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PI/ Law 099 FINAL Essay

Moral Distinctions between Passive and Active Euthanasia

Morally speaking, what distinguishes passive from active euthanasia? Is there even a moral distinction? Before we can answer these questions, it will serve us well to get a sense of what either type of euthanasia involves. Euthanasia is often termed 'mercy killing' or 'assisted suicide.' It is the intentional ending of a patient's life to ease his pain and suffering (typically caused by some terminal illness).[1] Euthanasia can be classified as passive or active. Passive euthanasia involves withholding common treatments (drugs, operations, respirators etc.) necessary for a patient to continue living. Active euthanasia, on the other hand, involves the use of lethal substances or forces (e.g. a lethal injection) to kill the patient.[2] The *prima facie* distinction between active and passive euthanasia is that the former involves killing a patient, while the latter involves letting the patient die.[3] Thus, some philosophers[4] suggest that by asking whether there is a moral distinction between active and passive euthanasia, we are really asking whether there is a moral distinction between 'killing' and 'letting die.' With that said, solving this age-old 'killing' versus 'letting die' moral dilemma is far beyond the scope of this paper. However, I believe we need not fully resolve the dilemma in order to gain insight into the moral differences between active and passive euthanasia. While we must inevitably dip our toes into the larger debate, we will tackle only a specific subcase of 'killing' versus 'letting die' in the

[1] "Euthanasia and assisted suicide." *NHS Choices*, National Health Service (NHS), www.nhs.uk/Conditions/Euthanasiaandassistedsuicide/Pages/Introduction.aspx. Accessed 7 June 2017.
[2] Ibid.
[3] Rachels, James. "Active and Passive Euthanasia." *New England Journal of Medicine*, PDF ed., vol. 292, no. 2, 9 Jan. 1975, pp. 78.
[4] These philosophers include James Rachels, Fiona Woollard, and Frances Howard-Snyder.

realm of hospice care. This specificity places some realistic constraints on the issue that will help us reach some moral conclusions.

In this paper, I will first examine arguments both for and against the claim that there exists a moral difference between active and passive euthanasia. Next, I will examine considerations that should play a role in determining whether either active or passive euthanasia should even be morally permissible at all in a specific case. I will also attempt to apply the ethical ideology known as the Doctrine of Double Effect (DDE) to both types of euthanasia, and assess what moral conclusions the doctrine would arrive at for each. Only after clearing such ground will I suggest why we are *not* equipped to make a blanket statement about whether active euthanasia is morally different from passive euthanasia; only the specific circumstances of each case, as well as the ethical framework used to assess each case, can clarify what moral distinctions, if any, exist.

I. Arguments For and Against the Existence of a Moral Difference between Active and Passive Euthanasia

First, let us review the arguments claiming that there is indeed a moral difference between active and passive euthanasia. In the medical world, conventional doctrine presupposes that such a difference exists.[5] Most notably, the difference is implied by the Hippocratic Oath, embodied by the maxim: “do no harm” (curiously, the maxim itself does not appear in the oath).[6] The Hippocratic Oath has strong deontological (duty-driven) connotations of non-maleficence: a doctor above all must not cause harm to his patient. Using this purely deontological framework,

[5] Rachels, James. "Active and Passive Euthanasia." *New England Journal of Medicine*, PDF ed., vol. 292, no. 2, 9 Jan. 1975, pp. 78.
[6] Shmerling, Robert H. "First, do no harm." *Harvard Health Blog*, Harvard Medical School, 13 Oct. 2015, www.health.harvard.edu/blog/first-do-no-harm-201510138421. Accessed 7 June 2017.

it is clear that active euthanasia (e.g. administering a lethal injection) is morally forbidden because it violates the deontological duty not to kill. What about passive euthanasia? At first, it might seem that passive euthanasia is morally permissible by the "first, do no harm" maxim because the doctor is merely allowing a patient to die (e.g. the doctor refrains from performing an operation). However, consider the passive euthanasia case in which the doctor removes some apparatus that sustains the life of a patient, say a respirator. The doctor is doing something; he is removing the respirator. So, is passive euthanasia really an 'allowing'? Philosopher Michael Moore has explored this conundrum, and classifies passive euthanasia as a type of "non-omissive allowing."[7] By turning off the respirator, the doctor performs an act of "double-prevention"[8]; the doctor prevents something (the respirator) from preventing the patient's death. Double-preventions are not causes (of death) if we accept omissions are not causes.[9] Thus, for the purposes of moral evaluation, a double-prevention should be judged in the same way an omission would be judged. Furthermore, Moore maintains that this particular act of double-prevention – passive euthanasia – is morally permissible because the doctor returns the patient to a moral "baseline."[10] By removing the respirator, the doctor merely removes a defense to death and lets 'nature' take its course (e.g. the illness kills the patient), omitting to provide support for the patient that *he provided* in the first place. The patient essentially dies the death he would have died anyways had the doctor not intervened at all. The upshot is that the moral distinction between active and passive euthanasia is preserved.

[7] Moore, Michael S. *Causation and Responsibility*. Oxford University Press, 2009, pp. 60.
[8] Ibid., pp. 62.
[9] There is much debate about whether omissions, or 'negative causes,' are true 'causes'. Moore believes they are not. Other philosophers, including Jonathan Schaffer (Schaffer, "The Case for Negative Causation", 2004), believe they are (for example, all voluntary human actions are due to muscle contractions, which result from the absence of a protein from a binding site). For this argument, however, we will assume omissions are *not* causes.
[10] Ibid., pp. 63.

A closely related argument for the existence of a moral difference also relies on an acceptance of deontological ethics. This argument can be framed in terms of the stringency of negative versus positive moral duties. Inventor of the well-known trolley problem, Philippa Foot, argues that our 'negative duties' (e.g. our duty to refrain from killing) are more stringent than our 'positive duties' (e.g. our duty to relieve the patient's suffering).[11] By this logic, we are more strongly prohibited from practicing active euthanasia than we are obligated to practice it in order to relieve pain. In other words, our 'negative rights' (e.g. rights against being killed) are stronger than our 'positive rights' (e.g. rights to a doctor to relieve our suffering).[12] Active euthanasia is therefore morally impermissible. In contrast, practicing passive euthanasia (a "non-omissive allowing" according to Moore) does not violate a stringent negative deontological duty by Foot's reasoning, establishing a moral gap between active and passive euthanasia. It is important to note, however, that there exist other positive and negative duties that complicate the issue. For example, if we consider the doctor's positive duty to *save* the patient, then neither type of euthanasia might be permissible at all in some cases. Furthermore, if we consider the negative duty not to interfere with the patient's self-autonomy, active euthanasia might be morally permissible in cases where passive euthanasia is not (discussed more in depth later). The interplay of multiple positive and negative duties makes reaching moral conclusions quite tricky.

Now, let us examine arguments claiming that there exists no moral difference between active and passive euthanasia. Perhaps the most influential set of arguments come from utilitarian[13] philosopher James Rachels in his article "Active and Passive Euthanasia." As a

[11] Thomson, Judith Jarvis. "Killing, Letting Die, and the Trolley Problem." *The Monist*, vol. 59, no. 2, 1976, pp. 206.
[12] Woollard, Fiona and Howard-Snyder, Frances, "Doing vs. Allowing Harm", *The Stanford Encyclopedia of Philosophy* (Winter 2016 Edition), Edward N. Zalta (ed.), URL = <https://plato.stanford.edu/archives/win2016/entries/doing-allowing/>.
[13] Hitchcock, Christopher. Class Lecture, PI/Law 99, May 16, 2017, "Doing vs. Allowing II", Slide 17.

utilitarian, Rachel subscribes to an ethical theory promoting actions that maximize human happiness and minimize suffering; deontological concerns are irrelevant or downplayed. In his article, Rachels argues that the distinction between active and passive euthanasia has no rational basis for several reasons.[14] First, Rachels notes that active euthanasia is often more humane than passive euthanasia. For example, Rachels cites early infant care cases in which some babies born with Down's syndrome have congenital defects such as intestinal obstructions, and require operations too intensive that the parents and doctors are unwilling to operate. So, they opt for passive euthanasia. In these cases, allowing the infant to die is excruciating; the process is physically agonizing to the dying infant and emotionally taxing for the parents and medical staff. Practicing passive euthanasia in these cases certainly seems cruel and morally wrong.

Second, Rachel argues that decisions of life and death are often made on irrelevant grounds.[15] In the same case of the babies with Down's syndrome, Rachels says that the parents and the doctors must first judge whether an operation to save the infant should be performed; they judge whether the life of an infant with Down's syndrome is worth living, or whether it would be more merciful to euthanize the infant. In making this tough moral decision, Rachel argues that it makes no sense to consider whether or not the infant has intestinal obstructions or not (these medical conditions are irrelevant to the moral question).

Third, Rachel believes the moral distinction between active and passive euthanasia is *exactly* the moral distinction between 'killing' and 'letting die,' and that all other things held equal, this moral distinction does not exist at all. Why not? Take the case[16] of two greedy

[14] Rachels, James. "Active and Passive Euthanasia." *New England Journal of Medicine*, PDF ed., vol. 292, no. 2, 9 Jan. 1975, pp. 78.
[15] Hitchcock, Christopher. Class Lecture, PI/Law 99, May 16, 2017, "Doing vs. Allowing II", Slide 22.
[16] Rachels, James. "Active and Passive Euthanasia." *New England Journal of Medicine*, PDF ed., vol. 292, no. 2, 9 Jan. 1975, pp. 79.

individuals, Abe and Joe, who both stand to gain a substantial inheritance should one of their infant relatives die. To acquire his inheritance, Abe drowns the infant in a bathtub, staging the scene to look like an accident. Joe plans to do the exact same thing, but before he can drown his infant relative, the infant hits its head and begins to drown. Joe sits and does nothing. From this hypothetical example, Rachel is fully convinced that Abe and Joe are equally morally guilty, and thus there exists no moral distinction between killing and letting die, between active and passive euthanasia.

Rachel's final argument takes the form of criticizing conventional doctrine that presupposes a moral distinction between active and passive euthanasia. In direct opposition to Moore, Rachel believes that passive euthanasia is not a morally permissible "non-omissive allowing." By doing nothing (e.g. not operating), the doctor *is* doing something: he is letting the patient die. Rachel believes that the decision to let a patient die "is subject to moral appraisal in the same way that a decision to kill would be subject to moral appraisal."[17] For the purposes of moral assessment, 'letting die' is the same as a 'killing.' Thus, in euthanasia cases, active euthanasia is almost always the more merciful, less painful option.

II. Considerations that Influence the Morality of Either Type of Euthanasia

There are several important considerations that influence the morality of either passive or active euthanasia in a specific case. The most obvious one is the patient's self-autonomy, which includes the patient's personal beliefs on the permissibility of euthanasia itself or the supposed moral differences between passive and active euthanasia. Often closely connected with the patient's religious or secular positions, the patient's autonomy can also be encapsulated by

[17] Rachels, James. "Active and Passive Euthanasia." *New England Journal of Medicine*, PDF ed., vol. 292, no. 2, 9 Jan. 1975, pp. 80.

philosopher Judith Thomson's notion of claim.[18] In libertarian societies, there is a strong belief that as a rational, intelligent being, you have claim or ownership over your own body. You have a 'right to die,' and doctors (or the state) have no authority to interfere with this right. Your individual preferences on how you want to die (via passive or active euthanasia, or via euthanasia at all) should matter immensely to the morality of the practice in a specific case. Organizations like Dignity in Dying[19] urge that doctors respect patients' personal beliefs on hospice and palliative care, allowing the patients to dictate the timing and manner in which they die.

Self-autonomy is not and should not be all-important, however. Consider the case in which the patient is a depressed teenager who recently broke up with his lover. Or a mentally unstable housewife who broke her arm in a car accident. Suppose both patients request that the doctor euthanize them to end their suffering. If autonomy is all that mattered, the doctor should comply in both cases. In both cases however, few of us would agree that either type of euthanasia is morally permissible. What considerations are we taking into account here? It is clearly not the patients' autonomies. We are considering the type and degree of the patients' suffering, as well as the patients' best interests. The former of these considerations can also be expressed in terms of the patients' chances of (emotional and physical) recovery. We would say that the teenager is just going through a bad breakup, and that the housewife's arm will heal. These are not terminal, incurable conditions, and so it doesn't make sense to consider euthanasia altogether.

[18] Thomson, Judith Jarvis. "Killing, Letting Die, and the Trolley Problem." *The Monist*, vol. 59, no. 2, 1976, pp. 215.
[19] "Our Position." *Campaign for Dignity in Dying*, Dignity in Dying, www.dignityindying.org.uk/assisted-dying/our-position/. Accessed 7 June 2017.

The latter consideration, often termed paternalism,[20] is more controversial. This consideration involves limiting a patient's liberty or autonomy in order to promote his well-being. By refusing the patients' requests to be euthanized, the doctor (or the law) is making a decision that the patients would supposedly make if they were in full control of their rational faculties (if the teenager were not love-struck, if the housewife were mentally competent). Advocates of paternalism argue that these patients should not have a 'right to die,' or at least should not have a 'right to commit suicide.' These advocates would be supported by legal precedent. For example, in Washington v. Glucksberg, the U.S. Supreme Court ruled that the Constitution does not protect an individual's right to commit suicide, and that the state had a legitimate interest in preventing assisted suicide to preserve human life and to protect vulnerable groups (the poor, elderly, disabled etc.) from abusing euthanasia. [21] Critics of paternalism, on the other hand, raise concerns of an overbearing, coercive 'nanny state' in which personal liberties and choices are unduly interfered with.

When determining whether either active or passive euthanasia is morally permissible in a specific case, a patient's self-autonomy, chance of recovery, and paternalism should all come into consideration. Furthermore, our analysis has been primarily patient-centric; the decision to euthanize someone often affects those around him emotionally and financially. In cases where the patient is comatose, this decision is even more complicated because the doctor might only have indirect evidence of the patient's wishes from family members or legal agents. All these factors influence the moral permissibility of the decision and should be weighed carefully.

[20] Hitchcock, Christopher. Class Discussion, PI/Law 99, May 16, 2017.
[21] Washington v. Glucksberg, 521 U.S. 702, 117 S. Ct. 2258, 138 L. Ed.2d 772 (1997).

III. Application of the Doctrine of Double Effect (DDE)

Before we apply the Doctrine of Double Effect (DDE) to euthanasia, let's first familiarize ourselves with the DDE and convince ourselves it makes sense to apply it in the first place. The DDE is a set of ethical criteria for evaluating the permissibility of an otherwise moral action when the action would simultaneously cause some harmful side effect.[22] Introduced by Saint Thomas Aquinas in the *Summa Theologica* (c. 1270), the DDE strongly incorporates Christian ethical values. According to the DDE, in order for an action (that has good and bad consequences) to be morally permissible, the following typical conditions must be met:

(a) The act must be morally good (or at least cannot violate a deontological obligation).

(b) The agent must intend the good outcome (but is allowed to foresee a bad outcome(s)).

(c) The good effect(s) must outweigh the bad effect(s).

(d) There is no other way to obtain the good outcome without causing the harm(s) (or some other equally bad harm(s)).

(e) The harm(s) done must not be a means by which the good outcome(s) is achieved; the good and bad effects must flow directly from the action from a causal perspective.[23]

In both cases of euthanasia, it seems natural to apply the DDE. The DDE concerns the issue of when it is permissible to perform an action that has both good consequences – the relieving of the patient's pain and suffering – and bad consequences – the death of the patient. Already, we have made a key assumption: death is a bad outcome and living is a good outcome; life is not suffering, so to speak. To simplify the comparison between the two types of

[22] McIntyre, Alison, "Doctrine of Double Effect", *The Stanford Encyclopedia of Philosophy* (Winter 2014 Edition), Edward N. Zalta (ed.), URL = <https://plato.stanford.edu/archives/win2014/entries/double-effect/>.
[23] Hitchcock, Christopher. Class Lecture, PI/Law 99, April 27, 2017, "The Doctrine of Double Effect", Slides 19-20.

euthanasia, will also assume that the patient's condition warrants the practice of some form of euthanasia (no medical alternatives exist).

Before analyzing how the DDE applies differentially to the two types of euthanasia, let us see which conditions are satisfied by both. Both types of euthanasia satisfy condition **(b)**: euthanasia is aimed at reducing a patient's suffering, and the doctor intends this good outcome. Both also satisfy **(d)**: euthanasia is the only resort to treating the painful terminal illness (we assumed medicine or other therapies would not help the patient).

We will now discern between the two types of euthanasia cases on the remaining conditions: **(a)**, **(c)**, **(e)**. First, let's apply these conditions to passive euthanasia. In this case, the bad effects are a *combination* of the patient's death and his increased suffering as a result of withheld treatment. The good outcome is relief from suffering. If we use Moore's conclusions, passive euthanasia does not violate a deontological duty (the 'non-omissive allowing' did not cause the patient's death); thus **(a)** is satisfied. In passive euthanasia, does the good outcome outweigh the bad effects **(c)**? The answer to this question is highly dependent on the circumstances. In certain passive euthanasia cases, the patient's suffering is brief (a comatose patient dies minutes after the respirator is removed), and in other cases, the patient's suffering is protracted and undignified (the Down's syndrome infant who must suffer dehydration and infection for hours or days). We must decide on a case-by-case basis at which point the patient's additional suffering and death (bad effects) outweigh his relief from suffering (positive outcome). How about **(e)**? I believe that condition is met. To reach this conclusion, however, we must we label passive euthanasia as a "double prevention," which according to Moore, is not a cause. The doctor is incapable of using the patient's death as a means to achieve the good

outcome because the doctor does not cause anything. Thus, both good and bad effects flow immediately from the double prevention (on a causal timeline), satisfying **(e).**

Now we turn to active euthanasia. In this case, the bad effect is simply the patient's death (e.g. the lethal injection is quick and painless). The good outcome is the same as in the passive euthanasia case: relief from suffering. Clearly, **(a)** is violated because killing violates a deontological duty. Interestingly, I believe active euthanasia passes **(c)**, a condition which passive euthanasia might not always satisfy. In an active euthanasia case, the bad effect is certainly smaller than that in the passive euthanasia case (which entails additional patient suffering from withholding treatment), while the good effect (relief from suffering) is just as desirable as in the passive euthanasia case. Unlike passive euthanasia, active euthanasia violates **(e)** because administering the lethal injection relies on the patient's death to achieve his relief from suffering; the bad outcome is a means to achieve the good effect.

In short, passive euthanasia might or might not violate condition **(c)** of the DDE, depending on the condition the patient suffers from. On the other hand, active euthanasia violates two conditions **(a), (e)** of the DDE. If violating fewer conditions of the DDE indicates moral correctness, then passive euthanasia is more morally permissible than active euthanasia. Again, we have made some implicit (but not universally true) assumptions to reach our conclusions. For example, let us consider morphine therapy as a type of active euthanasia (because it causes an accelerated death). In this case, condition **(e)** does not seem to be violated because a hastened death is merely a *foreseeable* bad effect, and is not a means to achieve the good outcome (relief from suffering). In this case, although the DDE still seems to rule in favor of passive euthanasia, the moral distinction between the two types of euthanasia is certainly undermined.

After considering the views of Moore and Foot that point to a moral distinction between the two types of euthanasia, as well as Rachels' arguments claiming that no distinction exists, I am inclined to believe the applied moral framework is causing the difference of opinion. Moore and Foot to a large extent subscribe to a deontological code of ethics and believe that only passive euthanasia is morally permissible, whereas Rachels is an unequivocal utilitarian and believes that active euthanasia is always morally preferable in the interest of reducing suffering. Similarly, we observe that passive euthanasia is more morally permissible than active euthanasia when the deontologically-driven Doctrine of Double Effect (DDE) is applied. In exploring considerations of a patient's self-autonomy, the severity of his illness, and paternalism, we also find that the morality of the two types of euthanasia is specific to each case; a doctor must balance a respect for the patient's wishes with the patient's best interests.

IV. Conclusions

The thesis that practicing active euthanasia is morally worse than practicing passive euthanasia, much like the thesis that 'killing' is worse than 'letting die,' cannot be answered simply. The type of moral framework – deontological versus utilitarian – used to assess the practices, as well as other case-specific considerations, highly influence the moral permissibility of each type of euthanasia. Furthermore, we have not considered practical matters that might sway our moral conclusions. Even if we assume both active and passive euthanasia are morally permissible, there remain significant obstacles in regulating euthanasia in such a way that the law would be satisfied. For example, we would still need to deal with valid concerns about abusing euthanasia as a cost-effective means to murder the terminally ill, or perverting euthanasia to undermine the dignity and value of the lives of people who are disabled.

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