

Chapter 15

Envisioning Markets in Assisted Dying



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Abstract Ethical debates about assisted dying typically assume that only medical professionals should be able to provide patients with assisted dying. This assumption partially rests on the unstated principle that assisted dying providers may not be motivated by pecuniary considerations. Here I outline and defend a *mixed provider* model of assisted dying provision that contests this principle. Under this model, medically competent non-physician professionals could receive fees for providing assisted dying under the same terms and conditions as physicians can in those jurisdictions where medically assisted dying is lawful. The mixed provider model blunts objections to assisted dying rooted in supposed clashes with medical values. In addition to generating a market likely to expand access to assisted dying, the mixed provider model would not create markets that are unjust because they are “noxious” in Satz’ sense or because they raise “semiotic” concerns about the value of human life.

Keywords Assisted dying · Medical values · Justice in markets · Debra Satz · Jason Brennan

Ethical debates about assisted dying have long focused on *medically* assisted dying, and all the more on assisted dying enabled or undertaken by physicians (Ost 2010: 503ff). In large measure, this focus reflects the fact that in most societies, physicians have a monopoly on legal access to the technologies that those who desire assisted dying wish to take advantage of. Only physicians have the right to prescribe or administer the lethal medications that enable the safe, fast, and relatively pain free deaths sought by those who desire assisted dying (Cholbi 2015). One result of this focus on physicians aiding patients to die is that much of the ethical debate about assisted dying has addressed whether it is compatible with physicians’ professional roles or with the values thought to undergird the medical profession (Callahan 1992;

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Baumrin 1998). Skeptics about assisted dying, for example, have often argued that the practice violates the principle that physicians may not kill (or knowingly contribute to killing) their patients; that it would undermine the trust needed for a healthy physician–patient relationship; that it would render physicians complicit in injustices toward vulnerable groups; etc.

Many defenses of assisted dying address these objections about physicians' professional roles or the medical profession's values head on, aiming to show that assisted dying is a threat to neither (Miller and Brody 1995; Seay 2005; Cholbi 2011: 145–148). But an alternative dialectical strategy is to concede the justifiability of assisted dying in principle but to deny that physicians must have a monopoly over its provision. If individuals sometimes have a right to others' assistance in hastening their deaths, it does not follow that doctors alone may provide that assistance. And if there were good reason for that assistance *not* to be the exclusive province of doctors, the aforementioned objections to assisted dying would be muted.

My purpose here is to defend just this possibility, namely, a regulatory regime in which physicians are one legal option for those seeking assisted dying. I will call this regulatory regime a *mixed provider* model for the provision of assisted dying. Again, this regime would enable those ethical objections to assisted dying relating to physicians' roles and medical values to be sidestepped. However, my case for the mixed provider model does not rest on this consideration alone. My case also questions a principle that has gone largely unstated in debates about assisted dying, namely, that providers of assisted dying may not be motivated by pecuniary considerations. Being human, physicians are of course economic actors, with the same material interests as anyone else. But the thought that a physician might have an economic motivation for providing assisted dying offends against the image of physicians as disinterested professionals entrusted with their patients' health. Indeed, medicine has long had an ambivalent relationship to the commercial sphere. Some ancient Mediterranean physicians took no fees for their services, and Hippocrates advised that physicians should forego payment from patients in dire financial straits (DeCou 2019). English practitioners in the medieval period were legally barred from billing patients for fees; payments from patients were instead conceptualized as voluntary "honoraria" for services rendered (Hall and Schneider 2008). No doubt such reservations have diminished over time. (In many parts of the world, physicians loudly advertise their fees, particularly for non-essential or cosmetic procedures). But the aversion to physicians' being financially motivated has persisted in connection with assisted dying, I would suggest. The Swiss organization Dignitas, for example, has provided what it calls "accompanied suicide" to over 3000 individuals. It operates as a non-profit organization in which individuals first pay a membership. Dignitas will sometimes waive the fees for assisting in death in cases of financial hardship. The group's practices are clearly meant to conform with Swiss law, which permits assistance in dying so long as the assistance is not selfishly motivated. However, Dignitas' model is also likely to echo public distaste for the notion that anyone—but especially a medical professional—should profit from another's death.

My mixed provider model rejects the notion that the provision of assisted dying must rest on such pure or morally impeccable motives. The model instead envisions

a *market* in assisted dying, wherein those jurisdictions in which assisted dying is lawful allow its provision by physicians but also by clinically qualified non-physician providers who may charge fees for their services. (Hereafter, I will call these ‘clinical providers’ for ease of exposition).¹ These clinical providers can be analogized to other specialized medical service providers whose practice is far more restricted than that of physicians’: dialysis clinics, medical imaging centers, testing labs, and the like, each of which has a fairly limited relationship with their patients, and correspondingly, a more limited set of moral responsibilities than physicians have to their patients. The provision of assisted dying on an explicitly for profit basis is compatible with these responsibilities, I shall argue. Moreover, a market in assisted dying would redress certain difficulties regarding access to assisted dying that have emerged in those jurisdictions where it is the sole prerogative of physicians. Finally, many philosophers believe that markets have moral limits, i.e., that not everything should be for sale. As I see it, markets in assisted dying need not be “noxious” nor give rise to what have been called “semiotic” concerns. Markets in assisted dying thus fall within the parameters of morally defensible markets.

If I am correct, then those otherwise sympathetic to the legal permissibility of assisted dying should therefore welcome the prospect of a market for assisted dying in which clinical providers ‘compete’ with one another and with physicians. The mixed provider model answers classic objections to assisted dying emanating from the role played by physicians in the process, would expand access to those eligible for assisted dying, and is not unjust in itself.

15.1 The Mixed Provider Model

My mixed provider model introduces market-oriented actors into the provision of assisted dying. Crucially however, the market I envision is not an unregulated one. I will first outline the model I have in mind before proceeding (in Sects. 15.2, 15.3 and 15.4) to defend it.

Jurisdictions in which assisted dying is legal vary in the exact roles that different individuals may take vis-à-vis the individual who is helped to die. US jurisdictions tend to follow the template set by Oregon’s Death with Dignity Act. In Oregon, physicians alone can evaluate an individual’s eligibility for assisted dying (determining if they are terminal and are competent to decide this matter for themselves) and prescribe the lethal agent. With respect to the patient’s death, physicians may witness the death but may not administer, or assist in the administration of, the lethal agent. This contrasts with, for instance, practices in the Netherlands, where physicians evaluate individuals’ eligibility for assisted dying, prescribe lethal agents for patients who seek it, and may administer the lethal agent themselves. As in Oregon, Dutch physicians may be witnesses to patient self-administration. Both

¹ Crisp (1987) proposes to call these professionals ‘telostricians’, corresponding to the Greek terms for ‘end’ and ‘artisan’.

systems also allow patient's families or volunteers to play a part as witnesses either to self-administration or physician administration of the lethal agent or as assistants to that administration.

A chief difference between systems like Oregon's and systems like the Netherlands is that the former mandate self-administration, whereas the latter allows for self-administration. It is not among my purposes here to assess the merits of assisted dying in which death is merely 'aided' by means of prescribing a lethal medication versus assisted dying in which active euthanasia is available. I merely wish to highlight that where assisted dying is legal, the law ascribes different roles to different individuals within the process of assisted dying.

My mixed provider model would allow clinical providers to play whatever role a given jurisdiction presently assigns to physicians. The central difference, though, is that assisted dying and the medical needs associated with it delimit the bounds of the professional relationship between clinical providers and those seeking assisted dying. Clinical providers would not be authorised to treat whatever underlying medical conditions might be responsible for individuals wanting assistance in dying, for example. They would not have the authority to treat cancer, recommend pain management regimens to patients, or provide counselling to patients with depression. Akin to allied health professionals, clinical providers would be medical specialists whose relationships with patients would begin (and end) with patients' soliciting their assistance in dying. Of course, it is very likely that for most patients, physicians will have already played a large role in their medical histories. After all, many will have terminal or chronic illness for which physicians have supervised their treatment. Some measure of cooperation between physicians and clinical providers would be necessary under the mixed provider model. For example, clinical providers would be entitled to access the medical records of those who seek their services. But the collaboration between physicians and clinical providers need not extend any further.

Clinical providers would therefore take fees from their clients seeking assisted dying and be responsible for whatever aspects of the process of assisted dying physicians may also oversee in that jurisdiction. This could include determining patients' eligibility for assisted dying within the relevant jurisdiction, ascertaining the patients' competence if doubts arise due to psychological impairment, prescribing lethal agents, administering lethal agents, and witnessing their administration. As the assisted dying market evolves, it is likely that clinical providers would augment this 'basic package' of assisted dying services with other options of patients' choosing. Clinical providers could provide individuals with specific settings in which their deaths could occur (their homes, but also forests, meadows, beaches, etc.), as well as other accoutrements meant to foster a 'good death' for the patient. Clinical providers could also play a logistical role, making travel arrangements for patients or their loved ones. In this respect, clinical providers may come to resemble pre-mortem versions of funeral homes, offering 'euthanatic' experiences to those eligible for assisted dying. And as with funerals, we might expect clinical providers to 'brand' themselves in order to attract clientele (a 'green' clinical provider, a feminist clinical provider, providers with specific language or cultural competencies, etc.).

Clinical providers are not physicians, but nor would they be medical amateurs. Like other non-physician medical practices, the clinical provision of assisted dying would require licensure, and in particular, the licensure of the providers themselves. With regard to knowledge of physiology, the requisite training would include understanding of the physiological nature of the dying process, the dosages of lethal agents needed to induce death, signs of bodily distress, and the jurisdictional criteria for declaring death. Part of clinical providers' training would be ethical or legal. They would need to know what the relevant jurisdictional standards are for assisted dying (whether it is restricted to the terminally ill or also extends to those with conditions involving incurable and unremitting suffering, for instance), the relevant jurisdictional standards for determining psychological competency and how to assess competency, and laws regarding the handling and disposition of corpses. Clinical providers would also benefit from training designed to establish a 'bedside manner' appropriate to the needs of those who seek assisted dying. Here their training might involve communication and listening skills, the ability to detect anxiety and other psychological stressors, and awareness of the psychology of illness, dying, and grief. Particularly important in this regard would be training to recognize ambivalence and rescinded consent to assisted dying. Finally, some measure of specialization within this specialization is possible: Some within a given clinical provider setting might be responsible for assessing patients' eligibility for assisted dying, others for discussing the circumstances under which the patient desires their death to occur, still others for the actual supervision of the patient's death, and so on.

A final aspect of a regulated market in assisted dying is the protections afforded to patients and providers. Clinical providers would presumably be subject to all the same reporting requirements as physician assistants, as well as being subject to criminal or civil sanctions for malpractice, the administration of assisted dying in the absence of valid and informed patient consent, etc. A further protection for patients might be to require that all deaths be witnessed by an individual unaffiliated with the assisted dying provider. A regulated market would also likely need financial protections for both patients and providers. Clinical providers could charge fees for the various preliminary steps in the process of assisted dying in order to recoup their costs. Likewise, a patient's fee could be held in trust until their death, and providers would be entitled only to partial payment if the patient rescinds their consent. Such rules would reduce provider incentives to ensure patients' deaths while also compensating them for the services they provide even when the patient does not end up dying thanks to their assistance.

15.2 Market Demand and Barriers to Accessing Assisted Dying

As domain-specific medical professionals, clinical providers would have a distinct and carefully circumscribed part to play in the assisted dying process. Their presence

would likely increase the ‘supply’ of assisted dying options. Is there reason to think that there is demand for assisted dying that would be responsive to this supply? This section offers evidence for an affirmative answer to that question.

For one, jurisdictions in which assisted dying is lawful—and keep in mind that these are almost entirely jurisdictions in which physicians alone can provide assistance—have witnessed steady increases in the prevalence of assisted dying over time. One UK publication has reported in 2019 that assisted dying rates are “soaring” worldwide (Davis 2019). The number of euthanasia cases in the Netherlands, for example, has risen from about 2% of all deaths in 2002 to approximately 4% of all deaths in 2019 (Groenwoud et al. 2021). Similar statistical findings emerge from studies in Belgium (Raus et al 2021). The number of prescriptions written and deaths registered under Oregon’s Death with Dignity Act has increased two- to three-fold since 2015 (Oregon Health Authority 2021). The number of participants under Washington’s assisted dying law has doubled since 2014 (Washington State Department of Health 2021). Reported deaths with medical assistance in Canada increased 700% since 2015 (Health Canada 2020). These findings are not atypical. Virtually whenever assisted dying has been legalised, deaths authorised by such laws remain small in number. Yet the numbers of individuals who take advantage of such laws often exceed what even supporters of legalization predict and their popularity grows over time.

Opponents of assisted dying sometimes point to such statistics as providing reasons to second guess or revisit its legalization. Certainly increases in the prevalence of assisted dying should invite scrutiny. Some have proposed that in Belgium, the increases reflect physicians not honouring legal safeguards (Raus et al. 2021). Such possibilities should be acknowledged and investigated. Nevertheless, the overall pattern of data across time and across multiple jurisdictions suggests that the better part of the explanation for these increases is straightforward: Many people prefer assisted dying to other pathways toward death. The growing popularity of assisted dying should in fact be viewed as a point in favor of its legalization.

In addition, we ought not assume that all those who desire assisted dying have ready access to it. Critics of legalized assisted dying often worry that it will be used in ways that fail to respect the rights of minorities and socially marginal groups. If anything however, we might have the contrary worry—not that minorities and socially marginal groups are too often compelled toward assisted dying but that they do not have sufficient access to it where the practice is lawful. Statistics from Oregon paint a picture wherein assisted dying is almost exclusively the province of the *least* disadvantaged social groups: whites, males, well-educated, and affluent (Oregon Health Authority 2021: 8). Marginalized groups in the United States, for example, may lack the relationships with health care providers necessary to facilitate assisted dying. Indeed, they may face structural barriers and implicit bias such that their low level of participation in assisted dying conceals an underlying interest in it (Sikka 2019).

It is therefore likely that there is sufficient patient demand for assisted dying that at least some clinical providers would be able to function successfully under the mixed market model I propose. Still, one might wonder whether there are specific

reasons to expect that clinical providers would attract a significant clientele. Why might someone prefer to use a clinical provider rather than a physician for assistance in dying?

As we observed earlier, it seems likely that commercial competition among clinical providers will, over time, make it possible for patients to have highly tailored assisted dying experiences. But an additional set of reasons concerns a patient's relationship with their physician. On the one hand, some patients may not have a relationship with a physician within which they are comfortable discussing or pursuing assisted dying, and they may furthermore not wish to seek out a new physician solely for the purpose of discussing or pursuing assisted dying. Clinical providers would presumably be visible and identifiable to such patients. Conversely, some patients may have strong relationships with physicians that they might not wish to cloud or complicate by discussing or pursuing assisted dying with them. They might not want a physician who has competently and compassionately provided them life-extending care to switch roles so as to facilitate their deaths. Patients may also value their physicians retaining their disposition to save life (Crisp 1987). Assisted dying may thus complicate a patient's care relationship with their physician and hence provide them with incentives to seek assisted dying from a clinical provider.

A patient's relationship with a clinical provider of assisted dying would not be *uncaring*. But at the same time, it would be a single purpose transactional relationship of relatively short duration, and therein lies some of the appeal of seeking assisted dying from a clinical provider. In relationships with physicians, assisted dying must necessarily be a chapter within the context of a larger professional relationship—typically a final chapter—a relationship that has the extension of life as one of its recognized goals. In contrast, a patient's relationship with a clinical provider rests on a narrower basis: that the patient seeks (or is at least seriously contemplating) assisted dying provides the foundation for the relationship and demarcates its professional bounds. Unlike their physicians in many cases, the patient can be confident that the clinical provider is not ambivalent about the prospect of assisting them to die. Hence, the very brevity and lack of ambiguity in patients' relationship with clinical providers is likely to appeal to some patients.

15.3 The Moral Limits of Markets, Part I: Satz on 'Noxious' Markets

Even if I am correct that the mixed provider model answers to legitimate patient interests that are not currently addressed where physicians have a monopoly on assisted dying, some philosophers may argue that a market in assisted dying is unjust in itself. Some things, according to these philosophers, should not be for sale, and perhaps assisting in the deaths of others is among these. In this section and the next, I consider two frameworks for the morality of markets and show that a mixed provider market in assisted dying does not transgress the limits of morally permissible markets.

In her *Why Some Things Should Not Be for Sale: The Moral Limits of Markets*, Satz (2010) proposes four parameters for what she calls “noxious” markets. A market for a good is noxious to the extent that it

- a. results in harmful outcomes for market transactors or identifiable 3rd parties,
- b. results in harmful outcomes to society at large,
- c. involves transactors with “weak agency” (due, for instance, to lacking information relevant to transactions involving the good), or
- d. involves transactors in highly vulnerable positions in relation to the good in question.

Satz’s account of noxious markets has a broadly republican pedigree. For as she sees it, markets characterized by these four features undermine or prevent individuals from relating to one another as moral equals by contributing to relations of inferiority or domination among them. Noxious markets generate problems “relating to the *standing* of parties before, during and after the process of exchange” (Satz 2010: 93). Echoing Adam Smith, Satz argues that markets should instead contribute to creating “a society of horizontal relationships based on free interaction, equality and reciprocal self-interest” (2010: 42).

What does Satz’s account of noxious markets imply about the justifiability of a market in assisted dying based on mixed provider model? Let us address each of the four features of noxious markets in turn.

a. *Harms to Transactors or to 3rd Parties*

We have reason to expect that transactions within a regulated market in assisted dying would be Pareto optimal. Clinical providers of assisted dying profit from its provision, for one. A mixed market would likely expand access to assisted dying overall, enabling patients to avoid harms they might otherwise suffer, as well as expanding the variety of circumstances, settings, etc., in which assisted dying can occur, allowing patients to enjoy deaths that better answer to their preferences or values. There is also no obvious class of 3rd parties who would be harmed (or harmed unjustifiably) by the mixed market. Granted, physician providers of assisted dying could be said to be harmed inasmuch as some individuals who might have sought their assistance would turn to clinical providers instead. But it is not clear that physicians are entitled to avoid such ‘competitive’ harms. Markets will of course have winners and losers, yet the losers in market competition (especially those who would otherwise have a monopoly on the provision of the relevant good) do not have the right to veto a market because that market does not accord them competitive advantage.

b. *Harms to Society at Large*

To assert that a regulated mixed market in assisted dying would never harm *anyone* would be foolish. Yet it is difficult to discern any large scale societal harms that would arise from the introduction of such a market. A society would have to bear the bureaucratic costs of regulating such a market. The mixed market in assisted dying would not cause pollution or other transactional externalities,

undermine anyone's basic rights, consign anyone to a lower status, or amplify the power of some citizens or groups at the expense of others.

c. *Weak Agency*

Worries about individuals' ability to rationally opt to hasten death have long been central in debates about the ethics of assisted dying. Should we worry that a mixed market in assisted dying would exhibit what Satz calls weak agency, i.e., will transactors lack the knowledge or understanding needed to properly consent to such transactions? No doubt the decision to hasten one's own death is fraught and complex. It will rarely be crystal clear (for example) whether a person with advanced stage cancer is better off dying sooner rather than later. My mixed market model does not pretend to simplify these questions, but nor does it complicate these questions beyond the level already present in end of life decision making. A patient who struggles to determine whether she is better off dying sooner rather than later is not likely to struggle more if opting for the former means she would later end up paying a clinical provider to help her die. Recall also that my mixed provider model does not offer one set of patient protections regarding competency or agency for patients who seek assisted dying from physicians and another (weaker) set of protections for those who seek assisted dying from clinical providers. The same protections apply regardless. Most jurisdictions have in place various safeguards meant to ensure that patients who opt for assisted dying do so carefully, under full information, with adequate forethought and free for undue pressures. For instance, patients are typically required to have multiple medical certifications that they meet the operative medical standards for eligibility for assisted dying (are terminally ill, etc.); to make multiple requests for assisted dying separated by an established time interval; to have their requests witnessed by others; etc. These same safeguards would apply to assisted dying via clinical providers.

In addition, under the regulatory transparency I propose, clinical providers would also have strong motivations to ensure that their clients opt for assisted dying under conditions of full information and robust agency. Like physicians, they could be subject to criminal or civil liability in cases of malpractice or malfeasance. But clinical providers would have the further incentive that the success of their commercial enterprise may well depend on their clients exhibiting robust agency in the course of deliberating about whether to procure assisted dying from them.

d. *Transactor Vulnerability*

A market in assisted dying might seem to invite exploitation of those interested in assistance in dying. Many of those seeking assisted dying might be in desperate straits, willing to pay someone to end a life whose quality is in rapid decline. Does the seemingly vulnerable position of such patients speak against my mixed market model?

My mixed provider model is of course predicated on clinical providers acting from financial motives. Its critics might then reason that clinical providers, in their eagerness to turn a profit, will take advantage of desperate clients. Some of the measures to counteract this were mentioned in Sect. 15.1: allowing fees to be

collected for patient consultations, partial payment for patients who rescind their consent, liability to criminal or civil action in cases of malpractice or malfeasance, etc. And again, we should keep in mind that my model establishes a right to purchase assisted dying services from clinical providers under the same medical circumstances as a jurisdiction permits individuals to seek assisted dying from physicians. Jurisdictions would require that clinical providers follow the same protocols as physicians in determining patients' eligibility and willingness to receive assistance in dying (including medical examinations, waiting periods, etc.) Clinical providers and physicians who offer assistance in dying would thus operate on the same competitive turf. No doubt those who seek assisted dying are vulnerable in various ways, but a regulated mixed market is unlikely to exploit that vulnerability in unjust ways.

On balance then, the case for a mixed market in assisted dying being noxious is unconvincing. No doubt there would be some failures in this market. But absent evidence to the contrary, we cannot assume that such failures would be more common or more egregious than they are when physicians monopolize access to assisted dying. Considered holistically and over the long run though, my mixed market model is likely to provide many of the benefits markets can confer while minimizing (albeit not eliminating) harms or abuses. In Satz's terms, a regulated market in assisted suicide would neither presuppose conditions of unequal status nor contribute to conditions of equal status. It would not exploit conditions in which individuals can 'push around' each other (or foster such 'pushing around').

15.4 The Moral Limits of Markets Part II: Brennan and Jaworski on 'Semiotic' Limits to Markets

In their *Markets Without Limits: Moral Virtues and Commercial Interests*, Brennan and Jaworski (2016) defend a more permissive view of markets than Satz'. In their pithy slogan, "if you may do it for free, you may do it for money" (2016: 10). Supposing that this slogan is correct, its implications for my mixed provider model for assisted dying are not straightforward. For one, rightly or wrongly, in many parts of the world, a person may *not* 'do it for free' when it comes to assisted dying; doing so would run afoul of laws against assisting in suicide. Moreover, where medically assisted dying is lawful, physicians do not provide their services 'for free'. They are often compensated indirectly, via patients' insurers or their own salaries. Nevertheless, the presumption is that even though physicians financially benefit from providing their services (assisted dying services included), they are not *motivated* by financial benefit in the sense that their reasons for providing particular services are financial. A physician 'profits' from the overall course of care provided to patients, not from their services viewed as distinct economic transactions. This 'transactional' picture is of course where my mixed provider model parts ways with convention: Clinical providers could be motivated by the financial gains associated with each assisted dying 'transaction.'

Hence, Brennan and Jaworski's slogan does not lend unequivocal support to a market in assisted dying. However, in defending their position, they address an objection to markets that is particularly salient in connection with the prospect of a market in assisted dying. What they call the 'semiotic' objection to a market rests on the observation that market activity seems to symbolically communicate something about how market transactors value goods. The objection maintains that markets can disrupt or alter ethically valuable meanings we attach to those certain goods. Markets thus come to "express or communicate certain negative attitudes" or prove "incompatible with holding certain positive attitudes" toward a class of goods (2016: 21). The commodification of some goods can ascribe a meaning to certain goods that "is essentially disrespectful or degrading" (2016: 83) to these goods or to what is valuable about them. For instance, some argue that paid gestational surrogacy signals that children are a commodity and so undermines the value of the intimacy characteristic of a pregnant woman's relationship to her fetus (Anderson 1990).

Those skeptical of my mixed provider model are likely to be attracted to such semiotic worries about markets in assisted dying. They may view paying a clinical provider, a professional with whom a patient has no wider professional relationship, as cheapening the process of assisted dying, as failing to reflect the value of human life, or as at odds with the solemnity of dying. Paying someone explicitly to kill oneself seems to communicate that a person's life is a kind of commodity. Ultimately, Brennan and Jaworski reject the semiotic objection altogether. Not only are the meanings we impute to various goods contingent and subject to revision over time, they argue, the consequences of assigning 'semiotic' significance to different goods vary, and it is the consequences of assigning such significance that should govern whether a good is made available for market exchange (2016: 83). In virtually every case, the adverse consequences of restricting market access to a good are greater than whatever benefit results from treating goods as having a significance or value that is disrespected or degraded by market exchange, according to Brennan and Jaworski.

In the spirit of dialectical charity, I will here assume the contrary—that semiotic objections *can* have force against the existence of markets in various goods—and proceed to consider whether such objections are convincing when directed against my own mixed provider market in assisted dying.

Evaluating semiotic objections to particular markets is a complex matter. It requires identifying (i) what 'pre-market' value the good in question has, (ii) what a market in such a good would express, and (iii) how this expression would be incompatible with the pre-market value. In the case of assisted dying, it seems likely that opponents of markets would hold that such a market expresses repugnant views about the value of human life—that a market in assisted dying in effect puts a price on human life by attaching a monetary value to life's cessation. (Kass 2002: 234ff.)

A central challenge to this reasoning is isolating the precise role that markets in assisted dying *as such* might play in undermining or expressing disrespect for the value of human life. No doubt many opponents of my mixed provider model oppose physician-assisted dying (and indeed, all forms of assisted dying) on semiotic grounds—that it fails to accord with the sanctity of human life. But then what additional objectionable statement about the value of human life would be made

if assisted dying were made available via market transactions, as I have proposed? Doing X may express a disrespectful stance regarding some valuable good, but it is not obvious that doing X from at least partially monetary motives expresses further disrespect. Unpaid gestational surrogacy may express a “negative attitude” toward pregnancy and motherhood. Does paying the surrogate add to the negativity thus expressed? Murder expresses disrespect toward its victims. Do paid assassins express greater disrespect than do other murderers? My defense of the mixed provider model is not meant to defend assisted dying as such. It aims only to consider whether, if assisted dying is in principle defensible, the provision of assisted dying in a regulated market is also defensible. My opponents may well believe that assisted dying as such raises semiotic concerns about the value of human life. But it difficult to see that market-provided assisted dying raises additional semiotic concerns.

In addition, as applied to markets in assisted dying, the semiotic objection misidentifies the good in question. Tempting as it is to describe market-provided assisted dying as others (or ‘the market’) putting a price on someone’s human life, a more accurate description is that individuals would be putting a price on, i.e., making a cost judgment regarding, what they are willing to pay for their own good death. A free and voluntary market transaction occurs at a price reflecting both the purchaser’s willingness to buy and the seller’s willingness to sell. In this regard, markets in assisted dying would be to some extent dependent on what those besides the patient care about. A patient considering the services of a clinical provider could not decide *unilaterally* how much to monetarily value the death she might hope to attain. Yet securing such services will have to reflect the value that, ethically speaking, should prevail in such choices: the value that the patient assigns to her dying by her own lights, a value measured by the monetary resources she is willing to forego to acquire such death on the terms she seeks. That we have a right to expend our own resources to provide ourselves with what we take to be a good death is indisputable. A person with the means to (for example) die in hospice has the presumptive right to do so, and more generally, patients have the right to make their own determinations about what should be exchanged in order for them to acquire the death they prefer. A patient has the right to forego pain medications in order to be more lucid in the days and hours prior to her death; the right to forego additional treatments for underlying illnesses in order to minimise time in hospitals prior to death; etc. In these cases, it is implausible to describe this as the patient (or anyone) expressing any negative attitude at odds with whatever value human life has. Admittedly, when the patient’s judgments have implications for how long she is likely to live (whether more or less than she otherwise would), she will perform a cost–benefit analysis one ingredient of which is the value of *continued* life. But this need not reflect any judgment about the value of her life, nor *a fortiori*, any societal or putatively objectively judgment about her life’s value (Kamm 2020).

In sum then, semiotic objections to market-provided assisted dying do not succeed. It is not clear that market provision of assisted dying expresses more objectionable messages regarding human life (or death) than does assisted suicide offered outside

the context of market exchange, and it is equally unclear that it expresses an objectionable stance regarding the value of a person's life (or the significance of their death).

15.5 Conclusion

As I see it, a mixed market in assisted dying, where clinical providers co-exist with physicians who provide assisted dying, answers to legitimate interests individuals have in connection with how they die, is likely to make assisted dying available to a wider population of those eligible for it, and would not devolve into an unjust market. No doubt certain opponents of assisted dying will not be moved by such arguments. Those who believe that actively hastening one's death is immoral or who maintain that we do not have a right to shape the circumstances of our deaths will not find my appeal to the merits of a market in assisted dying compelling. But I hope to have shown such opponents that a market in assisted dying does not introduce new ethical concerns not already present in physician-assisted dying. Such opponents are likely to reject my proposal for a mixed market in assisted dying simply because it makes possible assisted dying—not because it does so through market mechanisms. But I hope to have persuaded those largely sympathetic to the cause of assisted dying that a mixed market represents a possible improvement over the status quo. Moreover, perhaps some opponents of assisted dying will be converted to support its legalisation under precisely the market-based provision I have outlined. The opponents I have in mind are those who assert that assisted dying may be something which patients may rightfully claim but may not rightfully claim *from* their physicians because it is incompatible with physicians' professional duties or with the values that undergird medicine. These opponents might welcome the introduction of clinical providers as a way to 'siphon off' patients who desire assistance in dying to professionals whose responsibilities are explicitly crafted to allow for the provision of assisted dying.

Let me conclude by answering two final objections.

The first objection is this: Health care is a right, and if assisted dying is a form of health care, then individuals should be entitled to it without regard to their ability to pay. If the clinical provision of assisted dying were not part of the standard bundle of health care to which all patients are entitled, then it would not be equally open to all, since its availability to patients would depend on their ability to pay. Some individuals may not be able to afford the services that clinical assisted dying providers offer. Hence, clinical provision of assisted dying offends against the claim that health care is a right.

That health care is a right is a claim I accept. Yet it is implausible that individuals have an unlimited right to health care or a right to whatever health care they wish to receive. Regardless of exactly how health care is financed or delivered within different systems, each system must establish limits concerning what health care individuals may receive. These limits will depend on the benefits of various treatments, the cost of their provision, etc. It may well be that clinical provision of assisted dying

would turn out not to fall within those limits. In other words, it may turn out to be a health care luxury rather than a health care *need*. Yet this fact does not speak against markets in which clinical providers offer assisted dying services. A society that meets its members' health care needs should not necessarily object to some of its members exercising their ability to pursue health care luxuries. A society that meets those needs does not have *prima facie* reason to object to individuals using their private resources to receive non-essential care or to undergo cosmetic procedures, for instance. As I argued in Sect. 15.3, a mixed market is unlikely to harm to third parties. Nor will it undermine access to other forms of health care over which physicians retain a monopoly.

Here is the second objection: Some may worry that clinical providers will have a greater incentive to 'bend the rules' regarding eligibility for assisted dying. Not content to be able to provide assisted dying services to whatever class of individuals who have legal access to assisted dying in the relevant jurisdiction, clinical providers will agree to provide assisted dying to those who are not legally eligible: where available only to the terminally ill, clinical providers will be tempted to provide assisted dying to those with chronic and unbearable conditions that are nevertheless not terminal; where available only to patients deemed psychologically competent, clinical providers will be tempted to provide assisted dying to the psychologically incompetent; etc. Clinical providers may thus function as a shadowy back door for individuals to receive assisted dying illegally. My mixed market model, critics may allege, thus increases the likelihood of 'slippery slopes' wherein assisted dying is offered to those who, legally or morally, ought not have access to it.

In response, candor demands the acknowledgement that it is impossible for each and every such abuse to be prevented. But the possibility of abuse is not sufficient to ground a compelling objection to my mixed provider model. For one, there is no obvious reason to expect that such abuse will be more likely with clinical providers than with physicians—and some reason to expect it could be less likely in the former case. Physicians are occasionally charged with criminal misconduct in connection with assisted dying, but clinical providers would be subject to additional financial incentives not to bend the rules regarding patient eligibility. Secondly, we should not assume that there is no 'black market' in assisted dying provision as is. There appears to be significant illicit trade in the sedative pentobarbital, nicknamed "death in a bottle," by individuals wishing to end their lives (Costa et al. 2017). Some of these individuals may satisfy the criteria for lawful assisted dying where they live, and given that their evident willingness to pay to access lethal agents, they are likely to be among those who would seek out the service of clinical assisted dying providers. But over the longer term, this might well have a salutary effect on the overall market for assisted dying: A market in which some can purchase assisted dying could exert economic pressure against unlawful provision of assisted dying, and as a result, make it more difficult for those ineligible to access it through market means while expanding access to those legally eligible. A regulated market, with requirements related to provider training, safety, etc., is also likely to reduce risks to those seeking assisted dying. On balance then, we may be optimistic that my mixed provider market in assisted dying will have distinct advantages over a status quo in

which individuals' only options are either physician assisted dying or assisted dying with the help of black market providers with dubious scruples.

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