Dual or single gauge? Govert den Hartogh's 'dual-track' assisted death

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Abstract
In *What Kind of Death: The Ethics of Determining One's Own Death* (2023), Govert den Hartogh offers a 'dual-track' model for assisted death. According to Den Hartogh's model, mere access to lethal drugs would be lawful on the basis of an autonomous decision (Track 1), while 'full-blown physician-assisted death' (provision of lethal means under professional supervision and care) would be lawful in the presence of an autonomous decision and satisfaction of further conditions instantiating values including dignity and well-being (Track 2). I offer a critical reading of Den Hartogh's argument in respect of the nature and justification of Track 1. I argue that permitting mere access to lethal medication may be both 'lifting a blockade' (as Den Hartogh argues) and assisting an individual to die (as he denies). This conclusion about the *nature* of Track 1 opens the question of the sufficiency of Den Hartogh's claim that autonomy is its sole normative ground. A revised account of the *justification* for Track 1 is possible, however. I argue that Track 1 assistance may be permissible on the same grounds as Den Hartogh provides for Track 2: autonomy in conjunction with other values (albeit in a different mix). Rather than conceive of Den Hartogh's model for assisted death as 'dual-track', dual gauge, we might rather consider mere access to lethal drugs and full-blown physician assisted death as two services on a single normative gauge.

Keywords
assisted death; assisted dying; assisted suicide; euthanasia; Govert den Hartogh

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1. Introduction

Govert den Hartogh's monograph, *What Kind of Death: The Ethics of Determining One's Own Death* (2023), offers a rich seam of integrated thought on the ethics—and regulation—of end-of-life decisions and interventions, including suicide, stopping eating and drinking, suffering, advance decisions (or directives), palliative care, continuous and terminal sedation, as well as assisted suicide and voluntary euthanasia. Den Hartogh offers insights across these topics; his contributions merit wide reading and broad discussion.

Thus it is with some diffidence that my focus in this article is assisted death—an umbrella term for assisted suicide and voluntary euthanasia.[1] So to do risks neglecting the unity of *What Kind of Death* or unduly downplaying the significance of the book's other parts. Nevertheless, I shall attend to assisted death because of the interest and innovation that lie in Den Hartogh's 'dual-track' model (or schema) for access to life-ending means.

[1] Some definitions. A person (*P*) performs suicide iff a) *P* follows a course of conduct (φ) that causes their own death; and b) *P* intends that their death obtains by means of φ. I shall broach suicide assistance later on. A third party (*T*) performs euthanasia on *P* iff a) *T* deliberately (and proximately) causes *P*'s death; and b) death is good for *P*. Euthanasia is *voluntary* when *P* consents to *T* causing *P*'s death; it is *involuntary* when *P* refuses consent to *T* causing *P*'s death; it is *non-voluntary* when *P* is presently unable to consent to *T* causing *P*'s death and *P* has neither consented to nor refused euthanasia in the past such that it would be voluntary or involuntary, respectively.

According to Den Hartogh's 'dual-track' model, the respective tracks—(mere) access to lethal drugs (for example, mere prescription of a fatal dose of barbiturates by a physician) and access to 'full-blown' physician-assisted death (*viz*, provision of lethal means under professional supervision and care)—might co-exist as regulatory responses to the individual's interest in deciding (or wish to decide) the manner and moment of death within a single jurisdiction. On Den Hartogh's view, these two tracks are different in the nature, since mere access to lethal drugs (which I shall often call 'Track 1') does not involve assistance to die, unlike full-blown physician-assisted death (which I shall often call 'Track 2'). Further, Tracks 1 and 2 have eligibility criteria that reflect distinct and differently stringent normative underpinnings—mere access to lethal drugs takes support from the value of autonomy (or self-determination) alone, while autonomy together with other goods (such as dignity and well-being) ground full-blown physician-assisted death. To wit, within a dual-track regime there would be broad access to (safe) lethal medication and narrower access to full-blown physician assistance.

Den Hartogh's dual-track model innovates insofar as, to my knowledge, no jurisdiction has made provision for co-existing *permissive* regimes for access to life-ending means, where access to lethal medication is common to both limbs of the institutional framework and the limbs' substantive eligibility criteria follow the underpinnings detailed above. Further, Den Hartogh's dual-track model has normative attractions, since it extends the prospect of a minimally 'good' death to all autonomous individuals, that is, beyond the class(es) of individuals often thought the most appropriate candidates for full-blown physician-assisted death (self-determining agents with either terminal illness or

unbearable, persistent, and unrelievable suffering). As such, the dual-track model may offer a solution to the problems (and potential injustices) in denying *any* access to life-ending means in so-called 'hard cases' (or perhaps better: for 'hard classes'): individuals who suffer with refractory mental disorders or who are 'tired of life'.

I am friendly to Den Hartogh's dual-track model. However, in what follows—and after further elaboration of the model in the next section—I would like to apply critical pressure to the account that Den Hartogh gives for Track 1. I shall advance two main lines of argument. First, I argue against Den Hartogh's claim that when an agent deblocks another's access to lethal medication, the former does not assist the latter to die. Second, Den Hartogh rests the justification for Track 1 on the value of self-determination alone. I argue that setting autonomous agency as the sole exercise condition for Track 1 need not entail that self-determination is the sole value that justifies mere access to lethal medication; other values may be in play. These arguments yield the conclusion that the nature and justification of Track 1 is not unlike that of Track 2 for full blown physician-assisted death. Rather than two tracks for assisted death of distinct normative gauge, we might instead think of mere access to lethal drugs and access to full-blown physician-assisted death as two services on a single gauge.

2. Den Hartogh's dual-track model for access to life-ending means

For accessibility of the argument that follows and so readers may avoid constant reference to *What Kind of Death*, I shall attempt to précis Den Hartogh's dual-track model. I first outline Track 1, then Track 2.

2.1. Track 1: Mere access to lethal drugs

Den Hartogh argues that individuals possess a right to decide how and when to die (2023, pp. 28-34). (Elsewhere—discussing refusals of life-prolonging medical treatment—I style this right as 'right *D*' (Black 2018); I adopt the shorthand here.) Right *D* is underpinned by the value of autonomy;[2] it is 'most plausibly considered an element of the right to self-determination', that is, the:

> bundle of normative assets that together delineate a private domain within which it is up to you to decide what you do. You are not only free to make these decisions, you also have the authority to make them (Den Hartogh 2023, p. 29; see Mackenzie 2008).

On Den Hartogh's view, an autonomy-derived right *D* grounds a content-independent duty on others not to interfere in the execution of one's life (or death) plans. That is, others' duty to respect the right is not a function of the

[2] It follows that the conditions for the exercise of autonomy apply to the exercise of right *D*, *viz*, decision-making capacity and voluntariness: (Den Hartogh 2023, p. 31; Black 2018, pp. 37-38). We might further add that in order for an agent to take an autonomous decision, their decision must be sufficiently informed. However, I take it on a decision-specific conception of capacity, an agent with capacity has sufficient grasp of the information relative to the decision. It is not necessary, therefore, to insist on a distinct sufficient information condition for autonomy.

'prudential or moral quality' of one's decision-making (p. 29). Den Hartogh offers a variety of reasons for content-independence. First, we might say that 'the area of private sovereignty' enabled by the right to self-determination is intrinsically valuable (or has value in itself) (p. 30). Den Hartogh holds that autonomy is 'in itself an essential element of a good life' (p. 30; see Hurka 1987). Second, we might hold that autonomy is instrumentally valuable (or has value as a means to some end). Den Hartogh argues that a right to carve out an area of private sovereignty has value 'because of the social status it implies, of being an equal among equals' (p. 30). Here, it is the contribution of autonomy to status or equality that supports content-independence (see Nagel 1995). Third, a content-independent duty of non-interference with right *D* may arise for epistemic reasons (see Atkins 2000; Black 2018), *viz*, the individual occupying a privileged position in respect of knowledge of their own good vis-à-vis other actors. Epistemic deference may be instrumentally valuable. As Den Hartogh observes, 'allowing people to act on their own ideal of the good death [including suicide] may increase their opportunities to come closer to it' compared to the situation in which others set the parameters for the manner and moment of death (2023, p. 30).

I should emphasise that Den Hartogh takes care to avoid the implausible view that right *D* grounds an *unlimited* content-independent duty of non-interference on others: 'the authority, assigned by a right, need not be unlimited' (p. 30). Rather, Den Hartogh's position is that one has *pro tanto* unlimited autonomy rights—including right *D*—but one's *all things considered* autonomy rights depend on the interaction of self-determination with other valuable features of the moral or political constellation: 'the default is always

that you are free to do what you want, and there have to be good reasons for restricting that freedom' (p. 30). As Joseph Raz writes:

> Rights are (part of) the justification of many duties. They justify the view that people have those duties. But… only to the extent that there are no conflicting considerations of greater weight (1986, p. 172).

Thus we might say that our all things considered rights are just those that persist after specification (Richardson 1990), because the relevant interests are sufficiently important to generate duties (Raz 1986, p. 166). We hold right *D* (and others have a content-independent duty of non-interference) just when the interest in deciding the manner and moment of death outcompetes (or survives conflict with) the rights of others. Den Hartogh would add that the right must also be compatible with 'basic moral considerations, for example about human dignity, that cannot be cashed out in terms of human rights' (2023, p. 31).

In light of the above, how—on Den Hartogh's view—might one specify a right of mere access to lethal medication (Track 1) out of the value of self-determination alone? Central to Den Hartogh's account is the claim that supply of fatal drugs when an individual satisfies the conditions for the exercise of autonomy merely amounts to discharge of the duty of non-interference with right *D*. I outline the argument in stages. First, there often exist market restrictions on lethal medication (p. 81). Second, such restrictions are generally, but not universally, well-founded. As Den Hartogh observes, '[lethal medication] can be used impulsively [for] suicides that cannot be regarded to

be well-considered, or fully voluntary. In addition, they can be used for killing others' (p. 81). Third, in cases in which an individual has an autonomous wish to die, the reasons for restricting access to lethal medication do not apply: the agent has capacity and acts voluntarily (pp. 81-82). Fourth, in such circumstances, granting access to lethal drugs is not an act of assistance to die but rather and merely amounts to 'lifting a blockade' (p. 82). It is this purported fact of non-assistance that situates the individual's wish to die within their private domain, thereby giving rise to a content-independent duty of non-interference on others.

I shall say more on this argument shortly. However, I need first to outline Den Hartogh's argument for track 2—full-blown physician-assisted death.

2.2. Track 2: 'Full-blown' physician-assisted death

Den Hartogh defines 'euthanasia'—what I describe as 'full-blown physician-assisted death'—as a 'joint action' of the individual who wishes to die and a physician who takes 'final responsibility for assuring that [the former] dies swiftly, safely and without pain' (pp. 155-156). Euthanasia on Den Hartogh's usage, therefore, covers both instances of voluntary euthanasia *stricto sensu* and assisted suicide just when a physician is a co-participant in the relevant course of conduct. (As contrasted to the situation Den Hartogh foresees on Track 1, in which a physician might merely assess whether an individual is autonomous and prescribe lethal medication on this basis (p. 89).) I shall keep to full-blown

physician-assisted death. Nothing substantive hangs on the difference in terminology between Den Hartogh and me.[3]

It is the physician's status as a co-participant in a life-ending course of conduct—as a joint agent—that distinguishes the permissibility conditions of Track 2 from those of Track 1. While, on Den Hartogh's view, the value of self-determination alone justifies mere access to lethal medication, autonomy 'is only a necessary, not a sufficient condition' for full-blown physician assisted death (p. 156; cf. Raz 2013). As we shall see, the presence of other values is an individually necessary and jointly sufficient condition for the permissibility of Track 2 assistance to die. Why is this so? To pose the question:

> If we have the authority to decide to do something, correlated to other people's duty not to interfere, do we then not also have the authority to consent to someone else doing it, or cooperating with us in doing it (Den Hartogh 2023, p. 155)?

Den Hartogh offers a detailed explanation for why one's agential authority alone does not license another's ending (or participation in ending) of one's own life, which I can only summarise here. To pick out two central aspects of the discussion: first, some (though—importantly—not all) instances of assisted death may be incompatible with the value of dignity, and second, refusal of

[3] As Den Hartogh acknowledges, his extension of euthanasia is a matter of 'convenience… That there is no basic moral difference between euthanasia proper and suicide assistance of the full-blooded kind is not a conceptual truth' (Den Hartogh 2023, p. 90).

assistance to die when one believes death would be a harm need not amount to impermissible paternalism.

In respect of dignity, Den Hartogh emphasises two dimensions of the value: the *buck-passing* and the *qualification*, respectively. On the buck-passing dimension, dignity is a 'placeholder' for the set of reasons that require us 'to treat people in certain ways, for example to honour their rights' (p. 163). One's dignity comprises the contents of those reasons, including those the value of autonomy gives. However, one's dignity is not only these reasons, insofar as the qualification dimension mandates in addition 'a certain emotional disposition, an attitude of respect' (p. 163). It is this attitude of respect that stands in the way of some instances of assisted death, autonomy notwithstanding. For example, Den Hartogh cites cases in which the individual's wish to die indicates a 'basic lack of self-respect' such that the provision of assistance seems impermissibly confirmatory (p. 166).[4]

Importantly, Den Hartogh argues that respect may not be the sole moral emotion required in response to the reasons constitutive of a person's moral status; sometimes, what is called for is care (p. 166). To wit, 'on a correct understanding of the concept of dignity, the proper concern for a person's welfare should not be considered a response to her dignity but to her needs' (p. 166). It follows that some instances of physician-assisted death are compatible with human dignity, just when the provision of assistance

[4] 'A psychiatrist told me that a man with a personality disorder once came to him requesting euthanasia, saying "I am a plague to humanity, I am wrecking the lives of everyone around me". In a file concerning another psychiatric patient the following disturbing explanation of her request is given: "The patient indicated that she had had a life without love and therefore had no right to exist"': (Den Hartogh 2023, p. 166).

exemplifies appropriate care for the interests and rights of the individual who dies:

> A doctor who would grant a patient's request for euthanasia merely because it has been competently made would be lacking in proper concern for that patient. Perhaps he would even be lacking in proper respect. But a doctor, who grants the request because he reasonably considers it to be in the patient's true interest to do so, cannot be accused of violating that patient's dignity (p. 167).

In respect of paternalism, we should first clarify what we mean by the term. As an initial definition, let us say that an act is paternalistic just when 'the act in question constitutes an attempt to substitute one person's judgment [sic] for another's, to promote the latter's benefit' (Dworkin 1988, p. 123). Further, the judgement subject to interference must be that of an autonomous agent (p. 123). Next, it is helpful to identify the distinction between direct (pure) and indirect (impure) paternalism. As Den Hartogh writes:

> Direct paternalism is a two-place relation: A interferes in the execution of B's plans in order to prevent harm to B. Indirect paternalism is a three-place relation: A interferes in the execution of B's plans in order to prevent harm to C, even though C has consented to B's actions (Den Hartogh 2023, p. 157).

Plausibly, legal restrictions on physician-assisted death in jurisdictions where the practice is lawful are indirectly paternalistic. The State criminalises (or otherwise sanctions) physicians who assist autonomous individuals to die unless, *inter alia*, another substantive criterion (for example, going to the nature and degree of suffering) is also met. One way to explain the presence of this additional criterion is that its purpose is to avert harm to (or to promote the good of) individuals whose autonomous wishes to die will go unfulfilled as a result (see Kamm 1999; Sumner 2011; Black 2021). Let us grant that restrictions on the permissibility of physician-assisted death amount to indirect paternalism. Would this unsettle the foundations of Den Hartogh's Track 2 physician-assisted death? Only if it is true that paternalism is wrongful in this context. Den Hartogh considers two general objections—drawn from Feinberg (1986)—to paternalism that may seem to support a right to physician-assisted death on the basis of self-determination alone: the 'self-governance' objection and the 'status' objection. Neither succeed, for the reasons given below.

On the self-governance objection, it might be thought an affront or an 'insult' to an agent's autonomy to fail to lend a hand in their projects (Den Hartogh 2023, p. 169). However, this misidentifies where the value in self-determination is realised. Even if autonomy is instantiated on achievement of one's ends, one is also self-governing when 'allowed to set and pursue [one's] aims with the means at [one's] disposal' (p. 170). Consider an individual who campaigns—perhaps against the tide of public opinion and support—for some cause, never to see it widely realised during their lifetime (or maybe at all); we would not deny that their life was one of self-direction, notwithstanding the absence of success. Likewise, it seems a mistake to hold that an individual is

denied self-governance when their wish for physician-assisted death on the mere basis of autonomy goes unfulfilled. The end of death remains their own to hold, but this particular means is not theirs alone.

It seems, then, that the self-governance objection to paternalism in the context of Track 2 is not really in play. As Den Hartogh argues, 'in refusing to comply [with your wishes, no one] fails to recognize that your life belongs to you' (p. 170). The objection might be recast in the following way: it is impermissible paternalism to fail to *promote* the autonomy of an individual who wishes to die by physician-assisted death. But now the objection is rather weak. Autonomy is but one value among others; if those other relevant values (such as well-being, dignity etc) count strongly against assistance, one would have reasons of sufficient strength not to grant the individual's wish to die. As Den Hartogh argues:

> Nothing is… wrong if other people refuse to help… because they believe that such help would only be harmful. On the contrary, if [people] provide such 'help' out of indifference for the other person's fate, they are morally criticisable, at least for lack of concern (p. 170; see Foot 1977).

The appeal to care brings us to the status objection to paternalism, which we may treat briefly. I take it that Den Hartogh considers status, like dignity, to be a buck-passing value with a qualification dimension (p. 169). The qualification dimension of status requires respect for self-governance, but we have already seen that a refusal of assistance on grounds of harm is not

disrespectful of autonomy. Further, the qualification dimension of status might also mandate an attitude of care or concern. As Den Hartogh argues:

> By refusing [assistance thought not to be in your interests], it seems to me, [an agent] only shows concern for you, not any lack of respect. He leaves you full responsibility for your own actions, and only takes an equal responsibility for his own.

These points lead to the conclusion that the status objection to paternalism in the context of physician assisted fails.

Note that thus far, the examples used to discuss the self-governance and status objections have been dyadic: involving B's refusal to help A. But they apply also in the triadic, indirect paternalism case in which C stays B's hand: 'if your autonomy isn't infringed upon by a person's refusal to help you [when assistance isn't in your interest], it cannot be infringed upon either by the state obligating that person to refuse' (p. 170). A maintains their self-governance or status, while B merely has additional C-given reasons not to promote A's autonomy.

In this section, I outlined Den Hartogh's Track 2 account of the permissibility of full-blown physician-assisted death. In my view, it lies on robust foundations. Criteria that supplement an autonomous wish to die may be required by the values of dignity and care or concern; and such criteria need not be impermissibly paternalistic. We may now move to the more evaluative part of the article, in which I consider the nature and justification of Den Hartogh's dual track model.

3. The nature and justification of the dual-track model: dual or single gauge?

On the railways, tracks have gauge—the transverse distance between the rails. While there is a 'standard' railway gauge (1435 mm), it is in fact one choice available among many. Sometimes, tracks of different gauge run to the same destination. Here, the system operator may build *dual* gauge tracks to accommodate different wheelset widths—often a track with three rails.

We might characterise Den Hartogh's dual-track model for access to lethal drugs and full-blown physician-assisted death as dual gauge. Track 1 has a pair of rails exemplifying the value of autonomy. Track 2 shares a rail in common with Track 1 and has one rail of its own, reflecting how self-determination in combination with other values justifies full-blown physician-assisted death.

In this section, I challenge the conception of the dual-track model as dual gauge. I argue that the nature of Tracks 1 and 2 is the same: deblocking access to lethal drugs is assistance to die. Further, I argue that it is better to justify Track 1 in the same way as Track 2: by appeal to self-determination and other goods.

3.1. Deblocking access to lethal drugs: non-assistance?

Recall that on Den Hartogh's Track 1, mere provision of lethal drugs to an autonomous person 'is not really a form of assistance [to die], it is lifting a blockade' (p. 82). To wit, lethal medication may be prescribed on the basis of self-determination alone. I have doubts.

Den Hartogh develops his 'lifting a blockade' argument by reference to a baseline state of affairs:

> In a 'state of nature' people would have unlimited access. Then the state comes along, limiting access, for whatever reason. If the state then makes an exception for people who have chosen death without undue pressure and after ample consideration, it only stops interfering with their freedom. It stands out of the way (p. 82).

A difficulty with this strategy is that the causal dimension of conduct—here, whether something I do or allow restores you to a position you occupied before my intervention—is not conclusive of whether I assist you. My agential involvement and whether it amounts to assistance, aid, facilitation etc depends in addition on facts about my state of mind: if I intend or foresee (to some relevant degree) that you will achieve your ends, the centrality of your ends to my plans, my thought and effort etc (Wedgwood 2009, pp. 334-335). In short, it is compatible with helping an individual out of a situation that one is the reason they are in it.

Say that I am a naval captain blockading a port. Now imagine that, in virtue of some behaviour of mine, the blockade lifts. It seems an open question whether I assist you. Suppose that I sympathise with your cause and—against

the orders of superiors—I let your ships in or out. If found out, I am surely liable for treason, *viz*, assisting the enemy. This seems a clear case in which one both lifts a blockade and assists another to achieve their ends.

Let me bring this point home more precisely with regard to Track 1. An individual (*P*) has an interest in deciding the manner and moment of death (interest *D*). Interest *D* can be fulfilled (perhaps to differing degrees) by various means: D_1, D_2, etc. Say that D_1 is a refusal of life-prolonging treatment, D_2 is lethal medication. Suppose further (and plausibly) that a third party (*T*) controls D_2. *T* might be an individual, or the State (or both).

There seems to be a difference in strength of causal agential involvement between D_1 and D_2 that partly determines whether one assists you. In D_1 it seems difficult, other things equal,[5] to describe *T*'s respect for *P*'s refusal of life-prolonging treatment as assistance, since a refusal *excludes* others from exerting a causal influence that alters the underlying state of affairs. Of course, *T*'s respect is part of the causal story of the outcomes attendant on *P*'s refusal; my point is rather that *T*'s causal involvement is too low when *P* dies by means of D_1. By contrast, in D_2, in making available lethal medication to *P*, *T* is a central feature of the causal explanation of how and when *P* dies. Where the means of death is D_2, the degree of *T*'s causal involvement opens the question of assistance.

As I argue above, however, the causal dimension of agential involvement is not sufficient to determine whether *T* assists *P* to die. In addition, I suggest that

[5] I make the *ceteris paribus* qualification because things may be more complicated when the offer of palliative care accompanies refusal of treatment (and indeed stopping eating and drinking): (Den Hartogh 2023, p. chapters 7 and 8).

P's ends must count among *T*'s reasons for action. Certainly, this will be the case in D_2 if *T* shares with *P* the plan that *P* die by means of lethal medication. It may well be that something short of intention—such as *T*'s knowledge and acceptance of *P*'s ends—suffices too. We need not dwell on this potentially contentious detail of assistance in respect of Track 1. For here, it is plausible that when *T* grants *P* access to lethal means in full knowledge that *P* intends to use it for suicide, *T* intends the supply of lethal medication as a means to *P*'s ends.[6] It is the very point of regimes for lawful assisted death that one may openly intend to assist an individual to access otherwise unavailable lethal means in order to control the manner and moment of death.

At this juncture, it pays to consider an objection.[7] It might be said that, notwithstanding the argument above, individuals granted access to lethal drugs under Track 1 are not assisted by the third parties who assess or certify that the former meets the condition or status of being autonomous. Recalling that Den Hartogh envisages that physicians perform this task (2023, p. 89), the objection holds that it is problematic to describe Track 1 cases as 'physician-assisted suicide'; to the extent that there is a suicide assistor, it is the party who *dispenses* the medication—for example, a pharmacist who acts on the physician's certification. One way to characterise the objection is that it goes to the *quality*, as opposed to degree, of *T*'s causal involvement in *P*'s death.

In circumstances of an integrated (and possibly hierarchical) division of labour, we do not typically carve up agency as if it were prosciutto in a deli

[6] Of course, I do not underestimate some people's capacity for self-deception such that they might credibly deblock access to lethal drugs for an individual they know to hold a wish to die and yet not intend the use of these drugs as a means to suicide.
[7] I owe this concern to Gijs van Donselaar. See [title] in this volume.

slicer. Here, it is not only the person who performs a task on another's instructions or clearance—perhaps under some obligation—who is a participant in the relevant activity. The gatekeeper who orders '*raise!*' is implicated as much as (if not more than) the operator of the portcullis winch. Similarly, we might regard a physician who certifies and prescribes lethal drugs to an individual under Track 1 as much as (if not more) an assistor in suicide as a pharmacist under an obligation to dispense medication on presentation of a valid prescription. But perhaps this response does not address the gist of the objection. What if, against the usual run of things, physicians were only to certify an individual's autonomous status and pharmacists empowered to dispense on certification alone? Rather than unity and hierarchy, we might observe a degree of independence of function. We might describe physicians as *mere* gatekeepers, insofar as they declare, rather than mandate. Can such actors be assistors? At least sometimes, yes.

In many jurisdictions, there exists a system for mandatory periodic assessment of the roadworthiness of vehicles in the mode of the British MOT or the French *contrôle technique*. Examiners at test stations authorised by the State inspect vehicles for faults commensurate with the status 'unroadworthy', the absence of this condition being required, as a matter of law, to drive on publicly accessible roads. All being well, one's vehicle receives certification of roadworthiness. The task performed enables the motorist to evince that the vehicle in question has met the requisite criteria for presence on the roads. The roadworthiness examiner occupies the position of gatekeeper and service provider. In my view, it would not be misleading or an act of linguistic violence for an assessment centre to trade under the slogan '*Helping you to stay on the*

road!'. Even when the operator offers only testing and none of the services of a repair garage. It is not a distortion to hold that vehicle test providers assist motorists. (Notwithstanding that the latter might begrudge the necessity of the former's aid.)

Third parties authorised to assess and certify the autonomous status of individuals who wish to access lethal drugs under Track 1 occupy a similar position to roadworthiness examiners. Track 1 assessors control access to lethal drugs and in performing their gatekeeping function, they provide a service to individuals who go on to die by these means (and indeed those who do not). It is not problematic, I argue, to describe the exercise of this office as assistance: what is done enables individuals to demonstrate their eligibility for an otherwise legally restricted activity. If Track 1 assistors are physicians and there is a unity of prescription and dispensation, this adds a further dimension to the assistance provided.

Thus the 'assessors are not assistors' objection fails. Note, however, that its articulation and response help also to clarify the position of the State when it permits activities such as motoring or assisted suicide on satisfaction of some eligibility criterion or criteria. If the State establishes an official process governing access to some restricted activity, it 'lifts a blockade' but does not merely 'stand out of the way'. Rather, its activity—assuming effectiveness of the institutional framework—facilitates individuals' enjoyment of their legal entitlements.

To summarise, I have argued that the mere supply of lethal medication is both 'lifting a blockade' and assisting suicide, at least within a Track 1 structure. It follows that the nature of Track 1 is the same as that of Track 2; both involve

third party assistance to die. The difference between the tracks is the degree of assistance. And so the question arises whether self-determination alone is a tenable normative foundation for Track 1. If Den Hartogh's argument for the nature and justification of Track 2—physician-assisted death as joint action—are any guide, possibly not. As we shall see, this need not, however, be fatal to Track 1.

Before we move on, there is a further issue with Den Hartogh's use of a state of nature baseline that I wish to raise. It strikes me as problematic to hold that one has a natural freedom to access lethal medication such as barbiturates—substances that are fruits of civil society. Admittedly, this worry is somewhat hostage to one's conception of the state of nature.[8] Since it is not strictly necessary to ventilate the concern, I shall forego developing the issue in the interests of economy of discussion.

3.2. Justifying deblocking access to legal drugs: beyond autonomy

Den Hartogh justifies mere access to lethal drugs by appeal to the value of autonomy or self-determination alone. This normative footing relies on a conceptual argument whose merits I challenged in the previous section. If supply of lethal medication for the purposes of suicide is assistance to die, it seems less tenable that one has a right of access to such drugs on the normative basis of self-determination alone. As we saw in the exposition of Den Hartogh's

[8] Thank you to Gijs van Donselaar for urging caution here.

Track 2 argument, the greater the degree of agential involvement, the greater the assistor's answerability for helping another to die; and the lesser weight an answer justifying assistance merely in terms of the autonomy of the individual who dies.

I should clarify, however, that I am not against a right of mere access to lethal medication for suicide. My project is to offer a normative basis for the right different to Den Hartogh's argument for Track 1, but along the lines of his account of Track 2.

It is important to distinguish the conditions for the enjoyment or exercise of a right and its justification. I may have some right to choose freely—that is, merely in virtue of being an autonomous agent—but having a right to choose freely need not entail that the value of choosing is the (sole) reason I may choose. Yet Den Hartogh seems to reject this view of the justification of rights of autonomous free choice in his account of Track 1. Consider the analogy he draws between 'lifting the blockade' on lethal medication and access to guns:

> if the state allows access [to guns] in some cases, for example for shooting sports or hunting, it does not facilitate these activities, it only abstains from hindering or thwarting them. The default is unlimited access; access is only limited for some acknowledged reasons, to the extent that these reasons require. If they don't apply, access is free again (Den Hartogh 2023, p. 92).

Den Hartogh's argument seems to be that our rights of autonomous free choice consist in the residue of our autonomy. We have the right to choose freely just when we are autonomous and autonomy has greatest weight after

specification in light of other values and considerations. However, this is merely a contingent truth.

Let us grant that one has a natural freedom to access guns. Further, let me concede that in the state of nature it is the value of autonomy that explains why one has a right to access guns. I would challenge the view, however, that in a state of civil society the allocation of freedoms is justified by the overriding reason that applies in the state of nature. It is not obvious that appeal to one's natural freedom is sufficient to justify rights of autonomous free choice when natural freedom is no longer in play. Should some matter lie within an individual's area of private sovereignty, this may be in virtue of *plural positive* justifications.

Regarding Den Hartogh's guns example, we might hold that access is granted in contemporary circumstances not only because of the value of self-determination, but rather also for other reasons. We might allow shooting sports because there is a value of play (or recreation). We might also allow hunting because of the value of tradition. (Perhaps also or alternatively—depending on the quarry—because of the value of some ecosystem.) Our private domain rights may be a function not only of autonomy and its counterweights; instead a cluster or composite of interests on both sides of the scale.

To return to the right of mere access to lethal drugs under Track 1, it is plausible that the right has this more complex structure. That is, values other than self-determination determine whether the satisfaction of interest *D* by this means falls within the scope of an individual's rights of autonomous free choice.

Consider the following '"bad" means' example. An individual autonomously requests mere access to restricted medication that, rather than bringing about an easeful death, guarantees a passing that is nasty, brutish, and long. (No doubt there are manifold possibilities.) I imagine that we would struggle to grant such a request or concede that the individual in question has a right of access to such means of death. Our reasons would align with Den Hartogh's 'basic moral considerations' (p. 31), and those advanced in the account of Track 2 (pp. 163-174): suicide by such 'bad' means constitutes self-abasement, is so imprudent it exceeds the margin of content-independence etc. It would be impermissible to assist a suicide of this nature.

The 'bad' means example is revealing of the actual normative grounding of Track 1. We might grant individuals a right of mere access to lethal medication not only because they autonomously wish to control the manner and moment of death, but also because assisting individuals to die in this way exemplifies other important values. On the basis of the preceding discussion, these would include well-being (pp. 167-174), as well as dignity (p. 74). Den Hartogh might add solidarity and relationships (p. 74).[9]

If my argument is persuasive, the normative justification of Den Hartogh's Track 1 is both structurally and substantively similar to that of Track 2. Autonomy is an individually necessary condition for the permissibility of granting a right of mere access to lethal drugs, but sufficient only when combined with other individually necessary conditions.

[9] Den Hartogh makes the case for family assistance in suicide as an extension of the individual's Track 1 rights. I have omitted discussion of this interesting material for reasons of space.

Before we conclude, I should address a question that may linger. If the normative justification of Tracks 1 and 2 is similar, why permit mere access to lethal drugs on the basis of autonomy alone? The answer, I submit, lies in the reduced degree of agential involvement of Track 1 assistors compared to those of Track 2, and the effect their involvement has on the permissibility of their conduct (Black 2021). In virtue of the higher degree of agential involvement in Track 2 cases, assistors must be more attentive to the goodness of the state of affairs they jointly bring about with the individual who dies. In Track 1 cases, assistors are less agentially involved and the means prescribed are expected to be safe (at least relative to other means of suicide). Track 1 assistors may take some comfort that their agency is implicated in realising a minimally, comparatively good (albeit not necessarily best) state of affairs. I suggest that this explanation plausibly aligns with the reasons we might hold for allowing mere access to lethal drugs for hard classes.

4. Conclusion

I have offered a critical reading of Govert den Hartogh's 'dual-track' model for assisted death, focusing on the argument Den Hartogh offers for Track 1: mere access to lethal drugs on the basis of an autonomous request. I have argued, *pace* Den Hartogh, that permitting mere access to lethal medication may be both 'lifting a blockade' and assisting an individual to die. This conclusion about the *nature* of Track 1 opens the question of the sufficiency of autonomy as its sole normative basis. A revised account of the *justification* for

Track 1 is possible, however. I argued that Track 1 assistance may be permissible on the same grounds as Den Hartogh provides for Track 2 (full-blown physician assisted death), *viz*, autonomy in conjunction with other values, including dignity and well-being (albeit in a different mix). In this sense, rather than conceive of Den Hartogh's model for assisted death as 'dual-track', dual gauge, we might rather consider mere access to lethal drugs and full-blown physician assisted death as two services on a single normative gauge.

I suggest that my single gauge model of mere access to lethal drugs and full-blown physician-assisted death is philosophically more plausible and pragmatically advantageous compared to Den Hartogh's dual gauge account. The single gauge model owns up to mere prescription of lethal medication as assistance to die, and thereby avoids the potential charge of attempting to solve a difficult normative issue by conceptual means. Moreover, in making a right of mere access to lethal medication depend on more than autonomy for its justification, we broaden its normative basis from respect for what individuals autonomously will to what we might owe them as a matter of respect and concern; this may broaden its political appeal. Though perhaps we must concede that permitting mere access to lethal drugs instantiates the values of respect and concern in only a qualified and comparative way. Maybe that is enough.

5. Literature

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