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Assisted dying in Norway

ESSAY

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Assisted dying must be a matter of personal choice. Given that elective abortion is available in Norway, it follows that self-determined assisted dying should also be an option. There are also other compelling arguments to support this. In this essay, I will consider death within a broader context.

In this essay, I offer some reflections on the topic of assisted dying. I am now 96 years old and, as a 'competent amateur', have studied death and assisted dying for many years, and have also participated in the public debate on the subject (1–3). I believe I have gained a good insight into these existential issues and have reached a conclusion that I feel is both robust and surprisingly simple. As they say, the simplest solution is often the best.

What is assisted dying?

The concept of assisted dying essentially involves a person who no longer wishes to live seeking assistance to end their life in a jurisdiction where it is legal. For those wishing to explore the topic further, a wealth of material is available online and in print. Of particular note is Lars Johan Materstvedt's book (in Norwegian) on the concepts, definitions, laws, clinical practices and ethics of assisted dying (4), which is available in libraries and bookshops in Norway.

In accordance with the regulations of the relevant country, healthcare personnel determine whether an application for assisted dying should be approved. Many countries have gradually introduced provisions for assisted dying, and while the underlying principle is generally consistent, the details vary considerably.

In Norway, repeated calls to legalise assisted dying have fallen on deaf ears. Recently, however, the issue has re-emerged with greater vigour. Various political parties are now discussing a possible formal review of the issue, and shortly before the 2025 general election, some doctors, together with others, advocated for such a review (5). The Norwegian Medical Association was recently challenged by some members to abandon its opposition to assisted dying and adopt a neutral stance (6–8). The debate in Norway is thus also showing signs of renewed momentum.

My aim is to reflect on assisted dying within a somewhat broader context, based on Norway's societal vision. These include affording individuals the greatest possible degree of autonomy, of which self-determined death seems to be a natural part.

Who should have the final say?

It is clear that those currently advocating for assisted dying in Norway envisage a model similar to that of other countries. 'Decision by committee' I call it – the very opposite of self-determination.

For a long time, I considered this committee-based approach myself, but I have gradually realised that this is precisely what we must avoid. Denying someone access to assisted dying is highly unethical, as it needlessly prolongs suffering for the individual and those around them. The model is also unethical because others would decide whether you may or may not die.

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In a typical committee-based assisted dying arrangement, patient P applies for help to die and committee C evaluates the application. If C wishes to reject P's request, we are faced with two diametrically opposed wishes. All applications will either be accepted or rejected. Thus, C determines the fate of P. To ensure that P's application is treated fairly and appropriately, C must exercise empathy and make every effort to understand P's situation. Unfortunately, while humans are skilled at handling practical matters, we struggle to truly empathise with others. It can therefore be extremely difficult, if not impossible, for C to understand P's situation. Consequently, the most obvious solution, in my opinion, is for assisted dying to remain a matter of personal choice.

Assisted dying and abortion

Abortion is an important parallel to this debate. For a long time, abortion was illegal; it was subsequently subject to approval by a committee, and in 1976 elective abortion was permitted up to 12 weeks gestation, a time frame within which over 90 % of abortions take place. In 2025, the deadline for an elective abortion was extended to 18 weeks (9).

Everything points to the need for assisted dying to be subject to the same condition, namely self-determination. Anyone who supports elective abortion but is opposed to self-determined assisted dying goes against the societal vision of personal autonomy and undermines their own integrity.

Death

We often hear how 'we need to talk more about death'. The point is that we should be more comfortable with discussing something that is such a natural part of life. If we can reduce the taboo surrounding death, it will be easier to help those who need it to die with dignity and without suffering. After all, this is surely something most people would wish for themselves.

Any deliberations on potential legalisation for assisted dying in Norway must be impartial and independent. They should also seek to explore why we have such a strained relationship with death, which is said to be particularly the case for Norwegians. I hope that my reflections might help to stimulate discussion on the topic. Moreover, I am sure that if society were to engage with this issue seriously, it could foster more constructive discussions about our values.

> ***«It is important to recognise that being allowed to die is not a goal in itself but a means to an end»***

It is important to recognise that being allowed to die is not a goal in itself but a means to an end. The goal is to bring an end to a miserable existence, in which anxiety about an uncertain future is a major source of suffering. Access to assisted dying can offer a sense of control and can often shift a person's qualify-of-life score from the negative to the positive range. Paradoxically, I believe that providing access to assisted dying would decrease rather than increase demand.

Quality of life

Quality of life is an important concept in relation to assisted dying. It is a term well suited as the official name for an individual scale to measure perceived life quality. In everyday language, however, it is often more natural to use synonyms such as *well-being, welfare* and such like. A scale from 0 to 10 is often used, with 10 representing the highest quality. This can work well, which

is probably why the scale has become so widely adopted. In my view, however, a few important adjustments are needed. The subjective quality of life score that a person sets must be regarded as inviolable. Furthermore, the scale should include a negative range, from 0 to –10. Those who wish to die should be able to express this desire and its intensity.

I do not believe that a negative quality of life score necessarily indicates a desire for immediate assistance to die. It could just as well function as a backup plan, while the main objective remains to obtain support to move back into the positive range of the scale. As mentioned, many people experience considerable anxiety and uncertainty about what awaits them in the final stage of life. Consequently, they may prefer death at an earlier stage than strictly necessary, simply as a precaution.

Knowing that we have the option of assisted dying when we want it would immediately move many people back into the positive range of the quality-of-life scale. As a result, they may no longer feel a pressing urgency to die. By no means everyone would actually request assisted dying; for many, simply knowing it is an option would be sufficient. Both quality of life and longevity can therefore be improved simply by establishing a provision for assisted dying.

> ***«By no means everyone would actually request assisted dying; for many, simply knowing it is an option would be sufficient»***

Since quality of life captures an individual's subjective well-being, it can also serve as a measure of how different events affect us. Quality of life is therefore an excellent measure of everything that affects us. For example, the quality of care for the elderly can be expressed simply in terms of its effect on quality of life. All care is a *means*, and a positive impact on quality of life is the *goal*.

Coping

Coping is another concept that I have come to regard as increasingly important the more I have understood it. I believe it has not yet received the recognition it deserves in everyday practice within care for the elderly. It also serves as a good example when discussing quality of life.

Coping refers to an individual factor that has a reasonably clear definition, but, whether consciously or not, the concept tends to be limited to 'significant achievements'. Small things are often excluded, intentionally or otherwise. Yet what may seem trivial to one person can be hugely significant to another, and the concept should reflect that. Coping denotes any event or accomplishment that improves quality of life. Fastening a button, for example, can feel as great an achievement for one person as winning a gold medal does for another.

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Older people (and children) are often encouraged to push the limits of their abilities. However, fostering coping skills can be time-consuming, and time is usually in short supply in care for the elderly. Staff's busy workloads, as I have come to understand are a major problem for them as well, shape the clinical environment and undermine patients' sense of coping.

'Self-death'

The term *suicide* is relevant to any discussion on assisted dying, but given that attempted suicide ceased being illegal in 1902, I am puzzled as to why it is still in use. In Norwegian, the word for suicide (*selvmord*) literally means *self-murder*. The *self* element is fine: it is unambiguous and conveys its intended meaning. However, I would have liked an explanation as to why the act is still described as *murder*. (The word *murder* (*mord*) has otherwise been replaced with a different term in Norwegian legislation (*drap*), though the meaning remains unchanged.) *Murder* gives a misleading impression of what is actually involved. Can such a term describe anything other than an act carried out against someone's will? I have noted that others share this view, and that several alternative terms have been proposed. In my view, *death* is the best alternative, as it clearly states what the act entails. I therefore suggest that the Norwegian term for suicide be replaced with a word meaning self-death (*selvdød*).

> ***«I suggest that the Norwegian term for suicide be replaced with a word meaning self-death (selvdød)»***

There are undoubtedly several ways to categorise people who wish to die. A particularly useful distinction, in my view, is between those who are likely to regain a positive quality of life and those for whom such an improvement is unlikely. In any case, both groups must have the right to self-determined assisted dying.

We must also remember the importance of adapting to different situations and contexts. What may seem dramatic for a younger person can be entirely natural and unremarkable for someone older who is approaching the end of their life. Most of the anxiety surrounding death tends to relate to the process of dying rather than the moment of death itself.

Conclusion

I have highlighted here the points I consider most important and hope they have inspired some new perspectives. To conclude, I would like to emphasise three key points: First, if our society is to engage with death as humanely as possible, we need to be comfortable with the concept of death. Second, the assisted dying provision that will hopefully be established must be a self-

determined arrangement, with the patient having the final say, regardless of the circumstances. And last, but by no means least, quality of life alone is the goal; everything else is a means that impacts on that goal.

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