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A Dutch bill on ‘completed life’: An ethical reflection on some of its social conditions and possible societal consequences

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This Annotation is about the discussion of a contested Dutch bill titled ‘Support in Termination of Life on Request for Elderly Persons (Review Procedures) Bill’ (colloquially known as ‘Dignified End of Life’), developed by Pia Dijkstra, a Member of Parliament for the political party D66. The Annotation has two parts. The first part, sections one, two, and three, are written for a broad audience that wants to be quickly informed about the political and social background and broad outlines of the ethical debate in the Netherlands. Sections 4 and 5 contain an elaboration of some specific questions and arguments about the scope of the bill (section 4) and the possible broader effects on the position of elderly people in society (section 5). These sections are meant to deepen and stimulate the social debate and are written for ethicists and scientists as well as ordinary citizens.

Section 4 focuses on the development of an agenda for the professional standards of a life-termination practice provided for in the bill, and in particular on the interpretation of the voluntariness and deliberateness of a client’s request for assisted suicide. Section 5 focuses on the effects on public morality. In the most accessible manner possible, an argument is presented that was originally developed by American philosopher David Velleman regarding the consequences of an institutional and public regulation of assisted suicide for the elderly. Velleman believes that what at first glance appears to be an additional option for citizens

who wish to end their lives, does on closer inspection have consequences for the position of elderly people in society and for their potential considerations of whether to end their lives. In our view, these two issues – one conditional, one consequential – have not been sufficiently articulated in the social debate, at least up to the time of writing (2018). Central to this discussion is the notion of freedom and different interpretations and contexts of freedom.



Should the government formulate laws to enable and legally regulate professional help to elderly people who consider their life ‘completed’ and wish to end it?¹

Since 12 October 2016, this question has been one of the most controversial issues in the Dutch public debate. On that date, the then Minister of Health, Welfare and Sport, Edith Schippers, responded to a report of a commission chaired by prominent sociologist Paul Schnabel, which had been handed to her in February 2016. The commission’s assignment was to provide advice on legislation that would help elderly people who want to end their life, but who do not have access to the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act (hereafter Termination of Life Act or Wtl) because there are no medical grounds for their wish.² The Commission advised the government against developing such legislation. The group that would benefit from such a new law was considered to be too small, and the current Termination of Life Act was considered to offer a solution in most instances of distressing suffering experienced by the elderly. These cases often involve an accumulation of medical, psychological, and existential conditions.³ In her reaction, the

minister did not take up this advice. She wanted to follow a political path in this matter of principle and to investigate the possibility of meeting the wishes of individuals to die with dignity on the basis of their own judgement that their lives are ‘complete’ or ‘done with’.⁴ Two months later, D66 MP Pia Dijkstra presented her ‘initiative bill’ Support in Termination of Life on Request for Elderly Persons (Review Procedures) Bill (Wet toetsing levensindebegeleiding van ouderen op verzoek, hereafter Wlov),⁵ which aims to turn this possibility into a legal practice.⁶

This bill has been at the centre of the discussion ever since. The coalition talks that dragged on in 2017 were delayed by the issue. The conservative Christian Union party and the liberal party D66 particularly clashed on this issue, but during a further round of discussions they eventually succeeded in reaching a compromise.⁷ The new Cabinet took no initiative in this matter other than to stimulate further social debate and scientific research into the need for a Completed Life Act. This Ethical Annotation is a contribution to this social debate, but it is not a complete overview of all relevant aspects. It presents, from an ethical perspective, a description of the main positions in the debate (sections 2 and 3) and an elaboration of some specific questions and

- 1 We put ‘completed’ in inverted commas, because this is how the issue is usually referred to in public debates. However, we will not go into the meaning of ‘completed life’, primarily because the bill at issue here does not use this term. The law concerns ‘elderly people’ (over 75), and is named ‘Dignified End of Life’. At the core of the law is an elderly person’s own assessment of his or her life situation, the liberty to decide to end one’s life, and the right to be assisted by professionals in carrying out this decision. The term ‘completed life’ is also frequently discussed in the Explanatory Memorandum attached to the bill, often in combination with the phrase ‘suffering from life’.
- 2 The Termination of Life Act specifies conditions under which doctors can provide euthanasia or assisted suicide without being persecuted. One condition is that the suffering is medical in kind. Euthanasia differs from assisted suicide. In cases of euthanasia, a doctor administers a lethal drug (often via IV), whereas in cases of assisted suicide, the doctor provides the drug, but the patient takes it herself.
- 3 www.rijksoverheid.nl/documenten/rapporten/2016/02/04/rapport-adviescommissie-voltooid-leven, accessed May 2023. For the view that the existing Termination of Life Act allows room for euthanasia, see also Wijsbek (2006).
- 4 www.tweedekamer.nl/kamerstukken/detail?id=2016D38755&did=2016D38755, accessed May 2023.
- 5 Wlov is an abbreviation of the Dutch name of the Act. We have left the reference Wlov untranslated, assuming that it will be clear for the English-speaking reader on the basis of this translation.
- 6 In the Dutch House of Representatives, an ‘initiative bill’ is a proposal for a bill drafted not by the Government, but by an MP. <https://d66.nl/verkiezingsprogramma/voltooid-leven>, accessed May 2023.
- 7 Four years later, the coalition talks of 2021 were again delayed by this clash, and the ending was the same: it was solved by a compromise.

arguments about the scope of the bill (section 4) and the broader effects on society, especially the position of the elderly (section 5). In our opinion, these issues have not been sufficiently discussed in the social debate up to now. Central to the discussion is the notion of freedom and different interpretations of freedom in this context.

SOCIAL CONTEXT

The debate on assisted suicide for the elderly is neither new nor surprising. Increasing numbers of people live longer and longer, and being of a certain age, and particularly the last period of a person's life, is associated with numerous physical, psychological, social, and existential problems. Secularisation leads to citizens putting values such as autonomy and individual freedom at the centre of their lives, as opposed to the more objective normative ambitions of institutions such as church and state. The call for more personal control over the end of life fits in with this development. In 1991, the jurist Huib Drion wrote an appeal to society to develop a pill that would allow the elderly to actively end their lives when they feel the time is right.⁸

However, the arguments about being tired of life and suffering from life put forward for this purpose were weighed and rejected by the Dutch Supreme Court in 2002 in the Brongersma case. The Court opted for a strict interpretation of the legal requirement that euthanasia is justified only in cases of 'unbearable suffering', tailoring the application of the requirement to physical

suffering, as formulated in the Termination of Life on Request Act (WtI). Under the WtI, euthanasia remains punishable, but the law provides a ground on which physicians can be declared exempt from punishment in case certain procedural and substantive requirements of the law are met. However, up until now there have been no legal cases brought to court in which physicians have been sentenced to effective punishment. (The legal context will be explained in more detail below.) The more recent discussion began in 2010 with a successful citizens' initiative entitled 'Uit Vrije Wil' ('Out of Free Will'), which urged the government to legally regulate the issue of seeking professional help with suicide. Regulation, however, had not materialised by 2013 due to political indecision, and the issue was submitted for advice to a commission set up by the Cabinet and chaired by sociologist Paul Schnabel. The commission's advice as well as the follow-up of this issue at the political level after October 2016 were described at the start of this Annotation.

The discussion still continues and has already spread far and wide in Dutch society. All kinds of aspects and arguments have already been extensively commented on in the media – by ethicists, lawyers, and political philosophers – and by numerous citizens in letters to newspapers and comments on websites. This Annotation is *not* intended to be an overview of all considerations and arguments for and against. Many arguments are relatively easy to communicate and are already well known.⁹ What we are mainly concerned with in this Annotation are the conditions for and the

⁸ Drion (1991); also see Drion (1992).

⁹ For an overview, see a report commissioned by the (Christian) Platform Zorg voor Leven (Care for Life), carried out by the Prof. Dr. G.A. Lindenboom Institute, based on the following question: 'What pro-choice and pro-life arguments exist in the discussion about the end of life?' A large number of proponents as well as opponents were interviewed in this research. www.npvzorg.nl/wp-content/uploads/2021/02/Argumentenonderzoek-Voltooid-leven.pdf, accessed May 2023.

effects of an institutional regulation for situations of assisted suicide on the grounds of life being 'completed'. By institutional regulation, we mean 1) a coherent whole of formal legislation and review; 2) the establishment of specific professional training for end-of-life counsellors who have to implement the law, and 3) executive institutions such as review committees and jurisprudence through the courts in appeal cases. Such regulation requires the development of professional standards for assessment and implementation and the observance of public standards such as transparency, legal certainty, and equality before the law. Importantly, such a process involves the *prior* development of clear and accepted *public moral* standards around what is, in principle, a permitted practice of assisted suicide, rather than (as in the current situation) *individual* cases that can each be judged after the fact. Moreover, such an arrangement that is authorised and enforced by the state must

also take into account the effects that a legally regulated option would foreseeably have on the expectations of citizens in a society. Therefore, will mainly focus on the social conditions and effects of a legal regulation along the lines of the Wlov. We first briefly describe the differences between the existing Wtl Act and the Wlov bill.

The context of the request is not a doctor–patient relationship, but an existential situation involving help and assistance given to an individual who wants to die by a professional who helps this person to deal with this situation, and possibly helps them to realise this wish.

The current legislative situation in The Netherlands (2023)

The Wtl (which dates back to 2002) implements an article that was added to article 293 of the Dutch Penal Code. Article 293 of the Penal Code punishes ‘the deliberate termination of another person’s life at his or her explicit and serious request’ with a maximum sentence of twelve years in prison. The Wtl regulates the criteria the actions of a doctor must meet in order to be exempt from criminal prosecution in such a case. The most important substantial criteria are that (1) there must be an informed and voluntary request by the patient, (2) there must be no prospect of treatment, and (3) the patient must be suffering unbearably. The procedural regulations are that the decision is reviewed by one of five Regional Euthanasia Review Committees (RTEs) on the basis of information in a file provided and agreed to by the doctor and the SCEN doctor.¹⁰ From 2002, new standards concerning the interpretation of the criteria of the Wtl were gradually developed in court cases and by the RTEs. Unbearable suffering did not necessarily have to be physical. Psychiatric patients were also eligible for euthanasia. However, the most important basic principles have always remained the same, such as the necessity of a request, the hopelessness of the condition, and the suffering of the patient that must be judged unbearable by the patient as well as by the physician and the SCEN consultant. Furthermore, euthanasia and assisted suicide may only be executed by a doctor, and there must be a medical basis for the patient’s suffering.¹¹

This physician-centred legal framework for euthanasia is abandoned in the Wlov. Indeed, the fact that there is no medically classifiable disease involved is meant as a means for allowing access to the new law for people who do have a medically classifiable illness, yet are not eligible for euthanasia administered by a doctor under the Wtl. Furthermore, the bill involves the regulation of assisted suicide, not euthanasia.¹² This implies that the person giving assistance does not carry out the actions that lead to the death. The proposal is aimed at people who have come to the conclusion that their life is complete and want to be helped to end their lives with dignity.

The Wlov, like the Wtl, is based on the ‘voluntary and deliberate nature of the request by the person concerned’. The Wlov adds to this that the desire to die must be ‘sustained’ in order for the request to be valid. The substantive criteria of hopelessness and unbearable physical or psychological suffering, however, are dropped. The context of the request is not a doctor–patient relationship, but an existential situation involving help and assistance given to an individual who wants to die by a professional who helps this person to deal with this situation, and possibly helps them to realise this wish.

Judging whether someone’s life is ‘complete’ is explicitly reserved for the individual concerned, because, according to the Explanatory Memorandum, it is strictly ‘subjective and personal’. There is, however, provision for talks between the end-of-life counsellor and the client in which the hopelessness of the applicant’s existence is

¹⁰ The SCEN doctor is an independent doctor who re-examines the decision of the treating doctor prior to the act of euthanasia. SCEN is the abbreviation for Support and Consultation for Euthanasia in the Netherlands, a programme of the Royal Dutch Society for Medicine (www.knmg.nl/advies-richtlijnen/scen-steun-en-consultatie-bij-euthanasie/over-scen, accessed 12 May 2023).

¹¹ See the Code of Practice drawn up by the joint RTEs in 2015 (Regional Euthanasia Review Committees (2022), revised and translated version 2022). A large number of proponents as well as opponents were interviewed in this research.

¹² Conversely, assistance with suicide is quite rare within the Wtl. It is unclear whether this is exclusively due to the dependency of the patients involved or is also because of a certain preference of the patients not to cause their own death.

discussed in the light of possible alternatives to ending life. If there are no alternatives, the time of the assisted suicide will be determined by the end-of-life counsellor and client. The bill does not specify a deadline for this process of consultation. However, handing over the lethal drugs only to be used at a much later date does not seem to be an option.

The Wlov broadly follows the procedures of the Wtl regarding assessing the actions of the end-of-life counsellor. There is a second end-of-life counsellor who reviews the judgement of the first one and gives an independent judgement. The case is reported to the same Regional Commissions that formally review the files of the Wtl. The Wlov, too, specifies the conditions under which a person is exempt from being charged with a criminal offence, in this case for the end-of-life counsellor. The Wlov sets a lower limit of 75 years of age for those who wish to invoke it.¹³ The Wtl applies from the age of 12, and parental consent is required for children aged 12–16.

IMPORTANT DIFFERENCES BETWEEN WLOV AND WTL

- The Wlov applies to Dutch citizens, the Wtl to everyone.
- The Wlov applies to people from the age of 75, the Wtl to people from the age of 12.
- The Wlov is about the actions of end-of-life counsellors, whereas the Wtl is about the actions of doctors.
- The Wlov requires ‘permanence’ alongside ‘voluntariness and deliberateness’ as a condition for a valid request for assistance.
- The Wlov does not require the conditions of ‘hopeless’ and ‘unbearable’ suffering.

¹³ www.tweedekamer.nl/downloads/document?id=2020D30015, art. 1, accessed 12 May 2023. The Explanatory Memorandum to the Wlov (<https://www.tweedekamer.nl/downloads/document?id=2020D30016>, 4.2) gives as arguments for this limit that young people have a longer life perspective than the elderly and therefore still have unexpected possibilities, and that people over 75 are better able to assess whether their life is complete. It is also stated that from this age, problems of a physical and social nature that are inherent to getting older.

The public debate on the Wlov has roughly concentrated on two positions, for and against. A major difficulty is that both positions are often defended by appealing to the same concepts and values, such as dignity, autonomy, care, and rights, which in different interpretations are used for and against a regulation like the one described in the Wlov.

We try to avoid, or make explicit, these differences of meaning in the descriptions below.

IN FAVOUR OF THE WLOV

Proponents of the Wlov base their arguments on the following moral reasoning. There is a growing group of elderly or very elderly people who, in their own opinion, have ended up in a form of existence that is of such low quality that they want to end their lives. However, because they do not have a medically classifiable condition, they have no access to the Wtl.¹⁴ They feel their life is ‘completed’ but see no acceptable way to end it in dignity without help. That is why they want the freedom to end their lives with the help of a third party. In doing so, they are invoking a fundamental moral right to make their own decision about their own death. Control over the end of life is a crucial element of a person’s freedom. This applies especially to freedom in a person’s relation with the state.

This position seems to be primarily inspired by anti-state, libertarian ideas.¹⁵ In the case of the Wlov, however, the state is explicitly involved in assisted suicide. This step is justified by an appeal to the dignity of dying under one’s own direction. Assistance may be necessary because the person concerned is unaware of the right means of ending his or her life, but especially because the death should not take place in an undignified manner (suicide), in solitude, or in secret. A good death is an ending of one’s life in the midst of loved ones and in the presence of involved helpers who can oversee a carefully executed procedure which leads to a death that occurs peacefully and without pain.

These arguments appeal to ethical principles for which there is much support in a secularised, liberal, and democratic society. The freedom and equality of citizens are central in such a society. Freedom is a key concept in this discussion. Paternalism, that is, a third party impeding the freedom of individuals on the grounds that it is in the individual’s own interests to do so, is strongly rejected and opposed, especially when it comes to the state’s legal impediments to the actions of citizens. The fact that this discussion is about the end of life makes this opposition all the more fierce. If there is *anything* authentic and personal, it is the end of life. In that sense, the Wlov is a compromise between, on the one hand, a freedom-motivated standpoint that one ought to be able to decide on one’s own death and on the

¹⁴ The term ‘assistance’ has a precise meaning in the legal context. Conversations, advice, counselling, and providing information in the context of a wish to die, and being present at a suicide – are all permitted actions. They are protected by the Constitution and The European Declaration of Human Rights. But *instructing* people how to go about ending their lives is not, because in such a situation the person giving the assistance would or could be ‘in control’. ‘Instruction’ is understood to mean that the giver of assistance is ‘in command’. This is of course not the case according to the regulations of the Wlov nor in the case of self-euthanasia (see Vink 2017a, who uses the term ‘self-euthanasia’ with an emphasis on ‘the goodness of a self-fulfilled death’ and contrasts it with ‘doctor’s euthanasia’ within the meaning of the Wtl). The difference between self-euthanasia and assisted suicide as proposed in the Wlov seems to lie mainly in the fact that within the Wlov the assessment and execution are tested against the law by the RTEs that already exist.

¹⁵ Libertarians are strongly oriented towards freedom and individual choice and, in that respect, stand for a ‘minimal’ state, a ‘night-watchman’ state that should mainly provide security and freedom. For a defence of this position, see Tooley (2003).

other, a legal framework that specifies conditions and boundaries. Those conditions are intended to ensure that in specific cases, this freedom is not used impulsively, involuntarily, or for improper reasons and that the assisted suicide can be carried out carefully and by committed caregivers.¹⁶

AGAINST THE WLOV

Opponents believe that a separate regulation for assisted suicide, in addition to the regulation for the medical context that is provided for in the present legislation, is not needed in the first place. The pragmatic reason for this belief is that there is already a law, the WtI. This law has fairly well-developed substantive and objective criteria, such as there being no prospect of further treatment and unbearable physical and/or psychological suffering. It enjoys widespread public support. According to many experts, it also offers opportunities for a doctor to help elderly people with complex medical conditions to die (Wijsbek 2006; Den Hartogh 2017).¹⁷

Some of the opponents also base their position on religious grounds. These opponents believe that people are not allowed to freely dispose of their own lives, because one's death should be left to God. In philosophical ethics, philosophers defend a fundamental rational rejection of suicide

by arguing that suicide is against the moral law. The argument is that the right to determine one's own life is self-contradictory. After all, an individual who wants to kill himself or herself wishes to destroy the rational or acting capacity to which he or she owes his freedom to freely want or wish for something at all in the first place, that is, to want on the basis of reasons, including the wish to destroy something. It is that 'higher freedom', not the empirical freedom to do what one actually wants, which is the basis of the dignity of the individual human being. The intentions of a person must be compatible with the moral law and with respect for it, even if they concern one's own well-being or death, and this compatibility does not apply to the intention of killing oneself and thereby destroying this capacity. This dignity must therefore be respected not only by others, but also by the individual themselves.¹⁸

FREEDOM AS A CORE VALUE

In this Annotation, we will not directly address these arguments of principle. Instead, we attempt to address a coherent set of concerns and issues that are likely to be shared by both parties. We attempt to address these concerns and issues, what motivates them, and relevant arguments that may sharpen the discussion. Central to our

16 The Explanatory Memorandum to the WloV uses the term 'relational autonomy' for this, the idea being that the individual can only be him- or herself in connection with others who support him or her to exercise his or her freedom.

17 There are more counterarguments of a practical nature, which we cannot go into here.

18 For this viewpoint, which is mainly inspired by the eighteenth-century philosopher Kant (1724–1804), see Velleman (1999). Velleman also emphasises that euthanasia may be permitted in those cases where this capacity, and with it the dignity of the person, has been lost. In his view, however, this is almost exclusively the case in terminal situations. Incidentally, some philosophers inspired by Kant depart further from Kant than Velleman does (see, for instance, Gewirth 1978: 264–266). For further discussion, see also Korsgaard (1996: 161–164). Mertens (2017) discusses the question of whether Kant's work does indeed leave no room for any form of suicide or euthanasia. Utilitarianism, another influential modern ethical theory that holds to the principle that the greatest possible yield of positive over negative consequences ought to determine our actions, cannot be discussed here. In general, the views of utilitarians depend very much on the version of the approach they defend, in particular whether the principle should be applied to single acts or to the general rule or practice under which the act falls. For the arguments surrounding a regulation of assisted termination of life, the latter approach is particularly relevant, but a discussion of this topic would be too complex to include here.

discussion are the concepts and value of freedom. In the discussion of completed life, the concept and value of autonomy are often central. Autonomy, literally setting oneself a law or norm, means at least three things that are of great importance in this discussion, but often cause confusion.

First, autonomy is a value, an ideal, or a standard of independence and self-determination for individual life and for living together in society. We see this value in the Wlov as the basis for the view that (elderly) people in our society must have the freedom to choose a dignified end of life and be in charge of it. But it is also a description or characteristic of the character of an individual. Someone goes his or her own way and lives according to his or her own well-formed and unique conception of a good life. They may be stubborn in many situations that involve others or institutions, particularly the state, meddling with their life. Finally, autonomy is also often used as a principled moral as well as legal standard or requirement for certain actions of individuals, like doctors, to justify any action that concerns the (vital) interests of other individuals, such as patients. For example, surgery done by a doctor is justified by the patient's voluntary and informed consent, and assisted suicide is justified by a voluntary request.

All three meanings of autonomy involve complex practices, of which there are many kinds, interpretations, and opinions circulating in ethics. We have used the institutional context that the Wlov would create as the context for our

discussion. For that context, the third and first meanings are particularly relevant: the question of how the Wlov will give meaning to the autonomy of individuals involved in the practice of termination of life, and the question of how the Wlov will affect the freely given consent of the elderly in general. However, because the perspectives and arguments we wish to discuss here can also be clearly expressed in terms of the 'voluntariness' and 'freedom' of individuals, we will use these terms, rather than autonomy, hereafter.¹⁹

The idea of freedom is also controversial in many discussions.²⁰ Situations in which different freedoms or liberties clash or in which two parties each claim their own interpretation of freedom occur regularly. Both situations also seem to occur in the discussion about the Wlov. Next, we mention two problems concerning freedom and the Wlov.

First of all, the request or decision of individuals to end their lives must be voluntary, i.e. it must have been made freely. This means that the request has not been caused by internal factors that make the voluntariness questionable, for example psychological or psychiatric conditions such as major existential disappointments or depression, nor has it come about as a result of external pressure or coercion by others. Everyone agrees on this. But the bill raises a number of problems concerning the question of *when* and *under what conditions* there is a voluntary and

¹⁹ For a discussion of the Wlov, which puts the interpretation of autonomy at its centre, see van Nieuwenburg (2017).

²⁰ For an extensive discussion of numerous situations in which freedoms and rights collide, see Claassen (2011).

well-considered decision, and what considerations may or may not be important in establishing that the decision is voluntary and well-considered. Proponents may experience the appeal to these conditions as ‘patronising’, as an infringement of their freedom to end their lives with the help of someone they have chosen themselves and who is willing to help. But they may also agree with the idea that, in any case, any coercion or pressure in respect of vulnerable people is not acceptable.

Then there is the role of the other party, the end-of-life counsellors. How free are they to deal with their clients’ requests using their own judgement? How should their freedom to help, or to refuse help, be understood? From this perspective, the scenario seems to be that during the process that takes place between the client and the professional, a jointly supported and substantiated reasonable judgement, and a decision based on it, is sought. The professional cannot be merely the executor of the client’s will when this will is about such a consequential decision as being helped to die. This freedom is linked to moral integrity and respect for the other person(s) involved. It must be a decision that all parties involved can fully support. At the same time, in the context of the Wlov, this search remains a process that must fit within the boundaries of a law: the finding and fine-tuning of conditions and standards and the developing of a viable and reliable legal framework will inevitably come down to setting limits to the individual freedom of the professional counsellor

to act on his or her own discretion. The state has a stake in this with respect to protecting its vulnerable citizens and upholding equality before the law and creating a climate of trust and confidence with regard to its legal and professional institutions.

Leaving aside the professional context of end-of-life counselling, and looking at the broader social context, another question about freedom comes to mind, which concerns the ability of older people (over 75) to relate freely to their own life and death. Won’t *this* freedom be changed by the regulation and the possibility of appealing to this law? Many participants in the debate think that the Wlov will give the elderly the message that they are superfluous. Laws *usually* have psychological effects that are not necessarily intended by the legislator. Often these should be tolerated, because there are good reasons for accepting the law. But in the case of vulnerable groups and ethical issues concerning life and death, they have to be taken especially seriously. How can this argument be developed and weighed in terms of the freedom and position of the elderly?

Another question about freedom comes to mind, which concerns the ability of older people (over 75) to relate freely to their own life and death. Won't this freedom be changed by the regulation and the possibility of appealing to this law?



4

Societal conditions for the Wlov: the development of a normative framework for a professional end-of-life counselling practice

Because the Wlov takes assisted suicide out of the medical context of the Wtl, its introduction makes it necessary to create a new non-medical professional psychological and counselling practice within which the implementation of the law must take place. The design and regulation of such a practice requires a different discussion than that concerning individual cases of assisted suicide. In the public debate to the time of writing (2018), personal experiences and intuitions about unique situations have often been central. However, a new practice of professional, legally regulated assisted suicide in non-medical situations requires objective norms that establish a stable basis of mutual expectations on which all parties involved as well as society in general can rely. It is therefore important to anticipate difficulties that may arise in this practice. These potential future difficulties are not only technical or practical; they also concern the question of who should be involved in the process, the interpretation of moral concepts and criteria, and the development of norms in the light of broadly supported ethical and legal principles. The answer to these questions can make a profound difference to the social acceptance and operation of the law and to the position of all those involved.²¹

An important question is whether the substantive standards for euthanasia, which are laid down in the existing Wtl, can, with the necessary modifications, continue to guide this new

practice. These norms concern the hopelessness of the condition of the client, the investigation of possible alternatives that may cause the wish to die to fade away, and the unbearable nature of the suffering of life. Or does the Wlov presuppose *fundamentally* different assessment and review? And if so, can other standards be set for the relationship between the end-of-life counsellor and the client, and the assessment of the request? To answer these questions, we discuss some elements of a possible framework and suggest some questions.

A crucial text for such an alternative normative framework is article 2b of the Wlov, which states as a condition that the end-of-life counsellor ‘determines the voluntariness, deliberateness and permanence of the wish to die’. We will not go into further detail here as to whether the voluntariness and deliberateness refer to the *wish to die* or to the *request* for assistance to end the person’s life. There is a relationship, of course, between the wish and the request, but with regard to the request, the emphasis is more on the normative question of whether the request ‘objectively’ meets the ethical and legal requirements on the basis of which the assistance requested can be legitimately provided. The wish to die that is experienced is a psychological, subjective fact that may turn out to be more or less strong, more or less voluntary, or permanent.²² The difference between the two, the state of the wish to die that is experienced and the will underlying the request and the eventual compliance with it, is precisely where the room for discussion between client and

²¹ For this dimension, compare the following case: some time ago, in the debate about a new Organ Donation Act in the Netherlands, aspects of implementation and the implications of the letter of the law were only discussed in depth in the indirectly democratically elected Senate. This Senate is supposed to play a less political and more reviewing role regarding bills than the directly elected House of Representatives. This change to the executional level resulted in the introduction of some important new elements in the debate in the Senate, which is politically in tension with its brief.

²² And that, incidentally, need not lead to a request either, for example in the case of someone with a strong wish to die who, for religious reasons, deems it inadmissible to end his or her life themselves, but who does beg God to ‘come and get’ them.

end-of-life counsellor lies. We assume here, where the legal question is at stake, that it is the *request* that must be established as voluntary, well-considered, and sustained.

Voluntary, well-considered, sustained: these three characteristics of the request differ from each other, but they are also connected in different ways. The differences are perhaps best elucidated by the contrast with a request that is *not* voluntary, *not* well-considered, and/or *not* sustained. Voluntary is then contrasted with involuntary – forced by someone or something outside the person, or by something that works ‘within’ the person against his or her free choice and casts doubt on the voluntariness of the request, such as depression or addiction. Well-considered is the opposite of impulsive, which means not motivated by good reasons or by reasonable or relevant considerations. There is a difference between voluntariness and well-consideredness in that something can be voluntary but one may be well aware that there are no good reasons for it, e.g. an impulsive purchase. However, the weight of what is at stake when asking for help to die is also relevant when interpreting deliberateness. A request to be assisted with suicide weighs heavily.

There is often a clear correlation between well-considered and voluntary. Most of the time, when we do something in a well-considered manner, it is also voluntary, because we have good reasons for doing it. Perhaps we should make an exception here for the decision to enter into far-reaching personal, existential

relationships, such as when starting a marriage with a partner. These are decisions that are (usually) unproblematically voluntary but that are difficult to consider properly *in advance* regarding the longer term, for all kinds of reasons. The request for assisted suicide falls to a certain extent into this category of existential decisions, as evidenced by notions such as ‘existential suffering’ and ‘suffering from life’ as reasons for the request. It concerns literally a life-or-death situation, in which a person has come to find him- or herself and that was not *chosen* on the basis of reasonable considerations, but is rather a consequence of many circumstances, biological as well as psychological. However, in a situation involving the suffering of elderly people in the final stage of their life, the proportion of relevant considerations that motivate a request is greater and can more easily be imagined by others than in relation to more individually determined ‘open’ and ‘promising’ personal relationships earlier in life. These considerations also appear to be necessary as moral justifications vis-à-vis the counsellor, because of the irreversibility and moral weight of the (assisted) suicide and thus of the assistance provided.

Aristotle, a historically influential ancient Greek philosopher, treats such situations concerning action in his classic discussion of voluntarism as involving a ‘mixed judgement’. He gives the example of a captain who, in heavy weather, has to decide to throw the cargo overboard because otherwise the ship will sink. On the one hand, the captain would have

preferred not to be in this situation. In that sense, his action is involuntary. On the other hand, the alternative, sinking, is so unattractive that he voluntarily and with good reason decides to dump the cargo after all.

Finally, the concept of ‘sustained’, or ‘durable’, is opposed to the notion of something being transitory, temporary – think of the example of the impulsive purchase. This is the most ambiguous of the three notions in the context of a request for assisted suicide. Purely in terms of time, a lasting wish to die and a lasting request may also be the result of treatable depression and thus perhaps involuntary. But the request for help may also be a well-considered, well-motivated, and perfectly understandable choice that has grown over time. Here, sustainedness as a condition, in conjunction with voluntariness and deliberateness, seems to have the normative meaning of stable, permanent, and above all robust, resistant to criticism from outside and the changing moods of the day, and thus a good basis for the request for help. The addition of sustainedness as a condition in the Wlov, which is not a requirement in the Wtl, was probably prompted by the fact that in non-medical contexts, impulsiveness can play a greater role than in medical contexts. In medical contexts where euthanasia is at issue, the condition of the person concerned is, in a negative sense, already more ‘stable’ and more objectifiable, as evidenced by the terminal and hopeless nature of the situation (no treatment possible) and the unbearable (and persistent) pain as the cause of (physical) suffering.

The interpretation of article 2b, which concerns the conditions for the validity of the request for assistance, will probably prove to be of great significance in identifying professional standards for those assisting with suicide under the Wlov. As we have indicated above, by referring to clear cases of the negations such as the request being involuntary, the normative criteria are relatively clear in the abstract: there must be no external pressure, especially from others; depression must not be causing the wish to die and the request; and there must be no ‘impulsiveness’ or a transient mood. However, the well-considered character of the request, its motivation, seems to be open to different interpretations, because the question concerns what the understandable and valid reasons for the request are. Given the situation of the target group, these valid reasons seem to lie primarily in a ‘story’ that refers to the client’s life situation or his or her view of life and that is convincing for the end-of-life counsellor. However, a voluntary, i.e. well-informed and well-considered, request also requires that ‘viable alternatives’ be discussed and explored. All these existential dimensions could be taken into account to establish that the wish to die is not personal and subjective to begin with, but reasonable, understandable, and imaginable.²³

Whether such a dialogical process is the intention of the bill is questionable, given the fact that the Explanatory Memorandum often speaks of the wish to die as being pre-eminently personal and subjective. Article 2b could also lead to a practice in which any *substantive* interpretation of

²³ For an illuminating discussion of the notion of ‘subjective’ in the context of assessing ‘unbearable suffering’ in euthanasia requests, which is also broadly applicable to end-of-life counselling practice, see Wijsbek (2003) (with thanks to Ineke Bolt for this reference).

the request, especially on the basis of deliberate intent, is abandoned. The end-of-life counsellor would have to refrain from making any substantive judgement on the reasons. The argument would, in that case, be that such an interpretation could easily become ‘paternalistic’ and conflict with the client’s freedom. But it could also lead to an interpretation in which the reasons for the request are seriously and critically examined and alternatives are sought that might make the suffering less severe, or less hopeless. This would demonstrate a concern that someone should not simply be given up. In addition, factors such as the client’s life situation, his or her attitude and character, and the degree of involvement of the family may well play a major role. These factors will make each situation unique, but that in itself is no reason to decide on one of the scenarios described above, either the formal, procedural interpretation of article 2b and the conditions it contains or the more substantive one.

Out of the normative framework that the bill initially offers, we highlight one substantive issue that we can classify under the condition of ‘well-consideredness’, but also under ‘voluntariness’. This issue focuses attention on the way in which different notions of freedom can play a role in this discussion. Suppose a client explicitly states as one of the reasons for the request, or

even as the main reason, that she no longer wants to be a burden to her children, in a financial or practical sense. Or the client indicates that they find the quality of the care they are receiving in the care institution or at home so poor that this is a reason for their request. Or someone indicates that they absolutely do not want to move into a nursing home. Will these reasons be interpreted as *good* reasons that contribute to a well-considered judgement? Or will they be interpreted as reasons to regard the wish to die as involuntary, or at least to qualify this reason as in some sense a ‘forced’ choice?²⁴ Should these kinds of reasons be further investigated and tested, for example by discussing them with relatives or with the management of the relevant institution, or by providing information about nursing homes? Should there be an attempt to remove the grounds for these kinds of considerations or should this reasoning be accepted without much ado? A fundamental question is raised here that concerns how we should interpret the ‘reasonableness’ of freedom in the case of these kinds of reasons.²⁵ On the one hand, such reasons may very well go hand in hand with an independent judgement made by the individual about the state of affairs in his or her environment and in society. On the other hand, ‘we’ may also be concerned about the way in which these basically changeable, external

24 The ethicist Govert den Hartogh, the expert on the euthanasia issue and a sceptic as far as this bill is concerned, wrote an article that was published in a special issue of *Podium voor Bioethiek* on the practice of euthanasia, in which he discusses the debate on completed life. He concludes this article with the following question: ‘Should we not, despite all the associated risks, regard the notion of being a burden to others as a legitimate dimension of unbearable suffering?’ (Den Hartogh 2013). This consideration can also be found in the RTE’s Code of Practice published two years later (Regional Euthanasia Review Committees (2022), p. 19 note 18). The difference here, in the context of the WloV we are discussing, is that the question is not whether we should regard ‘being a burden’ as a ‘dimension of unbearable suffering’, which is a factor that contributes to that suffering and makes it easier to empathise with the condition of the patient, but as a *good reason*, or one of the good reasons, for referring to it as a well-considered request. One of the risks Den Hartogh is probably thinking of is mentioned elsewhere in the same special issue of *Podium voor Bioethiek*: ‘unlimited self-determination (can) have adverse consequences for the less independent individual. Those who do not wish to be a burden to their near ones may feel encouraged by unspoken tensions in their environment to choose ending their life’ (Koopman, Heine, and van der Valk 2013).

25 See, in relation to this the results of interviews with doctors and other stakeholders in the context of the third evaluation of the WtI, according to which one in three doctors reported that they had at one time been under pressure by relatives and that many citizens appear to think that relatives have a say in deciding in cases of euthanasia (ZonMw 2017: 106ff).

A fundamental question is raised here that concerns how we should interpret the ‘reason-ability’ of freedom in the case of these kinds of reasons.

factors, such as the burden on the family or on society, lead older people to make this choice.

Here we can refer back to Aristotle's example of the captain in dire straits who throws the cargo overboard. The request for assisted suicide is a clear case that calls for a 'mixed judgement' regarding voluntariness; the client's situation is involuntary (and bad), but given the situation, this is the best the client thinks he or she can do and in that sense the request is well-considered and voluntary. The next question is whether the situation does indeed leave no other option than (assisted) suicide and if so, to what extent this 'storm' is a natural and inevitable fact or whether there are also in principle conditions that can be changed by the action of others or the society that is involved in causing them. This question ultimately also affects the relationship between the counsellor and the client: can a negative 'mixed' judgement made by the end-of-life counsellor regarding such reasons differ from that of the client, or can it even be required in some cases, given the law and the developing standards of practice?

Here, we will have to make do with these preliminary considerations on the Wlov and the questions regarding the freedom to judge and decide of the end-of-life counsellor and client in the professional relationship. The answers to these questions concerning the relationship between counsellor and client will also affect the role given to the Regional Euthanasia Review Committees in the process. Regarding the possible connection between professional conduct,

legislation, and the development and review of standards – i.e. between professional and public standards – the experiences with the regulation of euthanasia and the Wtl over the past 30 years may be relevant here. To begin with, from the 1990s onwards, extensive and thorough empirical scientific research was carried out on the subject of euthanasia in medical practice. This research was carried out by the government and the results fuelled an intense public debate. Research and debate made it possible to develop an ethical and legal normative framework that was clear and widely supported in society. Moreover, the development of this framework was supported by the medical profession, which had a key mediating role in the debate. Griffiths (2002) refers to this professional support as the unique explanatory factor that demonstrates why a well-functioning euthanasia law was passed in the Netherlands and not, or less so, in other countries. In the process of developing and establishing the Wtl, and during its implementation in the years that followed its acceptance, there was also constant coordination between the legislator and doctors' organisations, between doctors' organisations and ethics committees, and between ethics committees and the Public Prosecution Service. This is the most likely reason why during fifteen years of the Wtl relatively few judgments of negligence were made by the RTEs about submitted files.²⁶ In the normative framework of the Wtl, which was developed over fifteen years, the discussion was about the interpretation of additional *substantive*

²⁶ Regarding the possibility of a normative framework for the Wlov, it is perhaps relevant and also remarkable that the annual reports of the RTEs show a shift from carelessness relating more to the medical execution in the early years to carelessness relating more to substantive issues concerning the voluntariness of the request and unbearable suffering in recent years (with thanks to Ineke Bolt for this comment).

criteria for hopelessness and unbearable suffering. Because of the medical context, these criteria could be objectified relatively unproblematically in many cases, especially those concerning terminal, difficult-to-relieve forms of cancer. The fact that requests typically involved objective medical conditions made it very well possible to recognise and empathise with the suffering.²⁷ This whole process has taken place in the context of an established professional practice with a deeply rooted ethos, that of doctors. With the Wlov, this process of setting standards has to be restarted for a new profession, that of end-of-life counsellors, under social and substantive conditions that are less easy to investigate and more controversial. It is possible that this process too will eventually lead to a stable, socially supported, verifiable, objective, and consistently applied framework of assessment and review. But it will be a difficult road, made more difficult by a social context in which the situation and status of older people are fragile and opinions on how to deal with ageing are divided. One of the arguments that we develop at the end of this Annotation therefore concerns the effects of the Wlov on the position of the elderly in general.

27 Note that the concept of voluntariness in these medical contexts has an interesting interplay with the presence or absence of alternatives in the given situation: the fewer alternatives there are (no prospect of recovery, no effective analgesic measures), the more likely it is that doctor and patient will feel 'free' to end the life, while the mere appeal to the patient's own will in the presence of alternatives according to the doctor will in any case make the doctor's willingness (and liberty) to comply with the patient's will more difficult.



A potential societal effect of the Wlov: pressure on elderly people's experience of freedom

The Wlov will enable a choice – assisted suicide – that was not legally possible before outside the framework of the Wtl. Previously it was not necessary for elderly individuals to think about this possibility in terms of public morality and to justify their choice, however subtle the pressure, to go on living. After all, there was no legal regulation and therefore no need for reasons to be given for or against making use of this option. As soon as this option is available, the situation changes, in the sense that people over 75 will be free to make use of it. But this may also change the position of those over 75 who do not wish to make use of this option. After all, won't one of the social effects of a new regulation be that older people will feel less free to 'just' carry on with their lives, without explanation, once the legal regulations exist and others in the same circumstances are making use of it?

In this vein, the American philosopher Velleman (1992) has developed an argument against the institutional provision of the option of assisted suicide.²⁸ Velleman's thesis is that regulation of assisted suicide problematises the freedom of all (older) people to deal with their own death. How does this argument work?

The starting point is the dual effect that regulating a practice by law has. Although it makes the practice possible for those who want the option, it puts others, and ultimately the proponents themselves, in a position where they have to consider whether or not to use it. The next

question that arises concerns what is wrong with that. After all, both users and non-users can make their own decision based on their own reasons and judgements and can be left free to do so. After all, you would think that this is just one more option and that it can only be a good thing, at least for those people for whom this option fulfils a serious wish to end their life in what they consider to be a dignified way.

Velleman disputes the general idea that more options always create more freedom.²⁹ According to him, this is just not true in many situations. In negotiations between trade unions and employers, for example, it is often easier to negotiate if you have been given only one possible strategic option by your members. By adding an option, for example at the request of the trade union members, the employers can put pressure on the negotiators to choose that option, and this weakens the position of the trade union negotiators. A more everyday example is buying unhealthy stuff like alcohol; doing so means you seem to have an extra option when you are at home. After all, you don't necessarily have to drink it. But this option also makes it harder for you to not drink it because it is easier to give in to temptation and/or easier for housemates to put pressure on you to drink it. By taking away the option, a person may feel freer. And they may actually *be* more free, especially if the person would have chosen to avoid the option in the first place. In this sense, having to choose can become a burden if there is a regulated practice in which the legal possibility of ending one's life is a public

²⁸ Velleman's argument focuses on legislation concerning euthanasia for those who are seriously suffering (which, with the Wtl in place and functioning, is no longer an issue in the Netherlands), but his arguments do seem relevant to the discussion about the Wlov.

²⁹ For further discussion on this point, see also Dworkin (1988).

and widely known fact and is made use of by people for reasons that are publicly defended and that apply also to *others*.

Velleman compares this with an invitation to an event you don't want to attend. Such an invitation is an extra option, but it is unwelcome because now you have to decline it, with all the consequences that entails, whereas if you had not received the invitation you would simply not have attended. Another effect of offering options is that they sometimes symbolically express that someone's situation is somehow a problem. This is the case, for example, with the growing number of genetic tests that provide information about the likelihood of having a disease or genetic defect. Anyone who qualifies for such a test is therefore faced with a choice. Not without reason, of course, but the consequence can be that those who do not make use of the possibility appear 'unreasonable' and can be looked down on, or held to account, by those close to them or those around them. The state has a specific responsibility for this matter in the social sphere.

Velleman argues that the legalisation of assisted suicide will, in the different respects indicated above, prevent people from experiencing their continued existence as something *self-evident*. Because our discussion concerns a legal regulation, it is uncertain for the time being, as we have seen, to what extent it is supported by society, so the real question concerns how this law will 'hold up' in the longer term. Social and economic circumstances concerning the care of the elderly

and their position in society may well change and give a new and different momentum to the law. Examples of such circumstances are the increasing pressure on the economy, the rapidly changing technological environment, and the greater demands on a relatively small next generation. The combination of these changes with the Wlov may strongly influence the current self-understanding and self-interpretation of the elderly as individuals who belong to society 'as a matter of course' and can be assured of care in their old age.

The feeling that it is 'normal' to (want to) keep on living is so deeply ingrained in the self-understanding of modern Western humans, who after all live in the most prosperous society in history, that it is hard to imagine what happens when it is questioned. People generally want to justify their choices to others, especially if those others are close to them. But this is certainly the case if the situation changes in such a way that the pressure for justification becomes stronger, for example if a greater reliance on scarce public resources for treatment and care no longer makes individual behaviour and individual choices self-evident. If other older people give strong justifications for leaving life, and you, as one of them, are unable to do so because you are less able to articulate your reasons credibly, and you are demonstrably in a situation where those 'good' arguments also apply to you, then this is threatening to your status and recognition as a person. This recognition is particularly important if you are ill or weak, and therefore dependent. If

you cannot justify your choices, you may appear to be unreasonable. When the pressure to justify them increases, it can lead to people feeling that they are redundant, experiencing their lives as meaningless, or believing that they are a burden to others.

The cultural emphasis on being active, on being rational, on autonomy, and on usefulness and productivity can also play a role in this self-understanding. In this context, a person may be better off making use of the option offered, *even* if he or she would have been better off not having that option at all. Such social, economic, and cultural debates will become more pressing in our society in the coming decades. In short, the availability and facilitation of a socially accepted and institutionally regulated way to end one's life fulfils the wish and need of some to end their own life in a free and dignified manner. But the possibility can also make the free choice of others not to do so more problematic and a matter of accountability that they experience as pressure.

Velleman compares this social effect with the discussion about banning the duel in the nineteenth century.³⁰ In that debate, too, life and death were at stake and the concepts of 'freedom' and 'dignity' also played a central role. It was about the liberty of the (military) nobility to duel without interference from the government in situations in which their honour and dignity were challenged by others. The social cost of refusing to duel was high in such a group culture. Refusal led to disgrace and dishonour for individuals who accepted being insulted without demanding

redress. A law against duelling was the only thing that removed these social costs from the individuals. They could then appeal to the higher power of the law. It was only in this way that the culture of the nobility and military could be changed. In this historical situation, there was a group of people who opposed, for their own reasons relating to social freedom and dignity, the introduction of a legal ban on risking their lives in a duel. It was not until the introduction of the ban on duelling that the situation changed to such an extent that individuals were given new social reasons for no longer entering into duels.

In the case of the Wlov, it is precisely the lifting of a ban which may have undesirable consequences. This means, still according to Velleman, that the option to be assisted with suicide gives (older) people *new* reasons to assess their lives and in certain cases to want to end their life. The use of assisted suicide is then not just a private matter between a counsellor and someone with a well-considered wish to die. It can also have long-term consequences for the kind of society and culture we live in and the way older people in particular can relate to their existence. In the case of the duelling ban, it concerned a particular group, the nobility, with its own moral code of honour and dignity. In our society, too, there are great differences between groups of individuals financially, economically, socially, psychologically, and educationally. In the ethical discussion, the personal life story and personal control are often taken as starting points for the interpretation of autonomy, but the fact remains

30 See Burkhart (2006).

that for many people, the script and scenario of their lives, including the ability to express them, is determined to a significant extent by social norms and conditions, by others, and by chance. The Wlov will create a public space in which an evaluative comparison of such ‘end-of-life stories’ of those aged 75 and over will become possible and real. Offering the option of being helped to die creates a social framework in which certain reasons, such as being a burden to those around you or to society, could become normal as reasons for ending one’s life. Perhaps a new standard for dignity and sacrifice may even emerge for the elderly in the process.³¹

Velleman’s argument is based on a number of assumptions about the social dynamics of options and their effects, which can be questioned. Whether the application of these assumptions to the Wlov is convincing depends in part on a number of uncertain developments in our society, such as the question of whether the costs of elderly care remain affordable or will come under pressure because of other financial or economic demands of society. Moreover, the arguments given earlier (see section 3) in this Annotation in favour of the Wlov being based on individual freedom are certainly not negligible and should be weighed against the objections, such as those raised by Velleman. It seems clear, however, that the Wlov will change our society, more so than other, more specific practices available to elderly people to end their life if they are in dire circumstances, such as palliative sedation, euthanasia, and abstaining from food and drink.

31 This is what the English philosopher David Hume writes in his essay *On suicide* (written in 1754, published in 1777), which is often quoted in the current discussion on completed life: ‘Suppose I am no longer able to serve the common good; suppose I am a burden to it; suppose my life is an obstacle to someone else serving that good far better. In such cases, my withdrawal from life should not only be considered without fault, but even commendable. And most people who consider turning their backs on life are in such a situation.’

Conclusion: perspectives on further discussion of the Wlov

This Annotation raised the question of whether, especially in the context of a public, institutional, and legal arrangement for assisted suicide for the elderly, the ambiguity of concepts such as dignity and autonomy is distracting rather than helpful for both advocates and opponents. Our suspicion was that an approach based on the concept of freedom could clarify these concepts, and the connection between them, in different interpretations. Advocates believe that the concept of freedom for individuals must take precedence, because otherwise a group of citizens, the size of which is still relatively unknown, will be denied a fundamental right to decide to end their own life and to receive help to do so. However, meeting the wishes of this group of people through an institutional arrangement means that an investigation into the social conditions and possible effects of such an arrangement becomes inevitable. A number of aspects and questions have been highlighted and discussed in this Annotation. The social and political discussion on the interpretation of the bill, as outlined in section 4, may bring further clarity to the normative framework of the Wlov. The argumentation in section 5 about the effect on the position of the elderly is perhaps too weak and speculative to be given greater weight than the arguments in favour of legally regulating assisted suicide. But the importance of the issue, literally a matter of life and death, and the fact that the issue will be an important expression of what ‘we’ as a moral community want the position of the elderly in society to be, means that it is worth having this discussion as widely and deeply as possible.

Advocates believe that the concept of freedom for individuals must take precedence, because otherwise a group of citizens will be denied a fundamental right to decide to end their own life and to receive help to do so. However, meeting the wishes of this group of people through an institutional arrangement means that an investigation into the social conditions and possible effects of such an arrangement becomes inevitable.

At least five books have been published recently in the Netherlands on the subject of completed life, and the number of contributions in the media is already countless. We will limit ourselves to a brief selection (mostly in Dutch, with a couple of suggestions in English). **Van Wijngaarden (2016)**, in her empirical study based on interviews, sketches a well-informed picture of the great complexity of considerations that individuals who express a wish to die take into account. The Nijmegen philosopher Ton Vink, himself a proponent of self-euthanasia, has for years been a reliable source for all legal, practical, and philosophical aspects surrounding euthanasia and assisted suicide (via the website ninemwells.nl, and a number of publications, most recently **Vink 2017a**; for a short English text see **Vink 2017b**). For a personal, down-to-earth, and readable view on termination of life from the perspective of a doctor by profession with great experience, the recently published reflection by publicist, philosopher, and staff member of the Levens-eindekliniek Bert Keizer in the series *Nieuw Licht* is recommended (**Keizer 2018**). Also recently, Nijmegen philosopher Paul van Tongeren published his thoughts on the issue (**van Tongeren 2018**). There are some important collections in Dutch on issues relating to ethics and law concerning termination of life: those of **Klijn (2001)**, **van der Wal (2003)**, and **Adams (2003)**. For those who want to consider the matter in more depth and learn about the (international) philosophical debates on assisted suicide, especially the different interpretations of key concepts such as dignity and autonomy, a good reference is the recent collection by **Muders (2018)**, which is in English.

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