'Existential suffering' and voluntary medically assisted dying

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Jukka Varelius[1 2] and others[3] have advocated that medically assisted dying should be made available on request to competent individuals experiencing 'existential suffering'. Unlike Cassell and Rich, Varelius believes that existential sufferers do not have to be terminally ill before being helped to die. He does not regard 'existential suffering' on its own as sufficient to justify voluntary medically assisted dying, but believes it to be one of a set of jointly sufficient conditions (that includes, presumably, irreversibility of the suffering, agent competency, medical professional willingness, etc). In 'Medical expertise, existential suffering and ending life', however, he aims only to show that if physicians have the expertise required to assess when suffering consequent upon illness or injury is unbearable, that they can equally have that expertise when confronted with 'existential suffering'. In what follows, I will neither be endeavouring to refute his more general claim (since I doubt that refutation is possible), nor his argument in the present paper. Rather, I will offer two reasons for thinking that even if it is sound it is of limited practical significance.

First, Varelius outlines his position without reference to relevant political considerations. He distances himself from what he terms the 'conventional view', namely, that voluntary medically assisted dying should be available only to those suffering unbearably because of illness or injury. On this view, what has come to be known as 'existential suffering'—characterised in the Dutch case of *Brongersma*,[4] as the condition of being 'tired of life', and construed by Varelius as suffering occasioned by the belief that life is not, and will never again be, worth living—should not be considered an appropriate ground for legal access to medically assisted dying. What Varelius omits to say, however, is that advocates of the legalisation of voluntary medically assisted dying have restricted their proposals in this manner because they believe that doing so represents the best hope of persuading various polities to permit competent individuals to have legal access to medically assisted dying. The political reality is that to date only a handful of jurisdictions have legalised voluntary medically assisted dying, and only then after lengthy campaigns. Moreover, at present, only one of those jurisdictions recognises 'existential suffering' as a basis for requesting medical assistance with dying: in Switzerland about one in five of those who have used the assisted suicide service provided by Dignitas have cited 'weariness of life' as their reason for seeking help with dying. (Although consideration is currently being given in The Netherlands to the possibility of permitting those experiencing 'existential suffering' to seek medical help with dying it remains legally impermissible.) It is hardly surprising, therefore, that advocates of the legalisation of voluntary medically assisted dying in jurisdictions where it is prohibited, have focussed on forms of suffering that are more likely to persuade legislators and the wider public of the need for law reform. For a similar reason, some advocates have even excluded from their proposals for legislative change those individuals who, strictly, are not terminally ill but who are suffering unbearably because of medical conditions such as 'locked-in syndrome', motor neurone disease, multiple sclerosis and so on. The upshot is that Varelius' contention is apt to be considered of relevance only for those jurisdictions in which medically assisted dying is already legally permissible.

Second, and more importantly, advocates of voluntary medically assisted dying have always maintained that it should be regarded as a component of appropriate *medical* care. That is why they have rebutted the suggestion by critics that it would have to be made available in morally fraught cases like that involving a young adult who experiences unbearable 'existential suffering' after breaking-up with 'the love of his life', satisfies the sorts of conditions Varelius regards as sufficient for assistance with dying, and seeks it from a willing physician.[5] In a similar vein, when the Dutch Supreme Court ruled that Dr Philip Sutorius had acted inappropriately in supplying Edward Brongersma with a lethal cocktail of drugs it did so because it considered both that Brongersma's problems were not medical problems (there being no consensus among medical practitioners that there is a medical duty to help the 'tired of life' to die) and that physicians were not especially knowledgeable about hopeless despair. It concluded that Sutorius had not provided appropriate medical care. With this in mind, let us suppose, contrary to the Court's second contention, that Varelius is right to claim that physicians are equally competent to assess when suffering occasioned by 'existential' factors is sufficiently unbearable to qualify a person for voluntary medically assisted dying as they are to assess when suffering occasioned by a medical condition, whether physical or psychological in origin, is sufficiently unbearable to warrant voluntary medically assisted dying. Even on this supposition, it is still reasonable to maintain that medical assistance with dying is appropriate medical care for instances of the former kind, but not for those of the latter. Of course, as Varelius is well aware, the boundaries for what is to count as medical care are subject to dispute. Not all care provided by medical professionals, for example, is medical care: consider some instances of cosmetic surgery. Even given that what is to count as medical care is open to dispute, it is, nonetheless, entirely reasonable to maintain that the provision of medical assistance with dying to someone suffering unbearably as a result of an irreversible, medically diagnosable, physical or psychological condition, counts as providing appropriate medical care, whereas providing help with dying to someone suffering unbearably as a result of being 'tired of life' does not. Accordingly, it can be allowed that a physician is equally capable of judging the suffering to be unbearable in each of the instances without it being allowed that the second comes within her professional domain. If so, a physician may justifiably consider that an individual who is 'tired of life' should consult a non-medical, professional counsellor, and if that produces no change in outlook, choose suicide. Outside Switzerland, an individual who makes that choice has to then be determined enough to do so unassisted (notwithstanding that the consequences for others may be distressing).

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