The legal response to euthanasia continues to be hotly debated across the disciplines: law, ethics, medicine and religion. At present the legal position can be summarized roughly as follows. There is a flat prohibition against active euthanasia, that is, killing any person, even with his consent, no matter how terrible and painful his condition. The law regards life as sacred, and it will punish for murder anyone who kills another individual or even hastens his death by any active means, be it by blows, strangulation, shock, starvation, injection or poison. The "malice" of the criminal law depends only on knowledge of the consequences, and it is not dimmed, no matter how lofty or noble the motive of the actor.

Passive euthanasia is more difficult to analyze because the law rests uneasily on the distinction between acts and mere omissions, where the latter, in the absence of a legal duty, are not ordinarily regarded as culpable. Today it is generally permissible to cease treatment, such as medication or chemotherapy, even though it is known that death will quickly ensue. It is also generally permissible to withdraw artificial support systems, such as a respirator, if that course of action is demanded by a patient. Indeed some cases go so far as to view the withdrawal of food and fluid as the mere cessation of treatment and not the killing of another person. In each instance when these steps are taken, the patient
Voluntary Euthanasia

Richard A. Epstein

will usually die shortly thereafter, but may linger on, perhaps in great pain, for weeks, months or even years. (See, for example, Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).)

This whole structure, which works to legalize virtually all forms of passive euthanasia, rests upon rickety intellectual foundations. Disconnecting a respirator or removing a feeding tube is as much an “act” as hooking up that same respirator or inserting a feeding tube. No one would regard disconnecting respirators or removing tubes as the cessation of treatment, to be treated as a mere omission, if that act (what other word can we use) were performed by a stranger. At that point it would be a clear case of murder precisely because the stranger was not authorized to meddling in the affairs of the patient. That same act done by a physician is—tautologically—still an act. If disconnecting the respirator or removing the tube is lawful, it is not because it is a mere omission, but because it is an act authorized by the patient. The decisive question therefore is authorization or consent. Without these the physician has surely committed murder, even in the core cases of merely withholding or ceasing treatment.

What would happen if the legal system stopped hiding its implicit policy judgments behind the misplaced distinction between acts and omissions? One conclusion is quickly clear: the convenient middle ground of the present law would no longer be defensible. The choices would assume an all-or-nothing character. One possibility would collapse passive into active euthanasia. The law would thus require heroic measures (or at least routine feeding and respiration) to continue until death, regardless of the patient’s wishes. The other solution would be to collapse active into passive euthanasia, thus to decriminalize both forms of killing. The dominant issue would then cease to be, how does a patient come to die? Instead it would become, who shall determine whether that patient should live or die, the state or that individual? While presently the answer is sometimes the person, sometimes the state, in my view the correct answer is both more categorical and less evasive: the patient, always.

I believe that the principle of individual autonomy—that each person controls his or her own life alone—applies so long as the person is sufficiently competent to control his or her own life. Accordingly, all forms of voluntary euthanasia, active and passive, should be decriminalized. The consent of the patient should protect physician and family against all criminal and civil charges. It should not matter, moreover, whether that consent was expressed the moment before death was brought about, or by some prior unrevoke instruction that remains binding even after the patient becomes comatose. In either case, patient consent determines the course of conduct in end of life decisions. Where the patient is comatose, then decisions may have to be made by family acting in accordance with the patient’s wishes.

To be legitimate, the case for making (or rather keeping) euthanasia criminal must override the twin postulates of autonomy and consent. Any such effort must be based on one of two claims: first, that the state must intervene to protect society at large and its interest in human life, or second, it must intervene to protect individual patients from their own incompetence. I shall call these the externality and the competence claims respectively. Both of these exceptions to the autonomy principle are part of any complete legal system. The question is whether they intrude so strongly in end of life situations as to justify overriding the normal principle of autonomy.

Autonomy and Self-Determination

A quick overview of medical ethics reveals the apparent dominance of the principle of individual autonomy. Physicians are not in the position to conscript patients into their care. Save in emergency situations, patients decide who shall treat their bodies and what that treatment should be. A strong conviction of a professional physician that an operation is necessary does not warrant his performing that operation, even if he could demonstrate before the proverbial panel of seven bishops
that any other course of conduct is ruinous to the patient’s welfare both in the long and the short run. If the case is that obvious, the proper forum in which to lodge the plea is with the patient. When a physician says to a patient, “you have no choice but to have this operation,” this language, the risks and costs of the operation, is still better with surgery than without.” Most of the time this advice will be taken precisely because the patient wants to live instead of die. But the choice is always his. If he should attach great costs to living with handicap, pain or disfigurement, then he may decide to forgo the treatment that 99 percent of the population in his position would beg to receive. Self-determination and self-control lie with the patient, not the physician.

The strength of the autonomy principle is confirmed with the rise over the last 30 years of the doctrine of informed consent. Before 1960, the autonomy principle was in practice often honored in the breach and not the observance. While patients in principle could decide to accept or refuse treatment, physicians were under no explicit legal or moral duty to convey to patients the pros and cons associated with various options that were open to them. In many cases, the dominant practice was for physicians to recommend and patients to follow the recommendations, without ever asking why. The argument was that the withholding of information was for the benefit of patients who might be too distressed to process it correctly.

To be sure, there were doubtless cases where on their own initiative patients and their families did cross-examine their doctors before deciding on a course of treatment, and nothing in the law prior to 1960 obliged the patient only to listen and never to speak. But since that time the duty of initiation has shifted to physicians, who generally must disclose the reasons for their recommendations as well as making the recommendations themselves. There is, I think, a real dispute over whether the norm of disclosure is well enforced by private medical malpractice actions, by the use of physician review boards, or by standard written disclosures. It may well be that a revised social understanding of what constitutes good practice is better than any form of legal sanction. But these questions are strictly of a second order. The principle of autonomy is not justified by the physician’s duty to disclose before treatment. The duty to disclose follows from the principle of autonomy.

The hard question with euthanasia is whether the same principle of autonomy should govern when the patient’s choice is for death and not for life. Why not? Clearly, any patient today can decide to refuse treatment, even if inaction promises a certain death, or to accept treatment, even if it increases both the chance of death (if it should fail) and the quality of life (if it should succeed). Life and death are never far apart in medical settings. If a patient is allowed to increase the risk of death in taking a chance for a better life, why can’t he choose death itself, by whatever means he desires? The autonomy claim demands no less. What can limit it?

**Externalities**

As noted above, government efforts to override individual choice may be justified in order to protect *other* persons from harms to which they should not be subjected. The most obvious illustration of social control of vicious externalities is the ordinary criminal law prohibition against killing and stealing. But what external costs justify government intervention in the face of the patient’s consent to euthanasia, either active or passive? Surely the patient does not seek to kill another person; he only wants someone to help him end his own life, which in his extreme condition he is unable to do by himself. Suicide, after all, is not murder, and should not be punished as such, or indeed at all. Accordingly, the physician who makes the lethal injection is not imposing his will upon another but is following the requests of a patient. Consent takes us a long way from murder, and brings us back to suicide.

But, it may be said, these judgments are too hasty, for there may be some externalities in the losses to friends and family. This objection, however, is weak for two reasons. In the ordinary case, where medical cure is sought, the patient has the ultimate power of decision. Friends and family, if consulted at all, cannot override the stubborn patient who does not wish to follow their advice. There is no reason why a different rule should govern here.

The claims of family, and perhaps even friends, may be stronger if they are entitled to support from the person intent upon self-destruction. Aban
doning one's spouse and children, in order to start a new life, is not a search for self-realization; it is the evasion of family obligations. The state may not coerce an individual to remain with his family when he longs to escape, but it may surely require financial support. Where suicide is contemplated as a means to escape such obligations, then perhaps government should intervene to stop it, although it is difficult to know how the state could keep alive someone determined to perish.

So, autonomy notwithstanding, John Donne is correct. No Man Is an Island. But the point does little to justify the prohibition against euthanasia, either active or passive. The decision to take one's own life is typically made in extreme circumstances. Euthanasia as a term of art is confined to such cases. The person who wants to die does not seek to evade obligations of support, which he could not discharge in any event. Quite the opposite, people in extremis often want to die in order to remove the enormous emotional and financial burdens that their condition imposes upon their friends and family, even if much of the cost is absorbed by insurance or public assistance. At the end of life, some people want to die, not only to put themselves out of their own misery, but also to allow their friends and family to get on with their lives. It is a far cry from running away from financial obligations.

In response, it could be urged that this narrow focus misses the point, for the real externalities are global and social. We believe that life is sacred in all forms and respects. Any person who takes his own life voluntarily, therefore, necessarily mocks that social convention. To defend the basic principle of the sanctity of life requires us to police any violation of it when and where it arises.

This argument proves too much. Indeed, it is a recipe for totalitarianism. Euthanasia is no threat to social order, for those who want to avoid the practice can always do so. Their decisions about their own lives are not compromised because other persons follow a different practice. To hold that some public value dictates a uniform prohibition on euthanasia guts the principle of autonomy under the guise of an exception. It is dangerous business to use government power to control psychic externalities, for these always abound whenever there is any social disagreement about right and wrong. We stray a long way from the paradigmatic externalities when we treat social distant as a part with aggression. The case for euthanasia cannot rest on the need to control externalities.

Incompetence

So we turn to incompetence, a far more serious issue. Can the case against voluntary euthanasia rest on the ground that the patient is not competent to make the necessary life and death choice? Stating the issue in this form is an effort to return to the core insights of the autonomy principle. Individuals are allowed to trade or waive certain rights by consent. It is generally assumed that when they do so, they have made themselves better off. So long as they know their own preferences, they should be allowed to follow their own lights.

But consent can be overridden by incompetence. When infants and insane persons attempt to enter into contracts, they are prevented from doing so because of their evident incompetence. They are protected from exploitation, from making contracts, or taking actions, that work systematically to their disadvantage. They have parents or guardians to act on their behalf.

These rules on limiting consent are generally easy to police. It is easy to stop a seven year old from making a contract that exchanges a thousand shares of IBM for a package of bubble gum. But mental incompetence is far trickier. It is often far from clear, for example, whether civil commitment protects needy persons from their own self-destructive tendencies, or only allows greedy relatives to railroad their frail relatives into a state mental hospital.

Unfortunately, the competence questions with euthanasia, both active and passive, are of the difficult type, complicating any social response. When the bases of state action are unclear, two forms of error arise, both costly. Type I error is the error of not limiting personal autonomy in cases where such limitation is needed to control personal incompetence. Type II error is the error of limiting personal choice where a person is in fact competent to decide for himself. So long as there is any uncertainty about an individual's true mental state, a sound set of legal rules and institutions has to deal with both kinds of error—simultaneously. We have to be careful about driving down one type of error, only to increase the other.

This question of error control often requires us to engage in shadow calculations of what we regard as rational behavior. Thus, suppose we observe a person in the prime of life who asks a physician to end his life by administering a lethal injection. This request is likely to take us aback. Even though we lack any detailed knowledge about the person's preference structure, we know enough about human nature to realize that individuals, especially those in the pink of health, attach a large positive value to their own future life prospects. There are not many wrongful death actions where the plaintiff cannot claim damages because the youthful and happy decedent, struck down in the bloom of life, really did not want to live.

If, therefore, we saw a healthy person seek death, we could make a pretty good judgment that there was something amiss but undetected in his mental processes. In some cases we might order a detailed psychiatric examination. At the very least we should require a "cooling off" period and a chance to talk him back into his senses.

At the end of life, some people want to die, not only to put themselves out of their own misery, but also to allow their friends and family to get on with their lives.
(as the expression goes). But if that proves unavailing, then do we have the
right to say that suicide is not allowa-
ble? Some people may be so afraid of
miscalculation that they will advocate
the more aggressive prophylactic rule
that flatly prohibits anyone from kill-
ing himself while in good health. This
rule will prevent suicide by anyone
whose hidden disability escapes us. By
the same token, however, it will neces-

Euthanasia, of course, does not
involve the case of a healthy person
wanting to die. It involves the case of a
very sick person wanting to die. In this
narrow context, we cannot be so cer-
tain that the patient’s desire to die
clashes with his rational interest in life.
While there is a long moral tradition
that says life is always worth living, that
judgment seems hollow in the face of
truly horrendous individual circum-
stances. The subjective utility of living
is not always greater than zero, and
where it is not the rational person
could conclude that he is better off
dead than alive.

But has the sick person taken leave
of his senses? Only if we reason in a
circle by assuming that the right
answer is always to choose life. But this
“right” answer inverts the relationship
between competence and choice. It
assumes that we can demonstrate
incompetence by knowing that some
choice is wrong. It does not give us any
independent test of competence which,
once satisfied, requires us to respect
the choice that the patient has made.
Looking at the content of the choice
is no way to determine competence
to choose. We have covertly substi-
tuted our collective judgment for the
patient’s.

To make the inquiry sensible, there-
fore, we must again confront the ques-
tion of two types of error. In the age
before modern medical advances the
question was easier than it is today.
There was little reason to worry about
people living longer than they wanted.
The direction to the physician was sim-
ple: Do all that you want to do to save
the fellow from death, because you
can’t do much anyhow. The patient
was too far gone and the technology
too primitive. So heroism lasted a day,
and then death followed. Type II error
might have been frequent, but its costs
were low. The total prophylactic rule
against voluntary euthanasia simply
did not have high error costs.

With the advance of technology,
however, it is possible to keep people
alive for long periods of time, with per-
manent pain or without the benefit of
any higher mental functions. But no
longer are the costs of keeping people
alive low. Today, heroism has its cost.
We can keep people alive for weeks
and months of pain, to them and to
their families. Because the error costs
of overriding subjective judgments
become much higher, there should be
a greater investment in finding out
whether the patient wants to live or
to die.

The task in some sense is daunting.
People are often not able to think and
speak clearly when they are in extreme
distress. The competence of the
moment may not be there. But these
difficulties do not justify disregarding
individual preferences across the
board. We do not disregard them
when the preference is for ceasing
treatment, or for conduct that verges
on passive euthanasia. Yet we could
not honor those preferences, especially
with comatose people, if we did not
respect their competence in making a
prior decision. There is a time when
death or coma may be imminent, but
competence is present. People with
cancer, for example, have a long time
to reflect on their condition and to
make their views known. Where treat-
ment is still possible, we ask persons in
extreme conditions whether they want
chemotherapy or surgery. We certainly
allow wills signed by persons in
extremis to control the devolution of
their property. If someone leaves
instructions that he should be allowed
to die if a cancer progresses beyond a
certain limit, or if brain functions dete-
riorate beyond repair, then we should
respect that judgment, even after the
patient is no longer able to think
clearly on his own behalf.

Any original decision, of course,
need not be irrevocable, and it may
well be that some third party should
be required to testify, first, that the
patient expressed the desire for volun-
tary euthanasia, active or passive, and,
second, that he understood the circum-
stances surrounding the choice. But to
indulge in the conclusive presumption
that people are always incompetent
when they choose death, either pas-
sively or actively, is to mask the tyr-
anny of state coercion in the friendlier
garb of autonomy and consent. Once
we allow consent to be operative, seri-
ously ill individuals will have an incent-
tive to make clear their wishes while
they are still able to do so. The eviden-
tiary problems can be minimized with
the living will or the videotaped inter-
view. We should not allow consent to
be vitiated by a two pronged attack:

While there is a long moral tradition
that says life is always worth living, that
judgment seems hollow in the face
of truly horrendous individual
circumstances. The subjective utility of
living is not always greater than zero,
and where it is not, the rational person
could conclude that he is better off
death than alive.
either it comes too early to express real desires, or it comes too late to express informed choices. There is a clear window between these extremes.

The case law on this point is heavily divided. There are some decisions, most notably in New Jersey, Massachusetts, and Rhode Island, that rightly refuse to erect a competence barrier. These cases will accept testimony from family members and close friends that a comatose patient wanted treatment to cease. They have thus allowed the patient to be transferred to other institutions that will allow cessation of treatment, and where transfer is not possible, require the hospital to cease treatment itself. Nonetheless, there are other states in which the autonomy principle has been limited in practice even as it has been acknowledged in fact. Thus a recent decision of the New York Court of Appeal (Matter of O’Connor, 72 N.Y. 2d 517 (1988)) is, in my view, a regressive step. In that case, the patient was an elderly lady who was a victim of a stroke. Her two daughters refused to authorize the insertion of a nasogastric tube to supply her with food, saying that their mother had frequently expressed her wish that she be allowed to die if rendered mentally incompetent. The court concluded that the evidentiary presumption had to be set against the decision not to treat, and that this presumption could not be overcome by the evidence offered in this case, given that her statements had not been made immediately before the stroke, or with clear awareness of that risk. But there was no evidence that her preferences had changed or that her daughters had misstated what their mother deeply wished. It is hard to resist the impression that the case was less about evidence of competence and more about freedom of choice. But the acid test in New York will doubtless come in other cases where the evidence is clearer and the presumption less important. In those instances, the autonomy principle should control.

Once we overcome the competence hurdle, why then stop at the legalization of passive euthanasia? By all means pull the plug. Passive euthanasia only substitutes natural lottery for the arbitrary will of another. It does not respect the right of an individual to control his or her own body. Once competence is established, patient consent should be determinative. Why leave persons to the mercy of the fates and their own physical condition when they can improve their lot by purposive action? Why require them to battle against needles, tubes, feeding and fasting, in order to pay for the privilege of slowly starving themselves to death? Why not a quick lethal injection instead? The cases which have allowed the cessation of treatment have balked at allowing voluntary euthanasia on the ground that there is a “suicide” exception to the general autonomy principle. But they offer no explanation as to why it should exist or what useful role it serves. There is no halfway house here that is worth defending. The person who is competent enough to decide to die slowly is competent enough to decide quickly and purposively.

Consent provides a far better road-map to the scope of permissible conduct. In extreme conditions the subjective judgment to end life is often rational. Safeguards are no doubt necessary, but it is a mistake to erect a prophylactic rule against individual choice when medicine can do so much harm by prolonging life.

My position is uncompromising. What, though, of those physicians or hospitals who do not want to participate in what they regard as a mission of death? Their course is clear. They announce in advance that they will treat only patients who want to live. They make it clear that they will not practice euthanasia—active or passive —under any circumstances. That choice is made all the time by doctors and institutions who are opposed to abortion, even to save the life of the mother. Patients can then choose their medical care with knowledge of how they will be treated; those who fear that they will be pressured into death can gravitate toward physicians who give them the guarantee they desire. But the moral convictions of physicians should govern only their own lives and practices. These physicians should have no power over individuals who are feeble, but competent, and who wish to control their own lives by ending them.