ASSISTED DYING, DEPRESSION AND AUTONOMY:

A CASE AGAINST SELF-DETERMINATION

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To an enthusiastic group of students, great people and dear friends who have taught me that it is imperative to stand up against injustice. May your voices never be silenced.

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ABSTRACT

Severely depressed people are allowed to die with assistance in only four countries in the whole world. Those who advocate for it claim that any seriously ill adult should have the opportunity to die with assistance through their right to self-determination – the right to determine what is in their best interest. Those who oppose it claim that depression makes patients non-autonomous and incompetent of making end-of-life decisions. In this thesis I argue that assisted dying should be available to severely depressed people. However, I disagree with both of the camps. I argue that the self-determination model is not adequate because it is either practically unlimited or it fails to achieve its function. Alternatively, I propose the consent model of autonomy on which patients merely authorize the doctors to assist them in dying, while the patient's best interest is determined objectively by the doctors.

INTRODUCTION

At this moment, exactly seventeen jurisdictions in the world allow for some form of medically assisted dying, either voluntary euthanasia or physician-assisted suicide. Out of those just four European countries – Belgium, Luxembourg, Netherlands and Switzerland – allow it not only for terminally ill patients and those with severe physical disabilities, but also for patients suffering from an irremediable mental condition (Jones and Simpson 2018, p. 2).

According to Jones and Simpson (2018, p. 2), among the four mentioned countries, the Netherlands has by far the most liberal regulations on assisted dying. In short, assisted dying is allowed for anyone who has an incurable condition which imposes unbearable suffering of the psychological or physical kind. Assistance in dying is available even for newborn children, if their medical condition is of the most severe type. Otherwise, the lower age limit is 12, with parental consent being mandatory in both cases. In Belgium, there is no lower age limit, but children are eligible only if suffering from a terminal illness. All other candidates are allowed to die with assistance if they are in a state of unmanageable, unbearable suffering. In Luxembourg, assistance in dying is legally available to anyone over 18 suffering from an incurable or terminal illness which imposes physical and psychological suffering with no prospect of improvement. Switzerland is the only country on the list which does not have a specific act on assisted death. The practice is made legal by being omitted from the criminal code. The lower age limit is 18 if the patient is suffering from a physical condition and 25 if non-physical suffering is the basis of the request to die. In thirteen remaining jurisdictions, assistance in dying is restricted mainly to terminally ill patients and, in Canada and Germany[1] in addition to terminal somatic illnesses, to people who are severely physically disabled as well.

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[1] German legislation is quite vague when it comes to assisted dying. Namely, it is considered not illegal if "performed on an individual for 'altruistic' reasons" (Jones and Simpson 2018, p. 2).

The wide exclusion of mental conditions from legislation on assisted death inevitably begs the question: is such exclusion morally justified? In this thesis, I will argue that it is not. In short, I will analyze the usual objections to the extension of assisted dying rights to patients affected solely with a severe mental condition and show that, if certain adjustments are made, all of them can be refuted. It is worth noting that 'severe mental condition' needs a qualifier. I am not going to argue for extending assisted dying to *every* mental condition out there. After all, most probably there are a number of mental conditions people are suffering from which could in no way qualify those people for assisted death. Even if it were the case that most of them could qualify patients for assisted dying, it would be excessively ambitious to claim that I can cover all of them in detail, given the space limit.

Accordingly, I will focus on one mental condition. Research from Belgium and Netherlands show that most of the people who request assisted death for psychological suffering, as high as 55%, are indeed patients with mood and, specifically, depressive disorders (Kim et al. 2016, p. 3; Dierickx et al. 2017, p. 3). For this reason, I am going to take "major depressive disorder" (MDD) as an example of a mental condition for which assistance in dying should be legally provided. I will use the definition of MDD set forth in the *Diagnostical and Statistical Manual of Mental Disorders* (DSM-V 2013) issued by the *American Psychiatric Association*. DSM-V (2013, p. 125) lists three groups of criteria that characterize a major depressive episode. The first group demands that in order to be diagnosed with MDD the person must be experiencing five or more specific symptoms from a given list for at least two weeks consecutively, with one of the necessary symptoms being (1) depressed mood or (2) lack of interest and/or pleasure. That is, in order to be diagnosed with severe depression, the patient needs to experience one of the symptoms stated above (necessary condition) and at least five of the symptoms listed below (sufficient condition):

1. "Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty or hopeless) or observation made by others (e. g. appears tearful)";
2. "Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation)";

3. “Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day”;
4. “Insomnia or hypersomnia nearly every day”;
5. “Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down)”;
6. “Fatigue or loss of energy nearly every day”;
7. “Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)”;
8. “Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)”; and
9. “Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.” (ibid.)

Second, the experienced symptoms must cause “clinically significant distress or impairment in social, occupational, or other important areas of functioning”. Third, the major depressive episode must not be attributable to the effects of a drug, substance abuse or other medical conditions (ibid.).

It is crucial to point out that when it comes to assisted dying, only the most severe cases of MDD are relevant, with the particular emphasis on resistance to treatment and incurability. What I mean by this is there are patients suffering from MDD who yield a positive response to the initial or secondary course of conventional therapy. I will not deal with such cases, because they would clearly fail to satisfy the usual conditions for permissibility of assisted dying. The *2017-2018 Florida Best Practice Psychotherapeutic Medication Guidelines for Adults* (2018, pp. 25–26) identifies four levels of treatment for MDD. Third level of treatment is advised only for the patients who have not responded to usual, conventional types of psychotherapy such as cognitive-behavioral therapy (CBT), serotonin reuptake inhibitors (SSRI) and serotonin-norepinephrine reuptake inhibitors (SNRI). On level 3, patients are treated with tricyclic antidepressants (TCA), electroconvulsive therapy (ECT) and transcranial magnetic stimulation (TMS), as alternative types of therapy. The most severe are the patients who have failed to respond to the third level of therapy and are undergoing treatment at the fourth. On level 4, intravenous ketamine therapy and some types of neuromodulatory approaches to treatment are proposed by the guidelines. In this thesis, depressed patients who have proceeded to the third, and especially fourth, levels are to be discussed as relevant candidates for assisted dying.

To put this into perspective, let us imagine two people suffering from MDD: Tom who has been experiencing a major depressive episode for the last couple of months and is just taking his first cycle of SSRIs; and Jerry who has had his first signs of depression in childhood, and has since tried more than two types of conventional depression pills, underwent cognitive therapy and even some alternative treatment options like ECT and brain stimulation. Tom is definitely not at stage of depression that could qualify him for assisted dying, so his case is not relevant for discussion of extending assisted dying rights. Jerry, considering the severity of his condition and apparent resistance to treatment, seems to be a relevant candidate for discussing extension of assisted dying rights.

As mentioned, my principal goal is to show that assisted dying rights should be extended to patients suffering solely from a serious mental condition, that condition being severe depression. In order to do that, it is necessary to do one more thing. Namely, I have to situate this particular debate in the broader context of moral permissibility of assisted dying.

Much has been written on this topic in the last couple of decades, and there are surely more than a dozen unique ideas about what makes assisted dying morally permissible or not. Instead of analyzing each of them individually, I will refer to Robert Young's (2020) five standard, encompassing conditions for the moral permissibility of assisted dying, as set forth in his entry in the *Stanford Encyclopedia of Philosophy*. According to Young, advocates of assisted dying think that the practice is morally permissible if the patient

a) "is suffering from a terminal illness";
b) "is unlikely to benefit from the discovery of a cure for that illness during what remains of her life expectancy";
c) "is, as a direct result of the illness, either suffering intolerable pain, or only has available a life that is unacceptably burdensome (e.g., because the illness has to be treated in ways that lead to her being unacceptably dependent on others or on technological means of life support)";

d) "has an enduring, voluntary and competent wish to die (or has, prior to losing the competence to do so, expressed a wish to be assisted to die in the event that conditions (a)-(c) are satisfied)"; and
e) "is unable without assistance to end her life" (ibid.)

Some of these conditions seem inappropriately restrictive. Namely, strictly upholding (a) would mean excluding all non-terminally ill patients from being eligible candidates for assisted dying. For example, tetraplegic and ALS patients, whose lives can without doubt be unacceptably burdensome, would not be allowed to have assistance in dying. Upholding (e) demands excluding the vast majority of all otherwise plausible candidates, for even the terminally ill are in most cases physically able to commit suicide, that is, are able to die without assistance.

I am inclined to ignore both of these conditions for several reasons. Firstly, because I am arguing for the extension of assisted dying to patients affected with mental conditions, which means I take assistance in dying to be morally justified in cases of terminally ill patients and even severely physically disabled patients[2]. Secondly, even if I argued for the moral permissibility of assisted dying in general, there are strong reasons to disregard the first and the last condition. The issue with the first condition is that it arises from a rather insensitive understanding of assisted dying. That is, it takes the fact that terminally ill patients are going to die either way as the primary (perhaps even the exclusive) moral basis for providing them assistance to die on their own terms (while they are still not experiencing intolerable pain and suffering). Such an account of assisted dying ignores a factor very much central to the debate on assisted dying – the alleviation of suffering. The fact that patients who are not terminally ill will not necessarily die as the result of their condition means that their suffering will be prolonged, perhaps as long as until they die of other causes, if they are not allowed to have assistance in dying. I take this to be a strong enough reason to disregard the first condition. In respect to the last condition, regardless of someone's ability to take their own life, we still have moral reasons to prefer assisted dying over suicide. For

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[2] It is worth noting one more time that assisted death for severe physical disability is legal in total of six jurisdictions (Belgium, Luxembourg, Netherlands, Switzerland, Germany and Canada). Debate about moral permissibility of assisted dying for severe disability is as important and pressing as the debate about depression. However, this is a separate issue which I will not (thoroughly) discuss in my thesis.

suicide is often violent, very difficult to perform and in most (if not all) cases undignifying both for the person in question and their loved ones. Assisted death, on the contrary, is non-violent, easily carried out and – for many – dignified. Furthermore, it seems that in everyday life we have strong moral reasons (in accordance with which most people act) to help and assist others achieve their goals. There is no clear reason stated why should it be any different when it comes to assisted dying. In short, it can be argued that assisted suicide is always morally preferable to suicide – when suicide is permissible, we might prefer assisting it; if suicide isn't permissible, we might prefer assisting it as a lesser evil.[3]

I take the reasons provided as sufficient for disregarding Young's (2020) first and last condition for moral permissibility of assisted dying. The remaining ones can be sorted into two groups, both of which must be satisfied if assisted dying is to be deemed morally permissible in a given case. The second and third condition, describing the curability of the disease and tolerability of pain can be sorted into the (i) the suffering group; and the fourth condition according to which patient's wishes have to be enduring, voluntary and competent, can be sorted into (ii) the autonomy group.

Those who oppose the extension of assisted dying rights to severely depressed patients, thus, object to the satisfaction of these groups of conditions – some think depressed patients are not autonomous, others deem their suffering less severe and, in rare cases, some claim both.

This thesis will be divided into four chapters. In the first chapter, I will present the standard understanding of patient autonomy in (bio)medical ethics and debates about assisted dying. I will outline autonomy-based arguments against the extension of assisted dying rights to depressed patients. In the second chapter, I will present an alternative understanding of patient autonomy which successfully avoids the objections raised to the standard model. In the third chapter, I will

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[3] Note that I won't be discussing the morality of suicide any further. This point was made just to illustrate how assisted suicide might be generally preferable to suicide, regardless of morality.

deal with the suffering-based arguments and show how they can be refuted. Here I am going to discuss the notion of objective best interest and objective well-being, and their relation to assisted dying. I will devote the fourth chapter to laying out and answering (potential) objections.

TERMINOLOGY

The terms 'assisted dying', 'assisted death' and 'assistance in dying' are used to mean both voluntary euthanasia and physician-assisted suicide (PAS). The difference between the two is in the person who administers the lethal dose of medication that subsequently leads to patient's death. In case of voluntary euthanasia, the doctor does all of the work, whereas in case of PAS, the doctor assists the patients with everything needed, while patients administer the lethal dose themselves, usually in the form of pressing a button. Although I will be using a term which encompasses euthanasia and PAS, I do not commit myself to any particular view about the moral differences between the two practices. While some authors claim that there might be morally relevant differences between the two which make one type of assisted death preferable to the other[4], I leave that question open and will not discuss it any further.

I will use the terms 'depression' and 'severe depression' to mean the severe, treatment-resistant cases of major depressive disorder (level 3 and 4), since only those cases are of relevance to my project. When I use the terms 'severely depressed patients' and 'depressed patients' I mean people suffering from those severe cases of MDD. I will not be taking cases of terminally ill or disabled patients who are, in addition, affected with severe depression. The focus of this thesis is on patients who are affected *only* with a mental condition (in this case severe depression) but are otherwise physically and neurologically healthy. In respect to this, it is important to mention that DSM-V (2013) as well as various scientific articles recognize that major depressive disorder, especially in its severe forms, can be accompanied by a comorbid anxiety disorder. Some even claim (Souery et al. 2007, p. 1069) it is unclear whether this comorbidity plays a role in resistance to treatment, and to what extent. For this reason, my arguments must be applicable not only to

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[4] For a brief review of contesting arguments about the differences see *ProCon.org* (2009), and for a more detailed analysis see Steinbock (2017, pp. 31–32) and Dixon (1998).

cases of severe MDD by itself, but also those frequent cases of severe MDD with comorbid anxiety.

By 'terminal illness' I mean any illness that will surely or most probably result in the death of the patient; by 'severe physical disability' I mean conditions such as tetraplegia and motor neuron disease, which can be reasonably seen as diminishing one's quality of life or being unacceptably burdensome for the individual.

Finally, it makes to distinguish between autarchy and autonomy. By autonomy in this thesis I never mean autarchy, that is, the implausible idea that autonomous deliberation requires not being influenced in any way. On the notion of autonomy used I admit personal decisions are influenced by various factors but require that decisions are 'one's own' even if they are influenced to an extent.

CHAPTER 1: WHAT DO WE MEAN BY PATIENT AUTONOMY?

In this chapter I will briefly explain the standard notion of patient autonomy. I will examine this notion through the Hohfeldian analysis of rights and outline the key normative demands of autonomy in discussions about assisted dying. At the end of the chapter, I will argue that the self-determination model of autonomy is not adequate when discussing assisted dying.

The self-determination model of autonomy

The standard textbook literature on medical ethics and bioethics is quite unanimous on the matter of patient autonomy. For the purpose of this chapter, I use Peter Singer, Udo Schuklenk and Helga Kuhse's (2016) editorial book *Bioethics: An Anthology* and Albert Johnson, Mark Siegler and William Winslade's (2006) *Clinical Ethics: Practical Approach to Ethical Decision-making in Clinical Medicine*. The latter is a philosophical, rigorously argumentative approach to questions of (bio)medical ethics, while the former, as the title suggests, is more in style of guidelines for efficient decision-making in the clinical context.

In Singer, Schuklenk and Kuhse (2016, p. 630), the section on autonomy begins with an excerpt from John Stuart Mill's seminal work *On Liberty*. Mill famously claimed that personal autonomy can be limited by the state if and only if it is done to prevent harming others. The editors then refer to the *Schloendorff v. New York Hospital* case in which it was established that "every human being of adult years and sound minds has a right to determine what shall be done with his own body" (ibid., p. 634).

Jonsen, Siegler and Winslade (2006) discuss the value of patient's wishes. These wishes are important, the authors claim, because they reflect patients' personal autonomy. Philosophers, they continue, defined autonomy as a moral right of a person to decide and execute their own concept of life and respecting autonomy means protecting people from unwanted outside interference. As they claim, autonomy is legally understood as a principle of self-determination, in reference to what was established in *Schloendorff v. New York Hospital* – every rational adult can do with their bodies as they please and prevent external interventions (pp. 73–74). The value of self-determination is illustrated in their claim that whatever the patients decide to do *is* a 'right' decision as long as it is in accordance with patient's values and wishes (p. 72).

What we see is that both textbooks on (bio)medical and clinical ethics treat patient autonomy as self-determination.

The situation is the same when it comes to texts that deal specifically with assisted dying. Daniel Callahan (2016) notes that the principle of self-determination is pivotal to most debates and "people are presumed to have an interest in deciding for themselves, according to their own beliefs about what makes life good, how they will conduct their lives" (p. 358). Jones and Simpson (2018) note that decisions about ending one's own life are justifiable if they are autonomous, and autonomy "is the fundamental right for competent adults to self-determination" (p. 3). Tania Salem (1999) notes that many proponents of assisted dying say that autonomy is a moral value in a sense that everyone has the right to choose the course of their own life according to their beliefs and values, without external interference, as long as they do not harm others (p. 31). Jukka Varelius (2015) thinks that "an autonomous person has the right to live his life in accordance with his own view of how it should proceed" (p. 61). Udo Schuklenk and Suzane van de Vathorst (2015b) explicitly claim that respecting patient autonomy means respecting patient's right to self-determination (p. 591). Finally, Emma Bullock (2015) in her paper about the adequate role of patient autonomy vis-à-vis assisted dying claims that, despite various philosophical accounts, respect for patient autonomy is commonly equated with respecting the right to self-determination (p. 13).

It is worth noting that the self-determination model and the rights it implies can be understood in at least two ways. I make this distinction in respect to the function of rights, that is, according to what do these rights imply for their holders. As Leif Wenar (2020) notes in his *Stanford*

Encyclopedia entry on Rights, on one hand, there are will theorists who claim that rights give their holders powers over others' duties – making them sovereign on a smaller scale. On the other hand, there are interest theorists who claim that the function of rights is to promote and further the interests of the holders. When we apply that to self-determination, in the 'will' meaning people are autonomous just because they are carriers of the right to self-determine their best interest; and in the 'interest' meaning, people are autonomous if their right to self-determination actually furthers and promotes their interest.

The literature on ethics and assisted dying seems to be in accordance with the 'interest' meaning of self-determination. There are two reasons why this is the case. First, if self-determination was understood in the 'will' meaning, the doctors would have the obligation to assist any person who wants to die – they would become mere tools in carrying out their duty to respect their patients' wishes. Almost nobody is willing to pay that price. Second, the very focus on self-determination as patient autonomy in medical ethics was done because it was believed, as Emma Bullock (2015, pp. 14–15) notes, that it is one of the ways to best protect the patients' well-being. In other words, because it is thought that the right to self-determination promotes one's interests.

This 'interest' conception of the self-determination model, practically and legally, implies two different rights: the patients have the right to determine what is in their best interest; and they have the right against unwanted interference to their bodies. These two are connected but can be analyzed separately. Having the right to determine what to do/what is in one's best interest implies the right to preventing external interventions, but not vice versa, for even if patients did not have the right to determine their course of life, they might have a right against anybody else determining it for them. Hence, the right to prevent unwanted interventions including – what is of my specific interest here – bodily interventions. This separation of rights is consistent with what legal scholars Jonathan Herring and Jesse Wall (2017) argue. They claim that it is wrong and implausible to reduce the right to bodily integrity to the notion of personal autonomy (as in the right to self-determination), because bodily integrity is “premised on a moral basis that cannot be reduced to respect for a person’s autonomy” (p. 576).

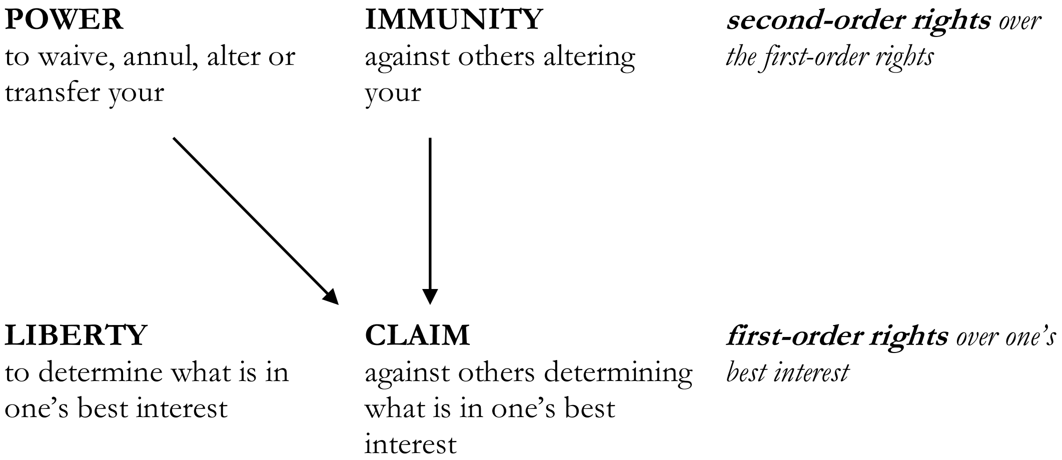
Accordingly, I will analyze the rights implied by the self-determination model separately, with the help of the *Hohfeldian incidents*.

The Hohfeldian analysis

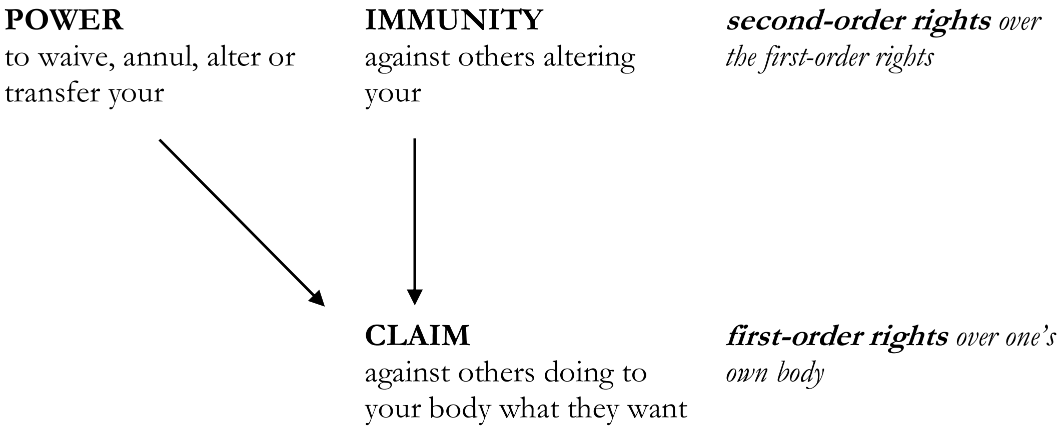
According to the *Stanford Encyclopedia* entry on Rights (Wenar 2020), Wesley Hohfeld thought that there are four fundamental components of rights – liberties, claims, powers and immunities. To have a liberty right to do something means that there is no duty not to do it. Having a claim right over something means that there is a corresponding duty the others have towards you. These are first-order rights through which agents are allowed to perform an action or refrain from it. To have a power right means that you have the ability to alter your own or other people’s first-order rights. Finally, having immunity right in respect to something means that others do not have power rights over that something. Power and immunity rights are second-order rights and they describe how agents can introduce and alter first-order rights.

To illustrate it, let us take the fundamental right of a person to own a car. A person has the liberty right to own a car because there is no opposing duty not to own it; they have the claim against others taking their car; they have the power right to alter or get rid of their claim right; and they have the immunity against other people changing their claim right.

The self-determination model of patient autonomy can be analyzed through the *Hohfeldian incidents*. The first part of the model, the right to self-determination is primarily a liberty right, but it also involves some claim rights against others, as well as second-order rights over the liberties and claims pertaining to the carrier, as shown in the figure below.



The right to bodily integrity, as shown in the figure below, is primarily a claim right – bodily integrity directs that the carrier has the claim against anyone interfering with their body. In addition, the carrier also has some second-order rights over their claim.



In summary, self-determination model is: a liberty right to determine what is in one's best interest; and a claim right against others unwanted intervention to one's life and body. These rights are quite stringent, meaning they cannot be overridden easily.

The figures[5] also show that these rights, although conflated under the self-determination mode, can be separated. In fact, they *are* separated in law. The right to self-determination, as in the

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[5] Figures are adapted according to Wenar's figures from his *Stanford Encyclopedia* entry.

right of the individual to determine what is best for them apropos medical matters, is recognized in the United States. It is protected under the *Patient Self-Determination Act* (1990). The right to bodily integrity, as in right against unwanted (medical) intervention, is explicitly protected in the European context under Article 8 of the *European Convention of Human Rights* (1952).

Enduringness, voluntariness, competence

Now that I have established what the standard, self-determination model of autonomy means and what rights it entails, I turn to the normative part. In this section I will explain what this notion of patient autonomy account *should* for in order to satisfy the autonomy condition for justifying assisted dying. As I have noted at the outset, the autonomy condition requires that the patient's request to end their life with assistance be "enduring, voluntary and competent". I will explain these terms one by one.

If autonomy is treated as the right to self-determination, an enduring wish to die would mean that a patient has a consistent and lasting determination that, according to their own values and beliefs, it is best for them to die. A voluntary wish to die, on this model, means that the patient's self-determination is a private determination not extremely influenced by someone or something to the point that it becomes inauthentic[6]. Last but not least, a competent wish to die means that the patient has, at least, the ability to determine that it is in their best interest to die.

I say "at least" because in addition to the ability for self-determination, competence on the standard model of patient autonomy requires that the patient is capable of providing an informed consent. The idea is that the competent patients *can* authorize others (doctors) to aid them in suicide. This is important since assisted dying procedures are not mere suicides, but medical interventions. Thus, having a competent wish to die (if autonomy is understood as self-determination) implies that a patient:

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[6] Note the distinction between 'autonomy' and 'autarchy' I make in the terminology section at the outset of this thesis.

a) is able to understand medical facts;

b) is able to understand the relevant consequences of their actions;

c) has a reasonable attitude towards their well-being and recovery; and

d) is able to determine what *is* in their best interest.

Another reason why I included (a–c) conditions for competence is because such conditions need to be met in clinical practice, in order to justify medically assisted death. Jonsen, Siegler and Winslade (2006) claim that in medicine, the capacity to make decisions about treatment demands the patient's abilities to: understand medical information, assess the medical situations and its consequences, and engage in reasonable decision-making in relation to medical advice (p. 81). In respect to the last condition, someone might think that I unjustifiably conflate the *right* to self-determination with the *ability* for self-determination. In the interest theory of rights (the one adopted in this thesis), the right to self-determination, to be a right in a true sense, needs to promote one's interests. And if one's not capable of self-determination, how can their interests ever be promoted by exercising what they are not able to exercise? In other words, for someone to have the right to self-determination needs to be able to exercise that right in the proper way – namely, in a way that promotes their interests and well-being.

Problems with the self-determination model

The first issue with the self-determination model is conceptual. It seems that the model cannot sufficiently account for the nature of assisted dying. As Callahan (2016) notes, assisted dying is a procedure requiring decision-making of at least two people – the patient requesting assistance with dying and the doctor deliberating upon and carrying out the request. In other words, "it is not a private matter of self-determination" (p. 358).

My criticism, following Callahan's footsteps, can be summarized as the following: the self-determination model of autonomy either presupposes fewer limits than doctors, lawyers and ethicists (even those who identify patient autonomy with self-determination!) would ever allow; or the model just does not achieve its function.

If a person should be given the right to assisted death primarily on the basis of their own determination of their best interests (as the 'will' meaning suggests), then introducing any severe limit on exercising that right is incoherent with the right itself. Namely, if we require that patients are either terminally ill or experience unbearable suffering in addition to their self-determination, it seems that such a condition would limit their right to self-determination. In fact, as I've mentioned at the outset, most proponents of assistance with dying hold that the person has to have an incurable, untreatable disease in addition to being autonomous to be allowed to die with assistance. The vast majority of all the countries that have legalized some form of assisted dying has specific legislation that requires the patients to be terminally ill or in unmanageable suffering. Even requiring the patients to be *capable* of self-determination seems conceptually incoherent with the demand that everyone has the right to determine what is in their best interest, if they do not inflict harm on others.

The issue is, without the ability of self-determination, it seems we could not comprehensively explain competence. Also, the doctors would then become just tools in carrying out their patients' requests. That is why we need to understand the self-determination model in a better sense – the 'interest' meaning. However, if we take the 'interest' meaning of self-determination, the model faces another serious issue – namely, it fails to achieve its function of protecting patients' interests. Bullock (2015) claims that the wide respect for self-determination stems from a belief that it is the best way to protect well-being of the patients (p. 14). This belief is, however, mistaken. The main argument for rejecting this belief, Bullock thinks, lies in the empirical studies done in the field of behavioral economics (p. 15).

The evidence derived from these studies suggests that people as individuals are not very good decision-makers, but poor ones who very often make decisions which do not direct their lives in any meaningful way (Thaler and Sunstein 2008 in Bullock, p. 15). Empriical data shows that individuals are not able to predict their reactions to future events, especially emotional ones – they do not know how (un)happy an event will render them to the extent that they don't know their own preferences (Blumenthal-Barby 2013, p. 212 in Bullock, p. 15). As Bullock (p. 15) continues, people seem to lack what is naturally presupposed by the self-determination model of autonomy. They lack "a set of preferences which are clearly-defined, well-understood, and rank-ordered so that people can make logical trade-offs among them" (Schneider 1998, p. 69 cited in Bullock, p. 15).[7]

In addition to that, the studies have shown the more severe the medical condition gets, the less patients suffering from it are willing to make a medical decision (Botti and Iyengar 2006, p. 32 in Bullock, p. 15). As Bullock concludes, "it simply turns out that individuals are rarely, if ever, capable of exercising self-determination in a way that is free from non-self-determined cognitive influences" (p. 15).

What Bullock shows is that people, and especially severely ill individuals, might be generally more incapable and unwilling to determine what is in their best interest than we usually assume they are. If we wanted to speak in terms of the conditions for justifying assisted dying, we could say that requests for assistance in dying coming from most patients should be seen as less competent than they actually are (perhaps even incompetent). This is relevant precisely in regard to the last (d) condition for competence – the ability to determine what is in one's best interest. Additionally, since the reason for poor decision-making lies in cognitive influences, it seems that the request to die with assistance is also generally more involuntary and possibly inauthentic. Finally, the only remaining condition (apparently satisfied by the self-determination model) is that

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[7] There might be some misunderstanding as to how the term 'preferences' is used in these studies. Note that at least one possible distinction can be made in respect to the term. Namely, the difference between revealed preferences (deduced post factum from actions or decisions of individuals) and settled or true preferences (the hypothetical, assumed ones). It seems that the authors imply the latter, and Bullock does not discuss why should we adopt them. For a detailed overview of preferences in philosophy and behavioral economics see Hansson and Grüne-Yanoff's (2017) entry in the *Stanford Encyclopedia of Philosophy*.

the wish to die is enduring – but what is the point of a lasting wish to die, if that wish is inauthentic and it does not stem from a competent individual?

Severe depression and self-determination

I take some time to examine how depressed patients would fare on the self-determination model of autonomy.

The central question in debates whether depressed patients should be allowed to die with assistance is related to them being competent decision makers. To revise, competence on the self-determination model of autonomy implies that the patient

a) is able to understand medical facts;

b) is able to understand the relevant consequences of their actions;

c) has a reasonable attitude towards their well-being and recovery; and

d) is able to determine what *is* in their best interest.

As mentioned in the beginning of this chapter, conditions (a–c) are related to the patient's ability to give an informed consent, while the last condition (d) is related to their ability for self-determination. I will now analyze these conditions one by one.

First and foremost, to be able to give an informed consent, the patient needs to be able to understand relevant medical facts. There is a worry that severely depressed patients, as a result of their psychological condition, tend more to negative information which may affect their understanding of medical facts. Joelle LeMoult and Ian Gotlib (2019) discuss the cognitive aspect of depression. In respect to interpretation bias, which is highly relevant for understanding medical facts and information, the authors state that when given ambiguous information depressed patients have a tendency to interpret it negatively. This is a fact, they claim, endorsed by recent evidence from clinical psychology (p. 55). Negative interpretation of facts happens both in social and nonsocial contexts and the negativity seems to intensify as the severity of depression increases (ibid.). A question arises: can this negativity bias affect depressed patient's understanding of information?

Definitely, but it is important to note that (negative) interpretation bias is not exclusive to severely depressed patients. LeMoult and Gotlib (2019) actually claim that negative bias has been observed to persist even outside depressive episodes and they mention it is sometimes, in psychiatry, considered as a risk factor for depression. In other words, negative interpretation bias has been observed even in cases where the biased patient was not (yet) depressed (p. 55). Aaron Beck and Keith Bredemeier (2016) think the same. While it is well known that depressed people are more prone to negative information and are more sensitive to negative feedback, there is growing evidence that these biases are not produced by depression, but they rather "confer vulnerability for depression" (p. 600). In other words, negative interpretation biases are not results of one's depressed state, but rather a precursor for developing depression. This means such biases exist in a portion of people who have not yet developed depression. Perhaps this is true even for those individuals who will never get severely depressed, since negative biases are just risk factors for and not determinants of depression. Additionally, LeMoult and Gotlib (2019) also note that depressed individuals seem to lack in positive interpretation biases, otherwise present in psychologically healthy individuals (p. 56).

I infer two important conclusions.

On one hand, if we are to argue that negative interpretation biases affect one's ability to give an informed consent, we must argue that indiscriminately. Negative interpretation bias is not necessarily a correlate of severe depression but can also appear in healthy or depression non-diagnosed individuals, which means many (if not all) people give informed consents which are biased to an extent. Since there is no assumption that healthy and depression non-diagnosed individuals are unable to provide an informed consent, even if they are consenting to assisted death, there should be no such assumption when it comes to depressed patients.

On the other hand, most people have positive interpretation biases which are in most (if not all) cases ignored. Nobody thinks such biases could undermine the ability of a person to give an informed consent. This begs the question: if positive interpretation biases are ignored, why should it be reasonable to give so much attention to negative ones?

Finally, in cases where it can be determined that the patient is cognitively affected, there are some ways to bolster patient's ability to give an informed consent. The helping factors are, included but not limited to, cueing, repetition and giving information in small steps and doses (*Relias Media* 2011).

Let's get back to the second condition for competence on the self-determination model. It demands that patients, if they are to give consent, need to understand the relevant consequences of their actions and the implications of treatment or medical interventions they opt for. Thomas Hindmarch, Matthew Hotopf and Gareth Owen (2013) state that, according to studies, depressed individuals show impairments in appreciating the information they're given (pp. 2–3). Specifically, they mention the distinction between factually repeating the consequences of a given treatment or intervention and taking personal, socially contextual features into consideration. They conclude with the claim that the ability to appreciate the implications of medical interventions is impaired (Leeman 1999; Young et al. 1993 in Hindmarch, Hotopf and Owen, p. 3).

On the basis of this, what could be said against depressed individuals' competence to give consent is that they might not be able to appreciate *what is at stake* when opting for assisted death. One of the symptoms of severe depression cited at the outset of the thesis (see Introduction, pp. 2–3), is indeed the lasting, debilitating feeling of hopelessness. Govert den Hartogh (2015) notes that people who are severely depressed are "unduly pessimistic" (p. 588). In my previous work (Kovacevic 2018, p. 11) I have argued that depression-characteristic symptoms of hopelessness are bound to have some effect on the ability of the patient to give consent.

I think this common objection is not very successful for at least two reasons.

Firstly, it comes with a heavy assumption. Namely, it is assumed that everyone has something to lose by dying, and in that sense, end of lives among individuals is made comparable. This is on par with what Nagel (1970) argues, namely, that death is generally bad because it implies a permanent loss of experience (pp. 74–75). In other words, when someone is dead, they no longer feel, do or have any kind of experience – no matter how (un)pleasant those experiences were, they still were, and once they are gone – that is bad. Secondly, the assumption that each individual should value their life highly is seen as rational by default. This is not so plausible in reality. Some people might argue that they lose much more by continuing to live than by dying. Such are, namely, the ones in extreme pain and suffering. The point is: whether it really is rational for everyone to value the continuation of their life to the maximum is still open for debate.

We know that people have a range of positive interpretation biases and there is an extensive body of evidence that shows that most people are unreasonably optimistic. David Benatar (2006) discusses this phenomenon in his book *Better Never to Have Been: The Harm of Coming into Existence.* Being overly positive, he notes, can be explained by a very influential psychological phenomena called the Polyanna Principle. According to this principle, people have a tendency to be too optimistic in several ways: they remember and recall positive events and experiences more and better than the negative ones, their expectations of the future are exaggeratedly positive, and they think of themselves as happier and better off than the average individual (pp. 64–66). It might be the case that most healthy individuals are rather too optimistic about what future will hold for them. Maybe most of us are wrong to value life so highly. This translates to all aspects of life, so even to considerations of what is at stake if one dies and to what extent should one value the continuation of their lives and experiences. What I am saying here is that lack of appreciation of continuing life in depressed individuals, or the lack of appreciation of what is at stake if they die, ought not be considered irrational by default. It might be quite rational to think that continuing to live is an option worse than death.

The next condition for giving an informed consent, as I asserted, is the patient's reasonable attitude towards their well-being and recovery. Reasonable should not be equated with positive, for, as mentioned before, even extreme negativity towards the continuation of one's life can be justified. Vis-à-vis depressed patients and assisted dying, one who has been depressed for years, tried all the treatment option and nothing helped in the long-term – such a patient is justified in believing that the suffering will persist in the future. The doctors have a simple way to determine whether a patient holds a reasonable attitude towards their recovery – namely, by taking a look at all of the treatment options the patient has gone through voluntarily and the numbers of recurrences of major depressive episodes. Still, I am willing to admit that perhaps most depressed patients have unreasonably pessimistic attitudes towards their recovery for that is just how depression usually is. But even the most negative of attitudes held by depressed individuals could indeed be reasonable.

This brings us to the last, and perhaps the most crucial condition for competence on the self-determination model: the ability of the patient to determine what is in their best interest. In the first place, there are studies from behavioral economics which suggest even healthy individuals might be incapable of properly determining what is best for them, of choosing an action that would maximize their well-being. Additionally, it was noted that when it comes to severely ill individuals, the lack of capacity for self-determination is accompanied by a lack of motivation to make decisions about their best interests as well.[8] In the second place, there is a great amount of evidence derived from clinical studies which shows that severely depressed people are cognitively and mentally impaired in various respects. That is, in addition to being poor decision-makers as a result of being human, they are impaired as a result from suffering a serious psychological disorder.

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[8] It is important to take the findings from behavioral economics with a grain of salt. While these studies may show that people are less capable (perhaps incapable) of self-determination in trivial situations their conclusions might not be fully applicable to emotionally invested situations (like deciding whether to end your life). For this reason, I do not take these findings as a conclusive reason against self-determination, but rather one of the reasons which suggest that the self-determination model is not the best model of patient autonomy when it comes to assisted dying.

Den Hartogh (2015) notes that depressed patients "have difficulty discriminating between more or less likely events" (p. 588), Matthew Broome and Angharad de Cates (2015, p. 586–587 in Schuklenk and van de Vathorst 2015b, p. 590) claim that depression causes distortion to people's affective states so their decisions about future should not be taken as competent. Christopher Cowley (2015) notes that, when discussing depression and assisted dying, questions about competence arise – to what extent depressed individuals' judgments about the future are distorted and whether their wishes are authentic, lasting and "deeply-held" (p. 585). Hindmarch, Hotopf and Owen (2013) reviewed the data from studies on the decision-making capacity in severely depressed individuals. Out of four abilities – understanding, appreciation, reasoning and ability to express a choice – which were all impaired, the capabilities to appreciate and reason about treatment options fare the worst (pp. 1–5).

In my previous work (Kovacevic 2018) I have voiced some concerns about the general decision-making abilities in depressed individuals. As I noted then, the studies have shown that depressed people are impaired in behavior control, planning, problem-solving, reasoning and decision-making in flexible circumstances (pp. 11–12). All of the mentioned above strongly suggest that, even if healthy individuals are poor decision-makers, then severe impairments characteristic to the depression can only worsen the capacity to make decisions. In other words, if we have a large amount of evidence on which we can assert that people are generally unable to determine what is in their best interest, then we even have more and much stronger evidence to say that depressed people are incapable of doing that. It seems that severely depressed people necessarily fail on the test of self-determination, which has some implications on the authenticity of their requests for assisted dying as well. For if a person cannot determine what is in their best interest, then it is necessarily the case that whatever they expressed as their voluntary wish is not produced by means of authentic self-determination. Finally, the lack of the ability for self-determination has some implications for the enduringness of the wish to die in a sense that there is no point in determining the longevity of the wish if that wish cannot be considered competent.

Patient autonomy understood as self-determination faces many obstacles. If we understand it in reference to the will theory of rights, it is inconsistent with other principles upheld in the medical ethics and practice. Namely, it leads to treating the doctors like mere tools, and it is inconsistent with requiring patient's competence and ability to self-determination. If we understand it in reference to the interest theory of rights, the self-determination model fails at protecting patients' well-being, which is its main function. This failure is suggested both by findings from behavioral economics (in respect to all people and patients in general) and clinical psychology (when it comes to severely depressed and their cognitive impairments). For the reasons stated, in the next chapter, I will present an alternative account of patient autonomy which manages to avoid the issues that the self-determination model faces.

CHAPTER 2: WHAT SHOULD WE MEAN BY PATIENT AUTONOMY?

In this chapter I will introduce an alternative account of patient autonomy in regard to assisted dying – the consent model. This model sees patient autonomy as an authorization of or a constraint on a medical intervention. In this model, the patients have the exclusive privilege for or against the procedure, while what is in their best interest is objectively determined by doctors. I will analyze the rights protected by the consent model with the help of *Hohfeldian incidents*, after which I will turn to the normative part. At the end of the chapter, I will outline the key advantages of the consent model.

The consent model of autonomy

In her paper titled *Assisted Dying and the Proper Role of Patient Autonomy* Emma Bullock (2015) establishes what I call the consent model of autonomy. She notes that since self-determination plays such a minimal role in protecting patients' well-being (for the majority of them are incapable of determining what is in their best interest), we are left with two options vis-à-vis assisted dying. Either the practice should be abolished, for the general lack of means to protect patients' well-being, or we should reconsider the role autonomy plays in such procedures. She opts for the latter claiming that autonomy in assisted dying procedures should be understood and respected as a "side constraint on an action" (p. 16). In other words, the role of patient autonomy is in providing a permission or a constraint on a medical intervention. On this model, determination of what is in the patient's best interest is not reduced to patient's self-determination, but it is rather objectively determined by doctors[9]. Assisted dying *could*[10], thus, be made permissible by the patient's consent on one hand, and objective facts about their best interests on the other (pp. 15–16).

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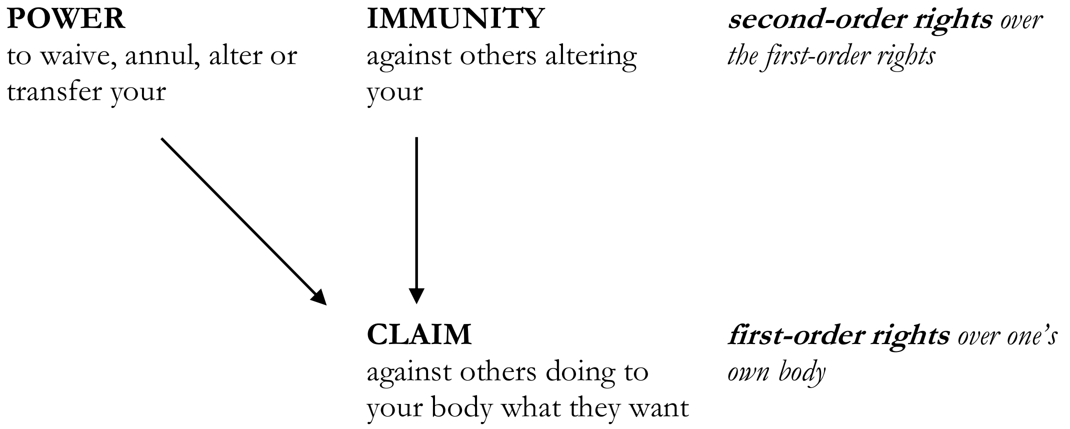
[9] I will discuss the notion of objective best interest and how it could be achieved in practice in the third chapter of this thesis.

[10] I use the term 'could' because Bullock herself claims that objective best interest and the given consent are merely necessary conditions for justifying assisted dying, while she is not sure if they are sufficient. She claims that, namely,

The value of patient autonomy is therefore situated in a competent informed consent given by the patient. As in the previous chapter, it is worth examining the rights protected under the consent model. On this model patient autonomy means that the patient has the right to consent or not consent to a treatment option or a medical intervention. The existence of this right helps protect individuals from unwanted external (medical) interference, that is, it helps preserve the patient's bodily integrity. In the next section I will explain what this means with the help of *Hohfeldian incidents.*

The Hohfeldian analysis

The right to bodily integrity on the Hohfeldian analysis would primarily be a claim right. This means that others have a special duty towards the person holding that right, this duty being respect for one's bodily integrity. On the Hohfeldian analysis, a person holding the right to bodily integrity also has second-order rights over their claim right, which is shown in the figure below.



POWER
to waive, annul, alter or
transfer your

IMMUNITY
against others altering
your

second-order rights *over the first-order rights*

CLAIM
against others doing to
your body what they want

first-order rights *over one's own body*

This figure shows that on the consent model patient autonomy is valued to a great extent: no medical procedure, no matter how non-intrusive, can occur without the patient's consent.

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doctors may not be able to objectively determine patients' best interest in practice, thus she does not commit herself to any view on that.

As I have mentioned in the previous chapter, the right to bodily integrity is a highly valued right in the European context. It is protected under Article 8 of the *European Convention of Human Rights* (1952).

> "The protection of private life under article 8 ECHR encompasses a person's physical and psychological integrity. A person's body is an intimate aspect of his or her private life (Y.F v Turkey) and a sound mental state is an important factor for the possibility to enjoy the right to private life (Bensaid v UK para 47) […] Administering medicine against the will of the patient or performing medical treatment interferes with the right to private life. Therefore, it has to be based on a law and necessary in a democratic society to be justified." (*Hembach Legal* 2020, para. 1, 3)

Aside from the law itself, the right to bodily integrity and its importance for the European (medical) law has been emphasized by various legal scholars. Herring and Wall (2017) note that the right to bodily integrity is thought of as the most important civil right (p. 566). This right, they claim, is very important because it protects people from infringement and unwanted external interference. This right is an exclusive right, meaning that it pertains to the individual at hand, it can be exercised against anybody (they use the term "the world") and it is immediately actionable (p. 580).

Enduringness, voluntariness, competence

Now that I have introduced the consent model of autonomy and explained how it is different from the self-determination model, especially in respect to what rights it entails, I turn to the normative part. As in the previous chapter, I am going to explain how the consent model accounts for the autonomy conditions for assisted dying set forth at the outset, that is, the enduringness, voluntariness and competence of a patient's wish to die.

When autonomy is valued as a permission or a constraint on an action, an enduring wish to die would mean that a patient has, fairly consistently and continuously (on multiple occasions), given their consent to dying with medical assistance. This requires that the window period between the request and assisted death is wide enough, at least wider than what, namely, the *Belgian Act on Euthanasia of 2002* (2002) requires – 1 month. In fact, the guidelines for assisted dying issued by five leading experts in the field suggested that the patient's consent for assistance in dying should be "repeated and durable". They claim that the request should expand over several months in order to single out hasty, unconsidered decision, while also giving space to doctors for a proper assessment of patient's competence and tracking consent (Verhofstadt et al. 2019, p. 153). My proposal for regulation is somewhat along those lines – at least 6 months has to pass between the patient's request to die with assistance and the procedure being carried out. During this time the patient actually provides consent multiple times: initially when requesting assistance in dying; then when they authorize the doctors to share their medical history and analysis with other psychiatrists and physicians; and finally, when they sign the doctor's decision to assist them in dying. Accordingly, the doctors could see the shifts and changes in reasons the patients give for proceeding to the next step and, thus, assess the competence of provided authorizations.[11]

Voluntary wish, on the consent model, means that the informed consent comes from the patients themselves. It demands that the patient is not coerced or heavily influenced by someone or something to the point that their given consent becomes inauthentic.

Lastly, a competent wish to die on the consent model means that the patient has the required minimum of abilities to provide an informed consent. In other words, a competent wish to die means that a patient:

a) is able to understand medical facts;
b) is able to understand the relevant consequences of their actions;
c) has a reasonable attitude towards their well-being and recovery.

When compared to how competence is understood on the self-determination model, we can see that the consent model *does not* require the patient to capable of determining what is in their best interest. In other words, the patients can be competent without having the ability to accurately and correctly determine whether assisted death is really what's best for them. As I've

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[11] Note that, by all means, the patient can withdraw their consent at any time during the (carrying out of the) procedure.

mentioned before, determination of the patient's best interests lies on the doctor who is supposed to do it objectively, while the patient's autonomy is valued as their (lack of) consent. In other words, patients can either authorize the doctors to assist them in dying or not, but the patients do not determine what's best for themselves *per se*.

Severely depressed patients do not necessarily fail on these three conditions for competence (as I've shown in the previous chapter). There are some potential objections to the competence of severely depressed patients to deliver an informed consent, but I will deal with those in the last chapter of this thesis.

Self-determination and consent – differences

Perhaps it is worth briefly describing the difference between patient autonomy as understood on the self-determination model, when compared to the consent model.

The self-determination model implies both the liberty right of the holder to choose what's best for them and the claim right against others interfering with their body. The consent model does not contain the former right – for empirical data suggests that self-determination fails to protect one's interests and well-being. The consent model protects the claim right to bodily integrity and ensures that patients have the last word when it comes to their death.

When it comes to competence, the self-determination model requires the person to be capable of determining what is in their best interest. This is quite controversial, for studies show that people are less capable of doing that than we usually assume. When we add some disease-related cognitive impairments into the picture (as it's the case with severely depressed individuals), it is evident how the ability to self-determination can be compromised. The consent model does not require the capacity for self-determination (for the doctors determine what is in the patient's objective best interest, rather than the patient themselves), but only the capacity to authorize an irreversible medical procedure.

Advantages of the consent model

Why should anyone adopt this model? Bullock (2015) thinks that the consent model is better primarily because studies show that humans are, at times, incapable of self-determining what is in their best interest (p. 15). Studies suggest that these capabilities are even more truncated when it comes to severely ill people, which are precisely the relevant group of people when discussing assisted dying.

I develop four additional arguments for adopting the consent model.

First, let us suppose patients should be the only ones who have the right to determine what is in their best interest without any external interference, that is, that the standard account of autonomy should be upheld when it comes to assisted dying. But if that is the case, on 'interest' meaning, we must be concerned with how (if it ever does) the right to self-determination promotes the patient's interest. On the 'will' meaning, on the other hand, someone could argue that imposing any restrictions on access to assisted death is in itself imposing restrictions on one's autonomy. In other words, someone could say that the only way to fully exercise autonomy as self-determination vis-à-vis assisted dying would be to allow each and every person to determine whether they want to die or not, without any paternalistic interference, and then assist them in dying if that is what they want. Widely enough, demanding that the person requesting assisted death should, in addition to being autonomous, also be severely ill with no prospect for improvement (which is indisputably required both morally and legally) – may be considered a paternalistic interference or a paternalistic restriction on autonomy as self-determination.

What I mean is, if we are and we should be autonomous in the sense of having the exclusive right to determine what is in our best interest, then even healthy people should not be prevented from dying with medical assistance – if that is what they think is in their best interest. Existence of such a candidate may be highly improbable, but it is nevertheless a conceptual problem for the view. As mentioned before, this also leads to doctors being treated as mere tools in carrying out requests of their patients. The consent model does not face this problem for the patient autonomy is contained not in self-determining best interests, but in the right against being coerced into what others (doctors) think it is in our best interest.

Second, if we understand patient autonomy as self-determination, a lot of potential (and actual) objections emerge. Let us take severely depressed patients requesting assisted dying who are the very focus of my thesis. Many authors claim that depression renders people incompetent of making decisions about their life. That is, because of having a conditionally negative view of their future, one can (and many actually do, as I elaborate in the previous chapter) argue that none of the depressed patients cannot properly assess what is in their best interest and are, thus, not autonomous. On the consent model, depressed patients need not be capable of determining what is in their best interest, but rather just be capable of giving an informed consent. For this reason, on the consent model of patient autonomy some depressed patients might be competent and autonomous in choosing whether to die with assistance or not (as they intuitively are considered by many, including myself). In other words, this model provides better answers to autonomy-based objections set forth by the opponents of assisted dying for depression.

Third, the consent model better corresponds to how autonomy works and how it is respected in other areas of medicine. People usually exercise their autonomy in the sense of self-determination. They choose who to love and marry, which career to pursue, which food to eat – in general – what kind of life to live. In the end, they also self-determine whether they should seek medical help or not. However, when they 'enter the doctor's office', it seems that autonomy shifts and changes. For illustrative purposes, let us imagine the following scenarios:

> **Scenario 1:** You have an itching feeling in your throat, and you visit your doctor. After the examination they tell you that the cause of the feeling is probably a tonsil infection. For this reason, they tell you that they think it is best if you take a very specific antibiotic – penicillin.

Scenario 2: You have extreme pain in your left leg, and you decide to visit the doctor. Once you get there, a team of relevant specialists examine you. After a brief discussion among themselves, they tell you that most of your internal muscle tissue is affected by necrosis and for this reason it is best to amputate it.

These scenarios are apparently very distinct, but they are quite similar in one respect – in each case the doctors determine whether it is in patient's objective best interest to do xy, while the patient, after being fully informed of the procedure and potential implications, merely gives consent or they don't. This is the way autonomy factually works in most cases and areas of medicine. What I am trying to say is that patients are (almost) never asked to determine what is in their best interest nor are any medical procedures justified primarily by the fact that the patient determined it is in their best interest to undergo that procedure. However, they are still, by the power of their consent, the ones who ultimately decide their own fate.

This is not something that merely I observed. Jonsen, Siegler and Winslade (2006) note that when medical indications for treatment are established, the doctors suggest or presents a plan to the patient, and the patient can accept or reject that plan (p. 71). This looks incredibly like autonomy on the consent model. My idea about patient autonomy is also in line with what Herring and Wall (2017) note. They claim that focusing on autonomy as a positive right in the medical law is misleading for, legally, it is not the case that such positive rights are respected. On the contrary, patient autonomy as a negative right – the right against unwanted interference (the right to bodily integrity) – is and should always be legally respected and protected. "In short, the patient has the right to refuse treatment, but not to demand it" (p. 567).

Fourth, note that the consent model singles out the possibility of patients consenting for the wrong reasons. Namely, it might really be the case that it is objectively best for the patient to die, but they do not authorize the doctors for that reason. Suppose that they do it because they think they do not deserve to live or, on the extreme side, because their favorite soccer team lost the championship. The consent model, by requiring the patients to have a reasonable attitude towards their well-being, eliminates (almost) all the possibilities of such cases – for if the patients do not provide a good enough reason for wanting to die, that is, if it is not in accordance with what is in their objective best interest – they would be deemed incompetent and their consent invalid. The self-determination model cannot account for this in any way.

In conclusion, patient autonomy is generally respected as a permission or a constraint on a medical intervention. The doctors who want to give you antibiotics, amputate your leg or perform a surgery on your brain – even though they might advocate for it – cannot do it without your permission. This begs the question: why shouldn't we treat autonomy in the same way when it comes to assisted dying? I do not see a valid reason for treating patient autonomy differently when it comes to assisted dying.

In the next chapter, I will explain and illustrate the type of suffering brought about by severe depression, while providing an answer to the skeptics. Then I am going to discuss how this model accounts for the objective determination of a patient's best interest.

CHAPTER 3: DEPRESSION, SUFFERING AND OBJECTIVE BEST INTEREST

In this chapter, I will deal with the suffering group of conditions – the idea that the person granted assistance in dying should be diagnosed with an incurable condition and be in a state of unbearable suffering. I will present skepticism vis-à-vis the nature of suffering resulting from severe depression and its incurability. Then I will lay out testimonies of severely depressed individuals to try and illustrate the severity of their suffering. Finally, I will discuss Bullock's idea of objective best interest and sketch a proposal as to how doctors can determine what is best for a given patient.

Is the suffering unbearable?

Among proponents of assisted dying it is widely held that the person requesting it should be in a state of unbearable suffering. This means that assistance in dying is understood as a last resort, a procedure available for those whose suffering cannot be alleviated by any available medical method.

When it comes to terminally ill patients, there is no much debate. Medical doctors agree that some types of cancer in their terminal stages result in severe suffering for patients. When it comes to depression, the opinions differ. There are authors who think that suffering brought about by depression is either not of the same kind or at least it cannot be measured akin to its somatic counterparts. Christopher Cowley (2013) claims that there is a fundamental difference in nature between somatic and mental illnesses (p. 227). Somatic diseases, he claims, are quite predictable because of the medical knowledge surrounding the causal mechanisms of such diseases. Medicine, in his opinion, rests entirely on the knowledge of these mechanisms (p. 234).

What he means by this is that for many types of (terminal) somatic illnesses like cancer, the doctors can establish a link between causes and risk factors on one hand, and the effects of the disease on the other. Through this knowledge they can predict the progress and the outcome of the disease. It seems that this point refers also to predictions about the type and severity of suffering induced by some somatic illnesses. When it comes to mental illnesses, the medical profession knows and can explain less. For these reasons (and some others as well, which are not very relevant to this part of the thesis), Cowley ambitiously claims that assistance in dying due to psychiatric reasons is never justified.[12]

In my previous work, I took Cowley's line of argumentation and taken it a step forward. I argued that the main relevant difference between physical and mental suffering lies in the fact that physical pain can be localized and understood in reference to the nervous system. As such, different types of physical pain are more or less comparable to each other in respect to their intensity and severity, even on a hypothetical level (Kovacevic 2018, p. 8).

I claimed that there is nothing more than an underlying assumption that mental suffering and quality of life that comes with depression is comparable to pain and quality of life of a terminally ill or a tetraplegic person. This assumption was, in my opinion, unjustified, because the sole concept of mental suffering is, as I then claimed, poorly developed, lacking in clarity and rigor (ibid.).

Another, possibly relevant difference between physical and mental suffering was brought up in a discussion with Vasko Kelic[13]. The thing is many of us have an intuition that mental and/or emotional suffering is more in our control than physical pain and suffering (at least of the kind and severity in terminal patients). For this reason, we might be able to alleviate it or put it under control if we try.

Cowley might have indeed correctly sketched the differences between mental and somatic illnesses. It is worth noting, however, that he managed to do just that. His claims have no

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[12] Despite his claims in the initial text, he seems to have not completely closed the door on mental illnesses when it comes to assisted dying. He admits that anxiety and other personality disorders might indeed be the types of conditions which impose unbearable suffering on people, but he is rather "incompetent" to discuss that (see Cowley 2015, p. 585).

[13] I give my thanks to Vasko for bringing up this point in our discussion.

implication for the suffering imposed by severe depression and whether it is of the right kind and intensity as to qualify depressed people for assisted dying. As for the claims I made in my previous work and the ones mentioned by my colleagues – they seem to be grounded in at least three assumptions about severe depression: first, that the unbearability of physical pain is more objective and, thus, somehow more severe than in mental or psychological suffering; second, that depressed patients do not experience chronic, if not (at moments) unbearable physical pain; and third, that all depressive states and episodes are of the same kind and intensity, which can be cured and/or alleviated.

All of these assumptions are wrong.

In reference to the first, while it may be the case that physical pain can be localized, explained with more clarity and put in a broader causal-mechanical context – none of it makes the *unbearability* of suffering any more objective. In the end, the standard condition for justifying assisted dying is that the patient is experiencing unbearable, unmanageable suffering. Regardless of whether the patient is suffering from terminal cancer, tetraplegia or severe depression, the question on how severe and bearable their suffering is, is a question only those patients can answer. Therefore, it is necessarily subjective in all cases.

When it comes to the second assumption, psychiatric literature suggests that severely depressed patients suffer physically as a result of their condition. Juli Fraga[14] (2018) notes that, in addition to feeling hopeless and worthless, depressed individuals frequently have tension headaches, decreased vision, pain in muscles all over the body, stomach pain, back pain, fatigue and consistent lower levels of energy. Moreover, one study she mentions (Marsala et al. 2015 in Fraga 2018) showed a correlation between major depressive disorder and decreased pain tolerance. In other words, when someone is severely depressed everything tends to hurt more.

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[14] Juli Fraga is a licensed psychologist from California; her text I am referring to was medically reviewed by dr. Timothy J. Legg. For a list of studies she refers to in her text see Fraga 2018.

As for the third assumption, there is a great difference between major depressive disorder and other depressive states such as dysthymia and exogenous depression (depression caused not by chemical imbalance but by external factors such as a loss of a loved one). Cowley (2013) does acknowledge this, but insignificantly. He does not mention any statistical data about how many people actually suffer from severe depression, which makes it seem that the majority of those who seek assistance in dying are dysthymic and exogenously depressed patients. This is not true. From what I cited at the outset, the majority of mentally ill patients who requested assistance in dying in Belgium and Netherlands were in fact people with diagnosed major depressive disorder or some other mood disorder (namely, bipolar disorder I or II). Also, may testimonies tell us that a lot of these people have been depressed since early childhood. While it may not be the case that the suffering brought about by dysthymia and/or some types of exogenous depression is unbearable, this does not tell us much about the suffering imposed by major depressive disorder. In fact, as Steinbock (2017) notes, the assumption that mental suffering is not as severe as physical is a result of misunderstanding and distortion of depression – the idea that depressed people are just feeling a bit unwell (p. 32).

I would conclude on the same note. The arguments stemming from an assumption that mental suffering is less severe and more bearable than physical – be it a result of stigma, prejudice or just benevolent intuition – is not necessarily true. Yes, the suffering resulting from mental illnesses is quite different than that resulting from somatic ones, but it doesn't follow that the latter is more bearable.

Is the suffering incurable?

Another condition belonging to the suffering group demands that the patient is not only suffering unbearably, but that their condition is incurable, that is, that there's no prospect for improvement of their disease. This must be taken with a grain of salt for even the most severe cancer patients can enter a miraculous remission and there is always a probability, no matter how small, that tetraplegic individuals might walk again. Therefore, by ‘no prospect for improvement’ I will mean no hope for the relief of symptoms/no expected cure *in reasonable time* after the patient has filed their request to die.

Following even this narrow reading of the incurability condition, there is a case to be made against the claim that there is something called treatment-resistant depression. Many psychiatrists (including Kornstein and Schneider 2001; Souery et al. 2006, 2007; Millet, Icick and Lepine 2011) have noted a serious issue with the way people are diagnosed with severe, treatment-resistant depression. All of them claim that there are different definitions of treatment-resistant depression. Some psychiatrists deem patients who have not positively responded to the first cycle of antidepressants as resistant, some think it’s after two, and some demand that the patient needs to try a third, less conventional type of therapy like electroconvulsion or deep-brain stimulation in order to be deemed truly treatment-resistant. Since there are different definitions, being a treatment-resistant patient means many things and nothing at all, at the same time. Souery and colleagues (2006) think this phenomenon of various and ambiguous definitions leads to ‘pseudoresistance’ – patients being diagnosed as resistant when in reality they are misdiagnosed (for the definition used in the diagnosis was too broad) or have been treated inadequately (pp. 16–17).

This brings forth a serious moral issue: if many patients are indeed mistaken to be resistant, then they might be likely to benefit from a potential cure and, accordingly, they might not be suitable candidates for exercising the right to assisted death. This opens up a series of questions. How many patients have been misdiagnosed? How many of the pseudoresistant patients have been granted assistance in dying? At the end of the day, isn’t this a strong reason against extending assisted dying rights to the severely depressed?

Despite many of us may take it as a strong enough reason, I do not think it is.

It is important to note that I am willing to admit that, as long as serious ambiguities are still present and the relevant notion of TRD is not decided on by a specific jurisdiction – this may be an argument for temporarily stopping the practice of medical assistance in dying for patients suffering from severe depression *in the given jurisdiction*. However, I do not think this argument supports not extending assisted dying rights to depressed individuals *in general*. On my view, the fact that there are still ambiguities about the definition of TRD means that such ambiguities should somehow be resolved in order to continue the practice.

One way to resolve this is, perhaps, by demanding the use of a specific diagnostical manual when considering and diagnosing the candidates for assisted dying. This could be included in the regulations. For example, in reference to what I wrote at the outset, the regulation can demand that all psychiatric diagnoses due to which patients are going to be assisted in dying should be done in reference to DSM-V and the *Florida Guidelines*. Alternatively, a jurisdiction can regulate it differently, according to a different manual. I am not going to discuss which specific definition of treatment-resistant depression from which specific manual should be used – it is rather important to highlight there should be *one* according to which the diagnoses and subsequent decisions about the patient's eligibility for assisted death should be based on.

Now that I have explained what the issue with the arguments against the unbearability and incurability of suffering resulting from depression is, I am going to present stories and testimonies from two severely depressed individuals: Emily and Adam. Through their stories I hope to illustrate the suffering these people go through and how this mental condition can be seen as depriving the people from their (sense of) dignity.

How does it feel to be depressed?

Emily was a young Belgian woman who, aged 24, requested to die with assistance due to mental suffering. Even though she appeared to have everything, she claimed her life was unbearable.

> "I've had enough of all this. It feels like nothing gets to me anymore, it's like I'm dead inside […] I tried, I really tried, but I just can't. It keeps feeling empty, whatever I do, and pointless. I can't even look forward in time because I can't picture myself anywhere, wherever, with whomever. I don't see it at all." (*The Economist* 2015).

Emily has been depressed her whole life. She has attempted suicide on multiple occasions, has been admitted to psychiatry clinics at least twice, and she is constantly on some kind of psychological treatment since 12 years of age. Emily recalls feeling depressed and anxious in early childhood, when she was just 3 years old.

> "It feels like there's a monster behind my ribcage constantly trying to get out. Cutting makes you feel you can calm it down and banging your head on the wall makes you think 'I can beat it', but even slamming and hitting can't stop it. And then to get up from a puddle of tears and carry on, that takes a lot of f***ing courage to do. That's the hardest, picking yourself up every time when you know five minutes later, it'll be back. And you'll have to go through it all over again. That's what makes it so unbearable. Every time you try and get up, it keeps coming back quicker and your feelings are still trapped inside" (ibid.).

Adam remembers being depressed since he was just a child. His symptoms significantly worsened at the age of 23 when he was, as a result of major depression, diagnosed with the somatic symptom disorder – feeling pain and aches all over the body. Reading, writing, talking or any kind of mental activity made his pain debilitating. He described it as a feeling like you're being "burned with acid". On the 13th of April 2017, after his request to die with medical assistance was denied by Canadian authorities, 27-year-old Adam drove off to a motel and took his own life (Hughes 2017).

These testimonies show that severely depressed people are not just feeling sad or empty or worthless at moments. These symptoms are persisting, debilitating and constantly present. It would be reasonable to assert that severely depressed people, at least some portion of them, are suffering to the extent it becomes unbearable for them. Nevertheless, I will try to refer to some of the strictest conditions for justifying assisted dying and show that severely depressed patients can be deemed as eligible candidates for assisted dying.

Such conditions are set forth by David Velleman (1999) in his paper *A Right of Self-Termination*. In short, he thinks assisted dying is never properly justified by appealing to interests of the person who wants to die. Following the ideas of Immanuel Kant, he claims people have value in themselves and this value is called dignity or personhood. If assisted dying should ever be permitted, it should not be permitted on the basis of protecting interests or well-being of the person – for that would mean violating the value in themselves, that is, their dignity. If assisted dying is ever permitted, in his opinion, it should be so because the person, at the point of requesting death, has dignity no more or they cannot both continue living and preserve their dignity.[15]

He also asserts that individuals themselves cannot be the exclusive (and perhaps competent) judges of their dignity. In his opinion, we ought not defer to the person's view about their dignity – for even if they think and claim they have none, it does not follow that is the case (Velleman 1999, p. 611).

On what constitutes the deprivation of dignity, Velleman (1999) takes the example of unbearable pain or suffering. If unbearable suffering is to justify assisted dying, he claims, it needs to be a sort of pain so profound it deprives the person from their personhood.

> „Not to bear pain is somehow to fall apart in the face of it, **to disintegrate as a person**. To find pain unbearable is to find it thus **destructive not just of one's well-being but of oneself** […] If pain is truly unbearable, then he isnt his rational self any longer: he is falling apart in pain. **Even if he enjoys some moments of relief and clarity**, he is still falling apart diachronically, **a temporally scattered person** at best.“ (p. 618) [stress added]

It seems that my example of patients suffering from major depressive disorder and treatment-resistant depression respectively, satisfies most (if not all) of the conditions Velleman posits.

First, the pain and suffering depressed patients go through can be argued to be of the kind that constitutes the loss of their personhood and their dignity. In the mentioned testimonies, severely depressed individuals claim they feel dead on the inside, they cannot picture themselves anywhere and with no one through time. They describe the intolerable part of trying to lift yourself

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[15] In his later work, he also noted that „respect for a person's dignity, properly conceived, can require us to facilitate his death when that dignity is being irremediably compromised“ (see Velleman 2015, p. 7).

up when you know in a couple of minutes you will be feeling miserable again. Some of them describe their pain as if they were having acidic burns, as something so debilitating, they cannot even think or talk, as a state of cold horror. It is not hard to relate these testimonies to Velleman's ideas about disintegrating as a person, of having oneself destroyed, and of being a temporally scattered individual.

Also, personhood and dignity can be linked to one's personal identity. Severe depression, by the claims of some psychiatrists, completely and irreversibly destroys one's old self. Schuklenk and van de Vathorst (2015a) claim that severely depressed patients, based on current psychiatric understanding of the condition, cannot recover their pre-depression self – their identity. Depression, in their opinion, can be described „to some extent by a loss of individual integrity.“ „It is true that the person these patients once were, and that they likely long to be, they are no longer and they will not be again“ (p. 581). This is yet another indication of how suffering imposed by depression affects the personhood and dignity of the individual.

This brings me to the second point. We need not defer to the patient’s opinion about their loss of dignity (although the diagnosis partly depends on their experiences). In fact, psychiatric experts are the ones who often claim that depression can be reasonably described in terms of loss of integrity and identity.

Both of Velleman’s strict conditions for justifying assisted dying can be justified when it comes to severe depression.

Additionally, Velleman (2015) makes another strong claim which might make justifying assisted dying a lot harder. Namely, he claims that the loss of a person’s dignity is followed by their compromised capacity for rational and autonomous decision-making (p. 7). In other words, patients who are in so much suffering that their dignity is deemed compromised and disintegrated are most likely to be unable to determine whether death is really in their best interest. My view avoids this issue because the justification of assisted dying is not grounded in the patient’s self-determination, but rather in objective determination of their best interest as well as their consent as a minimal constraint against being violated, that is, against being euthanized against their will.

In this next section, I turn to the notion of objective best interest and explain how doctors can (fairly) objectively determine whether death is in the best interest of a given patient.

Objective best interest

In the previous chapter I elaborated in detail what Emma Bullock's view on justifying assisted dying is. On one hand, we respect the patient autonomy in the form of their consent, that is, a permission or a constraint on a medical intervention to their body. On the other hand, what justifies assisted dying is the objective determination of what is in the patient's best interest.

The idea behind objective best interests is that there is something intrinsically good for those patients, independent of what they achieve by means of self-determination (Bullock 2015, p. 17). In the context of assisted dying, claiming that death is in the objective best interest of the patient would mean that there are objective factors which deem their quality of life (or their well-being) on a very low level – so low that their life can be considered not worth continuing.

As Bullock notes, this requires an objective list of well-being. This list contains more substantive goods, such as – life, consciousness and activity, health and strength, pleasure and satisfactions, happiness, truth, knowledge, aesthetic experience, harmony in one's life, freedom, esteem etc. (pp. 17–18).

A common objection to objective lists and theories of well-being, as she notes, is that they "cannot account for the differences in individual values and interests: as if the same things must be valuable for everyone" (Scanlon 1993, p. 188 in Bullock, p. 18). However, she thinks objective theory of well-being can be subject related, while still being predominantly objective. The point is that an objective list and theory of well-being is *not reducible* to personal preferences (pp. 18–19).[16] For illustrative purposes, let us imagine the following:

> **Person A** is a well-performing athlete who has just suffered an accident which has left her paralysed from the waist down.
>
> **Person B** is an IT developer who spends most of her days sitting in a chair or lying in her bed. She really dislikes walking or doing any kind of physical activity. She also just suffered an accident which has left her paralysed from the waist down.

In both cases the disability is an objective factor on the list of well-being. However, it seems reasonable to give more weight to that factor when it comes to person A, for the majority of their life centred around physical activity which is now impossible. This means an objective list is subject-related. At the same time, the person B might not care at all if they're paralysed or not (as ridiculous as it sounds, they might even prefer some parts of it), but we still treat it as an objective loss on the list of their well-being. This means that the objective list is not reducible to personal preferences.

In short, objective factors can be given different weight when assessing the well-being of two distinct persons, because one might prefer not having a certain objective deficiency, while the other may not care about it. However, even though a person might subjectively feel indifferent to all of the objective factors on the list, if they are all on a level zero, their well-being is nevertheless considered zero. In other words, subject-related preferences and objective factors are not independent, but they act like multipliers.

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[16] Notice how the objective list of well-being factors includes some respect for the self-determination of the patient. Unlike in the self-determination model of autonomy, Bullock's consent model sees it as *one of* the factors on the list, but not the *central* factor. That is what she means when she claims that an objective list and theory of well-being is *not reducible* to personal preferences.

A theory of well-being

The notion of objective best interest must be grounded in an objective list of well-being. This list includes factors which can be more or less realized or fulfilled. Depending on how low someone scores given each factor, the doctors decide whether it is in patient's best interest to die with assistance or to continue living. For this reason, it is worth dedicating some time to explain the notion of objective well-being[17]. In the first place, I think a general distinction can be made regarding such objective accounts of well-being in respect to what they aim to achieve or what is their function. In the first order there is the philosophical account, and on the other there is the practical account.

The philosophical account of well-being aims at what is true – what *really* contributes to each and every person's quality of life (or well-being). In this respect, there are different groups of theories: theories of objective well-being, theories of subjective well-being and combined theories.

Objective list theories of well-being consist of factors which are not reducible to pleasurable experiences or satisfaction of desires. As Roger Crisp (2017) notes in his *Stanford Encyclopedia* entry on Well-being, it is commonly held that every intrinsic good should be contained on the list. There are some differences as to what makes the factors good. Some claim that 'good' is whatever functions to perfect one's nature and that intuition or 'reflective judgment' is the faculty upon which it is decided what goes on a specific list of well-being. Nevertheless, what is at the core of any objective list theory is that, even though some value may be given to them, the list is not reducible to subjective preferences, pleasurable experiences and/or the satisfaction of one's wishes and desires.

Two of the most prominent theories of subjective well-being are evaluative hedonism and desire theories. As Crisp notes, evaluative hedonism equates well-being with a balance between

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[17] I won't be defending a fully-fledged theory of well-being because of the space limit. Instead, I will limit myself to sketching one.

pleasure and pain in one's life. Desire theories, similarly, identify one's well-being with the fulfilment of their desires (ibid.). Combined theories, which Crisp does not discuss, are theories which take into account intrinsical goods, but only if the subject cares about them (if they prefer them).

The practical account of well-being, unlike the philosophical, does not primarily and only aim at what really is the case, but what is applicable and what can be measured and determined. In other words, even though it might be the case that subjective preferences are what primarily affects everyone's well-being, they cannot be as accurately measured as the objective factors. They cannot be objectively determined because people are not that great at self-determining what is best for them, and when it comes to depressed patients, they are even more prone to mistakes (as shown in the second chapter). The fact that subjective preferences cannot be as precisely and accurately determined and measured gives us a reason to focus on the factors that can be more accurately measured in respect to their contribution of one's well-being and best interest.

In sketching a functional theory of well-being, I will somewhat follow in Bullock's footsteps, with a difference that I will leave the philosophical debate on the nature of well-being open. I will sketch what could be more adequately described as a practical account of well-being. There are several reasons for doing that. An account of well-being developed for the assisted dying procedures must be possible to institutionalize. In other words, we have to be able to determine and measure one's well-being clearly and accurately. Also, the account has to satisfy some publicity conditions – people should know what is expected from them. For that to be possible, there needs to be some universal and clear criteria which everyone could understand and comprehend how those criteria are met.

That being said, I take some time to sketch out an account of well-being.

Firstly, the majority of the factors on the list of well-being would be objective and measurable, meaning they are universally applicable and medically or psychologically assessable. In other words, the factors on this list need to be such that the doctors and psychiatrists have some objective way of gradually measuring their realization in a given individual. Secondly, these factors are weighted more or less in relation to the (type of the) disease the person is suffering from. Finally, these reasons can also be weighted in relation to subjective preferences of the patient. To illustrate it, let us take a following objective list of well-being factors:

- Physical pain
- Vision and senses
- Vital functions (i.e. breathing)
- Motor abilities and activity
- Strength
- Consciousness
- Cognitive abilities (knowledge, reasoning, understanding)
- Emotional capacity (happiness, pleasures, satisfactions, self-esteem)
- Personal identity
- Experiences of achievement

When I say that they can be narrowed and weighted in relation to the disease the person is suffering from, I meant the following: for the well-being of anyone requesting assistance in dying, these factors objectively play a significant role. However, the doctors are justified (perhaps even expected) to give more weight to some of the factors rather than the other, given the situation. Namely, they might be expected to give more weight to the physical pain factor if a terminally ill patient is the one requesting assisted dying, rather than a tetraplegic patient. That is simply because the pain can impose excruciating suffering in the final stages of the disease, while persons suffering from tetraplegia cannot feel any pain in most parts of their body. For a tetraplegic patient, the factor which is mostly affected and could perhaps be given extra weight is the motor abilities and activity. Similarly, if the patient at hand is severely depressed, it is reasonable to give more weight to their emotional capacity, cognitive abilities, personal identity and self-esteem over their motor abilities or physical pain.

These factors, as mentioned, can be given more or less weight in relation to subjective preferences. For example, even though physical pain is objectively present in most cases of severe depression, some individuals might not care that much about it as they care for the fact that they are cognitively and emotionally impaired – and this is taken into account.

It is important to note once more that objective factors and subject-related preferences, on my view, are dependent of each other as they act like multipliers. Even though some objective factors are given more or less weight according to subjective preferences of persons involved, their well-being, in the end, is always objectively on a higher or a lower scale. In simple words, even though there might be a person who does not care about their motor or cognitive abilities, and whether they are in serious physical pain – their well-being is considered on a lower scale than normal for that is objectively so.

This is a brief proposal of how the notion of objective best interests can be incorporated in the assisted dying procedures. As I have mentioned before, it might be the case that a functional, practical account of well-being such as the one I presented does not comprehensively explain what really constitutes every individual's well-being. In fact, delivering an answer to the question what really constitutes and defines our well-being may be impossible. That is why I am inclined to assert that the practical account is the best that the medical profession can offer – a list of factors, most of which can be medically or psychologically assessed and to some extent measured, which also accounts for subjective preferences as a part of one's well-being.

Nevertheless, as Bullock (2015) herself notes, it is quite controversial to claim that in some cases it is in the patient's best interest to die, regardless of their wishes (p. 20). Even though patients are protected from unwanted interference through the demand for their consent, someone may still find it problematic how doctors can determine whether death is best for someone. This is why I am going to deal with this objection, and some others, in the next chapter.

CHAPTER 4: OBJECTIONS

In this chapter I will outline and answer potential objections to the consent model of autonomy and the notion of objective best interests I developed in previous chapters. I group the objections into three categories: autonomy, objective best interest and anti-paternalism.

Competence, autonomy and consent

This group of objections centers around the concerns whether severely depressed patients are able to provide a competent informed consent.

First, there is the objection that even if we adopt the consent model of patient autonomy, severely depressed patients should se be seen as incompetent decision-makers. In other words, someone might say that depression compromises one's autonomy to the point that they cannot ever give a competent informed consent. While this objection is logically sound, I think it stems from an overdemanding notion of patient autonomy. As I pointed in the section on terminology, and then later on in the first chapter when I presented the difference between autarchy and autonomy – all of our decisions are to some extent affected and/or biased due to external factors. This does not make them non-autonomous by default. For instance, we often act on advice given by friends or out of respect for the law, which means we are influenced and perhaps even coerced (especially when it comes to law) to choose a specific course of action. Nevertheless, we still treat our decisions, and others do as well, as autonomous. What I am trying to say is that not every factor influencing our decisions makes our decisions non-autonomous or inauthentic. In order to claim that, in this case, depression renders people suffering from it non-autonomous, one needs to prove that the actions of a severely depressed individual are fully or primarily directed by the disease, and that the depressed individuals cannot override those actions by their own will. In other words, giving a competent consent can reasonably be seen as the minimum of exercising one's autonomy, so in order to show that people are not autonomous enough to give consent, one's evidence needs to be strong, extensive and inambiguous. As shown in the previous chapters, that is not the case.

At the end of the day, if we decided to treat severely depressed patients as incapable of providing informed consent, they would be put in a position quite comparable to comatose patients. Everyone would agree there needs to be some gradation in terms of competence and autonomy between these two groups. For the comatose patients lack the necessary condition for being autonomous (they are not conscious), whereas with the severely depressed, they are conscious, alive and we are not sure that their biases shape and affect their autonomy to the extent they become incompetent.

Second, an objection can be made regarding the scope of the consent model. Someone might argue since the scope is unjustifiably wide and the bar for competence set too low, any depressed patient can be deemed as competent. Someone might claim this does not reflect reality where we can see that many depressed patients are irrational and, at least temporarily, incapable of competent decision-making.

My answer to this is threefold.

In the first place, there are clear criteria which need to be met in order for a depressed patient to be deemed competent. As mentioned before, they need to understand relevant medical data, they need to understand basic implications of their options and decisions, and they must, at some point, show a reasonable attitude towards their own recovery. Accordingly, there might be, and surely there is a pool of depressed patients who are unable to understand medical information or to appreciate the treatment options available to them, or to have a reasonable attitude towards their well-being and recovery. There are, perhaps, some patients who are incapable of all these things. Just like in other areas of medicine and for other procedures, the doctors can assess whether the person is able to competently provide consent and act according to their assessment. Therefore, it is not true that every depressed patient is competent on the consent model.

In the second place, it is true that a depressed individual's competence can shift as they enter or exit a major depressive episode, this does not make their consent invalid by default. Moreover, for that reason, I proposed in the previous chapter that the window period – between the time of the request for assistance in dying and the procedure being carried out – should be appropriately wide. This makes way for doctors adequately evaluating and tracking one's consent.

In the third place, even if I granted my opponents that all requests by severely depressed patients were deemed competent by default, in no way it follows that all of them (not even a high number of them) will be granted the opportunity to die with assistance. For the consent given by the patient is just one of the conditions for justifying assisted dying. The other one demands that the doctors decides that death is in the best interest of the patient.

Well-being and objective best interest

There are two types of potential objections that may arise in respect to the notion of objective best interest.

The first, and the more fundamental objection, is that well-being cannot be adequately captured by objective factors. I am willing to admit this, and I already did in the third chapter when discussing objective best interests. It might indeed be the case that subjective factors contribute to well-being as much as the objective ones do. However, since subject-related preferences and desires, as well as satisfaction of those, are not easily measurable, we have a reason for adopting a more practical, applicable notion of well-being. That is why the doctors determine what is in the patient's best interest in reference to some objective, measurable, recognizable factors. In other words, while the objective account of well-being I proposed in the previous chapter may not be entirely philosophically true, it is favorable in various respects: it rests on some fairly uncontroversial claims – namely, that there are some factors which universally contribute to people's well being (objective factors such as pain, happiness and motor abilities); it gives some value to subject-related preferences and desires by giving more or less weight to objective factors on the list; and it is practically applicable when it comes to assessing both objective factors and subject-related preferences.

The second objection has to do with the doctors' ability to determine what is in the patient's best interest. What someone might ask here is if humans are at times not quite capable of competent determination of what is in their best interests, how are the doctors competent at deciding what is best for their patients?

My answer here is twofold.

In the first place, having the doctors to decide what is in the patient's best interest is favorable since we have some evidence against people's capacity for self-determination, but not against their capacity to determine what is best for others. In other words, we have some evidence which suggests that people are not good at determining what is best for them, but no evidence so far suggesting that they are not good at determining what is best for others – and specifically no evidence suggesting that doctors are not good in determining what is best for their patients.

In the second place, the factors by the help of which doctors decide what is in the patient's best interest (might) differ from the factors that we 'refer to' when we self-determinate. The doctors have a list of objective factors, measurable and recognizable by medical and/or psychological analysis. On the basis of scores the patients achieve on these factors, the doctors make a decision either that it is best for the patient to die or that is best for them to continue living. Perhaps, it is more precise to say that the doctors are determining what is in the *patient*'s best interest, rather than what is in the *person*'s best interest. On the contrary, the factors which we 'refer to' (if there is such a universal list of factors) can be quite different – they are necessarily more subjective and not measured (possibly even not measurable) akin to how objective factors are. In short, the doctors might be able to determine what is in the patient's best interest better than the patients themselves because they are making that decision in the narrow scope of the procedure of assisted dying, based on objective factors about the one's well-being.

Anti-paternalistic objections

Someone could argue that the fact that doctors are the ones who determine whether it is in the patient's best interest to die is an unjustified paternalistic interference. Instead of this, they could say, the patients should be able to determine what is in their best interests themselves.

The answer to this objection is twofold.

First, if objections are correct and any form of paternalism to any extent is unjustified, we are left with nothing but the self-determination model. And as I have shown earlier, this model of patient autonomy is problematic in several respects. On one hand, if we understand self-determination in reference to the will theory of rights then everybody, due to being human, has the right to choose what's best for them, as long as they do not harm the others. Vis-à-vis assistance in dying, on this view the doctors would become mere tools which are obliged to help the patient exercise their right to self-determination by assisting them in dying. On the other hand, if self-determination is understood in reference to the interest theory of rights, then the right needs to track some interests of the given person. The main problem is that self-determination, according to some studies from the field of behavioral economics and cognitive psychology, fails to track and protect the patient's well-being. Therefore, if we choose the paternalism-free path, we end up with a lot of issues, both conceptual and practical.

Second, while some may see the consent model as mildly paternalistic, it does not imply neither coercing people into doing what they don't want nor preventing them from doing what they want (at least not consequentially). For on one hand, nobody can forcibly euthanize a person without their authorization by consent; and on the other, if people want to die and actually satisfy the conditions, they are not prevented from dying with assistance. In other words, the consent model is not paternalistic in any relevant, objectionable sense. Moreover, this thesis in whole can be read as an anti-paternalist approach to assisted dying for the severely depressed – the project essentially aimed at explaining how depressed people can be assisted in dying *according to* their wishes, not *against* them.

CONCLUSION

The main question I dealt with in this thesis is – what is the justification for extending assisted dying rights to severely depressed individuals? Standardly, the proponents of extending those rights would say that justification lies in the fact that these patients are severely ill with no prospect for improvement, and that the patients determined assistance in dying is in their best interest. In other words, assisted death for depression is justified in facts about curability of the condition and the patient's self-determination.

As I have shown throughout this thesis, such an answer is problematic in several respects. Self-determination, if we take it as the exclusive right of the patient to decide on their destiny, independent of their well-being, leads to treating doctors like mere tools and implies fewer limits on patient autonomy than anyone would be willing to allow. If self-determination is valued for its function in promoting the patient's well-being, then the problem is that self-determination fails to achieve its function – for even healthy individuals are less capable of determining what is in their best interest than what we originally assume.

Nevertheless, I argued that extending assisted dying rights to the severely depressed is still morally permissible. On one hand, I ground the justification in the objective determination of patient's best interest. The idea is that the doctors can measure and assess certain objective factors which contribute to the patient's well-being, along with taking some subjective preferences into account, and analyze whether their well-being is so low that their lives can be considered not worth continuing. On the other hand, patient autonomy is respected as informed consent. The patients are the only ones who can authorize (or not) the doctors to assist them in dying. This is how their autonomy is valued and how they're protected against being euthanized against their will.

In summary, the model of justification I presented successfully combines the objective, factual justification of extending assisted dying rights with the adequate respect for patient autonomy. As such, it is possible to institutionalize and legally regulate, and it seems to avoid the objections usually posed to the standard model.

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