Autonomy, Euthanasia, and the Role of the Modern Physician

Is the Refusal of Euthanasia Requests Harmful, and if so, What Does This Mean for The Modern-Day Physician?

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Hugh Williams - 6790402

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Supervision and First Reading by:

Dr Naomi Kloosterboer

Second Reading by:

Dr Sven Nyholm

Universiteit Utrecht

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Abstract

An interesting defence for the anti-euthanasia movement is to argue that aiding a patient in dying is distinctly against the role of the physician, however, in this thesis it will be discovered that this is not the case. Not only is it possible to see a physician's assistance in the death of their patient as within their role, but something they should be obliged to do. This obligation derives from a physician's commonly understood role as a healer. A wellbeing promoter and a harm reducer. In coming to these conclusions, it will be necessary to understand how a request for euthanasia can promote wellbeing of a specific group of patients, namely, those at the end of their life, and those facing unbearable suffering. Alongside this, it will also be demonstrated how, by extension, the refusal of such a request is harmful to the patient. A necessity to look into the future also arises and, in doing so, it will be found that the role of the physician will change from being one where they are the main actor in the physician-patient relationship, to one of dispensing medical advice to better facilitate patient's choice, ensuring comprehensive promotion of that patient's wellbeing.

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Introduction

As of 2019, some form of assisted dying[1] was accepted in six countries, ten American, and two Australian states.[2] If we are to count the states as representative of the countries which they are in, this means that only 4% of countries in the world give their citizens the ability to choose how and when to die. Such a percentage seems bafflingly low when we consider that the concept of autonomy is held in such high regard. The main case that should be kept in mind when reading this paper is that of Tony Nicklinson who, due to the illegality of assisted dying laws in the UK, was unable to end his own life when he found the suffering caused by locked in syndrome[3], where the body is unable to move but the mind is entirely present, to be unbearable. Instead of being allowed to exercise his autonomy to die with dignity, he was instead forced to die through refusing food and starving to death. From cases such as Mr Nicklinson's, it seems evident that there is a necessity for countries to look seriously at people's ability to utilise their autonomy, something that is so widely regarded as having value, and look in closer detail at archaic right to die laws.

As a concept, especially in the public sphere, autonomy has had a great deal of attention in the past few decades and has only grown in popularity and appeal. In philosophy, autonomy has taken a position of intrigue, especially over the past forty years as part of the euthanasia and assisted suicide debate. Autonomy is most commonly defined as "The condition or right of a state, institution, group, etc., to make its own laws or rules and administer its own affairs; self-government, independence"[4], and to this end it can be used to argue that patients should be able to choose how, when, and where they die, as a request for euthanasia is simply an enactment of a patient's autonomy. However, this topic would not be a debate if there was not

[1] This term is being used in order to encompass both voluntary euthanasia (VE) and physician assisted suicide (PAS).
[2] "Assisted Dying in Other Countries." My Death, My Decision. Accessed March 2020. https://www.mydeath-mydecision.org.uk/info/assisted-dying-in-other-countries/.
[3] "'Locked-in Syndrome' Man to have Right-to-Die Case Heard." BBC News. Accessed March 2020. https://www.bbc.co.uk/news/uk-17336774
[4] OED Online. "Autonomy, N." Oxford University Press. Accessed March, 2020. https://www-oed-com.proxy.library.uu.nl/view/Entry/13500?redirectedFrom=autonomy#eid

opposition. It is possible to use autonomy to argue against the permissibility of euthanasia. Such arguments, some outlined by Sjöstrand et al.[5], suggest that autonomy, due to its inherent value in allowing people to see themselves as agents in the world, should be protected at all costs and any agreement to assist someone in their death would be to facilitate a destruction of autonomy, demonstrating a lack of respect for something that is so valuable. Other approaches, such as that of Emma C. Bullock, see the role of autonomy in euthanasia to be that of a side constraint, not as a vehicle for identification of a patient's best interests. This leads her to conclude "that whether or not it is in the best interest for the patient to die is a morally objective matter"[6] and that autonomy, demonstrated through consent, will dictate whether they die at the hands of the physician or not. Whilst this argument is in favour of using autonomy in the euthanasia debate, it relegates it to the role of action constraint, it is not the main driving force of the reason for euthanasia, this is instead, taken my morally objective fact. These are just two examples of how it is possible to argue against basing an argument for euthanasia on a patient's autonomous decisions, however, this is by no means an exhaustive list as so much has been written on the role of autonomy, self-governance, self-determination and best interest in relation to euthanasia.

These papers that relegate the role of autonomy to either a side constraint of action or suggest that to assist a patient in their death is to disrespect that same patient's autonomy, will be the main target of this thesis. In overcoming these opposing views, it will be possible to demonstrate how this thesis stands beyond the current literature and why it is philosophically interesting in that regard. Whilst the arguments of Bullock and those outlined by Sjöstrand focus on the role autonomy has in the debate, they do not consider the role of the physician in relation to their arguments. As euthanasia is defined by the aid that a person receives in dying, it is necessary to consider the

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[5] Manne Sjöstrand, Gert Helgesson, Stefan Eriksson, and Niklas Juth. "Autonomy-Based Arguments Against Physician-Assisted Suicide and Euthanasia: A Critique." *Medicine, Health Care, and Philosophy* 16, no. 2 (2013): 225-230. doi:10.1007/s11019-011-9365-5. https://link-springer-com.proxy.library.uu.nl/article/10.1007/s11019-011-9365-5.

[6] Bullock, Emma C. "Assisted Dying and the Proper Role of Patient Autonomy." Chap. 2, In *New Directions in the Ethics of Assisted Suicide and Euthanasia*, edited by Cholbi, Michael and Jukka Varelius, 11, Cham: Springer International Publishing, 2015. doi:10.1007/978-3-319-22050-5_2. https://link-springer-com.proxy.library.uu.nl/chapter/10.1007/978-3-319-22050-5_2.

relationship between the patient requesting and the physician being requested. To not relate the debate specifically to the role of the physician seems an oversight; one that this thesis hopes to rectify. In approaching the role of the physician, it is also necessary to contend with argument such as those of Randall and Downie[7] who suggest that euthanasia should never be part of a physician's responsibilities as it contradicts what it means to be a physician. Such a stance will be contended with as it is possible to reconcile the role of the physician with helping patients to die. In short, the arguments with which this thesis contends, such as how to view autonomy in the euthanasia debate and whether the role of the physician is undermined by a request for euthanasia, along with the way in which it overcomes these positions, is what motivates this thesis and makes it philosophically interesting.

Before advancing further into this project, it would be best to outline a number of key points that will not be covered in this paper simply to temper expectations for the work that will be done and the conclusions that will be drawn subsequently. Firstly, there is no intention to discuss any religious approaches to the debate, or include any religious connotations; this decision was made on a practical basis as a turn to any specific religion would not only alienate those of other faiths but also those of none. A philosophical discussion on the use of autonomy, harm, and the role of the physician will be more inclusive and will allow better grounding in the wider context of the euthanasia debate without distraction of deity. Secondly, it should be made clear that this discussion is only relating to patients with a terminal illness, and, or are suffering unbearably. Therefore, hypothetical cases such as the healthy 25-year-old wanting to exercise their right to die will not be discussed or considered. As most of the world does not allow any sort of assisted dying practices it will be best to start with the more 'obvious' cases where not as many grey areas exist. A consideration of euthanasia practices for those who are not suffering unbearably or terminally ill would be a natural growth of the position presented in this project, however, it will not be discussed at

[7] Fiona Randall and Robin Downie, "Assisted Suicide and Voluntary Euthanasia: Role Contradictions for Physicians." *Clinical Medicine* (London, England) 10, no. 4 (August 2010): 323-325, doi:10.7861/clinmedicine.10-4-323. https://www.ncbi.nlm.nih.gov/pubmed/20849002.

present. Finally, this project will make limited, if any, mention of Kant and Kantian principles. This decision was taken in order to maintain practical applicability of the project and reduce over theorising the topic. However, more importantly, to adopt a Kantian principle for something such as the formulation of autonomy, whilst it would give a rich understanding of the debate, the reason we should respect autonomy on a Kantian approach is not one that fits in to a bioethics setting, and, as such, precludes Kant from consideration in this project.

Whilst these specific thoughts and avenues will be omitted from the project, the ultimate aim will be, that through using a consequentialist framework, an argument for euthanasia for those at the end of life, or in unbearable suffering, will be developed. This will be done on the basis that an autonomous request does reflect a patient's best interests as it is made in order to promote their wellbeing, and to deny such a request would increase the harm the patient faces. Owing to this conceptual work, it will also be argued that providing the assistance a patient requires to fulfil their request to die, is not only in line with the commonly understood role of the physician, but something they should be obliged to do. The reason for using a consequentialist framework will be explained within the first part of the first chapter, wherein which it is understood why we value autonomy. To explain the reason here would be to undermine the necessity of that section and the context it will provide. Following from the understanding of why we value autonomy, will be a section on what autonomous choices are worthy of respect and, finally, an investigation into how it is possible to link autonomy, euthanasia and wellbeing.

Once it has been possible to demonstrate how an autonomous request for euthanasia can be argued to promote the wellbeing of a patient, it will be necessary to turn to how the denial of such a request can be harmful, as just because something improves wellbeing does not do enough work to have significant impact on the role of the physician. In examining how refusal of a euthanasia request can be harmful to the patient, what constitutes harm and how it can be evidenced in the world must be understood first. Only once we have this knowledge as a foundation will it be possible to

apply it to the euthanasia debate. As this discussion on harm marks the conclusion of the conceptual groundwork, a small recap will be attached to the end of the chapter to ensure the reader has all the tools necessary to continue and examine the role of the physician in light of the conceptual work done.

The role of the physician, being what sets this project apart from previous work, will begin with an examination of what it means to be a physician in general, and how this can be applied to the conceptual work on autonomy and harm that had preceded it. With this knowledge, a comparison will be drawn between the Dutch euthanasia practices and the arguments that have been made in the project. Such a comparison will allow for the role of the physician to be examined in context and illuminate why the physician is obliged to assist the patient in fulfilling their request for euthanasia. Finally, it is imperative when making such arguments to identify any objections or concerns that could arise and look towards the future to understand what impact the argument will have. For this reason, the final section of this thesis will look at the conceived problems with the autonomy based approach to euthanasia that has been developed throughout the project for the future of medical practice, and how they can be understood in a more positive light.

Chapter 1 - Euthanasia, Autonomy and Wellbeing

The aim of the first part of this project is to consider how an autonomous request for euthanasia can be understood as something which improves the wellbeing of the patient. This will be achieved through three sections. The first section will focus on how and why we value autonomy, looking closely at both the intrinsic and instrumental understandings of what it means to have autonomy. This will give context to the concept as we move forward, forming basis for the entirety of this project’s argument. The task of the second section will be to lay a foundation for which sort of autonomous choices must be respected by wider society. This section will be motivated by the bioethics setting in which this project resides, in order to provide grounding for the claims being made in this project. It also provides an opportunity to narrow the scope, to focus the discussion on the role of the physician in the final section more adequately. Finally, an

explicit link will be made between euthanasia, autonomy and wellbeing through elucidating the way in which a patient's autonomy can be demonstrated through the control the patient exerts in their final years, months, or days.

1.1 - The Value of Autonomy

As we have seen, by the definition of autonomy in the introduction, we are able to characterise it as a form of self-governance, however, it is not evident from this why autonomy is valuable, just that it is. For this reason, it is necessary that we answer the question: why do we value autonomy?

With contemporary literature, it is possible to comprehend the value of autonomy in two different ways, entirely distinct from each other. The first way to understand the value of autonomy is that it is intrinsically valuable. That is, the exercising of autonomy is valuable in of itself and not "based on the good which it makes possible"[8]. Thomas Hurka[9] attempts to make an argument for this position by suggesting that the exercising of autonomy reflects deeper values that we already hold to be intrinsically valuable, such as agency. It is difficult to argue that being an agent in the world is not an intrinsically good thing as, by placing ourselves in the world we can assert ourselves as a being of importance and an actor to be noticed; Hurka uses this understanding to argue that in reflecting similar values, autonomy is also intrinsically good.
Hurka bases his argument for this reflection on what he calls 'causal efficacy', that is, to have an effect on the world around you. The most coherent way to demonstrate autonomy is through choices and, as such, the choices we make have causal efficacy if they are autonomously chosen as:

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[8] Robert Young, "The Value of Autonomy." *The Philosophical Quarterly (1950-)* 32, no. 126 (1982): 36. doi:10.2307/2218999. https://www-jstor-org.proxy.library.uu.nl/stable/2218999?seq=1#metadata_info_tab_contents

[9] Thomas Hurka, "Why Value Autonomy," in *Drawing Morals: Essays in Ethical Theory*, ed. David Copp (New York: Oxford University Press, 2011), 139-153 https://www-oxfordscholarship-com.proxy.library.uu.nl/view/10.1093/acprof:osobl/9780199743094.001.0001/acprof-9780199743094-chapter-8?print=pdf

> "If one person chooses action *a* from ten options while another has only action *a* available, it may be true of each that she has made *a* the case, and is in that sense responsible for it. But there is an important difference between them. The first or autonomous agent has also made certain alternatives to *a* not the case; if her options included *b, c* and *d*, she is responsible for not-*b*, not-*c,* and not-*d.*"[10]

What this demonstrates is that all of our choices reflect part of our agency, that is, being a member in the world. The criticism that Hurka poses to himself is, that "if free choice is intrinsically good, it should be better to have one good option and nine bad ones than to have just the good option"[11] and through his discussion of causal efficacy he seems to answer this. Let us take the people who are used in the previous example, where one person is offered a range of choices and the other just the one; if we are to understand Hurka correctly, through being able to choose, the autonomous person is able to create those *not* cases, unlike the non-autonomous person, and therefore, the autonomous person is more expansively demonstrating their agency, even if the results are the same; good or bad. However, it is possible to have causal efficacy through random choice, whereby one does not necessarily demonstrate any autonomous choice in order to govern and legislate for themselves. Through any choice it is possible to create *not* cases and have some form of causal efficacy. Whilst this may be the case, it should be recognised that what would reflect agency even more thoroughly is if the choice was deliberate and informed; focused on doing what is best for the person making the choice, that is, being driven by autonomy. These criteria allow the person to be a more expansive agent and allow for a better depiction of their agency in the world. The point is also made that if we are presented with a full range of choices which we did not like, then we would not simply concede our control and ability to choose; we would still want to choose in order to make the outcome our own, and display our agency. In the same way that people do not like to be given things they have not worked for, people prefer to have causal efficacy in order to live up to what it means to be the ideal agent, not because it makes them happy, but because it is recognised as good. In this sense,

[10] Thomas Hurka, "Why Value Autonomy," 143.
[11] Ibid. 140

having autonomy is intrinsically good, as without it we would not be able to be as expansively an agent. Therefore, Hurka would suggest, there must be something more than outcomes that give autonomy its value. There seems to be something inherent in our being an agent that gives it its value.

The second way that it is possible to value autonomy is as something that is instrumentally good. With this outlook, we would see autonomy as good owing to the things that it allows us to do. For example, J.S. Mill sees the instrumental value of autonomy in that it allows one to be happy, develop a character with individuality and, subsequently, promote one's wellbeing. It should also be noted that throughout the course of this project wellbeing is defined as general happiness and contentment with one's life. Whilst Mill does not explicitly mention the word autonomy, much of his discussion in 'Of Individuality as One of the Elements of Well-being' is based in reference to Wilhelm von Humboldt's assertion that the two things necessary for human development are "freedom, and a variety of situations"[12]. From this, Mill argues that there is much to be said for the way in which our ability to choose freely from a wide range of possibilities allows us to develop an individual character. Additionally, Mill sees the use of autonomy similarly to that of a muscle as, "The human faculties of perception, judgement, discriminative feeling, mental activity, and even moral preference, are exercised only in making choices. He who does anything because it is the custom, makes no choice. He gains no practice either in discerning or in desiring what is best"[13]. The enactment of our autonomy allows us to develop our character, it paves our way to way to the ends and goals that we have designed in our life and, without practice we are unlikely to be able to achieve those ends and goals which will promote wellbeing.

It could be contended that, as Young notes, Mill's argument reflects some sort of deeper values that we find intrinsically valuable when he writes: "It really is of importance, not only what men do, but what manner of men they are that do it"[14]. This could suggest an

[12] John Stuart Mill *On Liberty* (Luton, Bedfordshire: Andrews UK Ltd., 2011), 75, http://ebookcentral.proquest.com/lib/uunl/detail.action?docID=770561.
[13] Ibid. 76
[14] Ibid. 77

inconsistency in Mill's writing as, if it is important what type of person acts, this would suggest that autonomy does not just have importance in promoting the wellbeing of an individual, but that it is about allowing the person to become the correct person, i.e. an agent in the world. However, it should be recognised that the basis of this argument is undermined by the sentence directly following it: "Among the worlds of man [...] the first in importance surely is man himself"[15]. This sentence undermines the argument that Mill is inconsistent as it shows that it is of utmost importance for man to be original and promote his wellbeing when exercising autonomy. I would argue that when Mill writes of the manner of men that do it, he is referring to whether they are original and whether they are promoting their wellbeing and happiness through their exercise of autonomy. Mill also returns to the importance of practice within the same section as he writes: "human nature is not a machine to be built after a model, and set to do exactly the work prescribed for it, but a tree, which requires to grow and develop on all sides, according to the tendencies of the inward forces which make it a living thing"[16]. Not only does this stress the need for originality, 'not a machine built after a model', but it also stresses the need to attain this originality through practising autonomy, 'grow and develop on all sides, according to the tendencies of the inward forces which make it a living thing'. Such a passage can easily be read to suggest making mistakes and learning from them is what it means to be a living thing. In essence, Mill argues that the value of autonomy comes from our ability to become original beings and promote our wellbeing in doing so, and the more we practice the more accomplished we will become, and our wellbeing will be promoted even further. There can be a suggestion that Mill is inconsistent in his handling of the value of autonomy, however, I believe there is overwhelming evidence throughout On Liberty to counter such a position.

To illustrate the divide between the two ways of valuing autonomy more clearly, we will use an example. If person A and B are given a choice set of 10 choices, the inclusion of an 11th choice would not be of benefit for person A who sees autonomy as intrinsically valuable. The 11th choice for person A would simply be another choice that they could

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[15] Ibid.
[16] Ibid.

either realise or not, the reflection of their agency does not depend on how many choices they realise, just that they do and that they do it deliberately. On the other hand, person B, who takes a more instrumental view of autonomy, would see the inclusion of choice 11 as an opportunity to ‘practice’ their skills of deliberation and exercise their muscles of moral decision making in order to gain a distinct character that moves them toward their own personal goals and ultimately, improves their wellbeing. A distinct line is drawn, therefore, between the instrumental and intrinsic approaches. Understanding autonomy as instrumentally valuable is focused more on the consequences of what its enactment facilitates, whilst, on the other hand, intrinsic value focuses more inwardly on what the enactment of autonomy reflects of the individual.

Whilst both of these approaches theorise the value of autonomy, the question still stands as to why we should prefer one methodological understanding over the other. Simply put, I do not see a necessity to dispense with one in favour of the other on a philosophical basis. Both of these articles are distinct from each other, nothing about either of their formulations disrupts the formation of the other, nor can either approach claim a full understanding of the value of autonomy. This being said, scholars who view autonomy as intrinsically valuable argue that there is little to be said for autonomy being valuable simply because it promotes wellbeing. If, for example, we lived in a society ruled by a dictator, where people have no choice sets, are told what to do, how to act and where to be, it is possible for them to still be happy, and to have a level of wellbeing without their autonomy. In short, autonomy does not necessarily beget wellbeing; the exclusion of autonomous choice could still result in wellbeing. However, in defence of the instrumental view, Mill sees the role of civilisation and societal customs to be parallel to the dictator, in that people are fettered by man-made ideals of how life should be, and are unable to practice their autonomous decision making as they would simply submit themselves to cultural norms. However, he still considers that if people promote their own wellbeing then they are happier than if they were to follow customs and culture blindly. The exercising of autonomy need not be either intrinsically valuable *or* instrumentally valuable, it can quite clearly be both; we can hold that it reflects our agency in the world and that it promotes wellbeing as we individually understand it.

However, as neither of the approaches identifying the value of autonomy can claim to fully answer why it has value, it is necessary to choose an approach as favourable. For this project the instrumentalist approach will be the focus. The reason behind this is that it is best to work within a consequentialist framework in order to have the most chance of exhorting physicians, such as Randall and Downie, to change their position, and to have a generally more practical discussion within a topic that is alive and changing. If we are to adopt the approach that autonomy is intrinsically valuable, whilst equally valid, the discussion on harm, and the role of the physician would not be as interesting. It is possible to envisage a defence of the physician's current role that would suggest the physician is a healer of the physical body and mental wellbeing, not the protectors of a person's ability to see themselves as an agent in the world; it is only possible to overcome this through contending that in not being able to see themselves as an agent in the world, a person's wellbeing is at stake, however, in doing so, this would become the part of the instrumental approach. Adopting this outlook, as part of a consequentialist framework, thus appears the most practical and dynamic view to take in examining how the request for euthanasia promotes a person's wellbeing, how the refusal of this request is harmful and how the physician's role should be examined in this light.

1.2 - Respecting the Autonomy of Others

Now that an understanding as to why we value autonomy has been reached, the next necessary step in the discussion will be to understand how and why we need to respect the autonomous choices of others. The work that has been done thus far has provided an overarching understanding for the individual to reflect on why they see autonomy as something they value. It is now necessary to step beyond this and discuss whether there is an obligation for others to respect the autonomy of agents in the world. If we do not find it necessary to value another person's autonomy then there is no obligation on anyone not to be self-centred, self-serving, callous beings. I endeavour to demonstrate that the autonomy of others should be respected but it is under only specific circumstances that we can identify an obligation to respect it.

On the Millian account of autonomy, it is suggested that the reason we respect autonomy, or the originality and development of character, of others is due to the impact it would have on society as a whole. The development, and overall wellbeing, of society relies on the ability for people to diverge and become their own person as, "in proportion to the development of his individuality, each person becomes more valuable to himself, and is therefore capable of being more valuable to others"[17]. Not only does the cultivation of autonomy lead to one being more valuable to others, but improves human beings as a whole, and "brings themselves closer to the best thing they can be"[18]. Any sort of curbing on this development diminishes wellbeing and it would be restricting a person only for the purpose of conformity. This is not to say that any sort of restriction is a negative thing that will lead to the decline of the human person as a whole, but instead anything which hinders the development of character or exercise of autonomy such as a lack of respect for a person's autonomous choices, is to be seen as a drawback on human development. In fact, Mill notes that laws and principles of justice should be invoked to stop people from hindering the liberty and autonomy of others as well as allowing for people to develop "the feeling and capacities which have the good of others for their object"[19]. The Millian account of autonomy and the subsequent character development which ensues, gives a positive outlook on why we should respect a person's ability to make autonomous choices. However, it seems to be unworkable in a bioethics setting to accept all autonomous choices merely because they are autonomous, if people are allowed to choose in this way there are likely to be unsafe and impractical consequences.

Whilst the general principles of Mill's commitments seem agreeable in that we should respect the autonomy of people, as people, owing to the fact it allows someone to become the person they want to be, and as a whole, society would ultimately benefit. If we are to take this approach, whereby as long as we do not molest others in what

[17] Mill, *On Liberty*, 81
[18] Ibid. 82
[19] Ibid. 81

concerns only them, then we should be free to enact our autonomous choice. At this point we can begin to see some practical issues. Namely that “if unhindered choice is the main thing to be respected [...] then it becomes questionable whether this is something that is sufficiently worth respecting”[20]. This seems to be an illogical concept and one that needs refining, for this reason we must discover what sort of choice *is* worth respecting. It is possible to understand respect in two ways: first, respecting a choice is to leave the person making that choice to enact it without interruption; second, respecting a choice is to provide the best possible conditions for the person making the choice[21]. This would allow the person to make mistakes safely and fail without damaging themselves or society. It is with the first definition that we will continue, as this is the one that is closest to the argument Mill makes, and it is one that will serve as an excellent foundation for discussion on the role of the physician in the final chapter.

The most basic type of choice that has been discussed thus far is characterised by John Hodson as ‘empirical choice’. So-called empirical choices are named owing to the observability of their expression and their basic nature of furthering the agent’s desired ends. These sorts of choices would come from respecting a person, as a person, and in doing so would mean deferring respect to all decisions just because they came from that person. To disrespect these choices would be to disrespect the person as a person. As it has been alluded to so far, there are issues with this basic consideration. To demand respect for an individual’s every empirical choice, would leave an inability to control any such desires agents have due to a fear of disrespecting that person. However, this would mean that *any* choices that moved a person closer to their desired ends would demand respect. Not only this, but a person’s empirical choices can vary over time and what they think would further their ends may, later in their life, frustrate these ends or even run counter to their initial thoughts. For example, if someone has an

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[20] Richard Dean, "Would Kant Say we should Respect Autonomy?" Chap. 10, In *The Value of Humanity in Kant's Moral Theory*, (Oxford, United Kingdom: Clarendon Press, 2006), 203. doi:10.1093/0199285721.001.0001, https://www-oxfordscholarship-com.proxy.library.uu.nl/view/10.1093/0199285721.001.0001/acprof-9780199285723.

[21] J.D. Velleman, "Against the Right to Die." *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 17, no. 6 (December 1992): 666-667. doi:10.1093/jmp/17.6.665. https://doi.org/10.1093/jmp/17.6.665.

end of gaining respect, at one point in their life they may think joining a gang to be a good idea, however, later in life may recognise that being an upstanding citizen, who played their part in the community, furthered that end more applicably. It is therefore difficult to respect empirical choices entirely due to the possibility of a lack of continuity, and the implications such respect may have for others.

It is also possible to appeal to the 'rational choices' a person makes. Hodson characterises these types of choices as ones which are made "by any fully rational being and is a will which is determined in abstraction from the individual characteristics of such beings."[22] Hodson's choice of words here could be questioned as to refer to something as the rational will could lead to confusion among people who feel that reference to a rational will or rational choice is too closely associated with Kant, compared to the explanation that he gives. However, this being said, I will continue with this terminology as it is necessary for understanding the next type of choices that we may find deserving of respect. Whilst an appeal to the rational will would remove the ability for agents to have a claim to every single choice they make being respected, the removal of these choices from the characteristics of the individual is troubling. It would be impossible for an agent to consider themselves as attaining their own, personal, ends if the choices must be made in conjunction with the rational will. The Millian idea of originality, and the wellbeing that accompanies it, would be removed as the only choices a person could make, that demand respect, are those that are ordained to be rational, leading us to conformity. In addition, to respect rational choices, means that the choices an individual makes are no longer, strictly, their own but are predestined to be part of the rational will. Even if we are to respect a person owing to their being a person, the appeal to rational choices does not necessitate we respect their choices as their own. For these reasons we must remove the idea of rational choices from our inquiries as to which sort of choices are worthy of respect.

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[22]John D Hodson, "The Ethics of Respect for Persons." Chap. 1, In *The Ethics of Legal Coercion*, (Dordrecht: Springer Netherlands, 1983), 4. https://doi-org.proxy.library.uu.nl/10.1007/978-94-009-7257-5_1

The third type of choices that Hodson demonstrates are rational empirical choices. These choices are those that demonstrate a person as a person; one who is capable of making choices of their own, but of these choices the ones to respect are those that are not contrary to the rational will. This type of choice, therefore, makes the agent the main actor in the making of choices, but it is only the ones they make in line with the rational will that should be respected. This will allow the agent to be respected as a person because it is they who make the initial choice, and if that choice happens to align with what the perfectly rational person would do in the same situation then it demands respect. The choice only counts as rational empirical "if and only if it is not incompatible with the choice a rational person would make in the circumstances [...] if the empirical choice is incompatible with that, it does not require deference."[23] It should be recognised that the difference between these types of choice and the rational choices that have previously been spoken of, is that with rational choices it is only when someone makes a rational choice that it is respected, and that this choice comes from the rational will. The picture Hodson paints of the rational will is one that suggests it is similar to a higher being acting through a person to make their decisions, and these decisions should be respected because of this. In comparison, the rational empirical choices that we see here, come from the individual and it is only the empirical choices that match the rational will that are respected. The issue with this type of choice lies in that there are specific times that we would consider some decisions rational but would still seem to be confusing to respect. The example that Hodson uses to illustrate this point is that in the heat of a marital spat, a couple decide to divorce. Whilst this choice would not be irrational, there is something that would mean the choice that had been made was not one others would think worth respecting. To take such a position is to "require deference unjustifiably to choices made under circumstances which render questionable even choices which are not irrational."[24] Not only is this the case, but it is also possible to find instances where we still give respect to choices that cannot be considered rational. It is the tenet of some of the most respectable and admirable actions, for people to believe in something that, in the circumstances, would not

[23] Ibid. 6
[24] Ibid.

necessarily be rational. These two points would therefore serve to suggest that it is not about the type of choice that is made but *how* an agent comes to the choices they make.

Hodson provides two considerations as to how an agent can make choices. The first to look at is what he names 'considered' choices. These choices are ones that must satisfy specific conditions in order to be respected. The conditions that Hodson says must be met are that choices should be made "in the light of full information, in the absence of pressure and with an appropriate amount of reflection and consideration".[25] In all of these instances, it is an agent's empirical choices that are the foundation, however, it is only when those empirical choices meet these specific conditions that they can be understood as considered. The issue with insisting that all choices that demand respect should be considered choices is that it is impractical to consider every single choice one makes. For example, choices such as what I should have for dinner, or what movie to watch, do not necessarily have to be made in light of all information and have any amount of reflection or consideration for them to demand respect. Whatever I choose in this regard should be respected. In this account of how we make our decisions it is therefore seen that to meet such conditions for some choices is unnecessary.

If it is not practical for all choices an agent makes to be wholly considered through proper reflection, and full information on the subject, a more applicable stance would be that the choices should be respected are ones that are made without meeting specific conditions. Again, as we are concerned with a person's observable choices, it is their empirical choices that must not meet these certain conditions in order to be considered 'unencumbered' as Hodson defines them. These choices are ones that have two conditions they must negate: firstly, choices must be free of general encumbrances whereby the agent is free of things that would have an adverse effect on all choices. Mental incapacities, for example. Secondly, one also must be free of specific encumbrances. In this sense one should not be ignorant to a specific fact about a specific situation which would not affect other decisions that are made. For example,

[25] Ibid. 10

being ignorant to the time of day will affect whether you go to the gym 5 minutes before an important meeting but will not affect, in most cases, whether you buy that day's newspaper. These types of encumbrances can originate from the choosing agent as 'endogenous encumbrances', when "the reason for the hindrance is something unusual about the person's ability to make choices"[26] such as decisions made in the heat of the moment like the couple who decide to divorce in the throes of an argument. The encumbrance could originate from an external stimulus as an 'exogenous encumbrance', one that is characterised by "ignorance of some relevant fact about a course of action where the ignorance is due to some obstacle to obtaining knowledge of the fact"[27] which could be, for example, a deliberate withholding of information in order to get a person to make a desired choice that benefits the deceiver.

In essence, the reason the autonomy of others should be respected is so that they are able to gain originality, develop their character, and increase their wellbeing. This will ultimately be of benefit to the whole of society, as people are not expected to contort themselves in order to fit with a particular societal norm only for the sake of conformity. However, to demand respect for all autonomous choices would be impractical and unsafe in a bioethics setting, as it would allow patients to further their ends in a way that has to be respected even if the ultimate result would be detrimental to health standards. Instead, we should respect people's autonomous wishes when displayed through unencumbered choices, even if they are detrimental to the overall individual's health, as, having considered them in an unencumbered way, the individual should know the risks and factor these in when wishing to attain their ends and developing their wellbeing. For this reason, in relation to euthanasia, if a request is made by a patient which can be seen as unencumbered, then there is no prima facie reason not to respect it. To do so would be to deny the patient the ability to develop their character, individuality in the world, and their wellbeing.

[26] Ibid. 12
[27] Ibid. 13

Hodson does present a compelling case as to why it is unencumbered choices we should respect. It must be questioned though whether unencumbered choices are entirely sufficient for making choices worthy of respect and, if so, whether some of these unencumbered choices have more weight than others? I would suggest that there is no need for an entirely sufficient condition as to which choices we should respect, just a plausible basis on which we can form an understanding about what type of choices we value when other people make them. There is no doubt it would be plausible to write another thesis on the choices that demand respect and how these choices are made, however, as a foundation for this project, unencumbered choices will suffice. Unencumbered choices present themselves as the most plausible options for why we should respect the choices of others as they demonstrate that the chooser is informed, that they have considered their choices, and have freedom from anything that would alter their decision beyond the parameters that would propel them towards ends which they wish to enact for the sake of themselves.

In relation to whether some choices carry more weight than others when they are made, for example, does an unencumbered choice for what to have for dinner carry more weight than an unencumbered choice of where to go to university? It could be seen that as long as these choices are unencumbered and are moving the chooser towards an end that is uniquely their own, they both demand the same ‘weight’ of respect i.e. being left to enact the choice themselves. The choice that is being made is that of the person who, through making the choice unencumbered, is able to move themselves towards their own ends. It is only when these choices infringe on the ability of others to make their own unencumbered choices that the weight of these choices can be observed. For example, if a person made an unencumbered choice to have pizza for dinner but deliberately misinformed me as to what ingredients were left in the shop, making it seem impossible for me to have pizza as well, we can therefore see that the unencumbered choice of that individual carries a lot of weight as it has influenced my ability to make a wholly unencumbered choice of my own. With this in mind, it must also be recognised that in the grand scheme of life, the ability for me to eat pizza for dinner is not a significant infringement on my ability to carry myself towards my ends of

originality and societal non-conformity. However, if we are to take a similar scenario where a person makes an unencumbered choice as to where to apply to university, and in doing so also provides me with obstacles to making a similar unencumbered choice, the trajectory of my ability to be rational and attain ends that I want are curbed. What university they attend, can, for some people, have a great impact on the outcome of their life in the way that having pizza for dinner would not. Therefore, it is only if the unencumbered choices of someone infringe upon another person's ability to make an unencumbered choice, that it would be possible to see these choices as having any weight to them. If this is not the case, then it should be viewed as a simple choice that is propelling an agent towards their ends of originality, societal non-conformity and, ultimately, wellbeing; owing to this, these choices should be respected.

1.3 - Euthanasia, Autonomy and Wellbeing

What we have seen thus far is that autonomous choices can promote wellbeing through making the chooser an original being, however, it would be peculiar to suggest that someone requests euthanasia in order to show themself as an original being. What would be more appropriate would be to suggest that people autonomously choose euthanasia in order to promote their wellbeing in stopping any suffering they may have. One step in reducing this suffering is through taking control of one's life. In a request for euthanasia a person is able to promote their wellbeing through demonstrating their control over their life. It is possible to elucidate this link further through considering the example of a bungee jump. When preparing for a bungee jump you can either be pushed, or you can choose to jump; the result is the same. However, if you are pushed, it would not be absurd to suggest that the whole experience would be more terrifying, and your overall wellbeing concerning the situation would not be as high had you chosen to jump of your own accord. If you had had the capacity to prepare yourself for the jump and committed to it of your own free will, then it is more likely that all outcomes and possible consequences would have been analysed and you would have made the decision that jumping would promote your wellbeing more than backing away and going home for instance.

This link between autonomy, control, and wellbeing, whereby if we are able to autonomously demonstrate our control then our wellbeing will be promoted, can be backed by empirical studies. One such study looked at university students and whether an addiction to the internet leads to a lower level of psychological wellbeing[28]. This study carried out by Mehmet Çardak defines addiction as "person's or being's feeling of necessity for something (like another person, substance, internet, sex, etc.) in order to sustain her/his existence and continue her/his way of existence as she/he desires"[29]. Already, it is possible to see just from this quote the relevance this study has to our discussion. In seeing something as necessary in one's life it is to see it as something that is outside of oneself and is in some form of control of the direction of one's life. It is also possible to see the wellbeing element in that, as we have seen, if someone is able to carry themselves toward ends which make them original, then their wellbeing is enhanced. To this end, a person's or being's feeling of necessity is related to how much control they have and attaining their life ends is related to their wellbeing. If they are not able to fully control the attainment of their life direction and life ends, then they would not have the same promotion of wellbeing in comparison to if they could.

The method of the study was to firstly discover what proportion of the 479 participants, 93% of whom were aged between 18 and 25, could be seen as addicted to the internet. Within this, internet addiction, defined as, among other things, feeling "the necessity for using the internet in an increased proportion in order to get the satisfaction they desire"[30] was measured by student responses to a range of statements. Students were given: 10 statements relating to impulse control; 6 statements related to loneliness/depression; 13 statements related to social comfort; and 7 statements concerning distraction. Statements such as "I am bothered by my inability to stop using the internet so much"[31] were rated between 1, strongly disagree, and 7, strongly agree. In giving each of the 36 statements a score between 1 and 7 the students would be

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[28] Mehmet Çardak, "Psychological Well-being and Internet Addiction among University Students." *Turkish Online Journal of Educational Technology-TOJET* 12, no. 3 (July, 2013): 134-141. https://eric.ed.gov/?id=EJ1016863.
[29] Ibid. 134
[30] Ibid.
[31] Ibid. 136

given an overall score between 36 and 252: the higher the score, the higher the levels of perceived internet addiction. The second half of the study consisted of understanding the student's psychological wellbeing; this was done in much the same way as the first half. Students were given the Ryff scale of psychological wellbeing[32], and again, were asked to respond to statements on a scale of 1, strongly disagree, to 7, strongly agree. The scale of psychological wellbeing (PSWB) focuses on 6 areas: "self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth"[33]. In responding to the statements, an overall score between 42 and 294 is possible, the higher the score the greater the individual's psychological wellbeing.

Ultimately, the study found that those who scored higher on the internet addiction responses had a diminished level of psychological wellbeing; specifically, in relation to impulse control, loneliness/ depression, and social comfort. It should be noted that impulse control showed the highest levels of negative correlation (r=-.22)[34] and would thus suggest those who responded highly to having a lack of impulse control had a much more diminished level of psychological wellbeing. In other words , there is a strong correlation between the individual's inability to control a situation and their psychological wellbeing, and for this reason it should not be surprising that the positive of this conclusion can also be drawn: the more control an individual has, whether over an addiction or over their life in general, the better their psychological wellbeing.

Obviously, this is not to say that Çardak's study is one that definitively proves the link between wellbeing and control as there are a significant amount of variables that can come with asking someone to introspectively examine their practices, especially in relation to such a stigmatised subject as addiction. It also must be considered that there is the possibility for people when assessing their levels of impulse control to see themselves as out of control when they are actually firmly in control and vice versa. This

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[32] Carol D. Ryff, "Happiness is Everything, Or is it? Explorations on the Meaning of Psychological Well-Being." *Journal of Personality and Social Psychology* 57, no. 6 (1989): 1069-1081. doi:10.1037/0022-3514.57.6.1069. https://psycnet-apa-org.proxy.library.uu.nl/record/1990-12288-001.
[33] Ibid. 1072
[34] Çardak, "Psychological Well-being", Table 1, 137.

is owing to the idea of external and internal loci of control. If someone has an internal locus of control, they simply believe themselves to be in control and that their actions are natural extensions from the decisions they make. This is not to say that they wish to be in control of every facet of their life, but that they see themselves as the main actor in the direction of their life. On the other hand, to have an external locus of control is to view oneself as out of control and that forces act upon them whether they like it or not. Therefore, when responding to these statements it is possible for people to see themselves as more out of control than they may in fact be. This being said, I believe that with the sample size being as large as it was, with almost 500 willing participants, these variables would have a negligible impact on the outcome of the study. Not only this, but it is possible to find a number of other studies including those by Nishat Afroz[35], Ligang Wang et al.[36], and Leo Sang-Min Whang[37] which all demonstrate similarly a link between addiction, i.e. a lack of control, and a reduction in psychological wellbeing.

If we are to return to the case of euthanasia, obviously, it is not possible to be addicted to euthanasia as it can only happen once, however, what Çardak's study has done is illuminated the strong correlation between a lack of control, manifested as internet addiction, and psychological wellbeing. Not only this, but Çardak also posits in the discussion that "consistent with the results of the present study, it appears that if individuals can enhance their psychological well-being, they may decrease their internet addiction"[38]. If this is the case then it would be possible to suggest that a link between the two exists, not just a strong correlation. Therefore, in a similar way to the bungee jump example that was written about earlier, for patients with a terminal illness there are

[35] Nishat Afroz, "Internet Addiction and Subjective Well-being of University Students." *Indian Journal of Health and Wellbeing* 7, no. 8 (-08-01, 2016): 787-794. http://web.b.ebscohost.com.proxy.library.uu.nl/ehost/pdfviewer/pdfviewer?vid=2&sid=485f53e9-ac5b-4435-aea7-0e8ae123b9a7%40pdc-v-sessmgr04.

[36]Ligang Wang, et al. "Internet Addiction of Adolescents in China: Prevalence, Predictors, and Association with Well-Being." *Addiction Research & Theory* 21, no. 1 (2013): 62-69. doi:10.3109/16066359.2012.690053. https://doi-org.proxy.library.uu.nl/10.3109/16066359.2012.690053.

[37] Leo Sang-Min Whang, Sujin Lee, and Geunyoung Chang. "Internet Over-Users' Psychological Profiles: A Behavior Sampling Analysis on Internet Addiction." *CyberPsychology & Behavior* 6, no. 2 (5th July, 2004): 143-150. doi:https://doi-org.proxy.library.uu.nl/10.1089/109493103321640338. https://www-liebertpub-com.proxy.library.uu.nl/doi/10.1089/109493103321640338

[38] Ibid. 138.

two options: take control and choose how to die or wait and deteriorate over time. Ultimately the results are the same. In taking control of their life, as they would take control of the jump when attached to the bungee cord, the patient is able to analyse and scrutinise the consequences of their actions and the decision they come to must be one that promotes their wellbeing. Therefore, it is possible to see how someone who is requesting assistance, as they are otherwise incapable of taking control, is attempting to promote their wellbeing.

One issue that can be raised at this juncture is that there can be no promotion of wellbeing when one is dead. Unsurprisingly, it is impossible to promote the happiness and overall wellbeing of a dead person. However, to make this criticism is to miss the point of the argument. The promotion of wellbeing comes from the ability to control how one dies, not that one is dead. In a similar way that one cannot make the decision to jump when at the fully extended end of a bungee cord, one cannot make the choice to die when dead. However, as we have seen, when one stares over the precipice and chooses the inevitable outcome it will increase “the likelihood that events will be experienced as a natural outgrowth of one's actions and, therefore, not as foreign, unexpected, and overwhelming experiences.”[39] To exhibit control over anything in life can improve a person’s wellbeing, even in the final stages, when it is arguably most important, as opportunities for wellbeing promotion are severely limited.

To conclude: it has been demonstrated that there is a plausible link to be found between the autonomous request for euthanasia and wellbeing. It has been established that the most applicable way of valuing autonomy is instrumentally, as doing so affords the ability to develop individual character and display control over one’s life, both of which promote wellbeing. However, it has also been shown that there is the necessity for some constraint on the autonomous choices which should be respected as otherwise any choice a person made should be deferred to and then allowed to enact it. Therefore, in order to preserve people’s ability to call a choice their own, unencumbered

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[39] Suzanne C. Kobasa, Salvatore R. Maddi, and Stephen Kahn. "Hardiness and Health: A Prospective Study." *Journal of Personality and Social Psychology* 42, no. 1 (Jan, 1982): 169, doi:10.1037/0022-3514.42.1.168. https://www.ncbi.nlm.nih.gov/pubmed/7057354

choices are indicated to be the most applicable form of choice architecture that deserve reverence and respect. In this way, it is possible to see that an unencumbered, autonomous choice for euthanasia can promote the wellbeing of a patient in the final stages of their life.

Chapter 2 - Harm and the Refusal of a Euthanasia Request

Now that it has been demonstrated a request from euthanasia can be seen to increase the wellbeing of a patient through marking them as their own original person, and someone who has control over the direction of their life, it is possible to move on to demonstrating how the refusal of this request can be seen as harmful. In demonstrating such a position, it will be possible, when examining the role of the physician, to make a stronger claim for the acceptance of euthanasia request and the obligation physician's face. In order to do this, we will begin by first looking at what characterises harm, looking mainly at the Millian harm principle. Such a strategy will provide firm grounding on which to base our claims. This analysis will elucidate three ways in which harm can be constituted, which will be scrutinised in a second section dedicated to understanding whether it is necessary to consider all three. Finally, these criteria will be considered in relation to the denial of a euthanasia request in order to show how denying a patient their request for euthanasia is harmful and thus reduces their wellbeing.

2.1 - The Characterisation of Harm

In order to reach the conclusion of this chapter, it is first necessary to form a strong basis for further sections by understanding how harm can be constituted and how it can be evidenced in the world. It is commonly understood that by harming someone we are reducing their wellbeing, i.e. diminishing their state of comfort or happiness; however, this definition does not allow for a concrete understanding of how this reduction in wellbeing manifests itself. As we are working in a consequentialist framework, the best starting point for this discussion is J.S. Mill's harm principle, wherein which he discusses the harm that comes to people through the actions of others.

The harm principle from Mill is based on whether someone unduly restricts a person's actions and ability to realise their autonomous choices. The only time it would be possible to restrict a person's autonomous choices, without causing harm, is when the enactment of these choices would threaten to harm others. As Mill writes:

> The sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant.[40]

In understanding harm, Mill writes that the sort of actions whereby someone restricts the liberties of another is harmful as it can be seen to set back important interests of a person, such as their wellbeing, generated by their ability to become an original actor in the world. To assert this "one simple principle"[41] is Mill's objective for On Liberty, however, as several scholars who have written on the topic point out, it is not quite this simple.

During his writing on the restriction of liberty, David Lyons notes that Mill sees:

> There are also many positive acts for the benefit of others, which he may rightfully be compelled to perform; such as to give evidence in a court of justice; to bear his fair share in the common defence, or in any other joint work necessary to the interest of the society of which he enjoys the protection; and to perform certain acts of individual beneficence [...] he may rightfully be made responsible to society for not doing. A person may cause evil to others not only by his actions but by his inaction, and in either case he is justly accountable to them for the injury. [42]

This complicates the matter. It is now possible to envisage that it is not simply inhibiting a person's ability to attain their autonomously chosen ends that is harmful, but, instead, we must also consider that the omission of action in specific circumstances is something that is also harmful. From this one quote we can understand that there are,

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[40] Mill, *On Liberty*, 26.
[41] Ibid. 25
[42] Ibid. 27

at least, two additional ways of representing harm beyond not allowing a person to enact their autonomous choices. Lyons identifies these as “the cooperation and good samaritan requirements”[43] and proceeds to argue that regulating actions such as these will certainly prevent harm from occurring to others. Therefore, it is possible to note these as markers of harm.

What Lyons refers to as a good samaritan approach, is based on the benevolence of actions with no reference to the other uses of the term, such as the biblical parable. The benevolence of actions, and the reduction of harm, is evidenced by Lyons through giving the example of a drowning man. If I am to come across a man floundering in a lake in obvious distress, then it would be in line with Mill’s harm principle that I owe it to this man to save him in order to cease the harm that is occurring and make sure that no additional harm happens. My inaction in such a scenario would be harmful to the drowning man, not because I have caused him to drown but, because I have failed in “eliciting harm-preventing conduct”[44]. Special notice should be taken that the harm caused to the man by my inaction does not stem from the fact that he is drowning but the fact I am not helping him. It is possible thus to see a picture that it is not only harmful to reduce a person’s ability to enact their autonomous choices but it is also harmful to not prevent a harm that is occurring, if presented the opportunity.

In relation to the court testimony example Mill gives, or as Lyons names it, the cooperation requirement, a denial to take part in this sort of cooperative action must be viewed as a separate instance of harm from the harm evidenced by not rescuing the drowning man. It is not so simple to identify that one protects another from harm through their testimony, or their cooperation in general. Lyons identifies that “Courts, though costly and burdensome, are needed to settle and prevent disputes and for an effective system of social regulation. Courts are needed to prevent evils that are worse

[43] David Lyons, "Liberty and Harm to Others," *Canadian Journal of Philosophy* 9, no. sup 1 (1979): 4, doi:10.1080/00455091.1979.10717091. https://doi-org.proxy.library.uu.nl/10.1080/00455091.1979.10717091.
[44] Ibid. 5

than the evils they entail"[45]. Ultimately, recognising one's role in society and taking up the cooperative mantle is what constitutes harm prevention in this scenario because, in doing so, one is strengthening an institution which is pivotal in the prevention of further harm and develops "a social practice that will help prevent harm"[46] as well. Therefore, in shirking one's role in society and facilitating actions that do not strengthen, or even weaken these institutions and social practices, would be considered to constitute harm on a much larger scale than just for an individual.

The characterisation of harm is, therefore, not as simple as the interference with people's ability to enact their autonomous choices as was initially proposed by Mill. It seems instead to be a multi-faceted concept that includes the omissions of beneficent actions on both a personal and societal level. In not rescuing the drowning man, one is causing harm as they do not act to elicit any sort of harm prevention in order to save the man. However, in not testifying in court one is causing harm by not doing their part to uphold the institutions that protect others from harm and create a strong society. Ultimately, we are left with three criteria, with which, we can understand harm more thoroughly.

2.2 - The Characterisation of Harm: A Critique

The three criteria that have been discovered in reading Mill and the analysis provided by Lyons are not without criticism, however. It can be argued that "liberals such as Smith, Mill and Kant did not maintain that the obligation to avoid harm exhausted human morality. Duties of benevolence were also important in their view, but less central"[47], and, owing to this, it may not be necessary to consider understanding harm, such as the good samaritan and cooperation, in the same way we consider the harm that is caused by the undue interference with autonomous choices designed to carry one towards their desired ends. It is even possible to argue further and suggest that the benevolent cases

[45] Ibid. 6
[46] Ibid. 7
[47] Andrew Linklater, "The Harm Principle and Global Ethics." *Global Society* 20, no. 3 (July, 2006): 330 https://www-tandfonline-com.proxy.library.uu.nl/doi/full/10.1080/13600820600816340?journalCode=cgsj20

of harm should only be considered if we are living in a society that enables people to enact their autonomous decisions[48]. If this is the case, then there needn't be any further consideration of the benevolent understandings of harm. In this section I will defend the stance that all three understandings should be carried through. The basis of this defence will be that it is possible to evidence an undue restriction of our liberties whilst also holding that not being benevolent is still seen as harmful. This should serve sufficient in carrying all three criteria forward and allow for a richer discussion in the subsequent sections relating to how we can consider the refusal of euthanasia to be harmful.

Let us start the rebuttal of the claim that we should not concern ourselves with the conceptions of harm based on benevolence, such as the good samaritan and cooperation, if we do not live in a world with free autonomous choice, by firstly exemplifying that we are not always able to enact our free autonomous choices. The best example of this is demonstrated by Sarah Conly when she writes that we accept laws making us wear seatbelts "even for adults who are sober, rational, competent, and so on, because they so clearly prevent great harms in circumstances where there is no other way to stave off the damage that will otherwise ensue."[49] Not only this, but we do not allow people to self-medicate and require them to see a physician in order to obtain a prescription for medication they could have identified as necessary themselves. Obviously, this is not an exhaustive list of what can be considered as paternalistic, in that whilst liberty is restricted it is for a supposedly greater good, protecting us from ourselves. However, these two examples do provide a basis for which we can plausibly say that the undue restriction of liberty is apparent and even promoted in society. If I do not wear my seatbelt, I harm no one but myself, however, it is possible to be punished for not doing so. If I research and self-medicate, I harm only myself, however, it is restricted. With this being the case, if we are to follow the line of argument we are

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[48] Ibid. 333.

[49] Sarah Conly, "The Argument." In *Against Autonomy: Justifying Coercive Paternalism*, (Cambridge: Cambridge University Press, 2012), 5, https://www-cambridge-org.proxy.library.uu.nl/core/services/aop-cambridge-core/content/view/6A4E0298B62030FF103DA673F3809CD4/9781139176101c1_p1-15_CBO.pdf/argument.pdf

countering, then there should be no reason for us to concern ourselves with the benevolent considerations of harm as they would only be of note if we were able to enact our free autonomous choices, which we are clearly not always able to do.

It is possible to identify instances whereby we value and find it necessary to consider the benevolent understandings of harm, even in a society which endorses the restriction of liberties through paternalistic laws, such as the ones mentioned above. We still see it as necessary to try and reduce the harms that are caused by people not testifying in court. I believe that this is shown by how much support is given, in several ways, to enable people to testify. There is a plethora of resources that have been deployed in order to aid people in testifying in court as either a defence or prosecution witness. Expensed travel to court, translators, disability access, witness care officers[50] demonstrate just a few. All these services are offered in order to make sure that people can give testimony and encourage people to do their part in strengthening society. From this it is possible to argue that in the attempt to get people to cooperate in strengthening the institution and society, we value this benevolence as something which negates harm, otherwise it would not be so important to encourage this cooperation. The amount of resources that are put into this project of encouraging testimony could suggest that we see the undermining of institutions, by a lack of benevolent actions, as harmful to that institution and society as a whole. It is worth noting as well that all the services listed above are provided by the UK government and will therefore be funded by UK taxpayer's money. This serves to further the idea that as a whole society, we recognise the harm produced by non-cooperation and in doing one's part in the societal project, even though not all actions are autonomously free to us even though they do not harm others. Whilst this is only one example, it seems to provide at least a basis for the claim that there is a weakness in the argument suggesting the benevolent understandings of harm should only be considered when we live in a society that allows for the full enactment of autonomous choices: it is possible to see that we still find a necessity to negate the harms caused to society and institutions by people not testifying or cooperating. Thus, we can see that even though we live in a society that restricts

[50] https://www.gov.uk/going-to-court-victim-witness

liberties, there is still value placed on at least one form of benevolent harm reduction as demonstrating what harm is.

The other half of the benevolent harm reducing actions we are trying to recognise is the good samaritan example, and in the same vein as testifying in court, it is possible to see evidence in society that we still value and consider it necessary to recognise the harm that is reduced through the actions of these good samaritans. The praise that is given to those who are good samaritans would suggest that we value what they do in reducing the harm that comes to others, even though it is not them who is responsible for the harm the person is initially facing. For example, a news report highlighted a flight attendant who had gone out of her way to help a girl she thought was part of a human trafficking scheme. After saving the girl, the celebration of this heroic act serves to demonstrate the plausibility that in society we still see the work of good samaritans as important and worthy of consideration in reducing the harm that comes to others. However, according to the argument we have set out to prove incorrect, we should not consider these acts as important or noteworthy as we are not free to enact all our autonomous choices.

Ultimately, it would seem that even though, as a society, we are unable to enact all of our autonomous choices to the fullest extent, we do still consider testifying in court as negating some sort of harm, otherwise we would not put so many resources into furnishing people with the ability to testify. In addition, the celebration of good samaritans demonstrates that society still sees the harms these samaritans negate as worthy of consideration, otherwise these people would not be celebrated. As we aim to place the answer to this project in the real world it would be incorrect to dismiss what this tells us about the forms of harm we have identified, namely, that we should consider all three when moving forward as they all demonstrate a different way of evidencing harm.

However, should we consider these conceptions of harm with similar weight? The first criticism raised at the start of this section was that concerns of benevolent harm

reduction are not as central to arguments that liberals such as Kant, Smith and Mill present. However, for the purpose of this project as we are considering the promotion of a patient's wellbeing and the definition harm simply being the reduction of wellbeing, in any instance where it is possible to identify harm occurring to a patient, whether this be through the restriction of liberties to enact autonomous choices, by someone not taking the opportunity to rescue a person from harms that are occurring to them, or through undermining the development of society and the societal project of not allowing harm to come to others, then we should consider these in the same way. In the next section, these three exemplars of harm, defended in this section, will be applied to the euthanasia debate to demonstrate how a refusal of the euthanasia request can be seen as harmful.

2.3 - Harm in Refusal

As has been argued in the previous chapter, it is possible to understand how a request for euthanasia from a patient is something that could promote their wellbeing, they are able to mark themselves as an original person in the world, whilst also displaying control over the direction of their life. However, in refusing this request for euthanasia, the wellbeing that could be developed by the patient is ceased, thus constituting harm to the patient. But why is it harmful to deny this request exactly? With the three criteria that we have displayed in the previous section: the undue restriction of liberties in order to enact autonomous choices, not aiding those who are already suffering from harm, and not participating in strengthening the societal project and the institutions which aim to protect others from harm, it will now be possible to elucidate the ways in which the refusal of a euthanasia request can be harmful beyond the simple reduction of wellbeing.

It is possible to see the refusal of a euthanasia request as harmful in that it is not a benevolent act that saves someone from the harms they are currently facing. In a similar way to the drowning man, this is a much more situational harm, it concerns whether there is a person being harmed or not. It would be impossible to rescue a

drowning man if there was no man drowning in the first place. In the cases of euthanasia we are concerned with, whilst we have already seen wellbeing is reduced, it should also be recognised that a request from a patient for euthanasia makes it evident that they considers death to be within their interests, and that they are facing harms they no longer wish to face. It is possible, then, to suggest that when a request for euthanasia is made, it is a similar situation to the drowning man; there is a situation of harm that the physician is not responsible for but neglects to help even though they are in a position to do so. A concrete example that serves to clarify this point is the case of Tony Nicklinson, mentioned briefly in the introduction to this project. Suffering from locked-in syndrome, defined as “the condition of an awake and conscious patient who because of motor paralysis throughout the body is unable to communicate except possibly by coded eye movements”[51], Mr. Nicklinson’s quality of life declined rapidly to a point whereby he was unable to eat or drink by himself and was also not capable of communication with friends and family fluently despite being compos mentis. In his suffering Mr. Nicklinson became a euthanasia advocate in the UK, and it is possible to see that in denying Mr. Nicklinson his requests for euthanasia that he was harmed. Similarly to the drowning man, if the person on the shoreside simply left them to succumb to the water, Mr Nicklinson was left to the harm that was being caused by his syndrome and no one ‘rescued’ him by accepting his euthanasia request. The refusal of euthanasia requests can therefore, in at least some instances, be argued to not adhere to the ideas of benevolent harm reduction, but instead actively makes the suffering worse as the person is unable to improve their wellbeing in the only way they see fitting.

We can also see that the refusal of a euthanasia request is harmful because it does not demonstrate any form of cooperation and, as a result, undermines the societal quest and fails to strengthen the institutions which aim to reduce the harm felt by others. It must be recognised that appeals to autonomy have become more prevalent in society, whether it be in relation to bodily autonomy as part of euthanasia and abortion debates, political autonomy in diversifying policy and candidates, or religious autonomy that

[51] Merriam-Webster.com Medical Dictionary, s.v. “locked-in syndrome,” accessed June 2020, https://www.merriam-webster.com/medical/locked-in%20syndrome

allows people to practice whatever and however they like. As autonomy and people's ability to self-govern becomes more prevalent so has its importance in many spheres of people's lives, the restriction of this becomes more questionable and people take more notice of the restrictions put on them. Therefore, if physicians are to deny the autonomous choices of individuals who know which ends they want to attain, it could be argued that the institution of medical care is undermining itself and presenting itself as unnecessarily paternalistic in not cooperating with societal ideas. The refusal of a euthanasia request, in this sense, could reflect negatively on the medical care institution as it does not "bear his fair share in the common defence, or in any other joint work necessary to the interest of the society of which he enjoys the protection"[52] in that it does not reflect the attitudes of society.

Finally, let us tackle what some may suggest is the most obvious form of harm that is portrayed by the refusal of a euthanasia request: it unduly inhibits a person's ability to enact their autonomous choices. The reason this seems to be the most obvious form of harm is that, as we have seen in the previous chapter, through a request for euthanasia a person is trying to promote their wellbeing by using their autonomous choices to display their control over a situation and designating themselves as an original agent in the world. Most importantly, the request for euthanasia does not harm any others; it is the patient's choice and it carries them towards ends they see to be both valuable and desirable, thus promoting their wellbeing further. Therefore, by denying the patient their request for euthanasia, so far as it does not harm others, there is an undue restriction on the liberties of the patient in the enactment of their autonomous choices.

This being said, it could be argued that the request does harm others, namely, the physician. Whilst the role of the physician will be discussed both in general and in specific relation to euthanasia in the final chapter of this project, it would be remiss not to discuss how such a request could be considered harmful to the physician. One of the most pervasive arguments in support of this claim is that to offer, or even agree, to aid someone's death for any reason, is contradictory to the role of a physician. Fiona

[52] Mill, *On Liberty,* 27

Randall, in line with both the British Medical Association (BMA) and General Medical Council (GMC), sees the role of the physician to be related to serving the patient's best interests and delivering clinical improvements which are "of course in relation to the patient's health circumstances, in terms of prolonging life, alleviating suffering, or restoring or maintaining function. An intention to bring about these improvements provides a positive definition of what it is to be a doctor."[53] In this vein, to exhort a doctor to agree with a patient's request for euthanasia would undermine what it means to be a doctor, as in Randall's view "to change the patient's state from being alive to dead is not in any sense bringing about a clinical improvement"[54] Therefore, as euthanasia can be argued to not bring about a clinical improvement, and to deliberately not bring about clinical improvements would be against the role of the physician, it could follow that causing physicians to debase themselves in such a way, is harmful and thus restricting the patient's liberties to enact their autonomous choices for euthanasia is not harmful as it can be justified through its protection of others from harm.

The most applicable way to rebut this claim is to understand the role of the physician more thoroughly. If we are able to do this then it will be possible to recognise how the physician's participation in, and the patient's request for, euthanasia is not something that debases the physician, therefore proving that the restriction of liberty is undue and ultimately harmful. Such a task will be undertaken in the next chapter.

Therefore, whilst there is still work to be done, it is possible to see, that the denial of euthanasia requests is harmful for two reasons: it is a non-benevolent action ultimately leaving people in the same situation of suffering they were already in; it also undermines the societal project and the institutions which are designed to reduce the harm occurring to others. To ignore the autonomy of people portrays the medical institution as unnecessarily paternalistic and uncooperative. As has been written, in the next chapter, it will be possible to demonstrate how the role of the physician is not out of

[53] Fiona Randall and Robin Downie, "Assisted Suicide and Voluntary Euthanasia: Role Contradictions for Physicians." *Clinical Medicine* (London, England) 10, no. 4 (Aug, 2010): 324, doi:10.7861/clinmedicine.10-4-323. https://www.ncbi.nlm.nih.gov/pubmed/20849002.
[54] Ibid.

step with the euthanasia practices, and thus how the refusal of a euthanasia request is unduly restrictive and, subsequently, harmful.

2.4 - Euthanasia, Harm and Wellbeing

Before the commencement of the final chapter, where in which we will discuss euthanasia and the role of the physician based on our current findings, I will take this opportunity to surmise the conceptual work that has been done so far.

Within the first two parts of the project, the goal has been to demonstrate that an autonomous request for euthanasia reflects the best interests of a patient. It was seen that the fulfilment of the autonomously made request would increase their wellbeing when they are either in an end of life scenario or unbearable suffering. In addition, any denial of this request can be seen as harmful. In order to come to these conclusions, I have firstly discussed that it is most applicable to understand autonomy as instrumentally valuable in that it increases our ability to become our own, original person within the world, and having this possibility, subsequently, increases our wellbeing. Having discovered this, it was necessary also to recognise that it would be both unsafe and impractical if there was an obligation to respect every single autonomous choice a person made. Therefore, through looking at how, and what, choices were made we came to the conclusion that the only type of choice that demanded respect from another person was an unencumbered choice; a choice free from both general and specific encumbrances as well as being unhindered by external forces and a person's inability to make sound decisions. Narrowing the scope in such a fashion thus made it possible to discover how an unencumbered choice to request euthanasia promoted the wellbeing of the patient through allowing them to exert themselves on the world and control over a situation. This enabled us to conclude the chapter by suggesting that, if the choice for euthanasia was unencumbered there is no prima facie reason to deny it, as it can increase the wellbeing of the patient.

With an understanding of how a request for euthanasia can increase a patient's wellbeing, it was necessary to look at how the refusal of this request could be harmful. It

was firstly defined that harm is the reduction of wellbeing, however, such a definition did not elucidate how the refusal was harmful, just that it was. Therefore, it was necessary to understand what harm is and how it looked in the world. As part of this investigation three ways were discovered. Firstly, a simplistic Millian account which had been alluded to throughout the first section; the undue restriction of a person's autonomous choices is harmful to that person. Secondly, David Lyons demonstrated the good samaritan aspect of the harm principle which suggested that for people not to act in a benevolent manner towards their fellow man, as part of a society, was harmful. Finally, cooperation to strengthen society and the institutions that protect others from harm is necessary. If one does not testify in a court of law, for example, they are causing a degree of harm to people as they are shirking their responsibility for upholding society and strengthening the position of institutions which protect others. Given these exemplars of harm it was possible to analyse how the refusal of a euthanasia request was harmful beyond simply reducing the wellbeing of the person who requested it. In two of the three aspects, the refusal of a request can be seen as harmful: it is not a benevolent act which stops the harms someone is already facing, and it does not strengthen, but undermines, the institutions tasked with protecting others from harm. It will be possible to understand the refusal of a euthanasia request as harmful in relation to the undue restriction of the patient's autonomous choice, however, such an exercise will take place in the next chapter where we examine the role of the modern physician.

With these conclusions reached, it is possible to see that a request for euthanasia can increase wellbeing, and that the denial of this request is necessarily harmful to the patient. As this is the case, it is now possible to answer the question of what this means for the role of the physician.

Chapter 3 - The Role of the Physician

In this final chapter we will examine the role of the physician in relation to the conclusions we have reached so far. On a prima facie understanding, what has been done so far would suggest that the physician should accept all unencumbered requests

for euthanasia in order to promote the wellbeing of patients and reduce the harm caused through the refusal. For this reason, the first section of this chapter will look distinctly at the arguments that would suggest the physician should accept the position presented thus far and analyse the commonly accepted definition of the role of a physician. Once this has been completed we will examine how current euthanasia practices can be reconciled with the role of the physician, how the argument that has been developed throughout this project is different to current reasons for allowing euthanasia, and what this would mean for the role of the physician. Finally, a glance into the future and how the argument we have made here could impact the medical profession moving forward.

3.1 - The General Role of the Physician

As has been said, at least prima facie, the argument that has been developed thus far calls for the physician to accept all unencumbered requests for euthanasia in order to promote the wellbeing and reduce the harm the patient will face if the request is denied. To assert this beyond a prima facie argument, it is necessary to look at how people traditionally characterise the role of the physician and thus, based on this, how it can be suggested the physician should accept unencumbered requests for euthanasia.

One of the most common and fundamental bases from which we can derive the role of a physician is the Hippocratic Oath. Written at some point between the 5th and 4th century BC, the Hippocratic Oath does a great deal to develop precepts of medical practice that are seen as obligatory today. For example, passages such as “I will never harm my suffering friend, because life is sacred” paints the role of the physician as a healer and a carer for the sick and infirm. Someone who holds that there is a sanctity in life, and will aim to relieve suffering in any forms, seeking guidance if they do not know how. The physician who swears by the Hippocratic Oath is one who swears “to care for anyone who suffers, prince or slave”[55]. It is for neither fame nor glory that the physician heals another being but as a servant of the people. Unfortunately, as an ancient text this

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[55] Amelia Arenas, and Hippocrates. "Hippocrates' Oath," trans. Amelia Arenas, *Arion: A Journal of Humanities and the Classics* 17, no. 3 (Jan 1, 2010): 73, https://www.jstor.org/stable/40646005.

oath has a plethora of different interpretations and has been “freely re-fashioned over the centuries to fit the convictions of the time”[56]. However, this being said, the main foundations of the text are still reflected to this day. Looking at recent medical board’s guidance of good practice, such as the General Medical Council, we can see guidelines directing physicians to “make the care of your patient your first concern”, “recognise and work within the limits of your competence” and “respect the patients’ right to confidentiality”[57]. All these types of dictums are, in some way, referred to in the Hippocratic Oath. Therefore, considering the conceptual work that has been done prior to this, whereby it is possible to see the refusal of a euthanasia request as harmful, if we see the physician as a healer in the same way the Hippocratic Oath has here, then it is possible to understand physicians as people who reduce the suffering a patient feels and thus, in order to alleviate the suffering and harm that comes to a patient, as well as promote their wellbeing, the physician should accept the request for euthanasia.

The way the role of the physician has developed for the modern day is that it now includes guidance such as working in partnership with the patients whereby a physician is expected to “listen to, and respond to their [the patients’] concerns and preferences”, “give patients information they want or need in a way they can understand”, “respect the patients’ right to reach decisions with you about their treatment and care” ,and “support the patients in caring for themselves to improve and maintain their health”[58]. Even though these directions are not included in the Hippocratic Oath specifically, they still seem to be in line with the picture that the oath paints of the physician: working in the interest of the patient and not for themselves. Such a development would suggest that there is a turn toward valuing the patient’s input in their treatment and thus allows for a us to suggest that a physician should respect the value of the unencumbered choice for euthanasia in such a way that would incline them to accept the request.

[56] Ibid. 74

[57] "The Duties of a Doctor Registered with the General Medical Council," General Medical Council, Accessed June, 2020. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice/duties-of-a-doctor#knowledge-skills-and-performance.

[58] Ibid.

Interestingly, one of the most common arguments that is attributed to the Hippocratic Oath does not actually appear there. The regularly toted dictum "first, do no harm", is commonly misattributed to the Hippocratic Oath as the foundation of what it means to be a physician. However, as it was written in Latin, 'Primum non nocere', this would suggest it is not Hippocrates' writing as he wrote in Greek. The 'first, do no harm' doctrine is actually the work of Thomas Sydenham and is attributed as such in Thomas Inman's 1860 writing 'Foundation for a New Theory and Practice of Medicine'[59] [60]. Whilst it may not be specifically attributable to the commonly held foundation of what it means to be a physician, this should not count against the idea of a physician reducing the harm a patient faces. Instead, as Daniel Sokol points out, it is not possible for a doctor to do absolutely no harm, instead the attitude should be: "first ,do no net harm"[61] . When we examine some of the more mundane processes of healing someone, processes that are held as the most common way to make someone well again, we will see that there is some sort of harm involved in these practices as, "whether it is by inserting a cannula, administering chemotherapy, performing a tracheotomy, opening an abdomen, or drilling into the skull. Most attempts to benefit a patient require the infliction of harm or, at the very least, involve risks of harm."[62] Therefore, if we were to adhere to the first do no harm doctrine, our medical advancements would be stalled. If someone is to characterise the more approachable, first do no net harm, version within the role of the physician, which does seem sensible, in that they are someone who does their best in order to do as little harm as possible to return a net positive wellbeing for the patient, then I would argue that they are obliged to accept the unencumbered requests for euthanasia from patients. Requesting euthanasia at the end of life has been suggested to improve a patient's wellbeing, and the refusal of this request has been demonstrated

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[59] Thomas Inman, Foundations for a New Theory and Practice of Medicine. (London, United Kingdom: J. Churchill, 1860,) 244
https://archive.org/details/foundationforan00inmagoog/page/n272/mode/2up?q=non+nocere.
[60]Cedric M. Smith, "Origin and Uses of Primum Non Nocere--Above all, do no Harm!" Journal of Clinical Pharmacology 45, no. 4 (2005): 372, doi:10.1177/0091270004273680. https://link-gale-com.proxy.library.uu.nl/apps/doc/A140794873/AONE?u=utrecht&sid=AONE&xid=e2830a86.
[61] Ibid.
[62] Daniel K. Sokol, ""First do no Harm" Revisited." Bmj 347, (25th October, 2013): f6426. doi:10.1136/bmj.f6426. http://www.bmj.com/content/347/bmj.f6426.abstract.

to harm the patient, therefore, in refusing the request, there is no net positive wellbeing, just net reduction.

It is also pertinent to mention the fact that in the Hippocratic Oath, there is a specific passage to condone the practice of euthanasia as something that is not within the role of the physician. One should not “give him an herb to soothe his pain, even if he begs for it in anguish, if it might take away his breath”[63]. If we are to use the oath to underpin what the role of the physician is, then such a passage should be contended with. Not only this, but the passage is used as one of the main criticisms of the pro-euthanasia argument. However, what undermines this argument somewhat is that it ignores how, in the modern day, we commonly practice surgery and abortion, both of which were also supposed to be outside of the role of the physician when the oath was written. For this reason, in decreeing what the physician should not do, the oath is significantly outdated when applied to modern medicine. Whilst it is useful in affirming the underlying precepts of what it means to be a physician, the wide acceptance of abortion, and the necessary role surgery plays in modern medicine, undermines the use of the Hippocratic oath as a way of defining the limitations of the role of the physician. If it is possible for abortion and surgery to be within the role of the physician, there is no reason why the status quo cannot change to include euthanasia as well.

From these common assessments of what it means to be a physician, it is possible to make an argument that obliges the physician to accept the request for euthanasia if they are to continue with their current understanding of what it means to be a physician. Not only this, but in understanding the physician’s role as one which is constituted by healing, reducing harm and promoting wellbeing, we are able to understand how no harm comes from a patient’s request for euthanasia, as the role of the physician is not under threat from such a request. Euthanasia is not contradictory to the role of the physician. Thus in this section we have concluded the project held over from the previous chapter, wherein which we aimed to suggest that the refusal of a euthanasia request is harmful in that it unduly restricts a person’s ability to enact their autonomous

[63] Arenas and Hippocrates, *“Hippocrates’ Oath,”* 73

choices. However, the argument that has been developed throughout this project is different from current euthanasia practices in the countries that do permit it. In the next section we will discuss this difference and what it means for the role of the physician.

3.2 - Euthanasia and the Role of the Physician

Whilst it is possible to suggest that the argument we have made throughout this project is one that is in line with the role of the physician and, owing to that, an argument it seems should be accepted; it is worth noting that the autonomy argument we have seen puts different strains on the relationship between physician and patient than the current euthanasia practices that can be found in countries such as The Netherlands. In this section I will use the Dutch euthanasia practices to realise some of the differences between the autonomy argument we have developed and the current practices, especially in connection with the physician's role in the physician-patient relationship, and how this relationship would change.

The Dutch Termination of Life on Request and Assisted Suicide Act (wtl) was implemented in 2002 to give jurisprudence to euthanasia in The Netherlands. What is important to note is that this does not fully legalise euthanasia, but it does give physicians an immunity to punishments associated with euthanasia such as the risk of imprisonment of up to twelve years or a maximum fine of €82,000. The way that the act protects the physician from legal recourse is through developing six requirements that demonstrate the physician took due care in coming to the decision to euthanise a patient. These six requirements are:

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 a-d above;
f. The termination of life on request has been carried out with due care from the medical perspective.[64]

What is most important in the protection of the physician, is that after they commit euthanasia, the act must be reported to their regional committee, who will preside over whether all due care requirements were met. If the committee decides that the requirements were not met, then the case will be escalated to the Public Prosecution Service, who can decide whether to prosecute the physician, and the Health Care Inspectorate who can opt to start medical disciplinary procedures. Such practice is uncommon, "In the period to which the second evaluation of the Act relates (2007-2011), the Regional Euthanasia Review Committees assessed almost 14,000 reports of euthanasia or assisted suicide. In 36 cases, the Regional Review Committee found that the physician had acted without due care in one or more respects."[65]

From these due care requirements, and the system in which they work, it is possible to notice the differences between the Dutch system and the argument I have developed within this project. One of the most striking differences between the two approaches is the motivations. If we look at the Dutch situation it is possible to see that the focus is on both autonomy and the compassion of the physician in order to carry out a euthanasia request. Whilst the autonomous, unhindered request of a patient is necessary, evidenced in due care requirement (a), there is also a necessity for compassion on the side of the physician. Such compassion is evident in two ways: first, the physician's need to empathise with the patient's suffering, which only the patient can know. The

[64] Johan Legemaate, and Ineke Bolt. "The Dutch Euthanasia Act: Recent Legal Developments." *European Journal of Health Law* 20, no. 5 (2013): 453. doi:https://doi.org/10.1163/15718093-12341298. https://brill-com.proxy.library.uu.nl/view/journals/ejhl/20/5/article-p451_2.xml
[65] Ibid. 454

physician can offer medical advice but they will not be able to experience the suffering the patient does, and, for this reason, must have some compassion when it comes to dispensing medical advice and recommending the best course of action. For example, if a treatment were to improve the patient's condition only momentarily, and their suffering remained in the long term, then it would be necessary for the physician to have some form of compassion in advising this treatment if they knew it would do little for the patient's suffering and overall condition. Second, in the Dutch context, the physician will "find themselves confronted with conflicting duties, and these situations are difficult to resolve"[66]. The clashing of these duties, to some extent, is what this project has aimed to solve, however, when there is a clash and the physician does what is best for the patient, not what is best for them, such a decision can only stem from compassion for the patient's plight. Therefore, whilst compassion may not be the bedrock of the Dutch euthanasia act, it is certainly a significant part of its development and enactment. If we are to compare this to the argument that has been developed throughout the paper, then with no room, or need, for compassion, the argument is based solely on the autonomous request of the patient. One ramification of this is that the physician-patient relationship will change from being a joint endeavour, predominantly led by the physician, to being a patient led relationship. The reason the relationship will be inverted, whereby the patient takes the lead, is because, as we have demonstrated, there is an increase in the wellbeing someone can feel through a request for euthanasia, and harm occurs when it is denied, and if the physician wishes to adhere to the commonly understood role of the physician then they should cede control to the patient. If the physician is to take charge of the relationship, it is possible for them to harm the patient and to deny them an increase in wellbeing which should be against their aims as a physician. Thus the relationship is inverted, the patient is in charge of the decision making, at least in this one instance, and the request for euthanasia goes from being a request for permission for the physician to being a request for help that the physician should accept.

[66] Antina de Jong, and Gert van Dijk. "Euthanasia in the Netherlands: Balancing Autonomy and Compassion." *World Medical Journal* 63, no. 3 (October, 2017): 14, https://lab.arstubiedriba.lv/WMJ/vol63/october-2017/#page=12.

One issue with taking such an autonomous approach, in relation to the role of the physician, is that if the patient is left to lead the decision making on whether euthanasia is the correct course of action in order to promote their autonomous decided ends and wellbeing, then the physician will no longer be able to act as a sort of checks and balances system. For example, the due care requirements that we saw in the Dutch context can be seen to provide the physician with a way to check the wants and demands of the patient, to ensure that the choice they are making is well founded and 'correct'. If we are to remove this, it is more than possible for the patient to make a mistake. However, I believe that this worry is misplaced. As we have stipulated in the opening part of this project, it is not necessary to respect every single autonomous choice someone makes, as to do so would be ruinous and dangerous, however, it is the unencumbered choices that should be respected. If it is only the unencumbered choices that should be respected, that is, it must be made with access to full information, and, therefore, when reflected on, this will result in the satisfaction of requirements (c) and (d). With all information presented to the patient, they should be able to decide whether there are any other viable solutions to the situation that they find themselves in. On top of this, "As it is the patient's own experience of pain and distress that causes the suffering, it is up to the patient to indicate what the nature or degree of this suffering is."[67] The suffering the patient is facing can only ever be known by the patient, and as such, should be enough to satisfy requirements (a) and (b). If a patient is to make an unencumbered request for euthanasia, then it would suggest that they consider their suffering to be unbearable and unsolvable as otherwise they would not make the request. Therefore, if the patient is to make a request for euthanasia, it should be evident that, as long as the request can be seen as unencumbered, the role of the physician where in which they act as a system of checks and balances, along with the due care requirements, is not a necessary one. The patient will be capable of checking and balancing their own request when making the choice as it will be in relation to the promotion and development of their wellbeing. Ultimately, what developing an autonomous argument for euthanasia has done in this sense, is that it allows the

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[67] Ibid. 12

patient, in taking charge of the physician-patient relationship, to be in control of the promotion of their own wellbeing at the end of their life.

Whilst such an approach does allow the patient to take control of the relationship, if they so choose, it is possible to argue that this is an issue and that the role of the physician should be one that is paternalistic in order to serve the patient's best interests. As we have seen earlier, paternalism, being characterised by restricting people's ability to make and enact autonomous choices for their own good, is part of everyday society, and within medicine it has been prominent for centuries. The Hippocratic Oath suggests that medicine should be open to all to learn, however, it leans on the side of the physician when it comes to treatment. With their knowledge and expertise, it is the physician who should make decisions and choices that would be best for the patient. However, this attitude that "Just as parents may sometimes have to make important decisions in a child's best interests against the child's will or by deception or without telling the child, so doctors sometimes have to act on behalf of their patients"[68] , has started to wane in recent years and patients, in all aspects of treatment, are beginning to have more of an input. It is possible to find in the Good Practice Guidelines of the General Medical Council some more patient centred principles that value a patient's input in the medical process, such as "Respect patients' right to reach decisions with you about their treatment and care"[69]. Whilst a physician is undoubtedly more medically qualified than their patient, "he is not better trained professionally to make moral assessments than is his patient, and even if he were many would object that it is not the doctor's role even to advise on his patient's moral decision let alone make them."[70] Therefore, it is possible to doubt that the role of the physician, especially in the physician-patient relationship, should claim any sort of paternalism. Admittedly, the position that I present takes the weakening of the paternalistic relationship to the extreme, in that it does not see it necessary to have one, but when we consider the

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[68] Raanan Gillon, "Paternalism and Medical Ethics." *British Medical Journal (Clinical Research Ed.)* 290, no. 6486 (29th June, 1985): 1971, doi:10.1136/bmj.290.6486.1971. http://www.bmj.com/content/290/6486/1971.abstract.
[69] General Medical Council, "The Duties of a Doctor"
[70] Gillon, "Paternalism and Medical Ethics," 1972.

promotion of wellbeing and the reduction of harm in doing no net harm, it would suggest that the removal of the paternal relationship during end of life care, for a specific subset of patients, would allow the physician to most fully endorse their role.

To some extent, this role inversion has already become part of the medical care institution as we have already seen through the GMC making it part of the physician's duties of good practice to work with their patients to achieve the best possible outcomes. Even though the role of the physician is no longer wholly paternalistic, and change is happening, there are still elements of paternalism that remain. Whilst physicians do cooperate more with their patients than they did, the relationship is still one that is physician led. The move that this project's argument makes, speeds up the trajectory of such change, allowing the relationship to become one led by the patient. This is what will achieve the greatest fulfilment of the patient's best interests. This inversion of the physician-patient relationship is the most major difference that can be observed when considering how the argument developed throughout this project would change the role of the physician from what it is commonly understood to be. Comparing it to the Dutch arrangement has allowed us to develop this point in relation to an understanding of what the role of the physician was in a country that offered immunity to physicians who correctly perform euthanasia.

3.3 - The Future

Finally, we will discuss how the autonomous approach we have advanced throughout this thesis would have an impact on the practice of medicine in the future, if it were to be adopted. In this section we will, firstly, discuss whether the physician should be the one who commits the act of euthanasia, as put forward by Randall and Downie. Alongside this, we will consider how, given that in defining respect we saw it to be about allowing the person to enact their choices, the physician is obliged to help the patient. Finally, these two points will lead into the main query of the future of medicine with the autonomous approach: are people capable of making the correct decisions for their health, and will a patient led relationship have a detrimental effect on people's health?

In answering these questions and concerns I hope to paint a more vivid picture of what I see the role of the physician to be in the relationship between physician and patient, and how I believe the practice of medicine would develop.

The first point that will be addressed is whether euthanasia is necessarily the physician's job. Such a point is raised by Fiona Randall and Robin Downie when discussing the methods of euthanasia. They point out that "this argument, however, does not show that doctors must necessarily be involved [...] If a method were to be proposed for AS/VE [assisted suicide/ voluntary euthanasia] which did not involve the administration of a lethal medication overdose, for example electrocution or cyanide, then there would be no presumption that doctors should make the decision or carry out the act"[71]. In response to this, I believe that it is not possible to remove a physician from the euthanasia debate, otherwise the death of the person would be suicide or murder. It is important that a physician is involved in the process in order to give the patient medical advice as to their condition and provide information that will allow the person to form their unencumbered decision on what they wish to do. However, it seems that Randall and Downie are more concerned with the final action of the individual actually dying. If there is no necessity to use methods that involve the lethal overdose of medication to induce death, then there is no need for the involvement of the physician. As we have argued throughout this section, the role of the physician is one of wellbeing promotion and doing no net harm, and for a physician to withdraw from the care of their patient they reduce the overall wellbeing that it is possible for the patient to experience. It would be distinctly odd, in any other treatment scenario, for a physician to turn their back on the patient. The role of the physician dictates that they are in that relationship until the patient is either healed, and no longer needs them, or is dead, and nothing more can be done; whilst the patient is still alive, it is the physician's role to aid in promoting their wellbeing and reducing the net harm that comes to them, and for those who cannot actively kill themselves, it is necessary for the physician, when it is

[71] Randall and Downie, "Assisted Suicide and Voluntary Euthanasia: role contradictions or physicians," 323

expressly in the patient’s best interests to die, to aid them in order to be congruent with what it means to be a physician. Therefore, the physician must be involved.

This idea of continuity of care, where the physician is seen to aid in the development of a patient’s wellbeing, by being with them throughout their medical journey, is also able to allow us to understand why, even though the definition of respect that we used earlier does not necessitate aid, the physician is obliged, by their role, to help the patient die. The definition of respect that was used previously centred around not obstructing a person’s ability to enact their autonomously chosen ends, instead of providing an environment where the person could enact their choices. Therefore, such a definition would not seem to oblige a physician to aid a patient in dying, if that is the unencumbered autonomous choice they had come to, instead they would have to respect the request by allowing the patient to enact their choice. However, as we have seen, through the role of the physician as a promoter of wellbeing, and a preventer of net harm, this is where the obligation to help derives from. If a physician wishes to not debase themselves from what it means to be a physician, then it would seem that due to the refusal of a request causing harm, that they are obliged to aid the patient.

Finally, one of the most important and worrisome criticisms that is apparent when developing arguments from autonomy is: if we are to make this argument in order to advocate for a specific set of patients who would request euthanasia to receive it, then why should this approach not be implemented into the rest of medical practice? Why should we not allow the autonomous choice of patients to take charge of the physician-patient relationship in all aspects of medicine? To this I reply: there is no reason why it shouldn’t be extended. Underlying this project has been the idea that through the exercising of autonomous choices, a person or patient is the most able judge of what would best improve their wellbeing, whether that be in relation to following their physician's advice, or their own decisions. As it has been written a few times during this chapter, it would seem that the general guidance for physicians in how to best achieve their duties, is also beginning to realise such an idea as well, and whilst the position in this paper might seem radical in suggesting allowing the patient to take charge of the

relationship, it would appear to be nothing more than a continuation of the current trajectory of the physician-patient relationship.

Again, however, we are met with a criticism: are people capable of choosing and would the reliance on patient autonomy not have disastrous effects on the general health of patients? Whilst this is a valid concern, the empowerment of people to own the physician-patient relationship need not lead to the dystopian future some people think it will. It should be remembered that, just because the patient is in control of the relationship does not mean they cannot realise their inexperience in medical matters and cede control to the physician if they believe that, with their best interests in mind, that cooperating with the physician’s treatment plan will bring them more wellbeing than not. If a patient is to refuse treatment for something mundane, such as routine surgery with a high chance of success, with such a decision being come to in an unencumbered way, in light of full information etc, then this patient will have decided that not having such a surgery will promote more wellbeing than following the advice and guidance of the physician. I would argue that as long as the wellbeing of a patient is promoted in either way, whether control is ceded to the physician or not, that the consequences, as long as they do not harm others, are not as disastrous as critics would suggest. Whilst such an approach would not sit comfortably with a number of people, it would be hoped that, due to their specialisation, a great deal of people, when faced with medical decision making, would cooperate with the physician on a treatment plan as it would promote their wellbeing more than not, however, even if they did not, their wellbeing would be promoted.

Simply put, the future of medicine when considering the implications of an autonomy argument for euthanasia, being implemented across the medical institution, is one that inverts the relationship of patient and physician. The patient is to lead the relationship in order to promote their wellbeing, whether this be through their own decisions or ceding power to the physician.

Conclusion

In conclusion, throughout this project we have demonstrated that a request for euthanasia from a specific subset of patients, such as Tony Nicklinson, when autonomously chosen, is something that can promote their wellbeing, and, as such, should be permitted. With this being the case, it is also possible to notice that the refusal of these requests are harmful, not merely because it reduces the wellbeing of the individual, but also because it unduly inhibits the patient's ability to enact their autonomous, wellbeing promoting, choices. Not only this but, it is a non-benevolent action which does not attempt to protect people from any further reduction of wellbeing, and it does not cooperate with society in upholding the societal idea of autonomous choosing, as autonomy becomes a more pervasive concept in society. Through demonstrating that an autonomous request for euthanasia can both improve a patient's wellbeing and be seen as harmful; this has allowed for the elucidation of what implications there are on the role of the modern-day physician. In looking at their role, it was seen that the modern physician is one who promotes the wellbeing of their patients, heals them, and does no net harm and, in adhering to their role, someone who should be obliged, when requested by their patient, to aid in that patient's death. It was possible to apply the autonomy-based argument that had been presented throughout the project to the euthanasia context by demonstrating the differences between it and the Dutch euthanasia practices. Ultimately, it found that such a strong reliance on autonomy would, most likely, lead to the role of the physician changing ever so slightly. Instead of the physician being in control of the physician-patient relation, as is currently the case, it would be inverted; the patient would take control. Finally, some speculation as to what such discoveries would mean for the future of medical practice. These noted worries and objections to specific parts of the autonomous argument, such as whether the physician needs to be the one involved with euthanasia if it does not include the use of lethal overdose of drugs, and how it would be impossible to promote an autonomous based euthanasia argument without developing it for every facet of medical practice. However, in dealing with these concerns, it became apparent that the results of our argument are just an extension of the trajectory along which, medical practice has been changing for the last few decades. It was also important to remember that not all

patients will retain their control when entering into the patient-physician relationship, and could decide that it is best for the physician to take charge as this is what will promote and nurture their wellbeing most comprehensively. This has allowed for the overall aim of the project to be achieved: for a specific sub section of patients, namely those at the end of their life, or in unbearable suffering, euthanasia should be permitted, and that physicians, in accordance with the commonly understood role of a physician, should be obliged to assist the patient in fulfilling such a request.

As this thesis marks a preliminary exhibition into the euthanasia debate, and the role of the physician for the author, there are a few methodological and philosophical questions that could provide a foundation for further research. For example, considering J.D. Velleman's arguments against people having a right to die, could prove interesting opposition to some of the claims made in this project, and even possibly used as a counter argument. One question that is also left open at the end of this project, is whether the paternalism of the physician has simply been moved a step back in the chain. Whilst the physician may not be in the role of checking and balancing the actual request a patient makes to ensure they are a suitable candidate for euthanasia, as has been seen in the Dutch context, they are now the decider as to whether the patient is making an unencumbered choice. Is it necessary for the patient to demonstrate they are making an unencumbered choice and, if so, how would this be possible? Can the physician just assume the patient will always do what is in their best interest, and that it will be unencumbered, whilst still being within their role as a physician? These are a few questions that can be raised philosophically and form the foundation for further research.

Methodologically, whilst it was mentioned in the section, both the instrumental and intrinsic approaches to autonomy were equally valid, however, the intrinsic approach to autonomy was rejected in favour of the instrumental approach, and a consequentialist framework. Further research could be done into what it would mean for the role of the physician, if a non-consequentialist approach was taken, and the intrinsic value of autonomy was favoured in the initial conceptual work.

Whilst reflection of this manner is necessary in order to provide a basis for further philosophical enquiry, and validate the claim that this topic is alive and changing, in approaching the debate through the lens of autonomy and the role of the physician, I believe that a convincing argument has been made as to why countries that do not allow any practice of euthanasia, should in at least some cases, permit it for the good of their patients that desire it. Ultimately, an argument from autonomy, such as the one presented in this project, should allow for ongoing, open and fruitful discussion on the rights and promotion of wellbeing in people at the end of life, especially in scenarios where they would see death as a preferable option to palliative care.

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