Euthanasia: not just for rich countries[1]

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1. Introduction

There is a broad recognition of the fact that continuing medical treatment is not always beneficial to the patient, nor need it always be what the patient wants. This has led to a debate about the way physicians may or may not be involved in the end of life of patients. On what grounds can they withhold or withdraw treatment? Could there be a justification for the active ending of life of the patient? This debate is certainly not typical for anyone country, rather it has, we believe, a global character. Much of this debate has been done in developed countries, but in developing countries (eg. Colombia) the debate is present as well, even when not considered a top priority regarding public health issues and even though there are no reliable data about the prevalence of end-of-life decisions.

While we do not want to deny the heterogeneity across developing countries (3), we think, at the same time, that two features seem common to most of these countries: poverty and inequality. For some (mostly only few) inhabitants of these countries all that modern health care can offer is affordable, for others not even a decent minimum is available. It is precisely this characteristic that prompts the question that we pose here: do these circumstances justify a more restrictive approach to end-of-life issues in developing countries? With respect to end-of-life decisions we will focus on voluntary euthanasia and physician–assisted suicide. Although one can argue that there are morally relevant differences between the two in some respects, for the purpose of this article we will treat them as ‘two of a kind’. We will use the term ‘physician assisted death’ (PAD) to describe both decisions.

In this article we want to answer the following question: if we assume that PAD is morally justified in industrialized countries should we accept it for developing countries as well or are there relevant moral reasons to refuse it there? At stake therefore is the moral relevance of differences between countries. We will not argue for the moral justification (or lack of justification) of physician assisted death as such, but will instead analyse whether there are special reasons for treating developing countries differently from developed countries. To do this, we will sketch the main arguments with which positions pro and contra physician assisted death are substantiated in the bio-ethical literature (4,5, add ref Peggy 2005). If we want to hold to different moral positions for different places we will have to argue for the moral relevance of the difference. Simply pointing to different circumstances or different cultural backgrounds will not suffice.

2. Common arguments pro and contra physician assisted death

2.1 Arguments pro physician assisted death

The two fundamental values that support the acceptance of physician assisted death are autonomy and well-being. We follow Feinberg in differentiating between the autonomy as a right and as a value (or ideal) (6). Autonomy as a value refers to the interest persons have in living their own lives according to their own conceptions of a good life. The right of self-determination protects the value of autonomy by ensuring that persons, once they meet certain criteria for competency, are left free to act on these decisions (with certain restrictions, of course). Autonomous decision-making is of value in the last period of one's life as well: many people will want to maintain the quality of their life in that period as much (or even more) as before. These people may also want to influence the circumstances and timing of their dying and death.

The counterargument will deny that the person who requests physician assisted death really wants to die: with sincere attention for the 'question behind the question' the request to die will surely turn out to be something else. There is some truth in this, since people sometimes do request PAD for other reasons than wanting to die. What this fact justifies, however, is serious attention for the motives of the person who asks for PAD, not a dismissal of all requests, nor of PAD as such.

Another counterargument will deny that choosing one's own death falls within the scope of self-determination: according to this view a person's freedom cannot be extended to allow for the removal of the very condition for freedom: life itself. We cannot justify someone's death on the grounds that it is good for him, while also denying the existence of another value, embodied in him (7). While we acknowledge the consistency of this argument, we do not think it rules out the possibility of PAD altogether. Recognizing the interest-independent value of a person, on the contrary, is essential to the notion of 'dying with dignity'. In some cases of unbearable suffering, however, life itself has become undignified. In those cases a person cannot sustain both life and dignity. Paradoxically then, respect for an object of dignity can sometimes require its destruction.

Often the counterargument of life being an unalienable right is supported by drawing a parallel with slavery: people are not free to sell themselves into slavery, thus giving up freedom. But as Frances Kamm stated, this is a false analogy (8). Requesting for physician assisted death involves waiving one's right to go on living, not turning the right over to someone who then has power over that person.

The second value supporting physician assisted death is patient well-being, or rather the absence of well-being. Obviously, the person who requests physician assisted death will not consider his or her life as a benefit but will have come to see it as a burden. It should be noted that in most systems tolerating physician assisted death the patient's opinion alone, even if competent, is regarded as necessary but insufficient evidence that continued life for him or her is worse than life at all. The physician will have to judge the clinical situation and the patient's prospects as well. The Dutch law on euthanasia for instance states that "unbearable suffering without prospect of relief" is one of the conditions for performing physician assisted death, to be determined by the physician (2). This condition necessarily means a limitation to the right of self-determination. The justification of this limitation lies in the role of the physician: physicians always need justifications for their acts other than patient preferences (e.g. medical necessity). The result of this view on physician assisted death is the medicalization of the end of life, since whether or not physician assisted death is justifiable becomes largely a matter of medical discretion (9).

The counter-argument will deny that there can ever be (or at least far too seldom to justify a policy) medical circumstances that would justify the physician to comply with a request for physician assisted death. According to this view good palliative care can relieve almost all suffering, albeit sometimes at the cost of consciousness as in terminal sedation.

2.2 Arguments contra physician assisted death

There would also seem to be two major lines of arguments against physician assisted death. The first is the deontological view that the deliberate killing of innocent persons (*in casu* the patient) is always wrong. Often this view will be stated with reference to the sanctity of life. Against this claim it will be argued that most opponents of physician assisted death do accept the forgoing of life-sustaining treatments. This dual position of accepting the latter but rejecting physician assisted death would seem to rest on the moral relevance of the distinction between killing and letting die. Proponents of physician assisted death will reject the moral relevance of that distinction, whereas opponents of physician assisted death will hold on to it. With respect to sanctity of life proponents of PAD would state that the principle holds for all those who share certain religious beliefs, e.g. the Judeo-Christian tradition. This is not to say that those outside that tradition think that life is of no value, only that this person may hold on to a more qualified version of the doctrine of the sanctity of life, allowing for the taking of innocent life at the request of the person concerned .

The second line of argument against physician assisted death would hold that although physician assisted death may be justified in some specific cases, accepting it on a policy level would lead to several undesirable consequences. Against the second claim it will be argued that evidence shows that countries tolerating physician assisted death have not slid down the slippery slope (10). Opponents of physician assisted death however usually have a complete different interpretation of the same data (11, 12). However, the disagreement is not about the correct interpretation of data alone. There is also disagreement about the consequences of a policy which would tolerate physician assisted death and about the relative importance of different effects of such a policy. These utilitarian arguments focus on effects in different realms such as the clinic, the law, public policy, or society. We will describe these effects here briefly, and will return to them while we address some aspects of the situation in developing countries.

Positive effects of a policy which tolerates physician assisted death will be that people who want physician assisted death can get it. A second, similar but distinctive, effect is that people who think that they might want it under certain future circumstances may feel reassured that they can indeed get it, should they ever want it. Another positive effect would be that there will be less agony caused by irrelievable pain in the terminal phase of a disease.

Negative effects that are mentioned are: permitting physician assisted death would erode trust in doctors, would weaken society’s commitment to provide optimal palliative care or the legal prohibition of homicide. Most importantly, however, tolerating cases of voluntary physician assisted death would lead to active physician assisted death being performed in other cases as well, endangering especially the frail, disabled and economically disadvantaged members of society. This is also known as the slippery slope argument.

3. Different places, different morals?

We now turn to the question which is at the heart of this article: are there morally relevant differences between developed countries and developing countries, which would justify different policies with respect to physician-assisted death? In order to answer this question we will go over the arguments described in the previous section.

3.1 Arguments pro physician assisted death

At first sight it may seem obvious that the first of the two major arguments supporting physician assisted death (autonomy) will do so equally well in the United States, Canada, the Netherlands as in developing countries. Autonomy is grounded in the respect that we owe to human beings as human beings. This respect for autonomy is a moral obligation in affluent countries as much as in developing countries. This is also reflected in the UNESCO declaration on universal norms in bioethics which was adopted in October 2005. (13)

However, it is often claimed that in developing countries, autonomy is frequently or routinely constrained. Lower levels of education than in developed countries, at least among the poor, mean less familiarity with legal options, including options in medical contexts, less capacity to choose among them, and less ability to negotiate a complex health care system. Illiteracy means that people are unable to read resource materials, utilize print and digital information sources such as newspapers, journals, and the web; less able to express their wishes in writing, and so on. Such limitations particularly constrain women, for whom levels of education are typically lower in developing countries, but everyone—both women and men—suffer from the limitations of autonomy that poor education means.

Low levels of education are not the only limitation on autonomy in developing countries. Low socioeconomic position means much less capacity to negotiate and utilize a system, assert one’s rights, explore and pay for alternatives. Low levels of political power and high levels of prejudice of various forms, including race and class prejudice between and among various subgroups, clans, tribes, and so on, may also exacerbate the constriction of autonomy: The preferences and wishes of people of the group against which prejudice is directed are often not regarded by the politically controlling group as worthy of respect. This catalog of reasons for which autonomy is said to be limited in the developing world could be greatly extended: the point is that the poor and disadvantaged have less say than the powerful in how their lives go. Thus, given these challenges to the very possibility of genuine autonomous choice, the argument from autonomy for PAD appears to be undercut. In spite of these constraints, however, we think that people have the right to be treated as autonomous persons. It may be that the possibilities to effectuate one’s decision are limited by the circumstances but it does not follow that the possibilities to decide are limited as well.

In the previous section we mentioned two other counterarguments against patient autonomy as a reason for accepting physician assisted death: the dispute about the real meaning of a request for physician assisted death and the rejection of the freedom to annihilate freedom by taking life. Whatever one thinks of these counterarguments, we submit that their force (or weakness) is exactly the same, whether applied to affluent or to developing countries.

With respect to well-being it goes without saying that unbearable suffering is not an exclusive feature of affluent countries. It might be true that there is even more of that kind of suffering in developing countries, since there is less access to adequate health care.

In Argentina, for example—though hardly among the poor nations—palliative care, designed to reduce or eliminate pain especially in terminal illness, is barely available. Palliative care is not recognized as a medical specialty in Argentina, and payment for palliative care is not included in most health plans.[2] As of May 2005, there were just *four* palliative care beds in hospitals in Buenos Aires, serving a country with a population of almost 40 million.[3] Or consider Saudi Arabia, also a nation of comparative affluence: Although a palliative care service had been established at the King Faisal Specialist Hospital and Research Center in Riyadh in 1992, it was not until a joint symposium of Saudi physicians and the European Society for Oncology took place a decade later that a fatwa was obtained from the religious authorities to condone the use of morphine, recognized as the most effective palliative drug—indeed, the gold standard of pain control--in patients with advanced cancer.[4] One commentator, recognizing the scope of poverty and lack of resources even in the midst of affluence, describes this palliative care program as “a commendable initiative—one of the few islands of care in a sea of suffering.”[5]

Or consider Thailand: one study reported that patients with HIV or AIDS were told by their doctors upon diagnosis that “nothing could or would be done for them”; the study comments with a good deal of irony that this “evidently did not help their pain management.”[6] The study further reports that, in part due to social isolation and negative attitudes about HIV/AIDS as well as physician fears of opioid addiction and the strict national drug legislation in Thailand, many patients both in centers and in the community “have to endure unrelieved pain.”[7] In India, palliative care facilities for AIDS patients are practically non-existent, and for patients with cancer, late diagnosis compounds problems of pain control: patients commonly first present and are diagnosed only after they have developed “huge ulcers, often with maggot infestation,” and pain management is corresponding more difficult.[8] Furthermore, many states in India have no medical facilities that dispense morphine, and palliative care is not in any case available to the needy: poverty is so pervasive, comment observers, that one is often “overwhelmed with the enormity of the problem”[9] and the evident impossibility of providing adequate pain control. In the 36 Western Pacific Region countries, less than half (48%) of patients and families are informed of the possibility of alleviating symptoms of disease among the dying, only a fifth (21%) of primary care health workers receive training in palliative care or hospitals have adopted WHO guidelines for palliative care, and in only 41% is morphine available at

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[2] Gustavo C. De Simone, “Palliative Care in Argentina: Perspectives from a Country in Crisis,” in *Pain and Palliative Care in the Developing World and Marginalized Populations: A Global Challenge,* ed. M. R. Rajagopal, David Mazza, and Arthur G. Lipman. The Haworth Medical Press, 2003, 23-43, p. 35.

[3] Personal communication, discussant, FLASCO seminar, May 2005.

[4] Alan Nixon, “Palliative Care in Saudi Arabia: A Brief History,” in *Pain and Palliative Care in the Developing World and Marginalized Populations,* 45-49, p. 49.

[5] M. R. Rajagopal, “Commentary: Lessons Learned from Saudi Arabia,” in *Pain and Palliative Care in the Developing World and Marginalized Populations,* 51-52, p. 51.

[6] Meg Spencer, “Pain Relief in Thailand,” in *Pain and Palliative Care in the Developing World and Marginalized Populations*, 53-64, p. 59.

[7] Ibid., p. 55, 59.

[8] M.R. Rajagopal and Chitra Venkateswaran, “Palliative Care in India: Successes and Limitations,” in *Pain and Palliative Care in the Developing World and Marginalized Populations*, 121-128, p. 123.

[9] Ibid., pp. 122, 124.

the primary health care level.[10] And as of 2003 in Uganda, legally prescribed morphine for palliative care is available only to people to have access to doctors—and so excludes residents of many rural areas of Uganda.[11]

As stated in the previous section, the voluntary request of a patient is a necessary but not a sufficient condition for a physician to comply with that request. The physician must also be convinced that there is unbearable suffering without the prospect of relief. In the Netherlands e.g., a case of PAD will not be accepted when a reasonable palliative alternative exists. This means that one assumes that there is suffering that *could* be adequately relieved though in fact it is not, and suffering that is relievable only by death. The frequency of the latter kind of suffering is the subject of fierce debates, but that debate needs not to be addressed here. Our problem is with the word *'could',* because in order to know what is possible you have to define your scope. Does this refer to possible relief anywhere in the world or to generally locally available treatments? What standard of care should be applied to evaluate the request for physician assisted death of a person in a developing country who suffers unbearably: a global or a local?

Interestingly, the question concerning the standard of care at the moment is hotly debated in quite another context: that of international clinical research projects. Clinical research is conducted according to international (ethical) guidelines, e.g. the WMA Declaration of Helsinki. Originally these ethical guidelines focused on informed consent, scientific validity and a proper balance of benefit over burdens. In recent versions of the guidelines a new (additional) emphasis can be discerned. The new emphasis reflects the idea that we should prevent one part of the world becoming the experimental garden of another part. This is a real danger when one considers the comparator in randomized clinical trials. Some have suggested that we can offer placebo (i.e. no therapy) to control groups when the research subjects are not denied care or treatment they would ordinarily get (14). Thus respondents could be searched and found but left untreated because of the poor local standard of care. Others would consider this use of placebo as exploitative and argue for a global standard of care (15, 16).

While we do think that in case of international research a global standard should be applied, we see relevant differences in the case of PAD. In case of a research project someone (a researcher) tries to find respondents with a certain disease, and then provides the intervention only to some of them, knowing what could be done to treat the condition of all of them. Not providing treatment in those cases amounts to negligence. In case of PAD the actor who knowingly withholds treatment does not exist. Therefore, we think it would be unfair to deny someone's request for physician assisted death because maybe (possibly) somewhere in this world a treatment exists that could relieve that patient's suffering. The world needs not to become ideal before we can justifiably grand a request for PAD (setting aside the question whether in such a world one would ever need to ask for PAD).

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[10] Sandro Pampallona and Paola Bollini, "Palliative Care in Developing Countries: Why Research Is Needed," in *Pain and Palliative Care in the Developing World and Marginalized Populations*, 171-182, p. 177, table 5.

[11] Helen Livingstone, Pain Relief in the Developing World: The experiences of Hospice Africa-Uganda," in *Pain and Palliative Care in the Developing World and Marginalized Populations*, 107-118, p. 113.

Of course, this situation speaks for improving palliative care facilities, expanding the availability of morphine (the gold standard), improving access for all residents of a region to adequate terminal care, and in the bargain increasing education, enhancing empowerment, and ending poverty. In the meantime, however, people in the third world continue to die in pain. Thus the pervasiveness of untreated and in the third-world context untreatable pain in our belief strengthens the “pro’ side of the argument concerning PAD. The heightened likelihood of dying in unremediable pain speaks for allowing the person who wishes it to receive assistance in dying.

3.2 Arguments contra physician assisted death

We mentioned two lines of argument against physician-assisted death: a deontological and an utilitarian one. The deontological one referred to the difference between acts and omissions and to the sanctity of life. Again, we believe there is no relevant difference between affluent and developing countries with respect to the applicability of these specific arguments. The second line of argument against physician assisted death focuses on several undesirable consequences a liberal public policy would have in different realms such as the clinic, the law, public policy, or society. We will now try to evaluate these different effects for developing countries.

3.2.1 Erosion of the moral centre of medicine

Often the fear is expressed that accepting PAD would make people lose trust in their physicians. Note that there is some vagueness in this expression. If it means that physicians will no longer be committed to prolong life in all circumstances, this is surely correct. The whole debate about end-of-life decisions in medical care is a response to the idea that this is not justifiable in all circumstances in the first place. The moral centre of medicine should not be vitalism, it should be the well-being of the patient. We therefore submit that physicians who do not show what the French call *acharnement therapeutique* (best translated as stubbornness) but who are prepared to evaluate the effect of their treatment from the perspective of the patient will gain in trust.

A second interpretation would concern the moral basis for accepting PAD. If that would be a right to die, in which self-determination is interpreted as a right to do with your life whatever you want, then indeed that basis might erode trust. The trust involved, however, does not concern only physicians but rather the trust people have in each other. Such an individualistic account of autonomy would leave little room for relations of trust at all (17). However, such an individualistic account of autonomy need not be the basis for accepting PAD. Moreover, if such an account would prevail, then not accepting PAD would certainly not be the solution to this problem.

The expression above may also mean that accepting PAD on request may lead to non-voluntary cases. That would amount to the slippery slope argument, to which we will return below. At this place, however, we should point to the erroneous assumption in this interpretation. The assumption seems to be that physicians once given the opportunity to kill their patients, will take it. There is no evidence for that. On the contrary, the common behaviour of physicians is to cure or to relieve suffering. This is probably true for virtually all physicians in all countries, including those in developing countries.

3.2.2 Erosion of society's commitment to provide optimal care

A second undesirable consequence of a liberal policy on PAD concerns society's commitment to provide optimal medical care. When euthanasia is available as a cheap alternative, people without adequate health care might feel pressured to make that choice. Since the difference between developed countries and developing countries is to a large extent an economic one, the discussion of this argument will be very relevant for our purposes.

We should start by saying that there is some empirical evidence that end-of-life decisions in developed countries do not lead to savings of cost. (18, 19) For example, it has been estimated that assisted suicide can save less than 0,1% of the health expenditure in the US (20). Of course, the fact that in these studies patients for whom end-of-life decisions were taken received as much care as did other patients can only be interpreted against a background of a situation of relative wealth.

But what about the relation between society's commitment to care and PAD? It is sometimes argued that PAD cannot be made available to people in vulnerable groups—whether specific groups in the first world or, we might add, the huge poverty-stricken populaces of the third—because that would lessen pressures for the improvement of background circumstances. What is particularly disturbing about this argument that PAD must not become available to people in vulnerable groups is the usually tacit assumption that the sufferings of those who, because they are in vulnerable circumstances where PAD cannot be allowed, will serve as leverage for improving the provision of such things as adequate terminal care, adequate pain control, and the like. The evidence appears to be the other way around. Pain management was improving in the Netherlands before PAD was fully legalized, but has continued to do so at an increasingly rapid rate (21). In Oregon, it has been particularly since the original passage of Measure 16 in 1994—implementation of which was delayed until 1997—that pain control has been extensively improved, reflected in higher rates of morphine usage, better access to Hospice, higher rates of advance directives, and higher rates of death at home rather than in institutional settings. It is legalization or the prospect of immediate legalization which appears to contribute to the improvement of terminal care and pain control at least in developed countries. Consequently the argument that not permitting PAD will serve as leverage for better pain control and terminal care is not only callous in the extreme towards those suffering inadequately controlled pain now—in Kantian terms, these people are being *used* for the benefit of others, being treated as means to ends that do not have to do with themselves—but there is evidence suggesting that it does not work, or not as well as legalizing PAD.

The argument might also mean that people without adequate medical care will opt for PAD because of financial reasons. As stated above there are good arguments to hold that an individual who has no access to health care can justifiably ask for PAD. At the same time it is clear that from a public health perspective the response to poor population health should be the improvement of health care, not legalizing PAD. The focus of health policy should be on gains in life-expectancy and on improvements of palliative care for persons for whom this goal was not reached. We submit that countries legalizing PAD should have a system of health care that does provide a decent minimum of care to its inhabitants. This would not be restricted to but should certainly include palliative care.

Allowing PAD without striving for a decent health care would deprive people from a normal range of opportunities and would thereby amount to a violation of human dignity.

In conclusion: countries that want to develop a liberal policy towards PAD have a strong obligation to improve (access to) palliative care at the same time.

3.2.3 Erosion of general legal prohibition of homicide

Another counterargument against tolerating PAD could be that it undermines the fundamental prohibition of civilized societies not to kill. The classical arguments against this position are that carefully circumscribed exceptions (e.g. a policy should tolerate only PAD on request) and a system of societal control should minimize the danger. This is easier said than done, however. Even in the Netherlands, where the euthanasia law is supported by a large majority of the population and of the physicians, physicians still seem insufficiently prepared to be transparent. The frequency with which cases of euthanasia are reported to the review committees is still only approximately 50% (2). Apparently it is difficult to find the appropriate way to achieve societal control. One could imagine other systems of control that are less dependent on the willingness of physicians to report cases, but this is clearly a question that merits more attention then can be given here.

The problem of societal control might prove even bigger in developing countries then in others. In some of these, widespread bureaucratic and police corruption make it almost impossible to organize an effective control system. In such circumstances introduction of PAD would be difficult since the chance of misuse would clearly be increased. As stated above with respect to a decent minimum of health care, some minimal form of a constitutional state that has the possibilities to set up a viable mechanism to monitor and control end-of-life practices is necessary.

We have now touched on the issue of human rights. We by no means claim that all developing countries show little respect for human rights, or that so called developed countries do much better in this respect. But at the same time we feel it is reasonable to state that some of these countries do not have a strong tradition of respect for human rights. If this is true, then this might provide a background in which human life is not valued the way it should be. Respect for human rights again is a prerequisite for accepting a liberal policy with respect to PAD. The claim that you need respect for human rights and human life in order to be able to tolerate PAD might sound paradoxical. At first sight, one might think that proponents of PAD are the ones who show a lack of respect for human life! That interpretation is mistaken, however. As pointed out above, sometimes illness and dying come with such suffering that life is reduced to pointless surviving resulting in an undignified end of life. If all other palliative measures fail, then PAD may be justified in such cases.

3.2.4 Slippery slope

Last but not least is the slippery slope argument. The claim is that when you start with justifiable cases (e.g. voluntary) of PAD you will end up with unjustifiable (e.g. non-voluntary) cases. Especially when the policy specifies that there should be unbearable suffering for a request of PAD to be fulfilled, it will be hard to deny PAD to suffering incompetent patients who cannot make such a request but would surely have done so, were they competent. Both in the medical ethics literature and in court decisions it has been held unreasonable to continue life-sustaining treatment that a patient would not have wanted just because this patient now is incompetent. Thus the competent patient's right to refuse treatment has been extended to incompetent patients.

Although this logic might be applied to PAD as well, we now have empirical evidence to the contrary. It is certainly true that non-voluntary cases do occur in the Netherlands, but what we also know is that the occurrence did not increase in the Netherlands between 1991 and 2001. We also know that the prevalence is much higher in other countries (Australia, Belgium) that did not slide down the slope by tolerating euthanasia for years after years (22, 23). Recently, the results were published of an European study conducted in Belgium, Denmark, Italy, the Netherlands, Sweden and Switzerland (10). The study design was the same as the one used in previous studies in the Netherlands and in Belgium. In all countries, except for the Netherlands and Switzerland, which have a liberal policy towards assisted suicide, the incidence of non-voluntary cases was higher than for physician-assisted death on request of the patient. Apparently, the occurrence of non-voluntary cases of PAD is at least independent from toleration of PAD and it may even be the case that an open and liberal policy is negatively associated with non-voluntary PAD.

This might also be true for developing countries. It may very well be that non-voluntary cases of PAD already exist, without control or real knowledge of the scope of it.
If end-of-life decisions are made in a context in which it is hard to discuss them this creates the danger of arbitrariness on the part of physicians. End of life decisions are then taken without the request of the patient or without a frank discussion with the families. Hence, we think avoiding an open discussion is not an alternative: a transparent and public debate is essential in which all interested parties can express themselves.

One cannot deny however that a policy tolerating PAD leads to a continuous discussion about the borders of such a practice. All legal systems allowing assistance in dying have interpreted the issue as being part of medical practice. However, assistance in dying is not only asked for to bring an end to severe refractory physical suffering: requests may also partly or even predominantly originate from psychosocial or existential problems and in many cases the exact origin may not be identifiable. Legislation of physician-assisted dying therefore inevitably involves further discussion of the medical borders of this practice: should it, for example, be allowed for types of suffering that do not originate from physical diseases per se, such as mental suffering due to depression or being tired of life at a very high age. Furthermore, it can be questioned whether assistance in dying should exclusively be given by physicians, especially when existential elements of suffering predominate. When society asks physicians to (also) act upon existential judgements they are not trained to make, the result is not only an extra emotional burden for physicians, but may also constitute a threat to the credibility of the moral and legal framework for the acceptance of physician-assistance in dying. Such debates however prove the existence of the logical form of the slippery slope argument, not the sociological one.

4 Conclusion

We think that arguments pro physician assisted death apply at least equally in affluent countries as in developing countries. The heightened likelihood of dying in unremediable pain strengthens the argument for legalization of PAD. Therefore we think that if PAD ought to be permissible anywhere, it ought to be permissible in developing countries. Some of the counterarguments however merit special attention in developing countries. Legalizing PAD should go together with an adequate health care, including an adequate palliative care, and with a form of societal control of PAD.

Would dying people in the third world actually seek PAD to avoid dying in pain, were it available to them? Surely the answer would vary from culture to culture as a function of beliefs about the significance of pain, the meaning of death, and similar matters. But the question we raised is whether aid in dying should be made available in the third world as a matter of policy to those who want it. Given that adequate pain treatment is simply not available and evidently will not be available any time soon in the third world, we can only guess that some will want PAD—maybe many, maybe not. Pain management in the developed world already falls far short of what it might achieve. People dying in the developing world, the studies cited earlier suggest, have far less adequate pain management—“a sea of suffering,” the commentator on the situation in Saudi Arabia described it. Nevertheless, we have no way of knowing who would choose PAD or why, and because the topic is not much discussed in the developing countries, there are few spokespersons for the vast numbers of third-world poor who might tell us what they would choose if the option of assisted dying were open to them. Yet the proportion of dying people in the developing world who would actually choose PAD makes no difference to the moral argument here; the question is whether PAD should be permitted, if anyone wants it and a willing provider can be found. We think the answer must be yes.

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