[5]

These requirements contain many 'open norms' – such as 'unbearably,' 'voluntary,' and 'reasonable' – meaning: norms that derive their meaning from continuous interpretation and application in different cases. As such, these requirements allow for the creation of a scale, from paradigm to marginal, on which cases can be placed according to their resemblance to past cases and interpretations. If these six requirements are demonstrably met a physician is not liable to persecution should he or she decide to provide assistance. After the act is completed the Regional Euthanasia Review Committee (*Regionale Toetsingscommissie*) will assess whether or not the physician indeed acted with due care and whether the case can be closed or instead should be handed over to the Public Prosecution Service. This system's aim is transparency – making every step and consideration during the process testable, all the while maintaining the possibility for a physician to help a patient. Meeting these requirements does not, however, entail a physician's duty to assist: his or her autonomy is respected and a request can be refused. Subsequently, a patient cannot make a claim to death.

It is often argued that it is impossible for prisoners serving life sentences to meet the due care requirements of the WTL. Either categorically, for the sole reason of their status as a prisoner, or, because there are some requirements cannot be met by anyone in this situation. I label the first as a matter of autonomy and the second one as one of conditions. These two topics, as can also be found in the debate, will form the main structure of this thesis.

[5] Johan Legemaate and Ineke Bolt, "The Dutch Euthanasia Act: Recent Legal Developments," *European Journal of Health Law* 20 (2013), 453.

1.2 The Debate

In public discussions the opinions on PAD for prisoners vary greatly. I will provide a succinct overview of this debate, drawing from different media such as blog posts, newspaper articles, interviews and other sources from all over the world. Although not every quote concerns the same case, what matters here are the underlying ethical concepts they implicitly refer to, which are most relevant to the subject of this thesis. I will point out these concepts and address them in more detail throughout this thesis.

A great deal of responses to the question of PAD in prison concerns the following: "People sentenced to life in prison should not be allowed to escape their punishment."[6] In more detail it is argued that "prison is not supposed to be enjoyable, and that it is inappropriate to allow prisoners an escape from their deserved suffering via euthanasia."[7] The fear that a prisoner might be better off dead is unacceptable to many, especially with regards to the relatives of the victims. An often posed question in this debate is: Should a murderer be allowed to die a humane death himself?[8] Many agree that because victims were mistreated, treating prisoners serving life sentences in a way that is inhumane is no important issue. These opinions can be filed under the 'no' camp. They regard death as an escape from a punishment before one's debt is paid to society. For these reasons, prisoners should a priori not be considered for PAD. In these opinions, I recognize the concepts of *revenge*, and (a denial of) *autonomy* of the prisoner.

In the 'yes' camp, I find arguments such as the following: "This man has already been punished for his crimes, which were terrible. […] If requesting euthanasia is a right, then of course it also extends to him." [9] And: "So it looks to me like the state is not only prepared to incarcerate people forever in certain circumstances, but to try and maximise the suffering of those individuals and I don't think we should have any part of that, at least in these situations, offer these poor people the option of a peaceful death."[10] These opinions regard death as a legitimate choice for a human being, not as an escape, but rather as a justified option in life. I recognize the acknowledgement of the human being behind the crimes committed and the rights that belong to him. The notion of *empathy* is present, as well as the question of the appropriate limit to (imposed) *suffering*. Contrastingly, responses to such arguments are as follows: "I don't feel for these 'poor people.' They are criminals who have sinned against

[6] "Mensen veroordeeld met een levenslange gevangenisstraf moeten het recht krijgen op euthanasia," accessed May 22, 2016, http://www.argumenten.nl/stelling/10718/Mensen-veroordeeld-met-een-levenslange-gevangenisstraf-moeten-het-recht-krijgen-op-euthanasie.html. My translation.
[7] Rebecca Roache, in "Should a Belgian murderer be allowed euthanasia?" *BBC Magazine,* January 7, 2015, accessed March 11, 2016, http://www.bbc.com/news/magazine-30708585.
[8] Servaas van der Laan, "Mag een moordenaar zelf op 'menswaardige wijze' sterven?" *Elsevier,* September 18, 2014, accessed May 22, 2016, http://www.elsevier.nl/nederland/article/2014/09/mag-een-moordenaar-zelf-op-menswaardige-wijze-sterven-1602734W/. My translation.
[9] Theo Boer, Ibid.
[10] Philip Nitschke, in: Stephen Gibbs, "Killers serving life should be able to choose 'peaceful' death in prison instead of suffering ongoing 'torture' in jail, claims euthanasia campaigner Philip Nitschke," *Daily Mail*, September 29, 2014, accessed March 11, 2015, http://www.dailymail.co.uk/news/article-2773244/Killers-serving-life-sentences-granted-peaceful-death-prison-choose-instead-suffering-ongoing-torture-jail-claims-euthanasia-campaigner-Philip-Nitschke.html.

society, for God's sake."[11] And: "Of course, some might think 'good riddance.'"[12] It is very difficult to see these criminals as human beings and not merely as monsters having committed terrible crimes.

There is a substantial camp of 'maybe' as well. For example: "Requesting euthanasia because of psychological suffering of a detainee is a fundamentally strange phenomenon. After all, 'suffering' is part of the prison sentence. A euthanasia patient must be able to prove that he is in a hopeless situation. A lifelong prison sentence is indeed not very hopeful. But whether this is sufficient for requesting euthanasia?"[13] Again, the appropriate limit to suffering is considered, but now concerning the conditions of the WTL. Can a prisoner meet these conditions, or not? And why? The concepts of *equal care*, *suffering* and *autonomy* are present here.

A final element I want to highlight here is the fear that seems to underlie the entire debate: the fear of setting a precedent. It is possible that the retraction of the decision to euthanize Van Den Bleeken is in part due to worldwide scrutiny as well as the fear of creating an example for other similar cases. In Belgium alone, immediately after Van Den Bleeken's request was first granted, fifteen other prisoners lodged requests; whereby the influence of the social debate and the media was inevitable. In the international debate, people tend to go a step further and argue that: "Allowing a prisoner, who is not terminally ill, to die by euthanasia has a whiff of the death penalty."[14] Fear of a *'slippery slope'* right down to re-introducing the death penalty appears to be one of the most prominent concerns in this debate: "European countries have abolished capital punishment but those that have or are considering right-to-die legislation may now face the possibility of seeing it reintroduced by the back door, ironically at the behest of the criminals themselves."[15] Setting a precedent that this is a justified option for those facing life in prison is worrisome to many. Another slippery slope argument is aimed at the extension of this 'right' to groups that should not be included: "So slippery is the slope, it seems, that euthanasia has become a right to be extended to all human beings."[16] If even prisoners can meet the requirements, where can the line be drawn? Again, the concept of a *right* is mentioned, as well as the fear of including vulnerable groups in these rights.

Closer consideration of the implicit ethical concepts will hopefully lead to a deeper understanding of individual cases. Particularly in cases at the margins, where cases of prisoners serving life sentences would arguably be placed, the conceptual justification carries

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[11] Peter Rolfe, Ibid.
[12] Kevin Yuill, September 24, 2014, "Belgium's insane right-to-die laws," *Spiked*, May 22, 2016, http://www.spiked-online.com/newsite/article/belgiums-insane-right-to-die-laws/15899#.V0nZq5OLSuV.
[13] Servaas van der Laan, "Mag een moordenaar zelf op 'menswaardige wijze' sterven?"
[14] Rebecca Roache, in "Should a Belgian murderer be allowed euthanasia?"
[15] Steve Mertl, January 11, 2015, "Should inmates fed up with prison be allowed the right to die?" *Yahoo News Daily Brew,* May 22, 2016, https://ca.news.yahoo.com/blogs/dailybrew/should-inmates-fed-up-with-prison-be-allowed-the-right-to-die-211232124.html.
[16] Kevin Yuill, "Belgium's insane right-to-die laws."

much weight. I will now elaborate on several key concepts identified in the debate that form the basis for the arguments in the chapters to come.

1.3 Autonomy

As announced above, I will discuss reasons for refusing to consider PAD for prisoners relating to autonomy in chapters 2 and 3, and relating to the conditions of the WTL in chapters 4 and 5. First, however, I will sketch a general account of the concept of 'autonomy,' which is a central and fundamental concept throughout this thesis, and some related notions such as competency and dignity.

Philosophers have offered a wide range of theories on the correct interpretation and application of the concept of autonomy. The concept of autonomy is broad and complex, but also very central in ethics and therefore subject of ongoing normative discussion. Within this discussion, some general directions in interpretation can be distinguished. Some philosophers argue in favor of regarding autonomy as concerning the individual.[17] Others, instead, regard it as something that takes shape through relationships with other persons.[18] Some philosophers claim that autonomy involves internal conditions whereas others argue that external conditions are most relevant.[19] Autonomy can furthermore be thought of in terms of having positive freedom, or instead be approached in negative terms.

However, instead of setting out to find one coherent 'core' of this concept, it is often thought to be a more fruitful endeavor to study the different meanings of autonomy within different contexts. Some note that different conceptions of autonomy fit different disciplines and for instance distinct political autonomy from legal, ethical, and social autonomy.[20] I will not do so here, but instead I focus on the concept itself and the different senses in which it is used. I will do so within the context of individual or personal autonomy, broadly involving the capacity to be one's own person and to live according to motives and reasons that are one's own.[21] I will distinct four senses of the concept of autonomy when applied to individuals, as introduced by Joel Feinberg. Next, I discuss the two senses of this concept that are in my opinion most relevant in the context of this thesis.

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[17] For an example of an account of individual autonomy, see: Joel Feinberg, *Harm to Self* (New York: Oxford University Press, 1986).
[18] For an example of relational autonomy, see: Catriona Mackenzie, "Three Dimensions of Autonomy: A Relational Analysis," in *Autonomy, Oppression, and Gender*, eds. Andrea Veltman and Mark Piper (New York: Oxford University Press, 2014).
[19] For an example of external influence on autonomy, see: Joseph Raz, *The Morality of Freedom* (New York: Oxford University Press, 1988).
[20] For an example of such a distinction, see: Rainer Forst, "Political Liberty: Integrating Five Conceptions of Autonomy," in *Autonomy and Challenges to Liberalism: New Essays*, eds.
John Christman and Joel Anderson (New York: Cambridge University Press, 2005).
[21] John Christman, "Autonomy in Moral and Political Philosophy," in *The Stanford Encyclopedia of Philosophy* (Spring 2015 Edition), ed. Edward N. Zalta, accessed February 5, 2016, http://plato.stanford.edu/archives/spr2015/entries/autonomy-moral.

Feinberg expresses doubt with regards to the existence of one 'core' meaning of autonomy. Instead, he recognizes four closely related meanings of the concept: autonomy as a capacity, as the actual condition of self-government, as a personal ideal, and as a set of rights expressive of one's sovereignty over oneself.[22] The first sense, autonomy as a capacity to govern oneself, is a matter of degree and is determined by the ability to make rational choices. Autonomy is understood as a minimal capacity to act independently and authoritatively. In a legal sense, this is a capacity with a threshold relevant to the task or situation at hand, above or under which specific amounts of competence are irrelevant. In a philosophical sense, the capacity is a continuum and a matter of degree; not an inherent skill but one that can be developed throughout life.

The second sense of autonomy, as the actual condition of self-government, is only present when an individual is actually able to exercise his rights or capacities. External factors beyond the control of an individual can constrain or deprive him of opportunities, however, under normal circumstances, there are ways to make the most of exercising autonomy. Autonomy as a personal ideal, the third sense, is explained as the ideal complex of character traits. This ideal complex must be consistent with the idea that human being are not merely individuals but also part of ongoing communities, resulting in reciprocal bonds: "The ideal of the autonomous person is that of an authentic individual whose self-determination is as complete as is consistent with the requirements that he is, of course, a member of a community."[23] Lastly, autonomy is used in the sense of a set of rights expressive of one's sovereignty over oneself. In other words, this is the right to make and act upon one's own choices, without interference by others; terms often used to describe negative freedom. Sometimes interference is justified, when for instance a person's choices are not deemed 'free' because of either internal or external forces. However, this sense of right is a protection of exercising one's capacity for autonomy and thus in a way enables it.

1.4 Autonomy-Competence and Autonomy-Dignity

According to John Christman, underlying most theories of individual or personal autonomy, even that of Joel Feinberg, is a basic idea of ability or capacity to self-government.[24] In my opinion, this can also broadly be described in terms of self-determination; which I take to mean a person's ability to act, reflect, and choose on the basis of factors that are somehow authentic or one's own. Being autonomous is sometimes understood as a functioning as a limit, or barrier, to paternalism.[25] The Stanford Encyclopedia of Philosophy reads: "Lacking

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[22] Joel Feinberg, *Harm to Self* (New York: Oxford University Press, 1986), 28.
[23] Ibid., 47.
[24] John Christman, *The Inner Citadel: Essays on Individual Autonomy* (New York: Oxford University Press, 1989), 5.
[25] Paternalism, the Stanford Encyclopedia of Philosophy reads, is: "the interference of a state or an individual with another person, against their will, and defended or motivated by a claim that the person interfered with will be better off or protected from harm." Gerald Dworkin, "Paternalism," in *The Stanford Encyclopedia of Philosophy* (Summer 2016 Edition), ed. Edward N. Zalta, accessed December 12, 2015, http://plato.stanford.edu/archives/sum2016/entries/paternalism/.

autonomy, as young children do, is a condition which allows or invites sympathy, care, paternalism and possibly pity."[26] Where exactly the line should be drawn that marks the balance between the two is unclear. This is also very evident in the debate on PAD for prisoners, as the following quote (regarding the Belgian prisoner) illustrates: "Rather than respecting his autonomy, allowing him to die would represent a form of abandonment."[27] This quote highlights the importance of the concept of autonomy in this debate. In this context, I recognize not four but two senses in which this concept is used: one regarding the decision that was made, and one regarding the respect for this person and the subsequent not-wanting to abandon or mistreat him.

I thus distinct autonomy as a descriptive term to describe a competence for self-determination from a more fundamental idea of the right (not) to be treated in a certain way. I will label the first 'autonomy-competence,' or 'autonomy-C' for short. The second, more fundamental idea, is a right against actions that disrupt or undermine autonomy in the first sense. But exactly how this form of autonomy is to be described is difficult. Here, I choose to label it 'autonomy-dignity' – or 'autonomy-D' for short. I have chosen to involve the concept of human dignity (henceforth: dignity), instead of the mere use of a 'right' such as is the case in Feinberg's theory. Dignity, in the sense of the unconditional status of a human being, adds an important element of the respect he is owed to this discussion, an element that will recur throughout this thesis. Whereas dignity in this general unconditional sense cannot be violated, autonomy-D can: if one acts toward another while underestimating or ignoring their autonomy-C. I recognize two kinds of violation of autonomy-D: either by acting toward another while unreasonably (under)estimating their autonomy-C, or, one can acknowledge the other's capacity but not let them exercise it. Autonomy-C, then, can be limited, but not violated.

What the exact relation between autonomy and dignity is, is as hard to define as defining them separately. Given the limited extent of this section, I will not attempt to discuss dignity in further detail. Nonetheless, the relation between the two concepts is addressed more and more often, as Joel Anderson describes: "Autonomy is arguably the central concept of a distinctively modern understanding of the dignity of the person."[28] It can be argued that acknowledging personal sovereignty is necessary for dignity, for dignity begins with choice: not forcing someone to do something against his or her will.[29] Along these lines, what it means to respect someone, is to be guided by this person's dignity – to acknowledge that this person has sovereignty, and can value and pursue things in his life. This acknowledgment can in turn serve as a basis for equality, and equal treatment. Hence, I argue in favor of an autonomy-based justification for treating persons as equals.

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[26] Christman, "Autonomy in Moral and Political Philosophy."
[27] Daniel Sokol, in "Should a Belgian murderer be allowed euthanasia?" *BBC Magazine,* January 7, 2015, accessed March 11, 2016, http://www.bbc.com/news/magazine-30708585.
[28] Joel Anderson, "Autonomy," in *The International Encyclopedia of Ethics* (Oxford: Blackwell Publishing Limited, published online 2013), 1.
[29] Feinberg, *Harm to Self*, 354.

Over the following four chapters, I aim to show that some of our intuitions regarding the possibility of PAD requests by prisoners collide with general ethical considerations. In the title of each of the following four chapters I state an objection against considering prisoners for PAD. These objections will, throughout these respective chapters, be discussed and refuted. Chapters 2 and 3 concern the possibility for prisoners serving life sentences to lodge a request, and reasons for taking these request seriously. I focus on autonomy, the ability to make decisions regarding one's own life and the request for assistance in acting on these decisions. Chapters 4 and 5 are dedicated to a more specific consideration of the possibility to meet the WTL's requirements of suffering within the prison context. In these chapters I discuss what 'imposed suffering,' prison conditions and penal goals can mean for a PAD request.

Chapter 2: Regarding the Objection That Prisoners Cannot Be Sufficiently Autonomous to Request PAD

In chapter 1 I discussed autonomy as a concept in general. In this chapter, I will examine what role this concept fulfills specifically within the prison context. Autonomy underlies the very possibility for patient decision-making, and whether or not a patient is deemed autonomous greatly influences the weight that can be attached to their decisions. To respect a patient's decision requires an assessment of his or her competencies to make an adequate decision, or, as I will call it, whether a patient has a legitimate scope of final authority regarding decisions. When considering autonomy-C it appears that certain individuals can be somehow restricted in these faculties. Whether these restrictions are internal, as is the case with mental disabilities, or external, as in cases of oppression, it seems possible that the autonomous abilities of some individuals are, or, can become constrained. Arguably, the prison context can have such a constraining effect on the abilities of prisoners. Because of the restrictions on a prisoner's liberty it can be argued that he cannot make autonomous (or voluntary) decisions; there is an insufficient number of options available to him to allow for an autonomous decision-making process, and the possibility of oppression or coercion is always present.[30] Hence, it can be argued that certain choices are beyond the reach of prisoners; for example, the choice of death.

According to Joel Feinberg, certain categories of death requests must be a priori rejected because it is doubtful whether they were voluntary. In his opinion, we do not know exactly how to determine which individual cases in these categories were actually voluntary and, because the consequence is irrevocable death, it is better to avoid the risk and reject these categories altogether.[31] He continues to argue the following with regards to prisoners serving long or life sentences:

> "One such category of death requests are those made by prisoners in jails and penitentiaries. […] Can we be certain that a formal death request from such a person must have been coerced, ill-informed, or the product of impairment or distraction? Surely not; but prisons are highly coercive institutions, seething with barely contained violence, and founded on mutual distrust. Penal authorities always have an incentive to get rid of trouble-makers if they can. The suspicion of manipulation or intimidation would always be present, no matter how authentic the request might seem, and furthermore, once euthanasia of prisoners were approved in principle, the incentive for foul play would be all the greater. It is quite understandable why self-destruction in prisons should be prohibited absolutely."[32]

In this chapter I aim to refute this objection. As I will argue, autonomy is indeed restricted upon imprisonment and there can be many additional factors in prison that can influence the

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[30] In favor of brevity I have decided to address both the 'prisoner' and the 'physician' as males. I want to emphasize, however, that these could just as well be females.
[31] Feinberg, *Harm to Self*, 351.
[32] Ibid., 351-352; Towards the end of this chapter it will become clear that Feinberg does not include every kind of prisoner in this argument.

decision-making process. This does not entail, however, that a prisoner cannot be autonomous altogether or that we must a priori deny every single request – this is a denial on practical grounds and disrespectful of an individual's autonomy-D. As I will argue, a prisoner can certainly be considered autonomous in many ways, and it is, therefore, possible for some prisoners to choose competently in existential matters.

2.1 Threats to Autonomy and Conflicts of Interests

Feinberg's above-mentioned passage amounts to the claim that imprisonment condemns prisoners to losing their autonomous agency, in the sense of autonomy that licenses choices that others must respect. With regards to threats to autonomy I distinct three relevant options to consider. First, one's right to self-determination can be threatened. This right depends on having a threshold level of capacity, which can be undermined by certain threatening circumstances. This amounts to threats to autonomy-C. Second, one's richer set of capacities can be threatened, capacities that link to the ability to lead an autonomous life. Third, and last, are threats to the fundamental claim to dignity; being taken seriously, even when one lacks a threshold capacity for decision-making. The latter amounts to threats to autonomy-D. In this section I will prove the importance of threats of threats to autonomy-C, and the fact that a lack of opportunities does not necessarily undermine autonomy-C. Even if one is less able to lead an autonomous life, autonomous decision-making can still be possible. However, crucially, one's autonomy-D must not be undermined.

In determining whether a patient has a legitimate scope of final authority regarding decisions, and in the subsequent determining of whether these decisions are to be respected, it is important to assess whether they were made voluntarily. Particularly for choices with great consequences, such as the ending of a life, it seems crucial that a great degree of voluntariness is present. Thinking again of Feinberg's passage, it is important that there is no doubt of oppression or coercion in these choices. Compare the PAD request of a prisoner to the following hypothetical situation:

> **The case of Anna:** *A forty-six-year-old woman suffering from kidney failure desperately needs a kidney transplant. She has been on a waiting list for quite some time, but no kidney has yet become available to her. All the while her situation is worsening. She has been married for twenty-five years, and her husband now decides he wants to donate her one of his kidneys. He would be a suitable candidate, however, their physician believes that a conflict of interests is very common in cases of spouses volunteering as living donors. The physician therefore considers turning down the husband's offer.*

Can people freely give consent when considering whether to donate to a spouse? It is not difficult to imagine there being little 'felt' choice; either you save your spouse's life, or not. Anna's husband might be desperate to save her life, or perhaps he feels there is a moral obligation to do so, or he might feel pressured by her family. It would be easiest for a physician to deny these requests categorically and forego this problem. But, then, an option is

denied to those spouses that really *want* to donate and *are* capable of making this decision voluntarily. The question underlying this case is: When does a very high burden of proof turn into a systematic denial of autonomy-D? Allowing spouses to be living donors might involve much effort in assessment and consent processes, but the alternative of not-allowing spouses this option is unacceptable. There is a fine line between underestimating the self-determining abilities of persons, and refuting the fact that they can meet the threshold for decision-making.

2.2 Limited Options

As mentioned above, it can be argued that there needs to be an adequate range of *options* available to choose from, in order to speak of true voluntariness or an autonomous life. This, in turn, is related to there being sufficient freedom to deliberate and act upon certain choices. John Christman proposes the following: "To be free (in a given context) means there is an absence of restraints (positive or negative, internal or external) standing between a person and the carrying out of that person's autonomous desires."[33] Just as the required degree of voluntariness can be approached as relative to a context, so too can this be said of 'being free.' The following question now arises: Does the necessarily limited freedom of a prisoner influence his ability to make voluntary choices and in this sense be deemed sufficiently autonomous to request PAD?

Joseph Raz argues that the internal characteristics of an individual alone are not sufficient for leading an autonomous life. In his opinion, another requirement for autonomy is that the social conditions of this individual provide him with a variety of options for leading his life. Consider Raz's example of the Man in the Pit:

> "A person falls down a pit and remains there for the rest of his life, unable to climb out or to summon help. There is just enough ready food to keep him alive without (after he gets used to it) any suffering. He can do nothing much, not even move much. His choices are confined to whether to eat now or a little later, whether to sleep now or a little later, whether to scratch his left ear or not."[34]

According to Raz, the Man in the Pit is less able to lead an autonomous life, because he has to make choices without an 'adequate range of options' from which to choose. Adequacy in this sense refers to options "with long term pervasive consequences as well as short term options of little consequence, and a fair spread in between."[35] The Man in the Pit cannot choose to develop lasting relationships with anyone, nor can he choose to wash his hair. In other words, not having an adequate range of options to choose from with regards to all aspects of one's life amounts to not being able to be the author of one's own life.[36]

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[33] John Christman, *The Inner Citadel: Essays on Individual Autonomy* (New York: Oxford University Press, 1989), 13.
[34] Joseph Raz, *The Morality of Freedom* (New York: Oxford University Press, 1988), 373-374.
[35] Ibid., 374.
[36] Ibid.

Comparing this situation to being sentenced to life in prison it could be argued that a prisoner who is serving such a sentence does not have an adequate range of options either. A prisoner certainly has more options than the Man in the Pit and can exercise some control over certain elements his life, but he is also forced and controlled by others to live a certain way. However, both the Man in the Pit and the prisoner can have a threshold level of capacity, and therefore have a right to self-determination. The limited options from which to choose do not influence the ability to make a voluntary decision; even in the Pit, it is still the Man's voluntary choice to eat, sleep, or scratch his ear. This life may be less autonomous, in a global sense, but this takes nothing away from the ability to make autonomous and voluntary decisions in individual instances, in a more local sense.

In many relevant aspects a prisoner retains options. I think it is important to regard this status-quo as a prisoner's new reality, his new life, a reality that in the case of a life-long sentence is permanent. Within this reality new, fitting, goals and motives can be adopted (to a certain extent – which will be discussed in terms of prospects in chapters 4 and 5) and often a way can be found to act on them. Yes, this is restricted, but it is necessarily so – this is what a prison sentence entails. This does not mean that every prisoner completely 'loses' his autonomous ability to make decisions. The issue of autonomy-undermining influences, such as oppression, coercion, and other conditions, is much more important for these cases; to that extent Feinberg is right. However, in my view, the underlying question should be: what features should a case present to create a willingness to evaluate this request on an individual basis, instead of a priori casting it aside on the basis of its category?

2.3 Self-Determination

As I argued at the beginning of this chapter, respecting a patient's decision requires determining whether a patient has a legitimate scope of final authority regarding decisions. Up until this point, I have addressed the issues of conflicting interests and limited options available to patients. I will now return to the legitimate scope of final authority in making the actual decision, which is a matter of having a threshold level of capacity. Being sufficiently autonomous to request assistance to die differs from being deemed autonomous to place a bet in a casino. I, therefore, believe that autonomy-C can be satisfied to different degrees and the required degree is dependent upon context. The legitimate scope of the necessary authority is then also dependent upon the specifics of this particular person, and case. As an individual develops, so can autonomy develop and expand. It follows that autonomy can also diminish; autonomy is flexible and can change with for instance changes in the societal and institutional contexts in which an individual is situated.

As argued above, upon imprisonment certain possibilities are limited, causing autonomy to be constrained. In such cases, I argue it is justified to speak of a required 'persistent' respect for autonomy. The constraint takes place at the level of autonomy-C: certain capacities can no longer be exercised. Referring to the distinction in senses of autonomy Feinberg made: possessing a moral right to self-determination does not mean that it can always be exercised.

In turn, the capacity for autonomy can be present even if some form of *legal* authority, due to imprisonment, is not. It is possible that there are legal limitations on the exercise of autonomy in prison, but they are not relevant in the moral sense.

Though a limitation may be placed on a prisoner's physical freedom, preventing him from freely undertaking certain activities, perhaps it is possible to speak of a certain 'mental freedom,' a state or status that cannot a priori be denied. A prisoner can write out his thoughts, he can form opinions on current news, he can decide what to think about; in many aspects this prisoner is autonomous. His reflective capacities are not per definition diminished upon imprisonment. It might even be possible to adapt to his new situation, to 're-write life,' and perhaps even to further develop certain capacities. Perhaps it is true, as some people claim, that prisoners must simply learn to live with their circumstances. In my opinion, however, the reflective abilities needed to learn to live with something, are the same kind of abilities needed to make a justified and voluntary choice to die.

Up until this point, I have tried to emphasize the importance of acknowledging the abilities of the individual, even a prisoner, as it is very likely that this person would, in fact, qualify for PAD. An a priori denial of the entire category, in my opinion, cannot be justified. A prisoner's autonomy is in some external ways *constrained* because of institutional conditions. This is relevantly different however from being for instance congenitally and severely mentally disabled, whereby autonomy or autonomous capacity is severely *limited*.[37] The external influences that affect the prisoner can entail certain restrictions on his or her autonomy, but this does not mean that his or her autonomy is fundamentally limited. The abilities to make autonomous decisions exist even if autonomy itself is in some way restricted. In my view, even if a person is legally incapacitated for some reason, this does not necessarily have consequences for the ability to make an autonomous decision – and the subsequent respect that this decision demands.[38] In the following section, I discuss an example of a case which illustrates that there is in fact general agreement to respect some prisoner's decisions and exercises of autonomy: namely in the case of hunger strikes.

2.4 Hunger Strikes and Autonomy

Of the three threats to autonomy I mentioned under section 2.1 I so far have not yet discussed the third: threats to the fundamental claim to dignity. Being taken seriously, even when one lacks a threshold capacity for decision-making, is necessary in respecting a human being. Whereas I have argued in chapter 1 that dignity, the unconditional value of human beings, cannot be violated, autonomy-D can. This happens when a person's autonomy-C is underestimated or ignored. In what follows, I discuss an example of a practice in which the above-discussed notions are applied in practice. This example illustrates the crucial role of

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[37] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics,* 7th Edition (New York: Oxford University Press, 2013), 102.
[38] Ibid., 102.

the concept of autonomy, and specifically the threat of undermining autonomy by not taking someone seriously, in the prison context.

I will argue that upon imprisonment autonomy should be no more restricted than is inherent to this deprivation of physical freedom, or liberty. This means that certain freedoms are necessarily restricted, such as the realization of certain life goals that require liberty, but that autonomy must be respected in existential decisions. Handtke and Bretschneider hold a similar view: "While a prisoner's autonomy may be reduced in certain areas, such as the choice of physician or the frequency of family visits, it does not impact existential choices of the person."[39] Marina Oshana makes a similar argument and writes that: "the incarcerated rational adult […] retains a capacity for autonomy; his talents for deliberation, self-appraisal, and planning are intact as is his attunement to the environment in which he operates. The prisoner is incapacitated in some ways but is not disabled in the relevant aspects. As a result, the prisoner enjoys the promise of autonomy."[40] A prisoner does not lack the rudimentary ability to be self-governing; this capacity is present – unlike in cases of, for instance, very small children or insane persons. In turn, this capacity 'empowers' a person to do certain things.

The respect the autonomy of prisoners demands is very evident in cases of hunger strikes. A hunger strike can lead to a situation in which feeding can be necessary in order to protect the life of a prisoner or prevent lasting harm to a prisoner's health. Especially in cases where the prisoner will most likely die if a physician does not intervene there is a conflict between the right to self-determination of the hunger striker and the duty of care of a physician.[41]

The World Medical Association's (WMA) Declaration of Malta states that one of the main reasons for not intervening when a prisoner has decided to go on a hunger strike is respect for autonomy. This respect demands a sometimes difficult assessment of the hunger striker's wishes whereby for instance involuntariness, threats or coercion must be ruled out.[42] It is unjustifiable to force feed a prisoner if he or she has informedly and voluntarily refused this option – even if this refusal results in death. The WMA Declaration of Kyoto states that: "Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially."[43] A physician thus needs to assess whether the patient, the prisoner, is capable of making this decision to justify a possible intervention. If the prisoner has drawn a do not resuscitate instruction in advance, in the event

[39] Violet Handtke and Wiebke Bretschneider "Will I stay or can I go? Assisted suicide in prison," *Journal of Public Health Policy* 36 (2015), 3.
[40] Marina Oshana, *Personal Autonomy in Society* (Abingdon: Routledge, 2006) p. 8.
[41] This duty of care will be discussed in further detail in chapter 3.
[42] "WMA Declaration of Malta on Hunger Strikers," accessed February 5, 2016, http://www.wma.net/en/30publications/10policies/h31/.
[43] "WMA condemns all forced feeding," accessed February 5, 2016, http://www.wma.net/en/40news/20archives/2006/2006_10/.

that he reaches a state of cognitive impairment, the respect for individual autonomy must still restrain a physician from intervening.[44]

The very assumption of a possibility of unimpaired and rational judgment by a prisoner is key: it demands respect and cannot justify an intervention that goes against his will. The standpoint of the Royal Dutch Medical Association (*Koninklijke Nederlandse Maatschappij tot bevordering der Geneeskunde*) on the subject of hunger strikers mirrors the principles of the WMA and calls the right to self-determination and the autonomy of the physician pivotal points in this discussion.[45] Whether or not a physician is convinced of the autonomous abilities of the patient determines whether or not his or her wishes are granted – however, the possibility for forced treatment is as unjustified inside as it is outside the prison. The right to self-determination of a prisoner underscores the possibility for autonomous decision-making within the prison context. Even though hunger striking does not have death as a primary goal but rather a change in life, this example can demonstrate an equivalent use of the relevant medical-ethical principles both in- and outside of prison. This importance of a patient's autonomy is just as relevant in prison and should, in my opinion, be respected – not merely in cases of hunger strike, but in PAD requests as well.

Contrary to Feinberg's claim at the beginning of this chapter I argue that there can certainly be PAD requests by individual prisoners that require deliberation, possibly even leading to granting these requests. Interestingly, Feinberg does agree elsewhere in his book that death requests by doomed prisoners waiting in Death Row could be voluntary enough to be valid.[46] Why can a prisoner who is undoubtedly going to die be considered for help to do so, when a prisoner certain of a life in prison cannot? There are cases imaginable in which granting such a request would univocally be deemed a disgrace, but, there are also cases in which the request is problematic and where this is actually a good thing. Those involved are then forced to make an extensive consideration and look at the specific case in-depth, taking into account the individual experience of prison and the vulnerable position of a prisoner. Being constrained in leading an autonomous life does not necessarily mean there is no possibility for autonomous decision-making, and underestimating or ignoring this ability violates autonomy in the sense of dignity. Categorically denying every prisoner the choice of death amounts to this latter violation.

I want to end this chapter with a question, deriving from the example of hunger strikers in prison: Why is it that prisoners who are physically able to starve themselves to death, arguably acting from a political motive, are allowed to do so, while others who may lack the means to kill themselves in this way are denied their requests for assistance? In the next chapter I will focus on equal treatment of prisoners, in relation to disabilities.

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[44] "WMA Declaration of Malta on Hunger Strikers," accessed February 5, 2016, http://www.wma.net/en/30publications/10policies/h31/.

[45] "Dwangvoeding aan hongerstakende gedetineerden," last modified 2002, accessed February 5, 2016, http://www.knmg.nl/Publicaties/KNMGpublicatie/62830/Dwangvoeding-aan-hongerstakende-gedetineerden-2002.htm.

[46] Feinberg, *Harm to Self*, 411.

Chapter 3: Regarding the Objection That Being Imprisoned Cannot Be Considered to Be a Disability

Persons who are not capable of killing themselves, and therefore most likely to request euthanasia, are often found in places where liberty and privacy are restricted.[47] Examples of such places are hospitals, or prisons. Committing suicide in prison is next to impossible: where can one find the required means and privacy? A prisoner's inevitable next step would be to request assistance. But does the condition of being imprisoned provide sufficient reason for equal consideration of a PAD request as compared to that of, for instance, a paralyzed person? The question of the moral right to decide over your own body and life, even if you are not capable of acting on this decision, underlies this discussion. Many argue, such as for instance the six philosophers who wrote the Philosopher's Brief, that every competent person should have the right to make momentous personal decisions.[48]

In the Netherlands, we have a 'right' to choose freely to end our lives by committing suicide. However, there are patients who want to die but whose disease, handicap or condition makes it impossible to do so. If those who choose to die but cannot kill themselves are to get their wish, they must consent to their own killings at the hands of an assisting party.[49] Some argue that the prison context is not a disabling condition that requires compensating assistance. However, a commitment to respecting autonomy could entail respecting the wishes of such 'disabled' patients. In this chapter, I explore the possibilities for a person with disabilities to obtain assistance in executing an autonomous wish to die and relate this to the prison context. I will focus on the moral question of justifying assisted death. My goal is to examine the argument that the prison context imposes similar 'disabling conditions' on prisoners, that are sufficient reason for providing the prisoners with equal means to control their own lives. As I will argue, there are arguments against this view, but they do not knock down autonomy-based considerations of the right to self-determination.

The structure of the argumentation examined in this chapter is as follows: From the moral right to commit suicide mentioned above, it arguably follows that it is sometimes right to stand aside and let someone kill themselves. If letting someone die is sometimes justified, then, according to the Philosopher's Brief, it can also sometimes be justified to provide assistance in dying. However, I will argue, if an institution or the state is to provide this assistance, then the reasons for someone wanting to die need to be very good, in order to escape the fear of this person being forced against his will to serve the aims of others. On the other hand, this fear cannot be a reason not to make this consideration, because the principle of equal treatment applies to prisoners just as much as to citizens. Finally, being forced to serve the aim of others can never be justified, so not in prison either; prisoners, as human beings, should never be used as mere means to the ends of others.

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[47] Feinberg, *Harm to Self*, 344.
[48] Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, and Judith Jarvis Thomson, et al., "Assisted Suicide: The Philosophers' Brief," *The New York Review,* March 27, 1997, accessed January 5, 2016, http://www.nybooks.com/articles/1997/03/27/assisted-suicide-the-philosophers-brief/.
[49] Feinberg, *Harm to Self,* 344.

3.1 Disability

Before I address the elements of the argument I introduced above, however, I will illustrate the need to consider cases in which persons are unable to commit suicide with an example. I will show that there are some noteworthy similarities between the case of a patient suffering from paralysis and the case of Eric, suffering in prison. Similar reasons for seriously considering death requests by physically disabled persons are relevant in considering these requests of prisoners.

Feinberg argues, with regards to people unable to commit suicide, that: "Some such people would commit suicide if they were able, but cannot because they are paralyzed, or closely supervised, or both. If these people are as capable as the suffering terminal patients of making voluntary requests, and as likely to convince humane and decent second parties to honor these requests, then […] it would be an unwarranted invasion of their autonomy to deny those requests when they are primarily self-regarding."[50] Not assisting human beings who are suffering equally severely, but who do not have the option of committing suicide, is a denial of their moral status as a human being. Now, there may be reasons why prisoners in particular cannot or should not be considered, such as Feinberg's argument in the previous chapter, but these are of later importance. First, consider the following hypothetical case of a severely paralyzed woman:

> **The case of Olivia:** *Ten years ago Olivia became permanently paralyzed from the neck down due to a stroke. Her mind is as it was before – but here body is not. Her physical disability in no way affects her ability to make this decision. However, her condition does mean that it is impossible for her to take her own life, even though she desperately wants to and has wanted to for several years. She feels her life is not worth living, and, being fully competent but trapped in a paralyzed body is unbearable to her. If she is to die, she requires assistance.*

Now re-consider the case of Eric.[51] His time in prison has left him deeply unhappy and suffering severely. The prospect of suffering this much until he dies a natural death is unbearable to him. Describing Eric's condition of being imprisoned in terms of a disability, is perhaps not appropriate, in comparison to Olivia's disability. Whereas she is disabled because of some biological and physical condition, Eric is in prison because this is his punishment. However, it can be argued that there is a legitimate question of equal considerations due to the inability to perform the same act. If Eric decides he wants to die, the ways to achieve this goal are very limited: the means to commit suicide are not available to him and alternative ways to die may not prove successful; they might even worsen his condition. If he is to die, he requires assistance.

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[50] Feinberg, *Harm to Self,* 351.

[51] Recap: Eric, aged 55, has been found guilty of murdering his wife and children, amongst several other terrible crimes, and has been sentenced to life in prison. He has been serving time for 25 years now – having been convicted when he was 30. At that time, he was not diagnosed with any mental problems and was deemed criminally responsible for his actions. Now, at age 55, Eric requests Physician Assisted Death.

In comparing these cases, three questions are important. When do we as a society feel assistance to commit suicide is justified? When can disabling conditions justify assistance? Can disability be regarded as a social construct or condition, or is it a biological reality only? Intuitively, PAD in Olivia's case seems directly justifiable, whereas in Eric's case more effort is required. His circumstances are social rather than biological; they are hard to empathize with, and assistance to die might feel undeserved. But the problem becomes even more stringent when altering Eric's case, to include that he now suffers from a severe physical disease himself. *What if Eric is paralyzed from the neck down, as a result of a stroke he had inside the prison walls?* Does this make any difference in assessing his case? Does it increase his need for assistance? Denying equal consideration to a prisoner who is suffering from a similar disease as someone outside of prison seems to undermine everything our liberal society stands for. But where to draw the line?

When suicide is possible without assistance, there is no real need to ask for help. Minimally competent persons are free to kill themselves. But, when suicide without help is impossible for some reason, the question for assistance becomes very relevant. Someone who cannot carry out the act of suicide alone, even though he has rationally come to the decision that this is his wish, has not lost his autonomy, self-determination nor his right to take his own life. The only relevant difference is that some conditions prevent him from fulfilling this potential. In my opinion, there would need to be special reasons why someone who could not carry out a suicide himself should thereby be denied the opportunity for this basic form of self-determination. Preventing the fulfillment of one's potential to be an autonomous human being is denying both autonomy-C and autonomy-D and disrespects one's humanity altogether. I will discuss this issue in further detail in the next section.

3.2 Killing or Letting Die?

If letting someone die is sometimes justified, namely in cases of threshold competence, then, according to the Philosopher's Brief, it can also sometimes be justified to provide assistance in dying. The considerations in this debate with regards to those unable of performing this act due to a disability are similar to the considerations in the case of prisoners. Both groups can be able to make a competent decision, but are equally unable to act on this decision. Within the context of assistance to die and disabilities there are two further relevant distinctions to discuss: the circumstances that make assistance necessary, and the degree of assistance that is needed. For, the reason why assistance is requested will most likely also influence the kind of assistance that is needed: a person who is permanently disabled will need a different kind of assistance than a person who is subject to other circumstances.

According to Glover the degree to which assistance is requested can vary. For instance, a person may ask for the *means* of suicide to be made available. Perhaps he is too ill to go out and buy substances that can cause his death, or he may be in a hospital and unable to leave. This kind of help is what Glover labels assisting a suicide. Another possibility is the request that the *act itself* is performed by someone else, for instance because this person is unable to

inject himself or picking up a pill and placing it in his mouth. This would be an act of voluntary euthanasia.[52] In the public debate, as well as the current medical and legal practice, the former option is regarded as more acceptable than the second. The final act of administering the lethal means seems too grave to assign to another. On the opposing side, there are those, such as the authors of the Philosopher's Brief, who argue that there is no morally relevant difference between these extents; there is a difference in physical movement at best. Why make a distinction, when the intention and outcome are essentially the same?

Glover agrees with the Philosopher's Brief but adds a distinction to avoid what he feels is an over-simplified argument: "If assisted suicide is possible, it is always to be preferred to voluntary euthanasia. If we know that a person himself knowingly took a lethal pill, there is by comparison with euthanasia little ambiguity about the nature of his decision."[53] Thus, on this view, the morally relevant difference would be that when the lethal drugs are self-administered – the patient is more likely acting on his own decision, leaving less room for doubt. In my view, this shows there is still a lot of fear and mistrust concerning assistance to die. Yes, it is extremely important to rule out coercion and hesitation, but does this make assistance any less morally justifiable? This opinion is also present in the Philosopher's Brief: "Why would it be okay to give lethal drugs to competent patients already dying and in severe physical pain, so that they can take these themselves; but the option of death would be denied to dying patients who are so paralyzed that they cannot take pills themselves? Or patients who are not dying but: "face years of intolerable physical or emotional pain, or crippling paralysis or dependence"?"[54] In my view, if it is morally justifiable to provide someone with the means to kill themselves, it is morally justifiable to euthanize them too, even if one is not dying, but is facing a life of severe suffering instead.

This point touches upon the second distinction up for discussion in this section: the circumstances that make assistance necessary. Glover writes:

> "If these circumstances are only temporary, this counts as giving assistance, as failure to help is not a permanent frustration of autonomy: unaided suicide will be possible later. But, if unaided suicide will never be possible, or will not be possible for a long time, the situation is different. To refuse to provide help is a very serious denial of the person's autonomy over the matter of his own life and death, and is only to be justified by powerful arguments appealing either to the future quality of his life or to side effects."[55]

If it is the case, as I have discussed above, that sometimes it is justified to stand aside and let someone kill themselves, then providing someone with necessary assistance can also be justified. What makes them different? Glover mentions side-effects: for instance a physician's feelings of guilt, the fear of establishing a precedent or the consequences of an

[52] Glover, *Causing Death and Saving Lives*, 183.
[53] Ibid., 184.
[54] Dworkin, Nagel, Nozick, Rawls and Thomas et al., "Assisted Suicide: The Philosophers' Brief."
[55] Glover, *Causing Death and Saving Lives*, 183-184.

illegal act.[56] If the situation leading up to a patient's request for PAD is likely to be temporary, this provides a physician with compelling reasons not to provide assistance. This patient may feel different in the future, his circumstances, as well as his attitude, may change. Paternalistic intervention seems easier to justify in such cases. But if the circumstances are not likely to change, and the current situation will be the patient's reality for the rest of his life, these motives are much harder to justify. A physician will, in such cases, propose other reasons for refusing the request.

Once it is decided that in some cases assisting death is justified, it becomes important to how assess the situations in which this is the case. The threshold for what is considered a 'good' reason for wanting to die might be very high in contexts in which individuals make claims to assistance. The reason for this high threshold is that a claim to provide assistance can lead to a situation in which people can be forced against their will to serve the aims of others. Minimally competent agents are free to kill themselves. Unless there are obvious signs of psychoses or delusional ideas that make meeting the threshold of competence for this act impossible, there can be no legitimate paternalistic intervention without seriously undermining one's autonomy. But, only a narrow range of reasons for suicide are admissible in cases in which society will accept providing assistance. Society must not 'help' people to die, who do not actually want to die. Society must, however, treat prisoners equally with regards to these requests. I will address this issue in the next section.

3.3 Equal Treatment

Several legal principles are in place to secure adequate treatment of prisoners. I will discuss some of them, but I will focus mainly on their moral connotation: equality. When a person is deprived of their liberty this creates negative obligations for the State, to refrain from torture or ill-treatment; as well as positive obligations, to take care of a person's health and life.[57] These positive obligations, such as the duty of care, are there to make sure that a prisoner can exercise his human rights while in custody – to protect, compensate and repair these rights if they are jeopardized.[58] Of utmost importance is the principle of equivalence of care. Prisons must provide prisoners with a standard of health care that is equivalent to that available to the rest of the community. According to Henriette Roscam Abbing: "Prisoners are entitled to the same level of medical care as persons living in the community at large. This general principle is inherent in the fundamental rights of the individual."[59] The principle of equivalence implies that prisoners have the same entitlements to (basic) medical treatment and care as people outside of prison, provided the treatment is necessary and adequate, in accordance with professional medical standards. Even though this basic principle exists, its poor execution is

[56] Ibid., 183-184.
[57] Pauline Jacobs, *Force-feeding of prisoners and detainees on hunger strike: Right to self-determination versus right to intervention* (Antwerp: Intersentia, 2012), 314-315.
[58] Ibid., 315.
[59] Henriette Roscam Abbing, "Prisoners Right to Healthcare; A European Perspective," *European Journal of Health Law* 20 (2013), 12.

reported in the media more often than desired.[60] Providing equal care for someone who we feel is undeserving of care is an important issue, as Leigh E. Rich addresses:

> "Equivalence isn't easy: Real crime cannot go unpunished; it is hard to garner support and earmark resources for incarcerated populations when many members of the non-incarcerated also are suffering; and issues of public safety come into play with prisoners in ways absent among the public. But these cannot be reasons to disregard principles of autonomy, beneficence, nonmaleficence, and justice or continue to relegate inmates to the forgotten and far away. No matter how strong the desire for punishment for even violent crimes, it is appalling to read of cruel and unjust treatment of prisoners […]."[61]

As it turns out, 'deserving' care should be a non-issue, because prisoners have every right to equal treatment. Instead, what the discussion comes down to is a conflict between the duty of care of the State and its authorities on the one hand, and the right to self-determination of the prisoner on the other. PAD is not part of standard health care and in that sense cannot be claimed by prisoners any more than by citizens. However, the principles of equal treatment does lay bare the fundamental respect that is owed to human beings regardless of their legal status and regardless of public opinion. The responsibility of caring for a prisoner's life is bound to conflict with a prisoner's wish to die. But in favor of which of these the decision should be made is a topic that requires more consideration than is presently the case. A case-by-case assessment of a prisoner's autonomous wishes, dignity, and worth of life – set alongside practical considerations of prison demands – is needed. What seems evident to me is the importance of taking seriously the matter of care for prisoners. As Rich writes: "Because prisoners and detainees have lost certain basic rights over body and the self, this means that even greater ethical considerations and obligations should apply."[62] Simply banning prisoners to a place where they are no longer considered part of society, or degrading them to lower-class humans cannot be justified. Furthermore, it can be argued that prolonging someone's life in conditions that cause severe suffering amounts to torture.

Unless a very strong justification can be given for restrictions in particular cases, prisoners retain their individual rights in prison. The principle of equivalence also applies to informed consent, the refusal of medical treatment, and, according to Roscam Abbing, even to for example the right to respect for the decision of prisoners to become genetic parents (as following article 8 ECHR).[63] Fear of offending public opinion should have no influence here, nor should it in questions of PAD. As I announced in the introduction to this chapter, the final element of the argumentation I will discuss is treating human beings as ends in themselves, and not as mere means to ends. This is closely related to the high quality of reasons society demands from a person lodging a request for assistance to die. The fear of forcing persons against their will to serve the purpose of others, is valid. However, based on respect for autonomy, both in the sense of competence and dignity, it cannot be justified to simply ignore

[60] On May 9, 1Vandaag reported on the difficulty of ensuring equivalence of care.
[61] Leigh E. Rich, "Crime and punishment, rehabilitation or revenge: bioethics for prisoners?" *Journal of Bioethical Inquiry* 11 (2014), 273.
[62] Ibid., 273.
[63] Roscam Abbing, "Prisoner's Right to Healthcare: A European Perspective," 13.

these requests and force prisoners to live out their lives suffering severely, for the mere sake of punishment, as mere means to an end.

3.4 Means to an End

As mentioned above, the punishment and subsequent suffering of prisoners are often thought of in terms of payback for the crimes committed. Upon imprisonment certain rights and freedoms are limited, but some form of autonomy remains intact and must be respected. If it is not, a prisoner's existence is reduced to a mere means to an end: his punishment, or the penal system. The respect that autonomy demands becomes apparent in the discussion of a practice in which this is directly relevant, both in- and out of prison, namely, that of experimentation on human beings. Based on the inherent worth of human beings no experimentation may ever take place without the explicit and informed consent of the subject or participant. It is impermissible to experiment on human beings without their consent – a right that unquestionably also extends to prisoners. Prisoners are considered to be a vulnerable population and are subject to influences that can further diminish their autonomy, such as oppression or bad custodial conditions.[64]

It is the responsibility of the physician and other caregivers involved to help enable and support autonomy and self-determination for this population. This responsibility becomes immediately apparent when considering the example of conducting experiments on prisoners. Margaret Oot Hayes describes the role of nurses in this situation as follows: "Nurses who are conducting research with prisoners or other vulnerable populations are obligated by their 'code' and by virtue of their humanity to treat them as worthy of the same considerations as other patients. However, the nature of their vulnerabilities and civil restrictions are such that special consideration be given to any limitations on autonomy that may exist."[65] These special considerations are then addressed in her recommendations for moral practice when researching prisoners: "Recognize that as the autonomy of the participants decreases, the researcher's responsibility to protect the participant from harm increases."[66] In dealing with a vulnerable population the danger to 'take advantage' of their position is imminent. Bypassing the process of assessment of prisoners' vulnerability and involving prisoners in experiments or examination without explicit consent would amount to using prisoners as means instead of ends in themselves. Doing so underestimates or altogether ignores prisoners' autonomy-C, and, in turn, violates autonomy D. Furthermore, and returning to the subject of prisoners requesting PAD in specific, ignoring any additional suffering that may be caused to prisoners, thereby adding to the suffering inherent in their punishment, reduces them to mere means of a penal system that cannot itself be justified.

As I have discussed in this chapter, there can be several reasons for a physician not to grant prisoners the possibility of determining some aspects of their lives. The duty of care, for

[64] Margaret Oot Hayes, "Prisoners and Autonomy: Implications for the Informed Consent Process with Vulnerable Populations," *Journal of Forensic Nursing* 2 (2006), 87.
[65] Ibid., 87.
[66] Ibid., 88.

example, can justifiably overrule some aspects of autonomy, depending on the characteristics of an individual case. There are cases in which such an overruling does not harm a prisoner's autonomy, for instance when this prisoner does not meet the threshold of required competence. However, these reasons do not categorically overrule the basic self-determination of a prisoner.

In conclusion, when a prisoner suffers from problems or conditions that can be solved or improved, like custodial conditions, there is a strong justification to intervene paternalistically in his request for assistance in suicide. An example would be a prisoner suffering severely from claustrophobia and requesting PAD – he should not receive assistance. Instead, his conditions can and should be changed; perhaps he can be assigned a bigger cell or more time outside. Suffering should fit the punishment, but suffering without limits amounts to torture. However, if a prisoner is severely depressed with no hope of recovery, or otherwise severely and incurably disabled, who can determine that he should not be treated equally to a patient outside of prison? Recognizing that the situation of a prisoner serving a life sentence is not temporary, especially in the Netherlands, and that he has no means to take his life into his own hands, it is of utmost importance to take his request seriously, no matter what the outcome will be. Prolonging a prisoner's life while he suffers severely, as a form of payback without limits, is not acceptable and fundamentally disrespects his autonomy. I will return to the subject of payback in chapter 5.

Chapter 4: Regarding the Objection That Suffering in Prison Is Not 'Hopeless'

The previous two chapters concerned the possibility for prisoners to request PAD. The following two chapters will concern what happens once it is accepted that the status of prisoners does not exclude them from lodging these requests. Can they meet the conditions of suffering? In this chapter I explore the possibilities of prisoners meeting the prerequisite of 'hopeless suffering' as is part of the WTL. Regional Review Committees (RRC) hold the following requirements with regards to hopelessness:

> "The suffering of a patient is considered hopeless if the illness or disorder that causes it cannot be cured and if it is not possible either to relieve the symptoms so that the unbearableness disappears. From a medical point of view, the hopelessness can be determined rather objectively; on the basis of diagnosis and prognosis. Whether there are reasonable curative or palliative treatment options depends on the possible improvements they will entail on the one hand and on the burden this causes on the patient on the other."[67]

In the debate, as discussed in chapter 1, a popular argument against PAD for prisoners concerns the fear that a prisoner might be 'better off dead,' and the unwillingness to grant him this 'escape.' Several kinds of objections can be made specifically against the hopelessness of these cases. For one, *theoretical* objections: prison sentences, even if life-long, can, in theory, be shortened by for instance new evidence or a pardon – options that would theoretically undermine the absolute hopelessness of these situations. Furthermore, it could be argued that it is trivial to describe a prisoner's situation as hopeless, as it is intentionally hopeless – what else would be expected from a prison sentence? *Ethically,* it can be deemed problematic that a prisoner 'gets to' refute alternative treatments for whatever reason, or that refusing care conflicts with the duty of care of a prison. *Medically,* one could argue that suffering as a result of imprisonment is nothing like suffering in paradigm cases.

Even though the criterion of hopelessness is often described as the more objective criterion, as compared to that of unbearableness, I argue that several aspects of personal experience are involved that must not be ignored. Suffering can be experienced as hopeless when no real and reasonable alternative can alleviate it.[68] What counts as real and reasonable alternatives and when the decision to refute them is justified remains ambiguous and dependent on context. This is especially difficult in a context so complex as the prison. In this chapter, I refute objections such as those mentioned above and argue that there are certainly cases imaginable in which prisoners can meet the condition of hopeless suffering – which is in turn something that should be taken very seriously. The conflict, in my opinion, stems from the importance that is attached to the cause of the suffering. I will argue that the role that the cause of

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[67] "Uitzichtloos en ondraaglijk lijden," accessed December 12, 2015, http://www.euthanasiecommissie.nl/zorgvuldigheidseisen/uitzichtloos-en-ondraaglijk. My translation.

[68] Esther Pans, *De normatieve grondslagen van het Nederlandse Euthanasierecht* (Nijmegen: Wolf Productions, 2012), 35.

suffering plays is very important, as well as the worth of a life and the possibility of refuting alternative treatments. This problem cannot be approached from a mere medically 'objective' viewpoint, but must include the personal experiences in every individual case.

4.1 Causes of Hopeless Suffering

Comparing the situation of a suffering prisoner to that of a citizen suffering from ALS shows not only the difficulties of applying the hopelessness condition to varying cases but also demonstrates that it is logical to approach the situation of the prisoner differently. Consider the following hypothetical case:

> **The case of Billy:** *A 40-year-old man afflicted with ALS is starting to physically deteriorate rapidly and as a result is suffering severely. It is expected that Billy will soon lose the ability to use his muscles and that he will eventually die of asphyxiation; a fate that is inevitable as there is no treatment or cure for his disease. After careful consideration over a longer period of time he decides to request PAD, before he will become incapable of doing so.*

This case would, considered on the scale of cases from marginal to paradigmatic, qualify as close to the 'paradigmatic end' for it can be generally agreed that it meets all of the requirements of the WTL. Billy suffers from a diagnosable physical disease that is unmistakably progressive, fatal and incurable and causes him severe pain and suffering. A physician who has spoken to Billy a number of times over a longer period of time and who has found Billy to be competent and capable to make this decision can justifiably respect and act upon his wishes.

Applying the requirements of the Regional Review Committee with regards to hopelessness to this case, it appears to be rather straightforward: Billy's suffering qualifies as hopeless. Even though there are some options available to alleviate his pain to some extent, success is not guaranteed, and it is above all not possible to cure his disease. Furthermore, it is probable that Billy will actively mentally experience his further physical deterioration. Billy's physician can agree, as well as make a compelling case in front of the Committee, that Billy's suffering is hopeless and that his situation meets all of the other prerequisites for PAD as well.

Comparing this case to that of Eric, who also claims to be suffering hopelessly, some striking differences seem to hinder equal consideration.[69] First of all, in Billy's case, it could be argued that his external circumstances are not very relevant. The features of his case alone, as with other paradigm cases, provide a solid justification for his request. In Eric's case, on the other hand, the notion of the exact cause and circumstances of his suffering seems extremely

[69] Recap: Eric, aged 55, has been found guilty of murdering his wife and children, amongst several other terrible crimes, and has been sentenced to life in prison. He has been serving time for 25 years now – having been convicted when he was 30. At that time, he was not diagnosed with any mental problems and was deemed criminally responsible for his actions. Now, at age 55, Eric requests Physician Assisted Death.

relevant. Thinking of these aspects in terms of being 'caused' by either Eric himself (by committing crimes and going to prison because of them) or by conditions as they are in prison, the focus appears to shift from the 'experience of suffering' now to include the 'circumstances of suffering.' Contrastingly, it could never be justified to label Billy's disease and subsequent suffering as caused by anything Billy has done to himself.

If Eric's suffering is a mental experience that can primarily be ascribed to his external circumstances, such as the prison conditions or the deprivation of his liberty, there might *theoretically* be hope for him: much can happen during a life sentence. Eric could get pardoned, laws could be changed to allow for parole or re-evaluation, new evidence might be found, etc. It could furthermore be harder for Eric to convince his caregivers of the gravity or seriousness of his request, for suffering and prison seem to go hand in hand. The thought that Eric would not have wanted to die were he not in prison, meaning that the sole reason for his PAD request is his imprisonment, might discomfort the physician handling his request. Then again, there is the danger of denying the most important (and hopeless) reality of Eric's life. Even though one could call upon technicalities that might undermine hopelessness, the way the current judicial system works there is no hope for early release for any prisoner serving a life sentence, unless this release is followed by death from a terminal disease.[70]

4.2 Hopelessness in Prison

The cause of the suffering, either mental or physical, has consequences for the demands upon the patient. In case of mental suffering these demands are higher, because the seriousness and hopelessness of the suffering are harder to determine objectively.[71] It can thus be argued that Billy's suffering can be assessed more straightforward as compared to patients who experience mental suffering. Mental suffering in prison seems to pose an even bigger challenge for a physician. And, yet, the problem does not disappear when imagining a prisoner suffering from a physical disease instead. A prisoner suffering from terminal cancer can suffer just as much as an ordinary citizen could, but whereas in the latter case a PAD request is viewed as paradigmatic, in prison there will still be controversy.

Imagine Eric would suffer not from prison conditions, but instead from terminal cancer. Because of the principle of equivalence of care, he is entitled to the same medical care as other, non-imprisoned, citizens are. At any stage of his treatment he can choose how he wants to be cared for. In later stages of his disease he even has the possibility of receiving compassionate release. However, allowing Eric to request PAD can still viewed as problematic and the objections I began this chapter with can still exist. If prisoners are deemed unable to autonomously lodge PAD request, one prisoner's terminal illness will not change this assessment. Even when the prognosis of the patient is hopeless, intuitively there still appears to be friction when reconciling *life-long sentences and life-ending procedures*. In

[70] Proposed alterations to the law after sanctions by the European Union, with regards to hopelessness of life sentence, presented to the public in 1Vandaag June 2, 2016.
[71] Pans, *De normatieve grondslagen van het Nederlandse Euthanasierecht,* 36.

response to this intuition I argue that on the basis of autonomy as described in earlier chapters, it must be possible to consider the PAD requests of prisoners, in cases of mental as well as physical suffering. There will be cases in which these requests will be refused, without violating autonomy, but there can also be cases in which it is impermissible to do so.

Even though hopelessness is often described as the more medically objective criterion, there is also an ineliminable subjective experience involved in this assessment. The hopelessness of a situation *is* to some extent a personal experience, just like its unbearableness. Furthermore, it can be deemed reasonable to ask more of one patient than of another, in the light of one's personal story, life's history, capacities and other relevant circumstances.[72] This personal or subjective character, combined with the consideration of 'relevant circumstances' could potentially prove difficult in a sensitive context like the prison, where there is a great dependence upon the empathy of a physician. I will now turn to the subject of deeming someone's life worth living or not, and the effect this has on responding to a PAD request.

4.3 A Life Worth Living?

As I briefly highlighted in Chapter 2, a person who is delusional should be prevented from killing themselves. He or she cannot be said to possess the minimal threshold of competency needed to make such a decision. As I have also argued elsewhere, a person who is minimally competent is free to take his or her own life. What is needed, then, to know whether the prevention of a suicide is justified, is an assessment of a person's competency. Is this person able to make this decision? When assistance is required to commit suicide the question of the quality of reasons comes into view: the threshold for good reasons for wanting to die is high, if society is to agree to assisting in suicide. A common argument in favor of assisted death is that some lives are no longer worth living. In the prison context, where many freedoms of prisoners are restricted and life is drastically different, this can be relevant too. But, even though this is a very important consideration, it is especially delicate. For: Can controversial ideas about the worth of one's life influence the assessment of one's accountability? In my view, a delusional prisoner should, equal to persons in society at large, be prevented from committing suicide. But, under which conditions is the idea that one's life is worthless a delusion and subsequently a reason for suicide prevention?

When considering the context in which a prisoner lodges a PAD request an important factor is whether or not his life worth living, according to himself, but also to his physician. Henri Wijsbek argues that on top of their medical skills: "Doctors involved in life and death decisions […] should have a large store of general knowledge about what makes life a worthwile life to draw from, together with some specific knowledge about the particular patient they are treating."[73] If a person requests death, and if he is capable of rational deliberation, he will be able to imagine what his future will be like and whether it would be

[72] Pans, *De normatieve grondslagen van het Nederlandse Euthanasierecht*, 35
[73] Henri Wijsbek, "Knowing Me, Knowing You," in *Taking Lives Seriously: Philosophical issues in the Dutch euthanasia debate* (PhD Dissertation, UvA), 20.

worth living. If his current life is bad, bad enough to think that death would be in his own interest, he will need some idea of the likeliness of improvement of this life.[74] Furthermore, in order for this to be deemed a serious evaluation it needs to be persistent over some time, to prevent distortion by a temporary mood.

According to Glover the life worth living is not comparable to, for instance, the states of 'life' or 'consciousness' because they are not intrinsically valuable: they matter, instead, because they are necessary for other things that matter in themselves.[75] The things that are valuable for their own sake are the ingredients of a life worth living, the exact contents of which can be discussed endlessly. Therefore, I opt for a very minimal conception of a life worth living: in the sense of a value that the great majority of human lives have, to some degree.[76] It could be claimed that people in irreversible comas do not lead a worthwile life. But, as argued above, the worth of a life does not merely concern consciousness: a conscious life can also fall below the level at which it is worth living. If this is merely temporary and it is expected that worthwile experiences will follow in the future, it does not have to affect the overall worth. But, according to Robin Attfield, "we could imagine a case in which there were no such prospects, and where failing faculties meant that whatever had previously made life worth living was no longer available (whether sensory experiences, communication with friends or family or memories of happier days)."[77] In such a case it could be argued that, given the lack of prospects for improvement, life is deemed no longer worth living.

Arguments concerning the life worth living are necessary for these discussions but are in themselves not sufficient. It is problematic for others to divide people's lives into those that are deemed worth living and those that are not: this might give way to the idea of it becoming permissible to kill those whose lives are deemed not worth living. This is not my aim. Instead, deeming a life worth living is merely *one* of the reasons why it is directly wrong to kill someone.[78] Killing someone whose life is worth living, is closely related to the notion of dignity; it is a denial of the worth of a human life. Using the terminology of a life worth living is an attempt to include seeing the life of another from this other's point of view, and to see what he 'gets' out of it, to imagine living that life, into the consideration. However, this person's own perspective will be most important, as Glover argues: "When the question arises whether someone's life is worth living at all, his own views will normally be evidence of an overwhelmingly powerful kind."[79] This is extremely important in the case of prisoners, where the ideas of others concerning this punishment could be at odds with the way this punishment is actually being experienced.

From the conception of the life worth living discussed up until now, it arguably follows that it is desirable to save a worthwile life. On the other hand, it can be argued that it is desirable

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[74] Glover, *Causing Death and Saving Lives*, 173.
[75] Ibid., 51.
[76] Ibid., 51-52.
[77] Robin Attfield, *Ethics: An Overview* (London: Bloomsbury, 2012), 54.
[78] Glover, *Causing Death and Saving Lives*, 53.
[79] Ibid., 54.

where possible to respect a person's autonomy.[80] Others having controversial ideas about the worth of one's life could negatively influence the assessment of accountability and subsequent need for paternalistic intervention. Relating these arguments to the prison context I raise the following questions: Is it desirable to save a prisoner's life or prevent him from committing suicide; is this a life really worth living or is continuing it simply in the interest of other parties? Does the prisoner's life merely have instrumental value or worth? Or, can he, perhaps on the basis of autonomy-D, declare when life is not worth living for *him*?

Underlying this discussion is the questionable possibility of leading a life worth living in prison. If a prisoner claims to suffer hopelessly because he can no longer live with the guilt of the crimes he has committed, it is doubtful whether he can meet the requirement of the WTL. If, on the other hand, a prisoner suffers hopelessly because it is impossible for him to lead a life worth living, or for that matter to live a meaningful life, then I think this could be deemed hopeless indeed. Knowing that circumstances will not change and that what made life worth living before imprisonment is no longer available, can be difficult. But perhaps the more stringent question in those cases should be: What can be done to make this life worth living? What can be done to ensure that this life has meaning for this prisoner; how can this individual's ability to make choices, have desires end ends, be facilitated to some extent? This is not to argue, however, that to change the conditions is always the answer. When alternatives should be tried, and when this is enough, will be the subject of the next section.

4.4 Refusing Alternatives

As the previous chapters of this thesis have shown, there are ways in which a prisoner can be considered to be autonomous, in both the sense of autonomy-dignity as well as autonomy-competence, and he is therefore potentially able to make autonomous decisions. Being autonomous also means being able to decide when enough is enough; to decide when the quality of a life is no longer acceptable or worthwile. With regards to refusing alternative treatment, this means that there is a personal point at which no other option is reasonably believed to offer a solution; a point at which life has lost its meaning. If the autonomy of the patient is valued this should be respected. Gerrit K. Kimsma describes this process as follows: "During the course of disease and treatment, patients react in a personal and individual way to the symptoms and loss of functions when there are no options to heal. In addition, they experience loss of meaning in life and loss of appetite for living. Each person has a different degree of ability to hope. Each person has his or her own moment in time when this loss of meaning reaches point at which "enough is enough."[81] Each person, so also each prisoner.

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[80] Ibid., 176.
[81] Gerrit Kimsma, "Evaluating Unbearable and Hopeless Suffering," in *Physician-Assisted Death in Practice: Assessing the Dutch Experience,* eds. Stuart J. Youngner and Gerrit K. Kimsma (New York: Cambridge University Press, 2012), 344.

Physician and patient together have to reach the decision that there is no other reasonable option to try. This does not mean that every treatment needs to be tried to reach this conclusion; some treatments have effects on the patient that can be difficult to endure. The patient's subjective assessment of their situation is very important, but this has no decisive force unless the physician agrees. Simply refusing an option is not enough to fulfill the requirement of there not being any reasonable alternatives. Chances of alternatives taking effect, how radical the expected improvement will be, but also the burden on the patient's capacities and his willingness to carry this burden are involved here. Hence; the decision to die involves an assessment of possible improvements in the future, assessing what alternative treatments could entail. The prison context might influence the possibility of reasonable alternatives to death. Ideas about the goal of prison sentences in relation to the way it is experienced by a prisoner could be important here. If a prisoner's life is a mainly regarded as a means to the goal of serving this sentence, perhaps the threshold for him to justifiably deny treatment will be higher – perhaps he will be expected to carry a heavier burden. If the main interest is to respect his autonomy, however, I do not think this can be the case. If respect for the patient's autonomy is of primary importance, paternalistic considerations about whether the refuted alternatives should not, in fact, be tried (for whatever reason), or whether the prisoner only refutes these because of external conditions, would move to the background. But, as stated above, a physician is never obligated to grant a patient's request for euthanasia, even more so when there are effective alternative means to relieve the patient's suffering.[82]

When a prisoner decides that his life is no longer worth living, for instance because the quality of his life is extremely poor, or he has such limited perspective that it does not matter whether he even gets up in the morning, this should be considered a red flag. If a physician can then agree with a prisoner that he qualifies for the hopeless criterion, this should mean that prison conditions need to be improved drastically rather than continuing to allow prisoners to qualify for this criterion on similar grounds. 'Hopelessness' cannot be a replacement for 'impossibility' to provide proper care. In which cases do we not focus on changing but instead on the equal consideration or treatment a prisoner deserves? If we can agree (if the prisoner declares it, and we can imagine that it is so) that this life is not worth living, and that there can be no improvement, then would it be wrong to prolong it?

In my opinion, prolonging a life that is not deemed worth living, for others' interests, is problematic. Forcing prisoners to live on hopelessly without adequate help is arguably even more tragic than the fact that these people want to die. The following argument by Attfield is relevant here: "Safeguards would be needed to ensure that such wishes were fully autonomous, and involved informed consent; but to refuse people this entitlement could involve condemning them to a life worse than death."[83] Imagine denying someone with a rare terminal disease the consideration for PAD on grounds of their still being young, and the possibility of finding a cure or treatment at some point in the future. Does this not deny this

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[82] Hans ten Have and Jos Welie, *Death and Medical Power: an Ethical Analysis of Dutch Euthanasia Practice* (Maidenhead: McGraw Hill Education, 2005), 80.
[83] Attfield, *Ethics: An Overview*, 55.

person's autonomous evaluation of his own current life? I will leave this question open and move on to the next chapter, in which I will expand on the notion of suffering; more specifically on the possibility of its unbearableness within prison, and the penal goals that underlie punishment.

Chapter 5: Regarding the Objection That Suffering in Prison Is Necessary and Deliberate and Cannot Meet the Requirement of Being 'Unbearable'

A commonly heard argument in the public debate on PAD for prisoners is the following: Prisoners sentenced to life in prison deserve to be there. They have caused suffering to others and now must suffer themselves.[84] In this sense, the suffering resulting from spending the rest of one's life in prison can be understood as deliberate, serving as payback for the crimes committed. How much a prisoner is supposed to suffer would then depend on the amount of suffering they caused. Allowing prisoners to 'opt-out' of this payback effectively undermines the very goal of their punishment. But is it this simple? Can *any* amount of suffering be regarded as acceptable, simply because it is implicit in the punishment? Closely related to this argument is: Accepting a limit of unbearableness to a prisoner's suffering may lead to a slippery slope – if even a prisoner who has committed terrible crimes can be considered for PAD, then everyone can. There are reasons for which punishment is supposed to inflict harm, but should this be allowed up to the point of becoming unbearable? In this chapter, I examine the criterion of unbearableness in general and its role in the prison context in specific.

Regional Review Committees (RRC) hold the following requirements with regards to unbearableness of suffering in PAD requests:

> "The unbearableness of suffering is harder to determine [as compared to hopelessness], because it is personal. What one patient experiences as endurable can be unbearable for another. The unbearableness of suffering is determined by the actual situation, the prospective, the physical and mental strength and the patient's personality. The physician must be able to sympathize with the unbearableness of the patient's suffering."[85]

Sympathizing with a prisoner's situation can be difficult. Just *how* difficult becomes immediately apparent by taking one glance at the critical worldwide debate sparked by the initial decision to grant PAD to Belgian prisoner Frank van den Bleeken. Unbearable suffering can be considered an open norm, and therefore the point at which suffering becomes unbearable is to some extent depending on public debate. I will argue that it is very important to take the notion of empathy for prisoners into consideration. A prisoner can just as much meet the requirement of unbearableness as any other citizen can. However, there does appear to be a discrepancy between the suffering necessary for a prison punishment on the one hand, and the threshold for this suffering to become unbearable and reason for requesting PAD on the other. Can suffering in prison be assessed as unbearable and subsequently serve as a criterion for requesting PAD, when suffering is actually a necessary and well-deserved component of the punishment? In this chapter, I aim to show that it can. Before addressing this problem, I will discuss the the role of the cause of suffering in assessing its unbearableness. The next two sections will be concerned with, respectively,

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[84] See section 1.2 for examples of such arguments in the debate.

[85] "Uitzichtloos en ondraaglijk lijden," accessed December 12, 2015, http://www.euthanasiecommissie.nl/zorgvuldigheidseisen/uitzichtloos-en-ondraaglijk. My translation.

penal goals in the Netherlands in relation to lifelong prison sentences, and the potential slippery slope of using 'unbearable' as a criterion at all.

5.1 Causes of Unbearable Suffering

In this section, I will elaborate on the point at which we consider suffering to become unbearable. In this context, I will discuss several arguments made by philosopher Henri Wijsbek, who addresses the difficulties in assessing the extent of another's suffering. My addition to these arguments is to emphasize the importance of the cause of suffering in this assessment: especially for prison cases this factor can obscure the assessor's judgment.

According to Henri Wijsbek, the point at which suffering becomes unbearable does not merely depend on the meeting of the RRC's requirements, but also needs the agreement of society. He argues the following:

> "The tipping point at which suffering becomes unbearable is not strictly determined by the physician's assessment of the seriousness of the symptoms and losses, nor by the meaning the patient attributes to them. It is a point determined by a social norm in which all these aspects are taken into account and balanced with our shared understandings of suffering and also the point at which it becomes incompatible with leading a meaningful life."[86]

Wijsbek argues that to assess suffering a physician must apply his professional medical knowledge, use his empathy, and interpret the objective symptoms and losses of the patient from his own subjective point of view. He does this against the background of his own biography, beliefs, and values. However, this alone does not suffice: the physician must also have practical knowledge of the public norm concerning unbearableness. Only then can he make the distinction between suffering that society considers to be unbearable, and suffering that it considers everybody should be capable of coping with.[87] This interpretation corresponds to the casuistry method discussed in chapter 1: from the paradigmatic to the marginal cases, a landscape is formed in which the meaning of open concepts and norms are continuously up for discussion and specification.

If the meaning of unbearableness is in part the outcome of an ongoing public debate, then this means that unbearableness does not simply concern what one patient claims not to be bearable any longer, but rather what we as the Dutch political community do not require *him* to bear any longer.[88] But when can we say we do not require the patient to suffer any longer if this patient suffers on purpose? Is his amount of suffering still equally relevant after 30+ years of life in prison? The cause of suffering, in this case, can cloud the necessary empathy of a physician in assessing the patient. But as just discussed it is not only the physician's

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[86] Henri Wijsbek, "The Subjectivity of Suffering and the Normativity of Unbearableness," in *Physician-Assisted Death in Practice: Assessing the Dutch Experience,* eds. Stuart J. Youngner and Gerrit K. Kimsma (New York: Cambridge University Press, 2012), 329.
[87] Ibid., 332.
[88] Ibid., 329.

empathy that is important – the opinion of society and politics in the ongoing debate on this norm is too. It is not just the public but also many in politics who agree that some people should suffer for what they have done, without much discussion on the limits of this suffering. As such, prisoners requesting PAD on grounds of unbearable suffering do not seem to stand much chance. Perhaps they simply have to cope with it.

Wijsbek adds that "the physician is not required to assess whether her patient is suffering, but whether he is suffering unbearably. In other words, she has to check whether the suffering meets the standard that the political community has set, or is setting, for unbearable suffering. People who claim to suffer unbearably because their favorite football team has lost the cup final, […] or because they have just been given an eight-year sentence, do not suffer unbearably whatever they may claim themselves. These are setbacks that we consider everybody should be able to cope with."[89] Where exactly the line is drawn for what a person should be able to cope with and when this line is crossed is often unclear. Especially in prison, where suffering is part of the punishment, this is a challenging issue. I will now focus on the relation between suffering and the extent to which this is desired, as implicit in the penal goals of punishment in the Netherlands.

5.2 Penal Goals in the Netherlands

The Custodial Institutions Agency (or *Dienst Justitiële Inrichtingen* in Dutch) mention three goals of prison sentences, which I will briefly explain before relating them to life sentences specifically:

- Retribution: the sentence demonstrates that society does not accept the violation of laws and rules.
- Safety of society: the offender is no longer a threat in detention.
- Preventing repetition or recidivism: most detained offenders will be released at some point. Society benefits from preventing recidivism.[90]

Gabriel Hallevy writes the following on retribution: "Punishment is the causing of suffering to the offender for committing the offense, and retribution is intended to make him pay the price for it. Retribution emphasizes the necessity to make exact payment, by means of suffering, for the offense – not more, not less ("suffering for suffering")."[91] Following logically from this approach is the general opinion that one who has caused great suffering should suffer greatly himself. To claim that this suffering is too much, or even unbearable, in this sense implicitly concerns the suffering experienced by those affected as well. Hallevy continues:

[89] Wijsbek, "Knowing Me, Knowing You," 17.
[90] "Straffen en Maatregelen," Dienst Justitiële Inrichtingen, Ministerie van Veiligheid en Justitie, accessed February 6, 2016, https://www.dji.nl/Onderwerpen/Volwassenen-in-detentie/Straffen-en-maatregelen/. My translation.
[91] Gabriel Hallevy, *The Right to Be Punished: Modern Doctrinal Sentencing* (Heidelberg: Springer, 2013), 21.

> "This assumption is too general, however, because it ignores the subjective meaning of suffering. People experience suffering in different ways. Different people suffer from different things, and the same measures of suffering cause dissimilar actual suffering in people. […] This match requires measuring suffering from the offender's point of view, because it is the offender who is the object of the suffering caused by the punishment."[92]

The simplistic approach of suffering-for-suffering would make it difficult to justify imposing a limit on the suffering of the offender, because of the severe suffering he or she may have caused to many others. When is this deemed to be proportionate? By adding the subjective or personal experience to the meaning of suffering, as I have discussed in the previous chapter, this can be prevented. A sentence must punish an offender in a relative or proportional way, taking the personal experience of the imposed suffering into account.

With regards to the second goal of prison sentences, that of the safety of society, or 'incapacitation,' Hallevy writes that "at times society has no other option to protect itself from delinquency than physically preventing the offender from reoffending. Physical prevention takes the form of incapacitating the physical (bodily) capabilities of the offender to commit the offense."[93] This goal of imprisonment regards the physical prevention of the occurrence of any further offenses but does not concern the harm or suffering that has actually been caused to society. Also focused on the future is the goal of rehabilitation. Like incapacitation, it merely concerns offenses potentially commissioned in the future. Unlike incapacitation, however, prevention is not merely physical but aimed at the development and rehabilitation of the offender before re-entering society.

When discussing life sentences, the third goal is more often than not deemed irrelevant and is therefore not part of the life sentence.[94] In the current situation, life sentences are truly lifelong and not subject to exceptions. Though there is talk of changing this legal situation in the near future, Dutch politicians have already expressed their promise that some prisoners serving life sentences will never be released into society again.[95] Which of the two first goals has the upper hand in rulings, however, seems to depend on the features of the particular case.[96] Surprisingly, this is no subject of discussion in the relevant literature, whereas I contrastingly argue this subject to be very important: in cases in which safety of society is the main reason for a life sentence it seems a more logical step to request PAD than in cases in which retaliation is the main reason.[97] If a prisoner is locked up and banished from society, to

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[92] Hallevy, *The Right to Be Punished*, 21, 22.
[93] Ibid., 46.
[94] Christiaan Pelgrim, "Hoogste rechter verwerpt levenslang," in *Nrc.nl*, July 5, 2016, accessed July 5, 2016, http://www.nrc.nl/nieuws/2016/07/05/hoogste-rechter-verwerpt-levenslang.
[95] On June 2, 1Vandaag reported on changes to policy regarding life sentences in the near future; Christiaan Pelgrim, "Levenslang gestraften krijgen kans op vrijheid," in *Nrc.nl*, June 3, 2016, accessed June 5, 2016, http://www.nrc.nl/next/2016/06/03/levenslang-gestraften-krijgen-kans-op-vrijheid-1624170.
[96] See for an example of such considerations in rulings: C. Kelk and R.S.B. Kool, "Strafmaatoverwegingen met het oog op de ernst van het feit in relatie tot de mate van toerekeningsvatbaarheid," (2011).
[97] See for a similar argument (regarding Switzerland): Handtke and Bretschneider "Will I stay or can I go? Assisted suicide in prison."

a place where he can serve no further purpose, it could be argued that his death would not make much difference to society. However, as it does remain a *combination* of the two goals that leads to life imprisonment this cannot be regarded as a knock-down argument. The following question requires an answer, however: When exactly is a lifelong prison sentence successful? The fact that at present this question cannot univocally be answered is worrisome, because this seems to leave the fate of an individual prisoner to a large extent up to luck and the well-willingness of caregivers involved. Just exactly where the line is drawn for what a person should be able to cope with inspires many to raise 'slippery slope' objections, which will be the subject of discussion in the next section. As I will discuss, making an assessment of the 'limit' to what another should be able to take creates an interesting field of tension.

5.3 A Slippery Slope?

Consider the hypothetical case of an Olympic swimmer, who is about to lose an arm, and preventively requests PAD because this prospect causes him to suffer unbearably. Requesting PAD in such a situation, for instance on grounds of losing one's athletic identity, maybe even dignity, purpose in life, or means to live according to a personally acceptable standard, will most likely be denied. Even though the requester will experience this suffering as unbearable, it intuitively does not suffice as legitimate grounds for a PAD request. Why? It can be argued that losing an arm is an occurrence that can be overcome in some way. This person can perhaps find a new purpose in life. The loss of limbs is indeed a terrible occurrence, but its very possibility is a part of life, and luckily we live in an age where we have the resources for living with disabilities. Accepting such a loss and subsequent suffering as being unbearable might be feared to lead to a slippery slope for PAD requests. If this soon-to-be disabled swimmer can convince others he suffers unbearably, it is feared that a teenager just turned down by his crush can do so too.

Comparing the Olympic swimmer case to that of Eric, there are some noteworthy similarities.[98] Denying that Eric's suffering cannot justifiably qualify as unbearable means denying that his suffering is as bad as he says it is. As with the suffering of the swimmer, it is the task of the physician to make an assessment of the suffering experienced. The swimmer, whose life and identity revolve around the sport of swimming, cannot imagine a life without this sport. Understanding and empathizing with the nature and depth of this reality is crucial. For Eric, life as a prisoner is his very reality – the life he leads and cannot escape – and his suffering is to be understood 'within' this reality. It is often argued that prisoners can find a new purpose in life within prison if they are open to it, such as studying or teaching others. The very possibility of finding a new identity in this new situation, just as is the case for the swimmer, might add to the reasons for dismissing the request.

[98] Recap: Eric, aged 55, has been found guilty of murdering his wife and children, amongst several other terrible crimes, and has been sentenced to life in prison. He has been serving time for 25 years now – having been convicted when he was 30. At that time, he was not diagnosed with any mental problems and was deemed criminally responsible for his actions. Now, at age 55, Eric requests Physician Assisted Death.

The suffering a prisoner experiences is in a sense inherent to the prison sentence and the goal of imprisonment. To deny or ignore that this suffering can become unbearable is in that sense denying the reality of a prisoner's life. As I have discussed above, the criteria of hopelessness and unbearableness are closely related. What can make suffering even graver is the lack of prospects of improvement, thus entering into the realm of hopelessness. The case of the Olympic swimmer differs from the case of the prisoner in the existence of personal prospects. Though the swimmer might not be able to swim again, he might be a candidate for prosthetics and find another calling in life. Eric will be in prison until he dies. The fact that he may find some activities to spend his time does not change his more fundamental prospects. One's personal experience of suffering in these cases should be assessed and respected, despite the fact that suffering is a crucial part of the sentence.

Against the use of slippery slope arguments with regards to cases of 'disappointed teenagers,' I would argue that the proposed causal chains of such arguments are overly simplified. One occurrence does not necessarily or exclusively lead to the next, and so on. As I have argued above, the process of working out the meaning of the concept of unbearable suffering is ongoing and gradual. Referring once more to Wijsbek, it can be argued that: "Unbearableness refers to a social norm, not a personal standard."[99] The growing database of related cases, as well as the ongoing debate in all relevant fields, serve as a rich background for particular rulings. I do, however, agree that there is a possibility of a slippery slope in solving issues in our prison system with unfit solutions. To fear for instance the decreasing quality of palliative care as well as manipulation into death in prisons is legitimate; such developments should be carefully monitored. PAD should not become a solution for other problems. The idea of requesting PAD as a last resort due to suffering caused by the prison sentence seems utterly tragic.

5.4 Unbearable Suffering in Prison

So far I have discussed the term 'unbearableness,' penal goals, the cause of suffering and the fear of slippery slopes. There is one more subject I feel needs to be explicitly addressed: the subjective experience of a prisoner's sentence. The fear that PAD in prison could be a solution for a deeper problem points to how a life sentence is experienced by prisoners and what is needed to avoid it coming to a request at all. Physician K.J.J Waldeck addresses the special needs of prisoners serving life sentences in a factsheet on this prison sentence in the Netherlands:

> "The usual somatic, psychological and psychiatric help cannot meet the needs of the person involved. What needs does he actually have? Do we even have the possibilities or do we even want to provide in the possibilities to meet those needs? Caregivers have a completely powerless feeling regarding this situation, or are they conscience-stricken in this ethical dilemma? The feeling that we know when a patient is in the final phase of a life-threatening disease. We are 'scared to death by death' and have the tendency to, against better judgment,

[99] Wijsbek, "Knowing Me, Knowing You," 17.

> continue irrational diagnostics and start useless treatments or… ward off and avoid the patient. But to let him go and choose his own death, is not an option either. One of us sighed in the psychomedical consultation: 'But in detention nobody should be allowed to die.'"[100]

Waldeck touches upon some crucial issues in this passage. The needs of prisoners serving life sentences are understandably different from those of prisoners serving other, shorter sentences. Knowing what an individual serving a life sentence needs is crucial. But once we know, would we even *want* to provide in the possibilities to meet these needs? And what does it exactly mean to be 'allowed to die' in this context – does this count as a 'way out'? These questions affirm the worries I raised in this thesis. Furthermore, they reveal just how much more there is to research on the goals, effects and complications of life sentences.

For every individual, the point of suffering becoming 'unbearable' will differ – there is an important subjective element to this experience. In prison it is especially important to carefully examine the possible effects of the punishment on an individual; more than is presently the case. The actual experience or reality of a prison sentence, the full dependence on the daily personnel who sometimes treat prisoners as mere numbers, the rigorous regime, the insufficient variety of food, the monotonous and mind-numbing activities, and the fact that both resocialization and communication with the outside world are meagre, remains subject of complaints.[101] Attention to the individual's capacities, not just those needed to make decisions, but also those used to cope with the reality of the punishment, is essential. Alison Liebling argues: "Prison is not a uniform experience."[102] Just like the threshold for suffering becoming unbearable will differ, so too will different prisoners cope differently with their environments and conditions. If prison is not a uniform experience, then prisoners do not require uniform treatment. Liebling adds elsewhere: Coping with prison is a major, private, and individual struggle that, for some, is unbearable."[103] What the threshold for unbearableness will be will vary with vulnerability and coping ability of prisoners, just like the threshold for unbearable suffering varies for any other citizen, as is included in the RRC's definition of unbearableness.

Suffering in prison, suffering from a life sentence and the desired effects of such sentences must, in my opinion, be a topic of further extensive research and discussion. For example: What do we as a society as well as the political realm think is an appropriate amount of suffering? This will only be settled through debate and an ongoing process of creating and adjusting a norm. Furthermore, the personal experience of how much a prisoner can endure and how well he can cope with the circumstances is very important here. The very possibility of suffering unbearably in prison should, as I have mentioned elsewhere, be considered a red flag as well as an instigator for reform. Suffering so severely that death seems the only way

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[100] K.J.J. Waldeck, "Een levenslange gevangenisstraf overleef je niet" in *Factsheet: Feitelijke gegevens over de levenslange gevangenisstraf* (Groningen: Stichting Forum Levenslang, 2011), 58. My translation.
[101] C.J. Kelk, "Subjectieve beleving als penititentiaire realiteit," 470. My translation.
[102] Alison Liebling, "Prison Suicide and Prisoner Coping," in *Crime and Justice* 26 (1999), 342.
[103] Ibid., 288.

out says a lot about the current state of affairs. As argued above, PAD cannot be a solution for a more fundamental problem.

Conclusion

Reconsidering the case of Eric can be helpful in creating an overview of the conclusions I have reached throughout this thesis. As I have aimed to prove, equal treatment extends to prisoners, despite the crimes that have led to their imprisonment. I have found that there are cases imaginable in which a prisoner's request can be dismissed without violating this prisoner's autonomy, but, that there are also cases imaginable in which a dismissal would be impermissible. Imagining Eric suffering from for instance claustrophobia and therefore requesting PAD falls under the former category, whereas imagining Eric suffering from a terminal illness falls under the latter. Denying him the possibility of assisted death in this latter case, while he is able to make a voluntary and well-considered decision in the sense of autonomy-C, can be seen as violating his autonomy-D. Furthermore, the suffering caused by his illness can be proven to qualify as hopeless and unbearable. If, however, Eric is not terminally ill but instead suffers due to dire prison conditions, the situation is much more difficult to assess. Whether or not his request is voluntary and whether his circumstances negatively influence his autonomous capacities, is not very clear. It would be easiest, and safest, to deny all prisoners this choice; a choice for which the threshold of the needed decision-making abilities is already necessarily very high. By denying all prisoners this option, there can be no doubt about the legitimacy of the reasons, interests and wishes of prisoners lodging these requests. However, it can be argued that categorically denying *all* prisoners this option is morally problematic. It violates the autonomy of the individual who *does* possess the necessary abilities but is not allowed to exercise them, for the sole reason of his status in society.

Regarding the required autonomy of prisoners to request PAD I have argued that a categorical refutation of PAD for prisoners undermines autonomy-D; as well as disrespects the possibility for autonomy-C, to some degree. Extensive consideration of the individual case is needed in order to justify PAD for a prisoner. The role of the context is extremely important – as is the extent to which the request is actually caused by this context. The prison context requires equal considerations as in cases of people suffering from for instance paralysis, because of an equal inability to perform the act of suicide. Even though the duty of care of a prison can justifiably overrule some aspects of autonomy, it cannot categorically overrule the basic self-determination of a prisoner. When a prisoner suffers from conditions that can be improved, such as custodial conditions, there is a strong justification to paternalistically intervene in his request for assistance to die. But, if a prisoner is severely disabled, he should not be denied treatment equal to that of a patient outside of prison. Recognizing that the situation of a prisoner serving a life sentence is not temporary, especially in the Netherlands, and that he has no means to take his life in his own hands, it is of utmost importance to take his request seriously, no matter what the outcome will be.

With regards to prisoners being able to meet the conditions of suffering as part of the WTL, I have argued that when a prisoner decides that his life is no longer worth living this should be considered a red flag. If a physician can agree with a prisoner that he qualifies for the

hopelessness criterion, this should mean that prison conditions need to be improved drastically rather than continuing to allow prisoners to qualify for this criterion on similar grounds. 'Hopelessness' cannot be a replacement for 'impossibility' to provide proper care. On the other hand, prolonging a life that is not deemed worth living by both the prisoner and his physician, is problematic, or even cruel. Just as the threshold for suffering becoming unbearable will differ per person, so too will each prisoner cope differently with their environment and conditions. Much has not been specified with regards to the life sentence: what exactly is its goal, and when is it successful? One thing is clear: suffering so severely that death seems to be the only way out says a lot about the current state of affairs – the very possibility of suffering unbearably in prison is problematic.

Prisoners should be able to request PAD, equal to people outside the prison context. Some prisoners are able to meet the prerequisites for PAD. Whether or not this is problematic from a governmental perspective remains to be seen, for this conclusion can spark several reactions. I will mention two I deem relevant for this thesis: either the prison conditions and the responsibility of the State are scrutinized, or, the openness of the WTL and the subsequent possibility for controversial decisions. The fact that the WTL is open and subject to continuous interpretation simultaneously calls for careful consideration of its contents, as well as for careful examination of whether it offers too much opportunity for controversial requests. The case I have discussed in this thesis demonstrates the many implications of applying this law to a multidimensional issue. The complexity of this case makes it extremely burdensome to a physician, and requires him to take into account many considerations that reach beyond his own professional knowledge. Being prone to (worldwide) scrutiny unfortunately does not simplify matters. Furthermore, there is a valid fear of requesting a physician to assist in solving a non-medical problem with a medical solution. Regarding the role of the State I therefore emphasize that the Ministry of Justice holds final responsibility with regards to prisoners.[104] It should live up to this responsibility. According to Wim Anker: "The government has a duty of care for detainees. She is able to make alterations to hopeless situations. It is now up to politics to change the circumstances of 'lifers.' And, it is up to the legislator to introduce a judicial review for those sentenced to life."[105] Hopefully, the latter will be the result of recent proposals to change the law on the execution of life sentences.

Some final remarks I would like to make concern the importance of taking prisoners serious. The fact that we as a society banish prisoners to a place where we no longer consider them to be part of it, is difficult to morally justify. Prisoners are no isolated case and they should not be degraded to 'lower class humans.' Interestingly, the majority of the Dutch population agrees that judges are too lenient in their sentencing.[106] Judges and lawyers have warned the

[104] Meijer and van Soest, "Doodsverlangen achter de tralies." My translation.
[105] Ibid.
[106] S.G.C. van Wingerden, "De samenleving roept om zwaardere straffen," in *De Vogel Vrij: Liber amoricum prof. Dr. Mr. Martin Moerings* eds. J.P. van der Leun, E.R. Muller, N. van der Schee, P.M. Schuyt, M.A.H. van der Woude (Den Haag: Boom Lemma uitgevers, 2011), 313-314.

Dutch public for years that the judicial system is becoming tougher and more repressive.[107] Recent news items in the media and subsequent responses of politicians and the public confirm this development.[108] I consider it worrisome that politics and the social debate can negatively influence, to a large extent, the way prisoners serving life sentences are treated. Even though there may be reasons not to consider prisoners as equal to the general public in some regards, these are no reasons for disrespecting their equal status as human beings. Furthermore, refraining from tackling this problem because it so complex and/or controversial is altogether unjustifiable. Prisoners' vulnerable position, restricted freedom and limited possibilities increase the responsibility of the state to look after their well-being; not to merely keep them alive and serving the purpose of punishment, but also to consider the ethical implications of doing so.

[107] C.J. Kelk, "Subjectieve beleving als penitentiaire realiteit," in *De Vogel Vrij: Liber amoricum prof. Dr. Mr. Martin Moerings* eds. J.P. van der Leun, E.R. Muller, N. van der Schee, P.M. Schuyt, M.A.H. van der Woude (Den Haag: Boom Lemma uitgevers, 2011), 463.
[108] See for example: Dijkhof's response in 1vandaag on June 2, 2016; or CDA's Oskam on life sentences in Trouw 31 December, 2014.

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