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Euthanasia and Consensual Harm: Evaluating the Moral and Legal Asymmetry of Self- and Other-Regarding Acts

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Suicide is legal in almost every country, but places where euthanasia is permitted remain in the minority (Mishara and Weisstub 2016). In many legislatures, suicide is not a criminal act. It is, however, a criminal act for you to assist me in this, either indirectly by providing the means (assisted suicide), or directly by performing the fatal act (euthanasia), even if I ask for your assistance. This dichotomy is emblematic of a pattern that can be found in many legal systems: person B – the agent, throughout – is prohibited from doing to person A – the principal, throughout – with their valid consent, or assisting them in doing, something which person A is permitted to do to themselves. Other behaviours frequently treated in the same manner are serious bodily harm, or drug use[1] (Ferreira 2017). The question is whether this is justified – whether we can prohibit consensual harm to others whilst not prohibiting the same harm if it is done to oneself.[2]

Any legal prohibition is a limitation of individuals' freedom, and there is extensive debate about when such infringements are justified. One famous proposal is Mill's (1909) harm principle, which asserts that the only reason for which power can be exercised over someone, as criminalization would do, is to prevent harm to other persons. Others, such as Hanna (2018) endorse more paternalistic views, under which it is permissible to interfere with someone's liberty if it is for their own good. Regardless of where such a limit is placed, however, there seems to be a particular puzzle when we consider it permissible for someone to commit an act on themselves, but not to involve another person in the same act. The involvement of another individual must constitute a morally or legally relevant difference, such that it then becomes permissible for the state to interfere both in the liberty of the agent to perform the act, and of the principal to have the act performed.

In this paper, I examine various attempts to explain this apparent puzzle, particularly in relation to the legality of suicide and simultaneous illegality of euthanasia. I employ euthanasia as a case study for two reasons. First, a number of the arguments I consider cannot be done justice without reference to a particular instance of the more general puzzle – questions about the practical enforcement of regulation, for example, by nature require an examination of particular regulations. Second, I have chosen euthanasia, rather than another instance of consensual harm, as the various aspects of the puzzle are most present and most pressing in it. It is, in some sense, the greatest harm (or most lasting) that can be done, and as such presents concerns about other-regarding harm in their most potent form.

To remain within the limits of the puzzle I have presented, I work with the assumptions that a) there are areas in our life in which the state cannot permissibly interfere, and b) that the acts themselves (i.e. when performed on oneself) fall into these areas. This is not, however, equivalent to the assertion that individuals are morally justified in performing these acts on themselves. It may be the case that the state simply should not interfere in self-regarding acts, however morally wrong these may be. The arguments in this paper do not relate to acts for which the assumption that they should be legally permissible if carried out on oneself do not hold, and I therefore do not attempt to reach a conclusion on these. The question of whether voluntary slavery should be legally permitted, for example, is not addressed – slavery constitutes a power relation between individuals, and it would be nonsensical to discuss whether someone can permissibly be their own slave. Further, I do not consider cases in which the principal does not intend to give their full voluntary consent.

I also make the assumption that freedom is of fundamental value to us, and that any infringement on it must be justified. It follows that the burden of proof lies on the side of the advocate of such an infringement. As adequate justification of any infringement of our liberty is necessary, we need only show that none of the reasons given are satisfactory to demonstrate that infringement is unjustified. I take the importance of freedom to be relatively uncontroversial, and adopt it in this paper as my focus is on the particular interpersonal problem present in our diverging judgements of what I may do to myself and what I may consent to having done to me. I examine the most compelling arguments in favour of prohibiting the involvement of another individual in an otherwise permitted act, which can be placed into three categories: 1. The principal does not have the power to consent – when someone gives their consent, they are not acting fully voluntarily, or they are mentally ill, and we cannot consider them capable of making such a decision. 2. Both the self-regarding and other-regarding forms of the act are morally permissible, but there are practical reasons for the state to treat them differently. A legal ban on euthanasia may be necessary, for example, because it is impossible to ensure that the person being killed has given valid consent. 3. The agent is not permitted to perform this act, even with valid consent from the principal. This may be because the agent's action is wrongful regardless of the presence of consent, or because the agent has a particular duty not to perform such an action.

I contend that these arguments are all unsatisfactory. The first set of arguments does not provide a satisfactory answer to our case study, euthanasia, as we do not have reason to believe that coercive pressure or mental illness would invalidate all instances of consent to euthanasia. We can reject the second set because the unwanted consequences of legalizing euthanasia are merely possibilities, whereas the unwanted consequences of the severe limitation of our freedom constituted by prohibition of euthanasia are certainties. It is my contention that the risk of the former cannot justify accepting the latter. And the third set cannot ground a prohibition of euthanasia as the agent's action cannot be construed as necessarily wrongful, and the existence of particular duties the agent has towards the principal which would prevent him from performing euthanasia is questionable. I therefore conclude that no satisfactory argument has been given to justify a prohibition on the agent of carrying out euthanasia on the principal, when the latter would be permitted to commit suicide. This means that any legal system which permits suicide but not assisted suicide or euthanasia is unjustified in its limitation of its citizens' liberty. This also casts doubt on other prohibitions of consensual other-regarding acts when the corresponding self-regarding act is legal.

The Principal's Consent

Consent is usually thought to nullify wrongdoing: if we agree to an action, no one is wrongfully harming us by performing it.3 This is because of the transformative power it holds: the difference between rape and sex is the consent of the involved parties, and the difference between a legitimate transfer of property and theft is the consent of the initial owner. This transformative power is, however, reliant upon such consent being valid. The law imposes limits on the ability of children and mentally impaired individuals to consent, for example, such that any apparent consent on their part does not in fact nullify the wrongfulness of harm done to them4. Children, for example, cannot consent to sex, such that any sexual act on them by an adult is treated as (statutory) rape. It is uncontroversial to hold that this is justified, as few would deny that most children do not yet have the capacity to reach important decisions concerning marriage, large sums of money, and so on.

The state is, arguably, justified in interfering in harm done to someone without their valid consent.5 Thus, a possible answer to the puzzle presented in this paper could be that the principal does not in fact have the capacity to give valid consent, meaning the agent wrongfully harms the principal. There are two main reasons often cited for a categorical impossibility of valid consent: even the possibility of such a choice places the principal in a bargaining position where they find themselves coerced into giving their consent (a position defended by Arneson (1980), for example), or the willingness to give consent to such an act is itself indicative of mental illness, and thus of an inability to give valid consent (an argument Bergelson (2007) examines).6 In both these cases, the state would be justified in criminalizing the agent, as the principal's consent is never valid. The state would further be justified in not criminalizing similar acts if they are self-regarding, as our inability to give consent for a particular action also releases us from criminal responsibility for it. Nevertheless, I argue that neither argument applies to all cases in which consent is given for euthanasia, and thus cannot ground a prohibition of it in those cases in which valid consent is given.

Coerced Consent

Arneson (1980) suggests that the state can be justified in prohibiting us from consenting to certain choices when the possibility of making that choice is itself coercive. He gives the example of Smith, who is close to starvation and willing to pay any price for food, and Jones, who has a loaf of bread he would be willing to part with for 75 cents (Arneson 1980, p. 472). An offer made by Jones to sell his bread to Smith in exchange for Smith's entire fortune could be classified as a 'coercive offer', to use Feinberg's (1989b) terminology, as Smith has no choice but to consent if he does not wish to starve. In this situation, Arneson (1980, p. 472) suggests, the unequal bargaining positions of the two parties mean that Smith is coerced into giving his consent. The state would be justified in placing a price ceiling on the trade – making it illegal to demand or pay more than this specified amount – in order to preclude arrangements resulting from gross power imbalances rather than the actual preferences of those involved (Arneson 1980, p. 472). In other words, the state might be permitted to preclude consent to 'coercive offers', to protect us from being coerced into acting against our interests. Thus, if the possibility of legal euthanasia introduced such a coercive offer, the state might be justified in prohibiting consent to euthanasia.

Velleman (1992) believes this is the case - he holds that the legality of euthanasia affects (some) people's options in such a way that they will be coerced into consenting to it.7 By introducing the option of euthanasia, he believes we would be altering the paths available to patients (Velleman 1992). Velleman (1992, p. 673) contends that "[t]he most important way in which the option of euthanasia may harm patients […] is that it will deny them the possibility of staying alive by default." Essentially, he regards it as mistake to characterize the situation as follows: if euthanasia is illegal, patients have only the option to live, and if euthanasia is legal, they have both the option to live and the option to die (Velleman 1992). Rather, a more accurate characterization would be: if euthanasia is illegal, patients have only the option to live by default, and if euthanasia is legal, they have both the option to live by choice and the option to die by choice (Velleman 1992). He contends that the loss of the option of continuing to live by default can be a significant harm to some patients (Velleman 1992). Being now forced to choose, Velleman (1992) believes that they will also have to justify their choice, so that introducing the option of euthanasia will require them to justify their existence if they wish to continue living. In cases where the patient presents a significant financial or emotional burden on their family, they may therefore feel coerced into choosing death, as they do not feel as though they can justify continuing to live (Velleman 1992). In short, Velleman contends that introducing the option of euthanasia not only adds an option, but in fact alters existing options in such a way as to create coercive pressure on ill patients to choose euthanasia. Thus, the offer of euthanasia can be regarded as a coercive one.

However, I disagree with Velleman's assessment that the introduction of the option of euthanasia creates significant coercive pressure on patients. He suggests that the option of euthanasia creates a coercive force because it robs patients of the option to stay alive by default. However, Velleman is mistaken in contending that the status quo is that patients have only the option of staying alive by default – this is already negated by the legal option of suicide. Even without the option of euthanasia, the patient does not in fact have the option of continuing to live by default, but rather already has to choose either life or death by suicide. Velleman (1992, p. 673) recognizes that the legal possibility of suicide represents a choice that individuals have, but denies that this option robs us of the possibility of staying alive by default: "we do not ordinarily think of ourselves or our fellows as continuously rejecting the option of suicide and staying alive by choice." The possibility of euthanasia, in his opinion, would be seen differently, and would therefore induce us to regard individuals who reject it as staying alive by choice (Velleman 1992). This is a dubious claim, however. If the legality of suicide does not make us regard individuals as staying alive by choice rather than default, why would the legality of euthanasia do so? Velleman does not justify his assertion that euthanasia would be treated in a different manner than suicide, and I contend – though it is impossible to prove a negative – that there is no convincing reason why we would treat euthanasia and suicide so differently.

One might question whether this argument holds for patients who are no longer physically capable of suicide, and therefore do stay alive by default. However, I contend that it does hold, as introducing the option of legal euthanasia be paramount to bringing them into the same situation we are willing to accept for less physically disabled persons – that of having the option to stay alive by choice and the option to die by choice. We would simply be placing an individual who is no longer physically capable of committing suicide into the same situation we find acceptable for an individual who is still capable of lifting a finger and turning off a life-supporting machine, for example.

In short, I believe that the legality of suicide negates Velleman's argument. Strictly speaking, most individuals already do not stay alive by default, but by choice, and though it is true that we typically regard life as the norm, the legality of suicide strongly suggests that also legalizing euthanasia would not alter our perceptions significantly. It would therefore not create new, significant coercive pressure. Thus, when we take into consideration the fact that the self-regarding act is legal, it becomes difficult to argue that making it possible to consent to the same act would introduce coercive pressure high enough to invalidate consent. The argument that the legality of some choices may result in coercive pressures which invalidate any consent to those choices may very well justify a prohibition. This is contingent, however, on the fact that coercive pressure is in fact introduced, which, as I have argued, is not the case for the class of acts being considered in this essay. The legality of making the same choice when the act is carried out by oneself means that the legality of consent to that choice when the act is carried out by another does not affect the principal's options enough to produce coercive pressures. In the absence of these coercive pressures, this argument fails to justify a prohibition of euthanasia.

Inability to Consent

Another frequent proposal attempting to account for a categorical impossibility of valid consent to acts like euthanasia is that such a desire is symptomatic of mental illness and demonstrates that the principal cannot give valid consent. This line of reasoning can be found in both popular opinion and legal decisions. In *People v. Samuels*, for example, the defendant's assertion that his infliction of physical harm (whipping during the production of a pornographic movie) was consensual was dismissed as a defence against criminal liability (Bergelson 2007, p. 27). The court stated that: "[i]t is a matter of common knowledge that a normal person in full possession of his mental faculties does not freely consent to the use, upon himself, of force likely to produce great bodily injury" (Bergelson 2007, p. 27). As the principal's willingness to consent to such harm is indicative of mental illness which invalidates the given consent, any agent who nevertheless performs the harmful action is guilty of harming someone who is incapable of giving valid consent.

As Bergelson (2007) points out, this is a somewhat circular argument – if individuals give their consent, then they are mentally ill, and therefore unable to give consent. Nevertheless, there are cases in which this reasoning is appealing. The case of Brandes and Meiwes, for example, where Brandes consented to be eaten and killed by Meiwes (Harding 2003). Meiwes was later convicted of murder, based in part on a psychological assessment that Brandes had suffered from a psychiatric disorder and desire for self-destruction, invalidating his consent (Harding 2003). It would be quite contentious to argue that Brandes' consent to be eaten and killed in this manner was not at least indicative of a psychological disorder which would invalidate his ability to give consent. We are therefore forced to conclude that the very act of consenting is, at least in some cases, an indication that the consent given is in fact invalid and the committed act constitutes criminal harm.

One might question why, if desire for the act is symptomatic of mental illness, it is not criminalized when done to oneself. The answer to this is straightforward: the principal's mental illness also releases them from criminal responsibility for their self-regarding action. They lack the mental capacity to consent, and thus also the mental capacity to bear responsibility for their self-regarding actions. This is an uncontroversial view – people who are mentally ill and commit crimes are not regarded in the same way as those who are not mentally ill, and their convictions for those crimes have different implications. Thus, when the principal is considered to be mentally ill, they cannot be criminalized for self-regarding harm, but they also cannot give valid consent for harm to be done to them.

However, there are scenarios in which the charge that consent itself is a symptom of mental illness seems to be moralism rather than an actual medical diagnosis. This can be seen particularly in the way borderline cases are treated. In U.S. courts, for example, religious flagellation is routinely permitted while sexual flagellation is not (Bergelson 2007, pp. 20-22). Why would someone's desire for sexual gratification through pain be less sane than someone's desire for religious gratification through pain? In such cases, assessments of an individual's capacity to consent appear to have less to do with their actual mental competence than with the personal moral opinions of those sitting in judgement. One way in which moralism presents itself is as an extension of moral judgements into areas of our lives in which they are not appropriate (Archer 2018, p. 343). This is clearly the case here – regardless of whether religious flagellation is more morally permissible than sexual flagellation, it is difficult to see how such moral judgements are relevant to a medical assessment of an agent's ability to give valid consent. It is very dangerous to conflate the morality of our decisions with

our decision-making capacity in this way – the very concept of autonomy requires that we respect other individuals as rational persons despite them making choices we may disagree with. If we begin confounding rationality with morality we will see ourselves in a situation in which anyone who acts in a way we regard as wrong must be regarded as lacking the competence to make autonomous decisions.8 In short, the charge that consent to any act is itself a symptom of a mental illness leads us into a territory where individual's actual mental competence becomes less relevant than our agreement or disagreement with their choices.

Furthermore, there are cases in which it is quite clear that the principal's consent is not an indication of mental illness. Take our case study of euthanasia. An opponent of euthanasia might use the mental illness charge in the following way: a desire for death and suicidal thoughts are major symptoms and components of mental illnesses like depression. Thus, individuals who wish to die likely suffer from such a mental illness, and do not have the mental capacity necessary to provide valid consent to euthanasia. However, I contend that we should be very reluctant, and indeed would be wrong, to say that it cannot be a sane choice for a terminally ill person facing months of slow and painful decline towards death to request a merciful, painless end. Of course, there might be cases where a desire for death is not a sane wish held by a competent mind, but rather a consequence of mental illness. However, we cannot generalize from the existence of some cases where consent is not valid to a claim that valid consent is impossible.9 In short, the argument that anyone who consents to euthanasia is mentally ill, and thus that valid consent to euthanasia does not exist, does not hold, and cannot justify a categorical prohibition of euthanasia. This is not to say that the possibility of valid consent should lead us to endorse euthanasia, but only that it invalidates a reason not to endorse euthanasia.

In this section, I have argued that we can reject the assertion that we are not legally permitted to consent to acts we would be permitted to perform on ourselves because it is impossible to give valid consent to these acts. Arguments which claim that the legal possibility of euthanasia is coercive fail to take into account individual's actual options; the possibility of suicide is close enough to euthanasia that legalizing euthanasia, if suicide is already legal, cannot exert sufficient coercive pressure. Additionally, the argument that consent to euthanasia is symptomatic of mental illness can be moralistic and fails to take into account that such a decision is often a very rational one for individuals suffering from painful terminal illnesses. Therefore, problems with the individual's consent cannot provide the justifications for a state to limit a principal's legal ability to consent to actions they would be legally permitted to perform on themselves. If a prohibition of euthanasia and similar other-regarding acts is justified, then, the ground for such a justification must be found somewhere else.

Practical Considerations

We have now seen that we cannot reject the possibility of valid consent to acts such as euthanasia, and so justify a legal limitation of our ability to consent to these acts. However, this simply means that we are rejecting the argument that it is impossible for consent to euthanasia and similar acts to be valid, and some would maintain that this does not map perfectly onto considerations of what should be legally permissible. Even if one grants that euthanasia and suicide can both be morally permissible,10 there may be considerations other than those of the moral permissibility of consent which entail that euthanasia should nevertheless be legally impermissible. There is, for one, the important question about whether there are feasible and reliable methods to determine whether consent is valid in a particular instance. In this section, I focus directly on euthanasia, in order to be able to examine particular practical issues and their consequences. This does not imply that the practical consequences of separate other-regarding acts face the same trade-offs. It can, however, be taken as an indication of possible lines of reasoning for these other acts, and demonstrates that such a practical argument is not a decisive ground for a prohibition of all consensual other-regarding acts since there is at least one to which it does not apply. An argument against euthanasia and similar other-regarding acts might run: if it is the case that it is impossible (or too difficult) to ensure that only individuals who have given valid consent will receive euthanasia, it is justifiable to prohibit euthanasia in general as a measure of protection of those who would otherwise be killed against their will. As Bosshard et al. (2008, p. 31) put it, this is "a field in which it is extremely difficult to establish appropriate decision criteria but, at the same time, any wrong decision has far-reaching and irreversible consequences."

In fact, arguments grounded on the impossibility of determining whether individual instances of consent to euthanasia are valid have often been cited by legal courts in their affirmations of euthanasia prohibitions (Beschle 2013). Concerns about establishing the validity of consent often run along similar lines as the issues discussed in section one: how do we establish that the principal was not coerced, and that they are capable of

giving valid consent? Is it possible to determine a specific set of criteria which would allow us to ensure that instances of supposedly voluntary euthanasia are not in fact instances of non-consensual killing?11 If we cannot answer this question positively, that is, if we cannot develop a feasible mechanism to ensure the validity of consent, then a legal prohibiting of euthanasia may be justified. In this section, I examine these practical concerns.12 I conclude that, although the regulation of euthanasia is indeed difficult, problems present in jurisdictions where it is legal can likely be mitigated. Furthermore, these difficulties, and the (low) associated risk of non-consensual euthanasia slipping through the cracks, cannot outweigh the infringement of our autonomy and freedom presented by a prohibition of euthanasia.

Difficulty of Determining Consent

In considering the practical problems presented by legal euthanasia, it is helpful to examine the situation in jurisdictions where it is in fact legal – such as the Netherlands (Jochemsen and Keown 1999). This allows us to examine how these jurisdictions have chosen to answer the above questions, and to assess how these answers play out. In the Netherlands, euthanasia and assisted suicide are legal under very specific conditions: patients must make a request "earnestly and with full conviction" (*Euthanasia, assisted suicide and non-resuscitation on request* n.d.). This may be done by an advance directive, and minors from the age of 12 may make such a request (with parental consent before the age of 16, and with parental involvement but without the necessity of their agreement after the age of 16) (*Euthanasia, assisted suicide and non-resuscitation on request* n.d.). If the physician is convinced that the request was voluntary, made by a patient experiencing unbearable suffering and well-informed about treatment alternatives, and the physician has consulted with another doctor who has given his assessment of these criteria in writing, the physician is legally permitted to perform euthanasia (*Appendix 1* 2011). After having carried out the euthanasia, the physician is then required to report it to the municipal pathologist, who in turn informs one of five review committees, who ensure that due care was taken (*Euthanasia, assisted suicide and non-resuscitation on request* n.d.).

These provisions, however, do not seem sufficient. Statistical surveys indicate that a number of patients in the Netherlands have had their life shortened without having made an explicit request13 – one survey identified 900 such cases in 1995, for example (Jochemsen and Keown 1999, pp. 17-18). These are frightening figures, and provide support for the argument that, at least in the Netherlands, regulation is not capable of preventing abuse of the law, and is not sufficiently capable of protecting patients from non-consensual killing. Indeed, the provision that physicians must themselves volunteer the information that euthanasia has occurred seems to contribute to this lack of control, as a majority of euthanasia cases are not even reported to review committees, and as such are not subject to any oversight (Jochemsen and Keown 1999, p. 19). Authors such as Jochemsen and Keown (1999) and Allen (2006) argue from these numbers that attempts to regulate legal euthanasia in the Netherlands have failed. This assessment, however, is not undisputed. Quite apart from the fact that the Dutch public has remained in favor of euthanasia under the current regulations (Cohen et al. 2006), other investigations into the regulation of euthanasia in the Netherlands have often had more positive results. In 2012, the Supreme Court of British Columbia, in Canada, found that the regulations in the Netherlands14 overall "work well in protecting patients from abuse while allowing competent patients to choose the timing of their deaths" (Beschle 2013, p. 576).15 Indeed, though the reporting in these jurisdictions was found to not be ideal, the judges found the regulation to be effective enough that a blanket prohibition of euthanasia was not tenable (Beschle 2013). Nevertheless, though the extent of the problems may be somewhat disputed, it is clear that there are problems with the Dutch regulation of euthanasia which leads, in some cases, to non-consensual killings taking place and going unpunished.

Relative Risk

Whilst regulation of legalized euthanasia presents great difficulties, it is far from clear that these are severe enough to justify a prohibition. First, even if current regulations in countries like the Netherlands are not ideal, this does not mean that they cannot be improved or that effective regulation of euthanasia is necessarily impossible. And second, the risks inherent in legalizing euthanasia posed by these flaws in the regulatory system (that someone may be killed without their consent), must be weighed against the risks inherent in prohibiting euthanasia (that someone is robbed of their dignity and that their autonomy is infringed). I contend that the latter wins out, so that a prohibition of euthanasia cannot be justified based on the practical risks presented by legalization.

First, it is implausible to assert that the flaws of the Dutch system of euthanasia regulation are irreparable. There are some who suggest, for example, that proper implementation of euthanasia should rather take the form of an established service, outside of clinical care, which is run by an interdisciplinary team (psychologist, medical doctors, volunteers…) and overseen by the government (Bosshard et al. 2008, pp. 30-31).16 Such a system would preclude situations in which a patient did not explicitly request euthanasia, as they would have to direct a request to the euthanasia service for the service to even become aware of their case. Within this service, one can also establish procedures such as an applicant needing to be seen by a psychologist and undergoing a certain waiting period before getting access to the doctor who would perform the fatal act. Such provisions would prevent that a principal undergoes euthanasia without anyone except the agent being aware of the case, and thus without oversight. In short, this could resolve many of the issues presented by the Dutch system. I am not arguing that such a system would necessarily be better than the Dutch system – indeed, there may be other problems with it, such as a lack of personnel willing to enter into such a career. I am simply pointing to the fact that it is implausible to assert that the issues present in the Dutch system cannot be mitigated. It is highly likely, in short, that the risk of abuse of legalized euthanasia are reducible by improvements to the regulation system.

However, it must be granted that even given the possibility of improvements of an (arguably) not intolerable system of regulation, it is likely that no system will ever be able to fully prevent some individuals from slipping through the cracks. The question we must ask ourselves, therefore, is whether this is a price we are willing to pay. An initial reaction might be that it is not: would not even one person unjustly killed be too high a price to pay? However, prohibiting euthanasia based on this thought would be fallacious, as we are ignoring the price we pay due to the prohibition of euthanasia. It is a very difficult question whether potential abuse of a right should preclude us from granting it to those who deserve it, particularly when the stakes are so high. This is a far-reaching question which I do not attempt to answer. I do suggest, however, that such considerations must surely be taken with regard to the relative risks, as well as the importance of the right in question.17 It would be very difficult to assert, for example, that competent adults should be legally prohibited from consenting to and engaging in sexual activities due to the possibility of sexual assault and the difficulty the state may face in determining whether consent was given in individual cases. This is because we consider the right to engage in sexual activity to be so important that the risk to our interests is much higher in case of a prohibition than the risk to our interests through assault in case of abuse of the legalization of consensual activity.

I do not suggest that euthanasia is as clear-cut a case as sexual activity, since we place very high importance on both our autonomy and desire for a dignified death of our choosing, if possible, and on our lives and desire to protect ourselves from a death we do not want. However, I believe that the relevant considerations run along a parallel line: we must decide whether the risk that our autonomy and right to make momentous personal decisions be infringed by a prohibition which denies us the possibility of choosing death by euthanasia is greater than or lesser than the risk that our autonomy and right to life be infringed by abuse of the legalization of euthanasia. I contend that we should weigh the first risk as more important than the latter – that is, we should consider the risks presented by prohibition to be greater than those presented by legalization. This is based not on a comparison of the rights which may be infringed in each case,18 but rather on the simple fact that, under a prohibition of euthanasia, we can be certain that individuals who wish to die by euthanasia will have their autonomy infringed, as they will not be permitted to go through with their wish – the risk of an infringement of individuals' autonomy is so high as to essentially be a certainty.19 The risk posed by legalization, on the other hand, is much lower. Though there is danger, this danger can be mitigated by regulation. Even under the Dutch regulation system, the risk of abuse remains a risk, not a certainty – patients who go into a hospital do not have fear that a doctor is likely to perform unwanted euthanasia on them. And, as I have argued above, it is very plausible to assert that even this danger can be reduced by improvements to the regulatory system, so that the effective risk under a well-regulated euthanasia program is very low. The point that the relative risk posed by prohibition should outweigh the risk posed by legalization is made also by Dworkin et al. (1997, III, para. 5), who state that it is a mistake to say that "a state may reasonably judge that the risk of "mistake" to some persons justifies a prohibition that not only risks but insures and even aims at what would undoubtedly be a vastly greater number of "mistakes" of the opposite kind – preventing many thousands of competent people who think that it disfigures their lives to continue living, in the only way left to them, from escaping that – to them – terrible injury."

In this second section, I considered the argument that practical difficulties surrounding the regulation of euthanasia justify a legal prohibition of it, regardless of the moral permissibly of euthanasia in individual

cases. I have found that it is difficult to regulate euthanasia and that ensuring the validity of consent in individual cases presents an important challenge. However, I have argued that these practical considerations are not sufficient to justify a blanket prohibition of euthanasia. The flaws present in some regulatory systems, such as the Netherlands, are more accurately depicted as areas where improvement is possible than as unavoidable features of a system of legalized euthanasia. The risk of abuse is likely to be low in such an improved system. Finally, I have therefore argued that it would be unjustified to prohibit competent individuals for whom it is morally permissible to receive euthanasia from doing so, in order to preclude the very low risk that someone may unjustly receive it. This would be, in essence, to ensure that some individuals have their right to make personal decisions violated in order to prevent a (low) possibility of some others having their rights violated by abuse, and not as a necessary consequence of, such a law. Though the focus of this section has been on euthanasia in order to facilitate the examination of particular practical considerations, it is nonetheless relevant for similar other-regarding acts. For one, it points to the inadequacies such a practical argument can have, and thus provides a template for how other prohibitions can be examined. Additionally, it demonstrates that these practical considerations cannot serve as an adequate justification for all such prohibitions – there is at least one prohibition (that of euthanasia) for which it is not sufficient.

Impermissibility of Agent's Action

In the two preceding sections, I examined arguments against the legalization of other-regarding acts related to problems surrounding consent. I argued that neither the suggestion that it is impossible to give valid consent to such acts, nor the concern that practical problems prevent effective regulation is sufficient to justify a legal prohibition, given that the corresponding self-regarding act is permitted. However, the argument in the previous section that we must weigh the low risk of abuse against the high importance of the right to receive euthanasia rides on the assumption that we consider euthanasia to be a valuable right, to the extent that it is a fundamental expression of our autonomy. This is the third major category of arguments for the prohibition of acts such as euthanasia – the act itself is impermissible. This is a shift in focus – we go from examining the principal's consent, to examining the agent's action. There are two possible ways in which the agent's action can be seen as impermissible: first, some philosophers argue that any attack on, or even worse destruction of, another person's dignity or personhood is wrong without exception. Even valid consent therefore cannot nullify the wrongfulness of such an act. Second, one can question whether agents have particular duties which would preclude them from carrying out the action. For example, physicians - the agents in euthanasia – are usually thought to have a very particular set of professional ethics, including, some believe, a duty not to kill intentionally. Therefore, it is not that euthanasia as such is wrongful, but rather that there is no agent for whom it would not be wrongful to carry it out.20 As in the previous sections, I argue that these lines of reasoning are not sufficient to ground a categorical prohibition of acts such as euthanasia. In particular, I question the separation Velleman posits between dignity and our interests and contend that, under the (more accurate) conception of dignity as inherently linked to our interests, we cannot trade one for the other. Further, I suggest that physicians' duty not to kill is a defeasible one, such that this also cannot justify a prohibition of euthanasia.

Dignity, Personhood, and Death

The argument that considerations of dignity and personhood justify a prohibition of consensual harm to others is espoused by philosophers such as Velleman and Baker. Velleman (1999), for example, has formulated what he calls the Exchange Argument, which posits that persons may not trade their dignity or personhood in exchange for benefits, or to avoid harms. This is due to the fact that a person's dignity has a value separate from his interests – the latter are entirely up to him, whilst "his dignity is a value on which his opinion carries no more weight than anyone else's" (Velleman 1999, p. 611). According to Velleman (1999), dignity is the value inherent in a person, which they possess simply by virtue of their personhood and which is unrelated to the value they may have for others. Harming someone's dignity, even our own, not only harms the person, but undermines the whole concept of personhood (Velleman 1999). Velleman (1999, p. 614) further believes that "trading one's person in exchange for benefits, or relief from harms denigrates the value of personhood, respect for which is a criterion of morality." By exchanging our dignity for our interests, we are saying that our dignity has value for the way in which it serves our interests, and not independently. The Exchange Argument therefore suggests that trading our dignity in order to advance our interests is paramount to an assertion that the value of dignity and personhood is instrumental. This argument can be taken to apply

to any form of physical harm – indeed, Baker (2009) endorses a very similar argument against any form of serious harm or death. However, it applies particularly to euthanasia, as death entails not just harm but destruction of the person. Additionally, Velleman (1999) does not suggest that this argument entails the moral impermissibility of euthanasia in all cases.21 Rather, he suggests that considerations of dignity and personhood should lead us to conclude that we should not have a right to euthanasia (Velleman 1999). From this, Velleman (1999) concludes that the risks he associates with legal euthanasia – the coercive pressures it might exert, as detailed in the first section - are so great as to justify a prohibition of it.

Though I deny the premise that legalized euthanasia creates a significant coercive force,22 there is a deeper issue with this argument: the implausible gap between dignity and autonomy it prescribes. While I am inclined to agree with Velleman that a person cannot choose to no longer have value as a human being, I do not think that the same is true for the content or expression of her dignity. Respecting a person is tightly linked to respecting their autonomy – by recognizing an individual's capacity to make their own choices, we are recognizing them as persons, as ends in themselves, and as possessing equal moral worth. The suggestion that respecting individuals' autonomy in regard to the expression of their dignity is much less far-fetched than one might think. Velleman (1999, p. 618) asserts that the few cases in which euthanasia would be morally permissible, any implementation of it would have to be in accordance with the patient's wishes. If, however, individuals may not receive euthanasia when this would harm their dignity, regardless of their wishes, why should they be permitted to choose not to receive euthanasia, when this harms their dignity by subjecting them to an undignified life? My contention is that respect for a patient's wish to live, regardless of how their life will look afterwards, is an essential component of acknowledging their personhood and respecting their dignity. The very importance we place on euthanasia being implemented only if a patient wills it demonstrates that respect for individuals' autonomy is essential to their personhood. Thus, I argue that dignity necessitates respect for an individual's autonomy, and that there is no reason why this autonomy should extend only to their interests and not the form of their dignity. This in no way conflicts with the assertion that individuals cannot choose whether they have worth as persons, whether they possess dignity. In short, my conception of dignity differs from Velleman's in one key aspect: where Velleman regards dignity as different, and separate, from our interests, I suggest rather that, while they are not one and the same, they are not completely independent from each other either. Thus, it is a fallacy to argue that we should not trade our personhood for our interests, as pursuing the latter entails respecting the former.

Velleman (1999, p. 625) attempts to discredit such a conception of dignity as interrelated with autonomy by pointing to the concept of self-respect: "if it were impossible to debase oneself in the pursuit of one's interests then there would be no such thing as self-respect." However, the concept of self-respect surely is different from our concept of dignity and personhood. The concept of self-respect is usually invoked in a moralizing way, from the external perspective of someone who disagrees with an individual's chosen life-path. One might hear, for example, someone commenting 'do they have no self-respect?' about a party guest who has overindulged in alcohol. It is not clear, however, how choosing to get drunk would undermine someone's value as a person. In short, the concept of self-respect allows us to express disapproval of another person's choices, perhaps even those choices relating to their dignity and personhood, but it is not clear that such disapproval is actually linked to genuine harm individuals do to their dignity. I have argued that philosophers such as Velleman and Baker mistakenly create an artificial gap between dignity and autonomy. Once this gap is removed, it is far from clear how respecting an individual's choice of what a dignified death would look like should not be a right due to people out of respect precisely for their autonomy and dignity.23

Nature of Agent

Another way in which the agent's action may be seen to be problematic is in terms of particular duties they have. A frequent charge against the legalization of euthanasia is not that it is in itself morally impermissible, but that those who would carry it out – doctors – are bound by professional ethics not to intentionally kill another person. In Germany, for example, euthanasia is not illegal in principle, but a physician's participation would violate their code of conduct and their legal duty to save lives (Bosshard et al. 2008, p. 28). Such an argument also gives a satisfactory answer to the question as to why the corresponding self-regarding act is not prohibited: individuals do not hold the same duties towards themselves that a physician has towards his patients, so committing suicide does not breach such duties. However, this is not an argument that cannot be as easily brought against different other-regarding actions, since those frequently would not involve an agent who holds such specific and formalized duties towards the principal. If I asked my (non-physician) friend to

cut off my arm, there may be a number of reasons why they should not do so, but none of these would be that they are bound by a code of professional ethics. Nevertheless, as this argument can be brought against the legalization of euthanasia, which is the case-study of this essay, I shall examine it.

There is indeed appeal to this argument – in their statistical analyses, Bosshard et al. (2008, p. 30) have found that "the overwhelming majority of medical organizations continue to view such assistance as incompatible with their code of professional ethics," and the Hippocratic Oath, which is widely seen as representative of the duties of doctors, states that physicians may not administer deadly drugs (Seay 2005). This is taken by many to be an explicit prohibition of intentional killing, and thus of participation in euthanasia (Seay 2005). Even without referring to the content of the Hippocratic Oath, it would not be a controversial assertion to state that doctors have a particular duty to protect and extend health and life wherever possible. The question, however, as Seay rightly points out, is whether physicians' duty not to intentionally kill can be outweighed by other medically relevant considerations, i.e. by other duties they have towards their patients.

The position that the duty not to kill is an unconditional one for doctors – that there are no justifiable exceptions to it – is undesirable and extreme. Seay (2005) points out that there are problems with this position, regardless of whether we take duties to be correlative with rights or not.24 On a view of duties as correlative with rights, the right which is correlative with a physician's duty not to kill intentionally can either be waived or is empty25 (Seay 2005). If, on the other hand, one views duties as not correlative with rights, the special duties that a physician has in virtue of being a physician are generated by the definition of his profession (Seay 2005). Thus, "[i]t must be shown that being categorically forbidden to kill is part of what it means to be a physician" (Seay 2005, p. 522). However, it seems false to assert that the preservation of life is the only purpose of a doctor. I am inclined to agree with Seay (2005) in his suggestion that a physician's purpose is also the prevention of suffering. Part of doctor's raison-d'être is also the provision of palliative care, and the mitigation of pain in the case of debilitating migraines through the prescription of painkillers, to name but a few scenarios. If we accept that the alleviation of suffering is also an important purpose of physicians, then it is not clear that the duty not to kill is indefeasible. There are likely to be scenarios in which a doctor must choose between the duty to alleviate suffering by providing euthanasia, and the duty to extend life, by keeping a patient alive despite his or her pain. It is far from obvious that the duty not to kill intentionally should always win out in such a situation. In fact, I contend that this should not be the case, and that a doctor's duty to relive suffering should in some cases take precedence. To hold otherwise would be to subject individuals to inhumane levels of suffering for the sake of a moral ideal: "[d]ying patients should not be forced by some dogmatic moral creed to endure burdensome conditions that they themselves would rather avoid" (Seay 2005, p. 526). In short, it appears false to assert that physicians do not have an unconditional duty not to kill. These considerations of the permissibility of the agent's action are therefore also not sufficient to ground to a prohibition of euthanasia.

In this section, I examined concerns about the agent's act which are often cited in debates about the permissibility of other-regarding actions such as euthanasia. I found, however, that neither concern is sufficient to justify a legal prohibition of euthanasia. The argument that euthanasia is wrongful regardless of the principal's consent because it harms their personhood is based on a conception of personhood and dignity which does not recognize the importance of autonomy. Once we take into account that respect for autonomy is intrinsically linked with dignity, we are forced to conclude that it is wrong to assert that individuals should not have a right to euthanasia because this is incompatible with human dignity. Further, the argument that euthanasia should not be legalized because those who would carry it out, physicians, are not capable of permissibly doing so, also fails. Once we examine the duties that doctors have towards their patients in detail, it seems wrong to conclude that such a duty cannot be defeated, either by a waiver or the corresponding right by the patient, or by a conflicting duty to relieve suffering. Thus, considerations of the agent's act are unable to motivate a prohibition of euthanasia, and which also casts doubt on the role they could play in prohibiting consensual other-regarding actions in general.

Conclusion

In this paper, I examined possible justifications for the prohibition of consensual other-regarding acts when the corresponding self-regarding act is permitted. In evaluating these arguments, I focused particularly on euthanasia, which is illegal in most jurisdictions, including many where suicide is legal. I found that none of the arguments examined in this paper are sufficient to ground such a prohibition. First, suggestions that

prohibition is justified because principals are incapable of giving valid consent to these acts – either because the mere possibility introduces a coercive pressure or because the willingness to consent is symptomatic of mental illness – are overly generalized. The argument that the legalization of some other-regarding acts creates coercive pressure does not apply to the class of cases examined in this paper, as the permissibility of the corresponding self-regarding act precludes such a coercive force. Further, the assertion that consent to such an act is itself an indication of an inability to consent – in addition to being worryingly moralistic – cannot apply to all other-regarding acts, as we would be very reluctant, for example, to write off a suffering terminal patient's desire to die quickly and painlessly as an irrational desire. Second, practical concerns about the legality of other-regarding acts fail – in particular in the case of euthanasia – due to a very straightforward risk calculation: although there is some possibility of unwanted consequences occurring under legalized euthanasia, there is a certainty of (similarly serious) unwanted consequences occurring under a prohibition of euthanasia. Finally, I found that arguments in favor of a prohibition of other-regarding acts due to concerns about the permissibility of the agent's action are insufficient. Appeals to the impermissibility of harming our dignity and personhood wrongfully separate dignity from our interests, and the suggestion that physicians have a particular professional duty not to engage in a particular act – namely euthanasia – is based on a mistaken conception of a physician's duties.

We have seen, therefore, that the arguments brought in favor of a prohibition of euthanasia are insufficient to justify it. Given the assumption about the importance of our liberty and autonomy made in this paper, which places the burden of proof onto those who would restrict it, we can therefore conclude that a prohibition of euthanasia is, in the absence of other arguments, unjustified. This is a negative argument – I have not attempted to defend the view that euthanasia is justified, or that it should be legal. Instead, I have pointed to the fact that there does not seem to be a compelling reason why it should not be legal.

In this paper, euthanasia was used as a case study for the more general case in which other-regarding acts are prohibited, though the same act is permitted if it is self-regarding. We cannot simply generalize from our conclusions regarding euthanasia to the general case, as considerations of practical consequences, or of the particular duties of the parties involved, for example, may take on different forms. What the case of euthanasia does suggests about the more general case, however, is that the avenues for justifying prohibitions of these other-regarding acts are narrow and face significant obstacles.

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Endnotes

1.) In these jurisdictions, possession of drugs for personal use, as well as the personal use itself, are not criminalized, but as soon as there is an intent to distribute, that is to provide the drugs to willing third-parties, it becomes a criminal act.

2.) I use the term harm for simplicity. It is not clear whether we can construe the consequences of such an act as a harm, strictly defined, in all cases: if the principal prefers state of the world A to state of the world B, then an agent would arguably be benefitting them rather than harming them by bringing about state of the world A. However, it also seems undesirable to categorically conclude that we cannot be harmed by choices we make – if someone preferred to have a leg amputated than die from an infection, we may still wish to maintain that the loss of the leg constituted a harm. This debate is not strictly relevant, however, to the question of why someone may do something to themselves, but not have the same thing done to them by a third party.

3.) This is known as *Volenti non fit injuria*, or the Volenti principle. For further reading on this see e.g. Dworkin (2012).

4.) The line is not always clearly drawn: in the UK, children under the age of 16 can consent to medical examination and treatment if their physician determines that they have the necessary competence. This is known as Gillick competence (Griffith 2016). Despite the difficulty of drawing an exact demarcation between those who can give valid consent and those who cannot, few would dispute the general assertion that some individuals can give valid consent, and others cannot (yet) do so.

5.) There is some debate about cases where an individual is incapable of consent – some argue that physicians are permitted to perform non-voluntary euthanasia on patients who are in a coma with no hope of improvement, for example. Note here that the concept of non-voluntary euthanasia applies only to patients incapable of giving consent – euthanasia performed on those who are capable, but unwilling, to consent, is involuntary euthanasia. For discussions of non-voluntary euthanasia see e.g. Manninen (2006) or Jochemsen (1998).

6.) There are some who argue that consent also cannot be used to justify or excuse certain actions – Baker (2009), Tadros (2011), and Velleman (1992, 1999) discuss the argument that no agent is permitted to harm the personhood or dignity of another, regardless of consent given. This line of argument is addressed in section 3: although it relates to the concept of consent, it is more concerned with the nature of the agent's action than the validity of the principal's consent.

7.) He does not believe that euthanasia is morally impermissible in all cases, but rather is opposed to euthanasia as a legal right. In his words, he believes that "[t]he best public policy on euthanasia […] is no policy at all" (Velleman 1992, p. 680)

8.) This is a reasonable worry: in a study conducted on pitfalls in competence assessments by physicians by Ganzini et al. (2003), 52% of respondents said it is a very common pitfall for physicians to fail to consider that a patient may not be competent to make decisions if the patient agrees with the physician's recommendation. The physician's own opinion about the attractiveness of the options available thus influences their assessment of the rationality of the patient's choice regarding those options.

9.) The question of what criteria should be used to determine the validity of consent, and whether this can be determined with sufficient certainty to permit euthanasia, is addressed in the next section.

10.) Under certain circumstances, including for example the provision that valid consent is necessary

11.) There are a number of other concerns as well, which bear on the question of what euthanasia regulation should if it is implemented look like. The question of whether patients should be able to consent to

euthanasia preemptively (similarly to a Do Not Resuscitate order), for example. However, these do not directly bear on the question of whether determining valid consent to euthanasia is technically feasible, and are therefore secondary to the issues discussed in this paper.

12.) One may wonder why I do not also discuss the slippery slope argument (the worry that legalizing voluntary euthanasia will trigger a descent towards societal acceptance of non-voluntary and, in particular, involuntary euthanasia). Although this is a recurring worry of opponents of legal euthanasia, the straightforward reason for this is that I do not find it to be as convincing as other arguments considered in this essay. I believe that the gap between doing something to someone with their consent, and doing something to someone against their consent is so significant that allowing the former in no way encourages us to accept the latter. For a discussion of this see e.g. Feinberg (1989a).

13.) These included both instances of non-voluntary euthanasia and involuntary euthanasia (Jochemsen and Keown 1999, p. 18)

14.) As well as other jurisdictions where euthanasia was legalized, such as Oregon, U.S. (Beschle 2013)

15.) This case was brought to the Supreme Court of Canada, and led to the legal ban on euthanasia being overturned (Payton 2015 ; "Timeline: Assisted suicide in Canada"2015, *CBC News*)

16.) This is close to the position held by the Swiss Academy of Medical Sciences on Assisted Suicide, for example (Bosshard et al. 2008, p. 31)

17.) Some would deny that euthanasia is an important right, or should be a right at all. I address this debate in the next section.

18.) Our autonomy, right to make momentous personal decisions, and right to life are all fundamental rights of incredible value, and I suggest that it would be difficult to conclusively argue for the importance of one of these rights over the others. I therefore do not attempt this, but build my argument instead on the supposition that they are, or can be considered as, being of equal importance.

19.) The only scenario in which this risk would not be realized would be one where, by chance, no individual wishes for euthanasia, and therefore does not have that wish denied. This is a very implausible scenario, however.

20.) One may be tempted to question the assumption that a physician need be involved in euthanasia at all. However, it is quite plausible that an exclusion of physicians from this practice seems undesirable. Even with the involvement of physicians, complications in the provision of euthanasia are not unheard of (Groenewoud et al. 2000), and it does not seem prudent to restrict involvement in euthanasia procedures exclusively to individuals with little to no knowledge of the drugs involved. I am therefore willing to grant this point.

21.) He concedes that there may be situations where euthanasia protects rather than destroys dignity, such as when a person can no longer live with dignity (Velleman 1999).

22.) See section 1

23.) There is a potential issue here, as death entails not just harm to but destruction of a person. One could therefore argue that euthanasia, unlike other harms, is not permitted because individuals should not be permitted to exercise their autonomy if they therefore lose their autonomy (this is an argument Mill (1909) makes in opposition to voluntary slavery, for example). However, all persons will die eventually, so that euthanasia does not entail a loss of autonomy that would not otherwise have occurred. Rather, it allows for individuals to autonomously choose how and when this (inevitable) loss of autonomy occurs.

24.) Seay (2005) distinguishes between two conceptions of duties – either they are correlative with rights, or not. Being correlative with rights means that a duty is linked to a particular right, which are "rights that imply a corresponding duty in someone else" (Seay 2005, p. 518)

25.) It can be waived if the corresponding right is conceptualized as a protection of the individual's ability to make choices, in which case protection of the choice requires the ability to choose both options – either life

of death; and is empty if it is conceptualized as a protection of the individual's interests, in which case the physicians duty is to provide the treatment with the greatest benefit for the patient, which may in some cases be euthanasia (Seay 2005).