**We Should Widen Access to Physician-Assisted Death**

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**Abstract:**

Typical philosophical discussions of physician-assisted death (“PAD”) have focused on whether the practice can be permissible. We address a different question: assuming that PAD can be morally permissible, how far does that permission extend? We will argue that granting requests for PAD may be permissible even when the PAD recipient can no longer speak for themselves. In particular, we argue against the ‘competency requirement’ that constrains PAD-eligibility to presently-competent patients in most countries that have legalized PAD. We think PAD on terminally ill, incapacitated patients can be morally permissible in cases when advance directives or suitable surrogate decision-makers are available, and should be legally permissible in such cases as well. We argue that this view should be accepted on pain of inconsistency: by allowing surrogate decision-makers to request withdrawal of life-sustaining care on behalf of patients and by allowing patients to request PAD, we rule out any plausible justification for imposing a competency requirement on PAD

**Keywords:**

Autonomy, euthanasia, killing vs. letting die, physician-assisted death, surrogate decision-making

**Introduction**

In October 2018, Audrey Parker, a Canadian woman with terminal metastatic breast cancer, requested physician-assisted death (“PAD”). Her request came months before her predicted demise, but the law forced her hand. While Parker said that she “would have liked to have really lived until Christmas,” she decided to end her life in November out of fear that she would soon become ineligible for PAD.[[2]](#footnote-2)  At the time, Canada, along with nearly every other country that has legalized PAD, had a “competency requirement” for PAD.[[3]](#footnote-3) According to this requirement, patients had to be competent at both the time that they request, and the time that they receive, medical aid in dying. Metastatic breast cancer can leave patients mentally incapacitated before death. Audrey knew that if this happened to her, she would become ineligible to receive PAD. And so rather than risk losing eligibility for PAD, Audrey opted to end her life prematurely.

 Philosophical discussions of physician-assisted death have traditionally centered around the question of whether the practice is ever permissible. But in those countries where a form of PAD has been legalized, the public debate has now moved on to a different question: assuming that PAD can be morally permissible, what limits ought we place on it? That is the question we will address in this paper. In particular, we will criticize the competency requirements that often restrict PAD-eligibility to presently-competent patients. We will argue, contra these requirements, granting requests for PAD may be permissible even when the PAD recipient no longer has decision-making capacity. More specifically, we aim to ultimately establish the following two claims:

**Legal Advance PAD**:In many circumstances, it should be legal for doctors to provide PAD to terminally ill, mentally incapacitated patients with advance directives requesting it.

**Legal Surrogate PAD**: In many circumstances, it should be legal for doctors to provide PAD to terminally ill, mentally incapacitated patients whose surrogate decision makers request it.

We argue that both claims ought to be granted in light of moral views that are already widely endorsed and legally codified in many countries, including the United States and Canada.

Our paper proceeds as follows. After offering preliminary remarks in **Section 1**, we begin our argument in **Section 2** with two widely endorsed claims:

**Permissible Patient PAD**:It is in principle permissible for doctors to provide PAD to competent patients who request it.

**Permissible Advance Withdrawal**: It is in principle permissible for doctors to withdraw life-sustaining care from mentally incapacitated patients with advance directives requesting it.

We argue that if these two claims are true, then we must endorse:

 **Permissible Advance PAD**: It is in principle permissible for doctors to provide PAD

to mentally incapacitated patients with advance directives requesting it.

Beginning with a case that supports Permissible Patient PAD, we offer a series of analogous cases terminating in a case of withdrawal of care requested via advance directive. We argue that there is no morally relevant difference between each pair of adjacent cases. Since PAD in the first case is permissible and there is no morally relevant difference between any of the cases, PAD in the last case must also be permissible.[[4]](#footnote-4)

In **Section 3**, we aim to establish the following claim:

**Permissible Surrogate PAD**: It is in principle permissible for doctors to provide PAD to mentally incapacitated patients whose surrogate decision makers request it.

Our argument for this claim, once again, appeals to a morally similar, and already accepted medical practice. Specifically, we generally think that it is in principle permissible for doctors to withdraw life-sustaining care from mentally incapacitated, terminally ill patients whose surrogates request it. We argue that, if we accept that this practice is in principle permissible, and also that advance directive-requested PAD is in principle permissible, then we ought to also accept that surrogate-requested PAD is in principle permissible.

 In the final section of the paper, we argue for Legal Advance PAD and Legal Surrogate PAD. We argue that, while there are reasonable concerns about the riskiness of both practices, and while these concerns give us good reason to monitor these practices closely and at times limit their scope, these concerns are not sufficiently weighty to give us an argument against the legalization of advance directive-requested and surrogate-requested PAD.

**Section 1: Preliminaries**

Throughout the paper, we will be using the following definitions. By **‘surrogate’** (or ‘surrogate decision maker’), we have in mind a person who makes medical decisions on behalf of a mentally incapacitated patient. Surrogates may be appointed by patients (at a time before their incapacitation), or by legal procedure. **‘Withdrawal of care’** refers to cases in which life-sustaining medical care is withdrawn from a patient, thereby hastening death. **‘Physician-assisted death’** (‘PAD’) refers to cases in which a medical professional provides medical assistance to a patient aimed at hastening death. This assistance can take various forms: it might involve writing a prescription, administering an injection, or helping the patient ingest a substance. We intend our argument to extend to all of these practices. We will also be discussing the means through which withdrawal of care and PAD may be requested: these procedures may be 1) **patient-requested**, if the patient competently requests them at the same time she receives them, 2) **advance directive-requested**, if the request is made in an advance directive or 3) **surrogate-requested**, if a third party makes the request on behalf of an incapacitated patient.

 In this paper, we will be focusing on cases involving terminally ill patients who have become mentally incapacitated as a result of their illness. Furthermore, we restrict our discussion to patients who are mentally incapacitated because of a terminal illness that has severely undermined their decisional capacities.[[5]](#footnote-5) We do not, at this time, intend for our argument to go beyond cases involving terminal illness, nor are we focused on cases involving long-term mental disability. Our reasons for this restriction are threefold. First, most countries, including the United States and Canada, limit PAD to terminally ill patients. Second, even within the countries that allow PAD in cases of non-terminal illness, the majority of PAD recipients are terminally ill.[[6]](#footnote-6) Third, we think that cases involving non-terminal illness and mental disability present complications that we cannot adequately consider here.

We will not be arguing for the permissibility of patient-requested PAD. Instead, we will assume that physician-assisted death is *prima facie* permissible in cases involving terminal illness. Nevertheless, it is worth noting that arguments for the *prima facie* permissibility of patient-requested PAD typically make two sorts of appeals: to patient autonomy[[7]](#footnote-7) and to patient interests.[[8]](#footnote-8) The appeal to patient autonomy proceeds as follows: we, as autonomous agents, have a broad right to determine what happens to our bodies, and this right extends so far as to give us the right to decide whether to live or die. The appeal to patient interests points out that quality of life before natural death may dip so low as to make continued existence a harm. If there is some amount of suffering that could make a life not worth living, then PAD is sometimes morally acceptable on grounds of beneficence.

**Section 2: Why Advance Directive-Requested PAD is Permissible**

In this section, we aim to show that if it is permissible for patients to request PAD directly (Permissible Patient PAD), and it is permissible for patients to request withdrawal of life-sustaining care via an advance directive (Permissible Advance Withdrawal), then it is also permissible for patients to request PAD via an advance directive (Permissible Advance PAD). We will offer a first pass at this argument, and will then consider (and reject) various objections.

**2.1—The Argument**

Let us begin by looking at a particularly ideal request for medical aid in dying:

**Albert:** Albert has been diagnosed with terminal cancer, with a life expectancy of less than six months. Since his diagnosis, Albert has found his quality of life to be steadily decreasing due to pain and impairment. Knowing that his level of pain and impairment will only increase, Albert requests PAD. His request is granted after being reviewed by two psychiatrists. A few months after his diagnosis, a doctor comes to Albert’s house, and establishes that he is still competent to make medical decisions. Albert affirms that he still wishes to end his life. He is then given several pills that send him into a dreamless sleep, followed by an injection that stops his heart.

This case involves a competent patient who has had time to process the shock of a terminal diagnosis, and a sustained desire to end his suffering by means of PAD. If PAD is ever permissible, it is permissible in cases like Albert’s.

Now imagine Bobby, whose case is just like Albert’s, with one crucial difference: whereas Albert’s doctor administers the injection directly after sedating him, Bobby’s doctor waits 15 minutes before doing so. Fifteen minutes of dreamless sleep does not seem to make a moral difference here. The doctor is not obligated to rouse Bobby in order to “re-consent” him. This case establishes that our autonomous declarations have some staying power—we do not need to consent to a medical procedure at the very moment at which it is performed in order for our consent to be valid.

Of course, extenuating circumstances may sometimes render past consent invalid. Recanting past consent, for instance, generally renders it invalid. Drastic changes in medicine—such as the invention of a more effective treatment option—could also render past consent invalid. Nevertheless, incapacitation is not by itself an extenuating circumstance that renders consent invalid. If it were, then it would be impossible to consent to any procedure that requires general anesthesia. And so, if Albert and Bobby legitimately consented to receive PAD, then a brief period of incapacitation prior to death would not, by itself, render their consent invalid.

How brief must this period be? Consider Clara:

**Clara:** Upon being diagnosed with terminal cancer, Clara fills out an advance directive. The directive mandates that she is to receive PAD if she ever ends up in a mentally incapacitated state that appears inconsistent with a reasonable quality of life and that is most likely irreversible. Six months after her cancer diagnosis, Clara suffers a stroke, which causes massive brain damage and requires her to be put on life support. Clara’s quality of life seems very low, and her prognosis is grim. Even if she somehow recovers from the stroke, the cancer will soon kill her. Clara’s doctors agree that her state meets the conditions for PAD outlined in her advance directive, and so they honor her request.

We think that PAD is permissible in Clara’s case, as it is in Bobby’s. But this judgment contradicts the legal situation in most jurisdictions that have legalized PAD, as they have generally disallowed PAD requests made via advance directives. What reasoning could be used to justify this restriction? Presumably, if there is any morally relevant difference between Bobby and Clara, it must relate to the difference in how much time elapses between when they request PAD and when they receive it. But why would this difference in time generate a difference in permissibility? We will argue below that the most plausible answers to this question fail, and as such, that this difference in time is irrelevant. Thus, we should accept Permissible Advance PAD.

**2.2—Appeal to Risk of Acting Against the Patient’s Will**

Let us begin by considering why time might make a difference to permissibility. One reason for limiting the amount of time that can pass between the request for and the provision of PAD is that, as more time passes, the risk that the patient will change their mind increases. Or if they are mentally incapacitated, the risk that they *would* have changed their mind increases. In Bobby’s case, there is very little risk of him changing his mind (or risk that he would have changed his mind, had he been conscious); in Clara’s case, the risk is greater.

We grant that it would be a moral mistake to provide PAD to someone who would have revoked consent if informed and competent. If allowing more time to pass between the request for and the provision of PAD increases the risk of making that mistake, that could provide reason to limit the amount of time that can pass between the request for and provision of PAD. But that does not provide reason to completely prohibit advance directive-requested PAD. To see why, consider Dawn:

**Dawn:** At age 75, Dawn signs an advance directive mandating that doctors withdraw all life-sustaining treatment from her if she ever ends up in a state of permanent (or likely permanent) unconsciousness. At age 78, Dawn is rendered unconscious by a stroke, and is put on life support. Her doctors judge her to have very little chance of meaningful recovery, and so they follow the mandate set out in her advance directive and remove her from life support, thus causing her death.

A lot might have changed in the three years that elapsed between Dawn signing the advance directive and suffering the stroke, including, perhaps, her attitudes towards life support. Certainly, if we know that Dawn *would* have revoked consent to withdraw care if she were able to do so, that would undermine the permissibility of removing her life support. But the mere chance that she *might* have revoked her previous consent cannot itself render withdrawing life support impermissible. There is always a possibility that a patient might have revoked consent between signing an advance directive and receiving whatever care was outlined in it, but this possibility does not give us reason to abandon the practice of abiding by patients’ advance directives. The ability to dictate the limits of one’s medical care is too important a right to be abandoned because of this implication.[[9]](#footnote-9)

This means that we cannot coherently deny the permissibility of advance directive-requested PAD out of concern that the patient’s will might have changed, unless we also want to deny the permissibility of advance directive-requested withdrawal of care on the same grounds. Both practices involve high stakes situations, and any reason to think that a patient’s will might have changed after requesting PAD via an advance directive is also reason to think that a patient’s will might have changed after requesting withdrawal of care via an advance directive. If concerns about the stability of the patient’s will are sufficient to render the former practice impermissible, they would be sufficient to render the latter impermissible as well. But they are not sufficient to render advance directive-requested withdrawal of care impermissible. As such, they are also not sufficient to render advance directive-requested PAD impermissible.

**2.3—Appeal to Risk of Killing Against the Patient’s Will**

We just argued that, if concerns about the stability of a patient’s will undermine the permissibility of advance directive-requested PAD, they also undermine the permissibility of advance directive-requested withdrawal of care. How might an opponent avoid this implication, and thus maintain an objection to advance directive-requested PAD that does not imply the impermissibility of preemptively requesting that life-sustaining care be withdrawn? Perhaps they could argue that implementing the former practice is riskier than implementing the latter. If we follow a withdrawal of care request made in an advance directive for a patient who—unbeknownst to us—would have no longer wanted it if informed and competent, we let them die against their will. But if we carry out a PAD request outlined in an advance directive for a patient who—unbeknownst to us—would have no longer wanted it if informed and competent, we kill them against their will. If killing someone against their will is morally worse than letting someone die against their will, then advance directive-requested PAD is morally riskier than advance directive-requested withdrawal of care. Even if we are just as likely to act against the patient’s will in either case, doing so in the case of advance directive-requested PAD would be worse than doing so in the case of advance directive-requested withdrawal of care.

The question, then, is: why is it so much worse to risk killing someone against their will than to risk letting them die against their will? One possibility concerns the difference between doing and allowing harm. Perhaps killing someone against their will *does* *harm*, but killing in cases of patient-requested PAD and letting someone die against their will does not. We do not do harm in cases of patient-requested PAD because death as a result of this request is not a harm. We do not do harm when letting someone die against their will because, while their death is a harm, we do not stand in the right relation (causal or otherwise) to count as ‘doing’ it. If doing harm is worse than allowing harm, then this could explain why advance directive-requested PAD is impermissible even if patient-requested PAD and advance directive-requested withdrawal of care are permissible.

Or perhaps we could distinguish advance directive-requested PAD by saying that killing someone against their will violates their right not to be killed, but killing in cases of patient-requested PAD and letting people die against their will do not.[[10]](#footnote-10) If advance directive-requested PAD risks violating the patient’s right not to be killed but the other two practices do not, this could explain why advance directive-requested PAD might be impermissible even if the other two practices are not.

We think that these are the two most plausible explanations of why advance directive-requested PAD might carry higher risks than patient-requested PAD and advance directive-requested withdrawal of care. But, as we will argue below, both ultimately fail to undermine the permissibility of advance directive-requested PAD.

Consider first the risk that advance directive-requested PAD might do harm. We agree that advance directive-requested PAD carries this risk. We even grant that doing harm might be worse than allowing harm. But we deny that a doctor’s reason to avoid doing harm necessarily outweighs their reason to honor PAD requests made in advance directives.

To see why we deny this, recall that we are assuming that terminally ill patients may permissibly request medical aid in dying. In these cases, there is always some risk that patients may make the request without genuinely wishing to die.[[11]](#footnote-11) They might, for instance, wish to die merely because they fear burdening others. In such cases, patient-requested PAD does harm. Nevertheless, those who grant the moral and legal permissibility of patient-requested PAD think that this risk of doing harm is typically outweighed by the likely benefits of the practice.

In the case of advance directive-requested PAD, the risk of doing harm may be higher than in the case of patient-requested PAD. But we think that the benefits are also higher. Specifically, advance directive-requested PAD has the potential to give patients like Audrey Parker additional months of life. We see no reason to think the risks must in principle increase at a disproportionately higher rate than the benefits. Whether they do in practice is another matter that we consider in **Section 4.1**. In the meantime, this observation is enough to show that even if advance directive-requested PAD carries higher risk of doing harm, this does not immediately render it impermissible.

Now consider the claim that advance directive-requested PAD might violate a patient’s right not to be killed. We agree that advance directive-requested PAD increases the risk of killing the patient against their will. But we deny that it violates the patient’s right not to be killed. To see why, consider a patient who agrees to receive general anesthesia during surgery. As part of the consent process, they are informed that approximately 1 in 19,600 patients will wake up during anesthesia temporarily paralyzed and unable to communicate.[[12]](#footnote-12) They learn that half of these patients suffer extreme anxiety as they witness themselves going under the knife, profoundly wishing they could revoke their consent to the surgery. Still, the patient gives their consent to the procedure. Unfortunately, the patient wakes up just as the surgeon makes the first incision, and immediately regrets having given their consent. As much as they wish they could revoke their consent, their paralysis prevents them from communicating. And so, the surgeon continues with the surgery. As long as the surgeon has no reason to believe that the patient is in distress, they do not violate the patient’s right to bodily autonomy—the patient’s consent remains in effect. Despite the patient’s wish to revoke their consent, their earlier waiving of their right remains in effect.

Likewise, consider a doctor who, following an advance directive for PAD, provides PAD to a patient. If the patient’s wishes have changed since completing their advance directive, the doctor kills the patient against their will. But if the doctor—like the surgeon—has no good reason to think that the patient’s wishes have changed, then they have not violated the patient’s right not to be killed. The reason why is that, by completing an advance directive requesting PAD, the patient has waived their right not to be killed. And so, we cannot appeal to a patient’s right not to be killed in order to distinguish advance directive-requested withdrawal of care from advance directive-requested PAD.

**2.4—Appeal to Contemporaneous Consent**

Our response in the last subsection assumes that, when we waive our right not to be killed, that waiver can remain in effect for some time. But our opponent might not grant this assumption, arguing instead that the right not to be killed is one that can only be waived contemporaneously, i.e. at the point at which the decision to be killed is being made. This, after all, is how some rights, like our right against sexual contact, work. If Jane agreed last week to have sex with Marshall on Friday, that does not make it permissible for Marshall to have sex with Jane on Friday without once again securing her consent.

If our right not to be killed cannot be waived in advance, then this could provide a principled reason for accepting that patients can request PAD directly, and can request withdrawal of care via an advance directive, while denying that they can request PAD via an advance directive. But this claim about when the right not to be killed can be waived lacks theoretical motivation. The best way to motivate it is by appeal to other rights that can only be waived contemporaneously. If there is a good explanation of why these other rights can only be waived contemporaneously, then this explanation might provide reason to think that a right against being killed cannot be waived in advance. But, as we will argue, the best explanations of the contemporaneous requirement in other cases do not provide any reason to think the right against being killed can only be waived contemporaneously.

Consider again our right against sexual contact. It is easy to see why there might be a contemporaneous consent requirement here.[[13]](#footnote-13) If consent is not contemporaneously obtained, then a serious rights violation has occurred. And it is a rights violation that cannot be outweighed by appeal to interests; even if it may sometimes be permissible for you to violate my rights to promote my interests, there are no interests at stake that would justify a rights violation here. The rights violation occurring is also especially serious; to borrow from Kant, Marshall is using Jane merely as a means to his pleasure.

These considerations suggest that our right against sexual contact can only be waived contemporaneously. But note that the defenses that we can offer for the contemporaneous consent requirement in the case of sexual contact do not apply in the case of PAD. Take the appeal to interests—while Jane’s interests are clearly not furthered by being sexually assaulted, a patient’s interests may be furthered by PAD even if it is performed without contemporaneous consent. This is because some terminal illnesses make life unbearable for their sufferers. Likewise, there is nothing objectifying about performing PAD in cases like Clara’s; by granting the PAD request that she previously made in her advance directive, Clara’s doctors are honoring what they take to be her seriously held values and are thus endeavoring to respect her as an end in herself.

While some rights can only be waived contemporaneously, the reasons for thinking that they can only be waived contemporaneously do not extend to the right against being killed. So, the claim that our right not to be killed can only be waived contemporaneously is theoretically unmotivated. This means that we cannot appeal to a contemporaneous consent requirement to distinguish advance directive-requested PAD from advance directive-requested withdrawal of care.

**Section 2.5—Wrapping Up**

We have now considered what we think are the most plausible explanations of why advance directive-requested PAD might be impermissible even if patient-requested PAD and advance directive-requested withdrawal of care are permissible, and found all of them lacking. And so, we should endorse Permissible Advance PAD.

**Section 3: Why Surrogate-Requested PAD Is Permissible**

Let us now consider whether we can extend the practice further, by allowing surrogate decision makers to make PAD requests on behalf of incapacitated, terminally ill patients. (‘Permissible Surrogate PAD’). This practice is the more controversial of the two under consideration: it is only permitted (or rather, is not legally prosecuted) in the Netherlands, and even then, the practice is restricted to terminally ill infants incapable of assent or consent.[[14]](#footnote-14) Nevertheless, we think that surrogate-requested PAD is in principle permissible for reasons similar to the ones that we have offered in defense of advance directive-requested PAD.

Our argument in this section will thus be structurally analogous to the one offered in Section 2. We will first use a series of cases to show that accepting the permissibility of advance directive-requested PAD gives us reason to accept the permissibility of surrogate-requested PAD. From there, we will consider whether there is any way to disentangle the two practices, such that only the former ends up being permissible. We will argue that none of the candidate distinctions stand up to scrutiny, either because they fall victim to the same objections raised against them in Section 2, or because they lead to the implausible conclusion that it is impermissible to grant withdrawal of care requests made by surrogate decision makers on behalf of terminally ill, mentally incapacitated patients.

**3.1—The Argument**

To begin to make the case for Permissible Surrogate PAD, let us first return to Clara. Recall that Clara had previously outlined in an advance directive what end of life care she wanted. And yet, no matter how precisely this directive was formulated, Clara’s doctors will still have some discretionary power in executing it. More specifically, they will have to decide when the conditions outlined in it are met—does Clara presently have a reasonable quality of life? And if there is a chance of improvement, does it qualify as a ‘significant chance’? Even though Clara’s doctors will have to make some judgment calls about her advance directive, the decision about whether to seek PAD at the end of life remains *hers*. What licenses her doctors to use their discretion, after all, is the fact that she has given them the power to interpret her advance directive.

 This result matters because it shows that the mere presence of another party in the decision-making process is not sufficient to render it impermissible to grant a PAD request made via an advance directive. And we think that nothing changes once the other party ceases to be a medical professional. Consider Ezra:

**Ezra:** Shortly after being diagnosed with terminal cancer, Ezra signs an advance directive stipulating that he is to receive PAD if he ever ends up in an irreversible state of mental incapacitation that appears inconsistent with a reasonable quality of life. He also requests that his husband, Emmett, be the person to make the call about whether or not he was in such a state. Shortly after signing the directive, Ezra suffers a serious stroke that leaves him irreversibly and profoundly mentally incapacitated and hooked up to machines. Emmett determines that Ezra’s quality of life is low enough to warrant PAD. As such, Emmett requests this aid, and Ezra dies.

That Emmett is Ezra’s husband, rather than his doctor, does not make a difference to the standing he has (or ought to have) to request medical aid in dying on Ezra’s behalf. What makes his request authoritative is the simple fact that Ezra put him in a position to make it.

 Ezra’s case, to be sure, is one involving an advance directive with clear instructions about PAD. This might give one the nagging feeling that what is doing the work to make Emmett’s PAD request legitimate is ultimately the presence of the explicit request for PAD in Ezra’s advance directive. But we think that we can preserve this permissibility even in cases that do not involve explicit PAD requests. Consider Francis:

**Francis:** Like the last few patients, Francis opts to fill out an advance directive upon receiving a terminal cancer diagnosis. Unlike those other advance directives, however, Francis’s is intentionally vague. It stipulates that, if he is ever mentally incapacitated, his wife Fiona has the power to make all decisions involving his care, up to and including a decision whether or not to request PAD. Soon after, Francis becomes mentally incapacitated due to a stroke, and Fiona decides to request aid in dying. He receives this aid, and dies soon after.

Francis does not lay out the conditions under which he would wish to receive PAD. Nonetheless, it is permissible for doctors to grant Fiona’s request for PAD. As in the previous two cases, the surrogate acts as an ‘extension’ of the patient’s will. The only difference is that Francis has entrusted Fiona with the power to decide *whether* to request PAD on his behalf, and not simply when to request it.

That Fiona has been tasked with a fairly open-ended decision should not be taken as proof that she is no longer acting as an extension of Francis’s will. Perhaps Francis left his advance directive vague precisely because he knows how the peculiarities of clinical decisions are hard to anticipate, rendering detailed advance directives difficult to apply at best and misleading at worst. Perhaps Francis simply trusted Fiona to make a better decision than he would himself. Or perhaps what mattered to Francis was not that the decision met some independent criteria, but that Fiona be the one to make it. His will, after all, was that his wife be in a position to make substantive decisions about his end of life care. And so, by respecting Fiona’s wishes, doctors would be respecting Francis.

In the last three cases, we have reason to respect the judgments of various surrogate decision makers precisely because we have reason to respect the judgments of the patients that they represent. Let us take a closer look at how our reasons to respect patients’ judgments can give us further reasons to respect the judgments of surrogate decision makers. Consider first why Fiona is justified in making decisions about Francis’s end of life care. First, Francis appointed Fiona to serve as his surrogate decision maker. Second, Fiona is likely especially well placed to serve in this capacity: the close relationship that she and Francis share makes her well-placed to use ‘substituted judgment’ to make decisions that reflect his values and commitments.[[15]](#footnote-15)

 One way to understand the reasons that we have to respect surrogate decision makers’ judgments is by making clear the relationship that those reasons have to patient autonomy. We can flesh out this relationship by appealing to a distinction that David Enoch has drawn between two different ways of respecting autonomy.[[16]](#footnote-16) First, we may respect an agent’s *sovereignty*, which involves allowing them to make their own decisions about how to live. Second, we may respect an agent’s *nonalienation*, which involves making the decisions for them that a suitably idealized version of themselves would choose, such that the decisions made reflect their deepest values and commitments rather than their superficial concerns.

When it comes to capacitated agents, sovereignty generally reigns supreme: we have reason to respect your decisions *even when* they do not reflect your most considered value judgments. But incapacitation often robs us of our ability to make normatively authoritative decisions, thus making sovereignty impossible. People do, of course, have ways of exercising their sovereignty while incapacitated, and advance directives are a prime example of such an exercise. But if such an exercise is impossible, we can respect their autonomy only by showing a concern for their nonalienation.

We think that the distinction that Enoch draws between nonalienation and sovereignty gives us a useful way to talk about the different sources of normative authority that surrogate decision makers may have. However, we are not wedded to it; there may be other ways of grounding that authority (Davis, 2004, 2009; Dworkin, 1986; Wrigley, 2015). For our present purposes, all we need is the supposition that surrogate decision makers are at least *sometimes* justified in making serious medical decisions on behalf of their patients, along with the supposition that a surrogate's authority sometimes stems from a patient explicitly delegating it to them and other times stems from the surrogate’s ability to act in a way that accords with the patient’s values (or what Dworkin called their “critical interests”). These, at the very least, are the kinds of assumptions that we need in order to justify the sorts of serious and value-laden medical decisions that surrogate decision makers are presently entitled to make.

We think that considerations of patient nonalienation and sovereignty are sufficient to establish the in-principle permissibility of granting PAD requests made by surrogates, both in cases where patients appoint a surrogate via an advance directive, and also in cases where patients and surrogate decision makers share a sufficiently close relationship. At the very least, *if* these considerations establish the permissibility of other value-laden surrogate decisions, then they also establish the permissibility of surrogate-requested PAD. This means that, if we accept that patients ought to be allowed to request PAD via advance directives, and that surrogates ought to be allowed to make a range of value-laden life-or-death decisions on behalf of patients, then we must also grant that surrogates ought to be allowed to request PAD on behalf of incapacitated, terminally ill patients.

For the remainder of this section, we will consider how one might try to push against this line of reasoning, either by identifying some distinction between advance directive-requested PAD and surrogate-requested PAD, or between surrogate-requested PAD and surrogate-requested withdrawal of care. We will argue that none of these distinctions stand up to rational scrutiny.

**3.2—Appeal to the Risk of Acting Against the Patient’s Will**

Let us first consider whether there is some morally relevant difference between advance directive-requested PAD and surrogate-requested PAD that renders the former practice permissible and the latter practice impermissible. What might that difference be? One thing that an opponent could point to would be the differing potential that each practice has of leading us to act in ways that violate a patient’s will.

 We have already granted that this risk, although present in the advance directive-requested PAD case, is not so great so as to render that practice *prima facie* impermissible. But perhaps the risk is much greater in the surrogacy case. After all, whereas we at least know in the advance directive case that a patient has *previously* wanted medical aid in dying, we do not have any similar knowledge in the surrogacy case. And so, one might worry that, by respecting the surrogate’s will, we run a serious risk of violating the patient’s will.

 We find this worry unpersuasive. To start, it is not true that the patient’s will is always absent from surrogate decision-making. Many surrogates are directly appointed by patients; as such, their decisions can be taken to be a direct expression of their patient’s will.

 Of course, not all cases of surrogate decision-making involve appointed surrogates. Family members may be appointed by a legal mechanism to act as surrogate decision makers in cases where patients have not filled out advance directives. And incapacitated patients who lack sufficiently close or willing family members may even have complete strangers appointed to act as their surrogate decision makers. In these cases, the relationship between the patient’s will and the surrogate’s decision maker is less clear; while the surrogate decision maker may still be acting out of respect for the patient’s nonalienation, this will not always be the case.

We will explore these cases in greater detail in Section 4. For now, let us note that, when it comes to other medical decisions that increase the risk of untimely death, we take it that the benefits that a patient may receive from being able to have those decisions made outweighs the risk of those decisions violating their will. This, at the very least, is how we can explain the reasons that we may have to respect withdrawal of care requests made on behalf of patients by surrogates who have not been appointed via an advance directive. If such withdrawal of care requests are in principle justifiable, then it is hard to see why medical aid in dying requests would not be justifiable in analogous circumstances.

**3.3—Appeal to the Risk of Killing Against the Patient’s Will**

It seems, then, that if our opponent is to successfully refute surrogate-requested PAD without denying the normative legitimacy of other forms of surrogate decision-making, they must find some way of distinguishing PAD requests made by surrogates from withdrawal of care requests made by surrogates. One way to draw this distinction is by arguing that there is a moral difference between making a decision that risks letting a patient die against their will and making a decision that risks killing a patient against their will. The former sort of decision, however risky, is justifiable; the latter is not.

 We have already considered the killing/letting die distinction as a potential means of distinguishing medical aid in dying requests made directly by patients from medical aid in dying requests made in advance directives. In that case, we found it wanting. We argued that even if killing a patient against their will is worse than letting them die against their will, and even if advance directive-requested PAD carries a higher risk than patient-requested PAD of killing a patient against their will, the additional benefits of advance directive-requested PAD outweigh the increased risk of killing. Likewise, we contend that even if surrogate-requested PAD carries a higher risk than patient-requested PAD of killing a patient against their will, the additional benefits of surrogate-requested PAD over patient-requested PAD outweigh this increased risk. The risks of surrogate-requested PAD may be larger than the risks of advance directive-requested PAD, but we see no reason to think that the risks must in principle be so large so as to outweigh the benefits it may confer to patients. But again, whether these risks do in practice outweigh these benefits is another matter. We discuss this in Section 4.

**3.4—Appeal to the Lack of Advance Consent**

When defending advance directive-requested PAD, the final objection we considered was that the right not to be killed may be the kind of right that can only be waived contemporaneously. We argued in response that the right to be killed can stay in effect for a considerable length of time, so advance directive-requested PAD can be permissible. Even so, this response does not undercut this objection when it is aimed at surrogate-requested PAD. This is because in the latter kind of case, the patient never waives their right not to be killed. And even if *we* can waive our right not to be killed in advance, surrogates may not be able to waive our right not to be killed on our behalf.

We contend that in some cases of surrogate-requested PAD, the patient does in fact waive their right not to be killed, and in others the surrogate may be able to waive that right on the patient’s behalf. Consider again the case of Francis, who signed an advance directive that gave his wife the ability to dictate his end of life care, up to and including PAD. Francis explicitly appointed the surrogate as someone who may request PAD on his behalf. If we accept that a patient can waive their right not to be killed by using an advance directive to describe the conditions under which they would like to receive PAD, then we must accept that they can waive that right by specifying the conditions under which they would like someone else to decide whether to request PAD on their behalf.

 Not all advance directives specify specific ranges of decisions that surrogates are allowed to make, and not all advance directives name specific surrogates. Moreover, most people lack advance directives. In at least some of these cases, we think that surrogates may waive patients’ rights not to be killed on their behalf. We must accept this on pain of either denying that we should defer to surrogates in a host of cases where it is clear that we should, or else by arbitrarily distinguishing the right not to be killed from other rights by claiming that even if these other rights can be waived on our behalf by surrogates who have not been appointed in an advance directive, the right not to be killed cannot be.

We must think that these ‘unappointed’ surrogates can waive at least some of our rights on our behalf when we lack decision-making capacity, including our right to access life-saving care. We see this waiver in cases where physicians grant unappointed surrogates’ requests to withhold or withdraw life-sustaining treatment. If we think that this is permissible, then we must think that unappointed surrogates can also waive our rights to life-saving care. Why would unappointed surrogates be able to waive this right but not also be able to waive our right not to be killed? Unlike the right to life-saving care, the right not to be killed is ordinarily a right to non-interference. It stems from our sovereignty. It protects our ability to control what happens in and to our bodies. But in contexts where patients lack that ability—and especially in cases where patients irreversibly lack that ability—both of these rights protect the same strong interest: our interest in staying alive when it would be good for us to stay alive. Surrogates waive these rights on patients’ behalf precisely when and because they think that the patients no longer have such an interest, or in cases wherein they think that the patients’ interest in continuing to live is outweighed by other interests, such as an interest in not suffering. In both cases, their concern is with the patient’s nonalienation. It would be arbitrary to grant an unappointed surrogate permission to waive a patient’s right to access life-saving care on grounds of nonalienation, but not to grant them permission to waive a patient’s right not to be killed on the same grounds.

If these arguments are correct, then granting PAD requests from unappointed surrogates does not necessarily violate patients’ rights not to be killed. We grant, however, that there may be additional risks associated with surrogate decision makers who have not been appointed by, and may not even be known by, the incapacitated patient. While these risks may not rule out PAD requests from such surrogates in principle, we will argue in Section 4 that they likely do so in practice. It is to this matter that we shall now turn.

**Section 4: Towards Legal Advance PAD and Legal Surrogate PAD**

Permissible Advance PAD and Permissible Surrogate PAD are modest claims, establishing only the in-principle permissibility of these two practices. We grant that, when it comes to medical aid in dying, there may be large gaps between principle and practice. Even if advance directive-requested PAD and surrogate-requested PAD are permissible in principle, their potential for abuse and harm might give us reason to object to their legalization.

We will conclude this paper by briefly considering concerns about abuse and harm in relation to both cases. The main questions we will ask are: does legalizing these options present new risks over and above the risks already associated with already-legal options? And, if so, are these risks adequately compensated by the promise of greater benefits? As we will argue, these practices present us with risks that are neither wholly novel nor so significant that they cannot be outweighed by the potential benefits that advance directive-requested PAD and surrogate-requested PAD may offer patients.

**Section 4.1—Advance Directive-Requested PAD Should Be Legalized**

To show that we ought to expand our PAD practices to allow PAD requests made via advance directives, let us start by assuming that the risk of error in cases of advance directive-requested withdrawal of care and patient-requested PAD are sufficiently small to make their legalization permissible. If this is right, then we should worry about similar errors in the case of advance directive-requested PAD only if 1) it carries a greater risk of error than the other two aforementioned practices, and 2) the additional benefits of allowing advance directive-requested PAD do not justify this increased risk, or if 3) it could cause a novel and substantive social harm that the other two practices do not cause that 4) is not outweighed by the additional benefits that it may provide.

Let us consider the risk of error first. We will concede that advance directive-requested PAD gives rise to an increased risk of error. PAD is often possible before withdrawal of care would result in death. If patients are mistaken in thinking that their lives would not be worth living under certain conditions, then having access to advance directive-requested PAD will allow them to end their lives sooner than they should.

The primary reason for thinking that patients might end their lives sooner than they should is that people without disabilities and health conditions systematically rate quality of life with those conditions to be lower than it is rated by people who actually live with those disabilities and health conditions.[[17]](#footnote-17) One natural explanation of this finding is that many people are not adequately informed about what it is like to live with disabilities and health conditions. If so, we should perhaps be concerned that people may create advance directives that call for doctors to provide PAD under conditions that actually turn out to be consistent with a reasonable quality of life.

This concern receives *prima facie* support from the fact that only 70% of end-of-life preferences remain stable through time.[[18]](#footnote-18) But a closer look at the data reveals that the preferences of those who seek advance directive-requested PAD are much more stable: people who engage in advance care planning have significantly more stable preferences than people who do not, the preferences of patients with serious illnesses are significantly more stable than the preferences of older adults who lack serious illnesses, and preferences to forgo treatment are significantly more stable than preferences for aggressive treatment.[[19]](#footnote-19) Indeed, one longitudinal study specifically of people with advance directives for euthanasia found that 96.9% of people in one large sample and 98.1% of those in another large sample expressed equally strong or stronger preferences for euthanasia across six years.[[20]](#footnote-20) If someone signs an advance directive requesting PAD under certain conditions only because they misunderstand what life with those conditions is like, then we would expect most people’s preferences for PAD to reverse once they are in those conditions. But most people’s preferences remain stable.

Further, what risk there may be of patients changing their minds can be reduced further through regulation. For example, we could limit advance directive-requested PAD to cases of terminal illness, even in jurisdictions that allow patient-requested PAD for chronic illness. Or we could put hard caps on how old advance directives can be before we disregard the requests outlined in them. Or to try to prevent controversial cases similar to one that recently occurred in the Netherlands, in which PAD was performed on a patient with Alzheimer’s who seemed no longer to want to die,[[21]](#footnote-21)  we could make it illegal to carry out PAD requests in cases where the incapacitated patient expresses any signs of dissent, distress, or even discomfort.[[22]](#footnote-22)

While such regulations may not be fail-safe, we believe that we should not continue to prohibit PAD requests made via advance directives solely in order to prevent potential harms. The potential harm in question—that of depriving a patient of a short future life in which they are either unconscious or severely and likely irreparably incapacitated—does not outweigh the harm that patients may endure if uniformly denied access to medical aid in dying. Such patients will, like Audrey Parker, be forced to either end their lives even earlier than desired, or else experience the suffering and loss of dignity they wished to avoid by requesting medical aid in dying. To paternalistically disallow people from preemptively requesting PAD in order to prevent a small number from ending their lives slightly earlier than preferred would be to undermine patient sovereignty in order to do what is, in expectation, unlikely to respect patient nonalienation. It thereby constitutes an attack on patient autonomy from all sides.

We will close by considering the concern that advance directive-requested PAD could be socially harmful. One argument that has often been made against patient-requested PAD is that its legalization negatively expresses a negative message about people with disabilities, *viz*. that their lives are not worth living.[[23]](#footnote-23) These concerns may be exacerbated in the advance directive case, as the patient is not able to affirm the desirability of PAD at the time that they receive it. Nevertheless, we think that there is at least some reason to think that the expressive harm that may be present in relation to patient-PAD legalization is actually ameliorated somewhat by this proposed expansion. Specifically, insofar as advance directive-requested PAD would give patients the right to dictate their wishes in advance, it would also give them the chance to live longer with progressive terminal illnesses under certain pre-defined conditions. Patients would not feel pressured into ending their lives prematurely lest they risk losing eligibility for PAD, but could instead continue to enjoy their lives so long as those lives continued to be (by the patients’ own lights) valuable. Allowing patients to request PAD via advance directives can help send the message that serious terminal illness is still compatible with quality of life.

**Section 4.2—Surrogate-Requested PAD Should Be Legalized**

Now to consider surrogate-requested PAD. As in the case of advance directive-requested PAD, the main concern with legalizing surrogate-requested PAD is that it would allow surrogates to make decisions that fail to respect patients’ nonalienation. In addition, we may worry that individuals may come to serve as surrogates in ways that bear no connection to patients’ choices, thus undermining their sovereignty.

The severity of these worries differs depending on how surrogates are appointed. Ideally, surrogates are appointed explicitly by patients in an advance directive. In less ideal cases, patients lack an advance directive that appoints a surrogate decision maker, and so, one is designated for them via a legal mechanism. In such cases, surrogates are typically selected based on the closeness of the relationship that they share with the patient; spouses have the strongest claim to act as surrogates, then children and parents, then less closely-related relatives. If a patient has no family members capable of or willing to serve as a surrogate, the state will appoint an unrelated third party.

We can divide surrogate decision makers into different categories based on the method of their designation, and the relationship that they bear to the patient:

|  |  |  |
| --- | --- | --- |
|  | **Patient-Appointed** | **State-Appointed** |
| **Familiar** | “patient-appointed, familiar” | “state-appointed, familiar” |
| **Unfamiliar** | “patient-appointed, unfamiliar” | “state-appointed, unfamiliar” |

In the next two subsections, we will examine whether the risks of allowing surrogates in these various categories to request PAD are sufficiently large to undermine the case for legally permitting this practice.

**Section 4.3—Patient-Appointed Surrogates**

Typically, patients appoint surrogates with whom they share their closest, familial relationships, but they may also appoint people with whom they do not share such relationships to serve as surrogates. We will consider both practices in turn, starting with patient-appointed, familiar surrogates.

Let us start by returning to Francis’s case. Francis’s doctors have two reasons that they can appeal to in order to explain why Fiona’s PAD request for her husband ought to be respected. First, they have reasons relating to Francis’s sovereignty to respect her request, insofar as Francis has appointed her to act as his proxy decision maker. And second, they have reasons relating to Francis’s nonalienation, insofar as her marriage to Francis has given her special insight into his values and commitments.

If worries about Fiona’s authority arise in practice, they will most likely arise in relation to Francis’s nonalienation. That is to say, his doctors might have reason to worry that, by requesting PAD for Francis, Fiona is not *really* respecting his values.

There is empirical evidence that arguably supports this worry. A meta study on surrogate decision-making and patient preferences found that patient-designated and next-of-kin surrogates predicted patient preferences accurately only two-thirds of the time.[[24]](#footnote-24) If showing concern for a patient’s nonalienation is tantamount to making decisions that line up with the ones that they would have made, then surrogates are not especially good at showing this concern.

But our claim that Fiona may show concern for Francis’s nonalienation by requesting PAD on his behalf did not rest on the supposition that she will make the same choice that Francis would have made. Our values and commitments often support multiple courses of action; the fact that surrogates may pick a different course than the patient would have is not itself evidence that they have acted against those patients’ values and commitments. Instead, our claim rests on the more minimal supposition that Fiona’s close relationship with Francis puts her in a unique position to know and take seriously his values and commitments. So long as she is guided by this knowledge and care, her decision will show concern for his nonalienation.

To be sure, we have assumed altruistic motives on Fiona’s behalf in our discussion thus far. Perhaps this is overly optimistic. Maybe we should instead worry that patient-appointed, familiar surrogates will often request PAD for terminally ill, incapacitated patients out of self-interest, rather than concern for the patient’s nonalienation. Fiona might, for instance, request PAD because she feels emotionally and physically overwhelmed by Francis’s care. But this objection wrongly assumes that the self-interest of patient-appointed, familiar surrogate decision makers conflicts with the nonalienation of patients. Instead, we think that, given their close relationship, Fiona’s well-being is likely something that Francis deeply values. By considering her own interests, Fiona can still show concern for Francis’s nonalienation.

 Still, we might worry that surrogates may abuse this practice by acting in ways that are directly opposed to the patient’s preferences and values. Suppose Fiona requests PAD for Francis simply because she wants to collect her inheritance and move to Reno with her lover. In this case, doctors would not be showing respect for Francis’s nonalienation by respecting her wishes—Francis’s deepest values and commitments presumably do not involve having his life cut short in the service of his wife’s affair. Nor would respecting Fiona’s wishes show concern for Francis’s sovereignty, as his decision to appoint her was made under grossly false pretenses.

 Relatedly, we might also have a variation of the expressivist worry raised previously towards patient-PAD. We might think, for instance, that allowing surrogates a right to make this sort of decision on behalf of patients expresses disrespect for the value of those patients’ lives.

We will address both concerns in turn. There are several reasons why we should not oppose the legalization of surrogate-requested PAD in order to avoid the risk of duplicitous surrogates. First and foremost, if concerns about duplicitous surrogates are a concern in PAD cases, then they are also a concern in withdrawal of care cases. Surrogates may opt to withdraw life-sustaining treatment for the same sorts of malevolent motives that might move them to request PAD. But given that we grant that withdrawal of care requests are often in patients’ interests near the end of life, it is reasonable to think that the benefits that patients reap from this surrogacy practice are large enough to outweigh the risk posed by malevolent surrogates. The same argument, we think, applies to surrogate-requested PAD.

Further, even if we grant that surrogate-requested PAD presents more opportunities for malevolence than surrogate-requested withdrawal of care, it is not clear why this possibility gives us reason to oppose the practice, rather than just demand that it be strictly-regulated. If surrogate-requested PAD were legalized, it should of course benefit from safeguards similar to, or even more stringent than the safeguards used to regulate patient-requested PAD. Surrogate decision makers might, for instance, be required to have their request approved by multiple medical professionals, be required to undergo a waiting period between requesting PAD and having their request granted, or be required to discuss their wishes with a medical ethicist. We might also narrow the window in which surrogate-requested PAD may be requested by requiring that death not merely be reasonably foreseeable, but likely imminent. We offer these suggestions not to officially endorse them, but to make clear some of the ways in which risk of malevolent surrogate decision makers may be mitigated.

We think that similar responses can be made to the expressivist worry offered above. If we are concerned about the disrespectful messages potentially expressed by surrogate-requested PAD, we must be able to explain why those messages are different from the ones present in surrogate-requested WOC. After all, the latter practice involves the recognition that extending a life may sometimes constitute a harm to a patient. We think, further, that providing serious legal safeguards on the practice, as well as limiting the range of time in which PAD may be requested by surrogates, can also communicate the message that deciding whether to request PAD for someone else is in no way trivial, easy, or a means of ‘offloading’ the burdens of end of life care.

What about surrogates who are appointed by patients, despite not sharing close relationships with them? Imagine that, rather than appoint his wife as medical surrogate, Francis instead appointed his accountant, Freya. Perhaps he thought that her impartial reasoning would prevent her from making impulsive medical decisions. Certainly, Freya may not be as well placed as Fiona to act in accordance with Francis’s deepest values and commitments. Nevertheless, Francis’s doctors would still have a reason to respect Freya’s decisions: after all, he told them to respect those decisions. So if Freya decides to request PAD on Francis’s behalf, we will have a reason relating to patient sovereignty to respect her request.

 This suggests that, while we might prefer to be able to justify surrogates’ normative authority to request PAD on grounds of both sovereignty and nonalienation, sovereignty alone is sufficient for a justification. Next, we will consider whether, and when, surrogates whose only source of normative authority is patient nonalienation may justifiably request PAD on behalf of incapacitated patients.

**Section 4.4—State-Appointed Surrogates**

Most adults in the United States[[25]](#footnote-25) and Canada[[26]](#footnote-26) do not have advance directives. And so, most surrogates are state-appointed. Since these surrogates have not been expressly appointed by the patient, we cannot justify their PAD requests on grounds of patient sovereignty. Nevertheless, in cases where stated-appointed surrogates are closely related to the patient, the relationships that they typically share may enable them to act out of concern for patient nonalienation.

 We have already considered some of the worries associated with this second source of normative authority in **Section 4.3**, and found them to be unpersuasive. Still, one might contend that concerns about surrogates’ ability to act out of regard for patient nonalienation are heightened in cases where the patient has not expressly appointed them as surrogates. We might worry, in other words, that a ‘concern for nonalienation’ only gives surrogate decision makers normative authority when they also have normative authority *qua* patient sovereignty.

 To respond, note that we have a strong social presumption in favor of letting our close kin make decisions for us in cases of our impairment or death. That this social practice is ubiquitous gives us reason to think that patients have tacitly consented to it, absent advance directives specifying otherwise. We already take this tacit consent to be sufficient to justify the current widespread practice of allowing state-appointed, familiar surrogates to waive a number of seriously weighty rights on behalf of patients. An unwillingness to grant surrogate decision makers this further power would thus be at odds with current practice surrounding their decisional authority.

 What about state-appointed surrogates who do not share close relationships with, or even personally know, the patient? The case for their normative authority is much weaker than any of the other cases considered above. Since they were not appointed by the patient, we do not have reasons relating to patient sovereignty to respect their requests. Further, since they will rarely have direct evidence of what the patient values, we have much less reason to assume that they are capable of showing genuine concern for their patient’s nonalienation.[[27]](#footnote-27) That PAD requests made by state-appointed, unfamiliar surrogates may not be justifiable on either grounds of patient sovereignty or patient nonalienation makes surrogate-requested PAD far riskier in these cases. The heightened risks associated with these surrogates, coupled with their relative lack of normative authority, provides strong reason against legalizing PAD under those circumstances.

**Conclusion**

This paper has argued that patients need not presently be competent when they receive PAD. More specifically, we aimed to establish two claims:

**Legal Advance PAD**:In many circumstances, it should be legal for doctors to provide PAD to terminally ill, mentally incapacitated patients with advance directives requesting it.

**Legal Surrogate PAD**: In many circumstances, it should be legal for doctors to provide PAD to terminally ill, mentally incapacitated patients whose surrogate decision makers request it.

We first argued that, unless we are willing to deny the permissibility of medical practices like patient-requested PAD, patient-requested withdrawal of care, and surrogate-requested withdrawal of care, we ought to grant the in-principle permissibility of advance directive-requested PAD and surrogate-requested PAD.

 We then sought to bridge the gap between in-principle permissibility and in-practice permissibility by arguing that the additional risks associated with these more expansive PAD practices were not, in most cases, so great as to outweigh the potential benefits that patients may derive from having access to them. The case for Legal Advance PAD was relatively simple: assuming that appropriate legal safeguards are put in place, then the risks associated with it, we argued, were not sufficient to justify the infringement that the current prohibition on advance directive-requested PAD places on patient autonomy.

 To make the case for Legal Surrogate PAD, we considered the extent to which different types of surrogate decision makers are likely to be able to act out of concern for patient autonomy, which we understood as involving both sovereignty and nonalienation. We can sum up the relationship between different categories of surrogates, and different types of concern for autonomy, as follows:

|  |  |  |
| --- | --- | --- |
|  | **Concern for Sovereignty** | **Concern for Nonalienation** |
| **Patient-Appointed, Familiar** | Yes | Yes |
| **Patient-Appointed, Unfamiliar** | Yes | Possibly |
| **State-Appointed, Familiar** | No | Yes |
| **State-Appointed, Unfamiliar** | No | Possibly |

Thus, in all cases but those involving state-appointed, unfamiliar surrogates, we will have reasons related to patient autonomy to respect PAD requests made by surrogate decision makers. Provided that appropriate legal safeguards are put in place, we think that this consideration provides a strong defense of Legal Surrogate PAD in all but the most distant surrogacy cases.

Our aim in this paper has ultimately been to provide a way out of the catch-22 situation that current PAD legislation often forces upon terminally ill patients. One of the hopes for medical aid in dying is that it will make the ends of our lives less harrowing. Unlike much of what we fear in dying, dying in pain is avoidable. Physician-assisted death thus has the power to give patients back some quality of life that may otherwise be lost throughout the dying process. As it is currently practiced in most jurisdictions, however, PAD also imposes a tragic dilemma on those considering it. If someone wants to end their life because they fear that they will otherwise face a prolonged death in unbearable agony, they may feel pressure to end things prematurely lest they risk losing eligibility for PAD. Audrey Parker lost out on potentially months of valuable life because she feared dying naturally from metastatic breast cancer. By reexamining our commitment to competency requirements for PAD, we can ensure that patients like Audrey will not face such dire choices in the future.

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**Bibliography**

Amarasekara, Kumar, and Mirko Bagaric. “Moving from Voluntary Euthanasia to Non-Voluntary Euthanasia: Equality and Compassion,” *Ratio Juris* 17, no. 3 (2004): 398-423.

Appelbaum, Paul S. “Assessment of Patients’ Competence to Consent to Treatment,” *New England Journal of Medicine* 357, no. 18 (2007): 1834-40.

Auriemma, Catherine L., Christina A. Nguyen, and Rachel Bronheim. “Stability of End-of-Life Preferences: A Systematic Review of the Evidence.” *Journal of the American Medical Association Internal Medicine* 174, no. 7 (2014): 1085-1092.

Bernfort, Lars, Björn Gerdle, Magnus Husberg, and Lars-Åke Levin. “People in states worse than dead according to the EQ-5D UK value set: Would they rather be dead?” *Quality of Life Research* 27 (2018): 1827-1833.

Brock, Dan W. “Voluntary Active Euthanasia,” *The Hastings Center Report* 22, no. 2 (1992): 10-22.

Buchanan, Allan and Dan M. Brock. *Deciding for Others: The Ethics of Surrogate Decision-Making.* Cambridge: Cambridge University Press (1989).

Dworkin, Ronald. “Autonomy and the Demented Self.” *Millbank Quarterly*, 64, no. 2 (1986): 4-16.

*-------------Life’s Dominion: An Argument About Abortion, Euthanasia and Individual Freedom*. New York:

Knopf, 1993.

Emanuel, Ezekiel J., Bregje D. Onwuteaka-Philipsen, and John W. Urwin. “Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe.” *Journal of the American Medical Association* 316, no.1 (2016): 79-90.

Enoch, David. “Hypothetical Consent and the Value(s) of Autonomy.” *Ethics* 128 (October 2017): 6-36.

Foot, Philippa. “Killing and Letting Die.” In *Abortion, Moral and Legal Perspectives*, edited by

Patricia Hennessy and Jay L. Garfield, 355–82. Amherst: University of Massachusetts Press,

1984.

Golden, Marilyn and Tyler Zoanni. “Killing Us Softly: The Dangers of Legalizing Assisted Suicide.”

*Disability and Health Journal* 3 (2010): 16-30.

Hanvey, Louise, Carolyn Taylor, and Doris Barwich. “What Do Canadians Think of Advance

Planning? Findings From an Online Opinion Poll.” *BMJ Supportive & Palliative Care* (2013): 1-8.

Kamm, F. M. *Intricate Ethics: Rights, Responsibilities, and Permissible Harm*. Oxford University Press.

Accessed May 16, 2007.

Keown, John. *Euthanasia, Ethics and Public Policy: An Argument Against Legalization*. Cambridge: Cambridge University Press (2002).

Kuhse, Helga. “Some Reflections on the Problem of Advance Directives, Personhood, and Personal Identity.” *Kennedy Institute of Ethics Journal* 9 (1999).

Lacey, Heather P., Dylan M. Smith, and Peter A. Ubel. “Hope I Die Before I Get Old: Mispredicting Happiness Across the Adult Lifespan.” *Journal of Happiness Studies* 7 (2006): 167-182.

Liberto, Hallie. “Normalizing Prostitution versus Normalizing the Alienability of Sexual Rights: A Response to Scott A. Anderson.” *Ethics* 120, no. 1(2009):138-145.

*-------------* “The Problem with Sexual Promises.” *Ethics* 127, no. 2 (January 2017): 383-414.

Lillehammer, Hallvard. “Voluntary Euthanasia and the Logical Slippery Slope Argument,” *Cambridge Law Journal* 61, no. 3 (2002): 545-550.

Manninen, Bertha A. “A Case for Justified Non-Voluntary Active Euthanasia: Exploring the Ethics of the Groningen Protocol,” *Journal of Medical Ethics*, 32 no. 11 (2006): 643-651.

Menzel, Paul T. and Bonnie Steinbock. “Advance Directives, Dementia, and Physician-Assisted Death,” *The Journal of Law, Medicine and Ethics*, 41 no. 2 (2013): 484-500.

Miller, David Gibbes, Rebecca Dresser, and Scott Y. H. Kim. “Advance euthanasia directives: A Controversial case and its ethical implications.” *Journal of Medical Ethics* 45 (2019): 84-89.

Pandit, J. J. et al. “5th National Audit Project (NAP5) on Accidental Awareness during General

Anaesthesia: Summary of Main Findings and Risk Factors.” *BJA: British Journal of Anaesthesia*

113, no. 4 (October 1, 2014): 549–59. https://doi.org/10.1093/bja/aeu313.

Prentiss, Mairin. “‘I wanted to make it to Christmas’: Woman calls for assisted dying law changes.” *CBC*, November 1, 2018. https://www.cbc.ca/news/canada/nova-scotia/audrey-parker-assisted-dying-legislation-1.4887472.

Quinn, Warren S. “Actions, Intentions, and Consequences: The Doctrine of Doing and Allowing.”

*The Philosophical Review* 98, no. 3 (1989): 287–312.

Rao, Jaya K., Lynda A. Anderson, Feng-Chang Lin, and Jeffrey P. Laux. “Completion of Advance Directives Among U.S. Consumers.” *American Journal of Preventative Medicine* 46, no. 1 (2014): 65-70.

Reed, Philip. “Expressivism at the Beginning and End of Life.” *Journal of Medical Ethics* 46 (2020): 538-544.

Savulescu, Julian. “End-of-Life Decisions,” *Medicine* 33 no. 2 (2005): 11-15.

Shalowitz, David I., Elizabeth Garrett-Mayer, and David Wendler. “The Accuracy of Surrogate Decision Makers.” *Archives of Internal Medicine* 166 (March 2006): 493-497.

Smith, Dylan M., Ryan L. Sherriff, Laura Damschroder, George Loewenstein, and Peter A. Ubel. “Misremembering colostomies? Former patients give lower utility ratings than do current patients.” *Health Psychology* 25, no. 6 (2006): 688-695.

Sumner, L.W. *Assisted Death: A Study in Ethics and Law*. Oxford: Oxford University Press, 2011.

van Wijmen, et al. “Stability of end-of-life preferences in relation to health status and life-events: A Cohort study with a 6-year follow-up among holders of an advance directive.” *PLoS ONE* 13, no. 12 (2018): 1-14.

Walasek, Lukasz, Gordon D. A. Brown, and Gordon D. Ovens. “Subjective well-being and valuation of future health states: Discrepancies between anticipated and experienced life satisfaction.” *Journal of Applied Social Psychology* 49, no. 12 (September 2019): 746-754.

Young, Robert. *Medically Assisted Death*. Cambridge: Cambridge University Press, 2007.

1. Both authors have made equal contributions to the content of this article. [↑](#footnote-ref-1)
2. Prentiss (2018). [↑](#footnote-ref-2)
3. Canada has just recently relaxed this requirement; as of March 2021, patients must now be competent at the time that they make the initial request, but not at the time at which they receive medical aid in dying (House of Commons of Canada Bill C-7 (2021)). It now joins the Netherlands and Belgium as the only countries that allow PAD requests made via advance directives (*Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, 2002; The Belgian Act on Euthanasia, 2002).  [↑](#footnote-ref-3)
4. Other authors have pointed out the symmetry between surrogate-requested PAD, surrogate-requested withdrawal of care, and patient-requested PAD, though they have often done so as part of a slippery slope argument against patient-requested PAD. See, for instance, Keown (2002) and Amarasekara and Bagaric (2004). For objections to this slippery slope argument, which take the form of denying the moral symmetry between voluntary PAD (i.e. patient-requested PAD) and nonvoluntary PAD, see Savulescu (2005), Lillehammer (2002), and Young (2007). [↑](#footnote-ref-4)
5. We follow Appelbaum (2007) in using "competence" and "decision-making capacity" interchangeably. Although different methods exist for assessing competence, we make only the standard assumptions that competence requires certain abilities to understand, appreciate, reason, and communicate. [↑](#footnote-ref-5)
6. In the United States, Canada, and Europe, for instance, cancer patients account for 70% of PAD-recipients (Emanuel et al. 2016). [↑](#footnote-ref-6)
7. Brock (1992); Dworkin (1993). [↑](#footnote-ref-7)
8. Sumner (2011); Young (2007). [↑](#footnote-ref-8)
9. Dworkin (1986), Buchanan and Brock (1989), and Kuhse (1999). [↑](#footnote-ref-9)
10. See Kamm (2007), Quinn (1989), and Foot (1984) for views that invoke the stringency of negative rights to explain why killing might be worse than letting die. [↑](#footnote-ref-10)
11. Golden and Zoanni (2010). [↑](#footnote-ref-11)
12. Pandit et al. (2014). [↑](#footnote-ref-12)
13. Liberto (2017), for instance, argues that even if one can promise sex in advance, their promisee will be under an obligation to refuse the promise. See also Liberto (2009). [↑](#footnote-ref-13)
14. For a discussion and defense of this practice, see Manninen (2006). [↑](#footnote-ref-14)
15. The ‘substituted judgment’ standard requires that surrogate decision makers make decisions by reasoning about what the patient would have wanted. When patient preferences are unknown, surrogate decision makers must follow the ‘best interests standard’ (*AMA Code of Medical Ethics*, Opinion 2.1.2 https://www.ama-assn.org/delivering-care/ethics/decisions-adult-patients-who-lack-capacity). There are empirical questions about whether our loved ones are well positioned to use the substituted judgment standard; we will touch upon these questions in **Section 4.3**. [↑](#footnote-ref-15)
16. Enoch (2017) pp. 30-35. [↑](#footnote-ref-16)
17. Walasek et al. (2019); Smith et al. (2006); Lacey et. al. (2006); Bernfort (2018). [↑](#footnote-ref-17)
18. Auriemma et al. (2014). [↑](#footnote-ref-18)
19. Ibid. [↑](#footnote-ref-19)
20. van Wijmen et al. (2018). [↑](#footnote-ref-20)
21. Miller et al. (2019). [↑](#footnote-ref-21)
22. Menzel and Steinbock (2013). [↑](#footnote-ref-22)
23. Reed (2020). [↑](#footnote-ref-23)
24. Shalowitz et al. (2006). [↑](#footnote-ref-24)
25. Rao et al. (2014). [↑](#footnote-ref-25)
26. Hanvey et al. (2013). [↑](#footnote-ref-26)
27. State-appointed, unfamiliar surrogates may still, arguably, be able to reason about whether PAD is in a patient’s best interests, without having information about the patient’s values. We do not have the space to consider whether the ‘best interests standard’ could justify PAD. Nevertheless, we think that this justification would be weaker than one that appeals to patient autonomy, in part because whether or not PAD is in a patient’s interests is arguably determined by the patient’s values. [↑](#footnote-ref-27)