

Active and Passive Euthanasia

1. Active vs. Passive Euthanasia: Imagine two cases:

- Peggy is suffering from terminal, untreatable cancer. She has a month to live, but in the meantime is in extreme, incurable pain. She spends her days screaming and unable to sleep, asking for death. The doctor inserts a lethal injection into her I.V. Minutes later, she dies.
- Sue is suffering from terminal, untreatable cancer. She has a month before the cancer kills her, but in the meantime is in extreme, incurable pain. She has degenerated to the point that she is being kept alive with a respirator and a feeding tube. She spends her days in agony, asking to die. The doctor turns off the respirator. Minutes later, she dies.

Most people think it would be **WRONG** to administer lethal injection in the first case, but **PERMISSIBLE** to essentially “withdraw treatment” in the second case. The difference is that the first is **ACTIVE** euthanasia, while the second is **PASSIVE** euthanasia.

Euthanasia: Literally, in ancient Greek, “good death”. The act of bringing about someone’s death (directly or indirectly) for their own good.

There are 2 kinds of euthanasia:

Active Euthanasia: Directly bringing about someone’s death for their own good.

Passive Euthanasia: Indirectly bringing about someone’s death (e.g., by withholding or withdrawing treatment) for their own good.

Passive euthanasia is currently legal in the U.S., while active euthanasia is illegal. But, is there really a moral difference between active and passive euthanasia?

2. Physician-Assisted Suicide: First, a related note: Closely related to active euthanasia is physician-assisted suicide. The crucial difference is that, instead of the **DOCTOR** administering the lethal injection, the injection is instead placed in the hands of the patient, who then administers the dose to himself.

The idea here is that, by merely **ASSISTING** the death, the moral blame is transferred from the physician to the patient. In other words, the doctor is morally blameless if she merely **PRESCRIBES** a lethal dose to the patient. Some suggest that, while active euthanasia is wrong, assisted suicide is not. This is reflected in the legal code to some degree as well, since active euthanasia is banned across the U.S., while physician-assisted suicide is legal in Washington, Oregon, Montana, and Vermont.

But, is this correct? Imagine that you have a gun collection, and a friend asks,

Friend: "Hey, can I have one of those guns?"

You: "What do you want with it?"

Friend: "I'm going to put it in my mouth and pull the trigger."

You: "Look, I'll give you the gun, but I can't be held responsible for whatever you do with it."

Friend: "No, I PROMISE you. I am DEFINITELY going to use it to kill myself."

You: "Ok, here you go. But, remember, I'm still not responsible."

Friend: "Ok, bye! I'm off to kill myself now! Thanks!"

Are you not responsible for your friend's death? It seems that you are, in this case, an accomplice. Similarly, then, it seems that, if active euthanasia is morally wrong, then a physician who assists suicide is still blameworthy. If that's correct, then the REAL question is simply whether or not active euthanasia is in fact wrong.

[Do you agree? Is blameworthiness preserved if you merely FACILITATE a death? Even if murder is not permissible, is suicide morally permissible? If so, does the doctor do anything wrong by helping someone else carry it out?]

4. Killing vs. Letting Die: Most people think it is much worse to DO harm (or KILL) than to merely ALLOW harm (or LET DIE). When the physician administers a lethal injection, she is KILLING the patient. On the other hand, when the physician withholds treatment, she is merely LETTING the patient die (and the former is MUCH worse, morally, than the latter). Why?

- (1) In passive euthanasia, the disease is responsible for the death of the patient, while in active euthanasia, the physician is responsible. This is expressed by statements like, "Just let nature run its course" or "Stop prolonging death".
- (2) Killing an innocent human being is always wrong.
- (3) There are cases where killing is clearly morally worse than letting die (for instance, recall the Crowded Cliff scenario).

5. The Definition of Death: So long as we're talking about KILLING someone, we had better get clear on what death IS. There are three views on this:

- (1) Death occurs when respiration and circulation ceases.
- (2) Death occurs when all brain activity ceases.
- (3) Death occurs when higher brain activity ceases.

Which of these views is correct? Though (1) used to be the universal view, many have since rejected it, since the body can be artificially kept “alive” (respiration and circulation) indefinitely, long after someone has clearly died. So, (2) became the new paradigm. But, (2) would classify what we call “human vegetables”—either someone who is in a persistent comatose state, or even someone who appears awake, but has not capacity for consciousness or awareness—as alive. Their lower brain functions continue to keep their heart and lungs operating, but there is “no one home”. So, some have suggested a move to (3). Higher brain functions are responsible for consciousness, and THAT is who we really are. If consciousness disappears forever, we are, for all intents and purposes, already dead, even if our body continues to function on its own.

If (3) is correct, then administering a lethal injection to someone in a persistent vegetative state is not a “killing” at all. For, the person is already dead (though their body still functions).

Here, we will focus on the more controversial cases: Is it morally permissible to euthanize someone who is fully aware; that is, fully conscious? (not to say that euthanizing human vegetables is not controversial—it is just LESS controversial)

6. Killing is No Worse Than Letting Die: James Rachels believes that there is no morally relevant difference between doing harm and allowing it. In order to defend this stance, he asks us to consider the following two cases:

- **Smith:** Smith stands to gain a large inheritance if anything should happen to his six-year-old cousin. One evening while the child is taking a bath, Smith sneaks into the bathroom and drowns the child.
- **Jones:** Jones also stands to gain if anything should happen to his six-year-old cousin. One evening while the child is taking a bath, Jones sneaks into the bathroom to drown the child. However, just as he enters, the child slips and hits his head, falling face down in the water. Jones is delighted. He stands by, ready to push the child’s head back under if necessary, but it is not necessary. The child drowns.

Smith is doing harm, or killing the child. Meanwhile, Jones is merely allowing harm, or letting the child die. If there *were* a morally relevant distinction here, we ought to think that what Smith does is far worse than what Jones does. But, we do not. What Smith and Jones do seem to be equally wrong. (Do you agree?) Therefore, Rachels argues, the do-allow distinction is not a morally relevant one.

Rachels' argument might be stated as follows:

1. If killing were morally much worse than letting die, then what Smith does to the child would be morally much worse than what Jones does to the child.
2. What Smith does is NOT morally much worse than what Jones does.
3. Therefore, killing is not morally much worse than letting die.

Therefore, Rachels concludes, active euthanasia is NOT morally much worse than passive euthanasia. So, if we think that withholding treatment is permissible, then we should think that lethal injection is also permissible.

3. Objection to Rachels: Judith Thomson thinks this sort of argument is a bad one. She says it is no better than the following one that "proves" that cutting off someone's head is no worse than punching someone. Consider two cases:

- **Decapitation:** Alfrieda knows that if she cuts off Alfred's head he will die, and, wanting him to die, cuts it off.
- **Nose Punch:** Bertha knows that if she punches Bert in the nose he will die—Bert is in peculiar physical condition—and, wanting him to die, punches him in the nose.

What Alfrieda does is just as wrong as what Bertha does. Have we proved that there is no moral difference between cutting off someone's head and punching someone in the nose? Not at all, Thomson says. At best, all we have shown is that decapitating someone CAN BE as bad as punching someone in the nose. Obviously, in many (nearly all?) cases, the former is still worse than the latter.

So, though Rachels MAY have proved that allowing harm is SOMETIMES just as bad as doing harm, has he proved that it is ALWAYS just as bad?

Consider the following three cases:

- (a) Killing: Jones actively kills his sick cousin in order to gain an inheritance, by administering a lethal injection.
- (b) Withdrawing Treatment: Jones removes his sick cousin's feeding tube (resulting in his cousin's death) in order to gain an inheritance.
- (c) Withholding Treatment: Jones purposely refrains from giving his cousin his medication (resulting in his cousin's death) in order to gain an inheritance.

All three of these seem morally wrong. What seems to matter is that—just as in the 2 bathtub cases—the death is brought about INTENTIONALLY, FOR PERSONAL GAIN.

Are Intentions All That Matter? In our unit on deontology, we explored the idea that causing harm is morally wrong if it is INTENDED as a means to an end, rather than merely foreseen as an unfortunate side-effect of one's action (we called this The Doctrine of Double Effect). Are bad intentions all that matter, morally?

One objection to this distinction is that, the SAME EXACT action could be morally permissible or morally wrong, depending upon the physician's intentions. Consider:

- (a) A physician administers a lethal injection of pain-killers in order to bring about the death of a patient.
- (b) A physician administers a large dose of pain-killers in order to relieve the patient's suffering (any lower dose will not relieve the suffering), though he knows that, as a side-effect, this will result in the patient's death.

Is there really a moral difference between these two actions?

[Note also that "Withdrawing Treatment" seems to be an ACTION. However, removing a respirator, or feeding tube, or "pulling the plug" are all generally thought to be acts of PASSIVE euthanasia. There is some debate about this. What do you think? Is pulling the plug or removing a feeding tube an act of killing or of letting die?]

3. In Favor of Active Euthanasia: Dan Brock suggests that the intent behind euthanasia is two-fold:

- (1) Autonomy: Euthanasia respects the patient's autonomy to decide how the end of their life plays out. Many patients do not want to spend their last days being sick or feeble or in pain, nor do they want to be remembered that way.
- (2) Beneficence: Euthanasia is in the patient's best interest when it relieves pain and suffering, or when it takes away a life that is no longer a benefit, but is rather a burden to the patient.

The Definition of Harm: If it IS morally worse to kill rather than let die in normal circumstances (i.e., if our doing vs. allowing or intending vs. foreseeing distinctions are correct), then it is because doing HARM is morally worse than allowing harm, or intending HARM as a means is morally worse than merely foreseeing it as a side-effect of one's actions. But, then, what is "harm"? It is generally defined as follows:

Harm: Making someone worse off than they would have otherwise been.

But, euthanasia is not proposed in cases where it makes the patient WORSE off. On the contrary, it is proposed in cases where it makes the patient BETTER off. (if their life is in the negative on the scale of well-being, then their death—if thought of as zero—brings the patient UP to zero from some negative number). Thought of in that way, euthanasia is a BENEFIT rather than a harm.

As Rachels points out, if there WERE such a distinction (that doing harm is much worse than allowing harm, or intending it is much worse than foreseeing it), then it seems that, on the flip side, DOING a benefit for someone would be morally superior to merely allowing a benefit to come to someone. But, in that case, active euthanasia would be morally BETTER than passive euthanasia.

In normal cases of killing, you ARE harming the victim (by depriving them of happiness). But, it is argued, in cases of active euthanasia, you are BENEFITTING the victim (by depriving them of suffering). So, in cases where a patient is suffering terribly from a terminal illness, it would be BETTER to put them out of their misery (this is, for instance, why we think it is better to shoot a suffering horse when there is nothing we can do to save it than to just let it lay there dying). If all the patient has to look forward to is suffering, you are actually benefiting them by ending their life sooner.

Mercy Killing: This is, for instance, why we think it is permissible to shoot an animal that is suffering, in order to “put it out of its misery”. (e.g., “putting down” a dog at the vet). The intent is to relieve suffering. It is a good deed. Only a monster would allow a dying dog who is in extreme pain and can no longer move or eat or drink, to lie there for days suffering, and dying of hunger, dehydration, and illness.

Doctor’s Goals: Physicians are taught that their primary goal is to save lives, preserve health, and prevent suffering—not take away lives. Normally, these things are not in conflict, but rather go hand in hand. But, sometimes, TAKING a life is the ONLY way to prevent suffering. Brock proposes, the TRUE goals of physicians are the preservation of well-being (beneficence) and autonomy. If THESE are the true goals of the field of medicine, then euthanasia need not be in conflict with these goals.

Note that the Smith & Jones cases differ importantly from euthanasia in three respects:

- (a) The physician must obtain the CONSENT of the patient.
- (b) The physician acts in accordance with a SANCTIONED ROLE.
- (c) The physicians intentions are NOT SELFISH (the goal is to relieve suffering, not gain an inheritance).

5. Against The Legalization of Active Euthanasia: Regardless of how the debate above turns out, let us pretend for a moment that we have demonstrated that active euthanasia is clearly permissible. Some argue that, even if that were true, it doesn't matter—ultimately, active euthanasia should remain illegal because its legalization would lead to BAD CONSEQUENCES. For instance:

- (1) Erosion of Doctor-Patient Trust: Patients need to be able to visit their doctors knowing that the doctor will not kill them. If patients know that euthanasia is legal, they may fear being “put down” against their will. This erosion of trust would be disastrous. (Think of those who opposed putting “organ donor” on your driver's license, for fear that doctors would intentionally allow patients with donor cards to die in order to obtain their organs.)
- (2) Demand to “Justify” Continuation of Life: Right now, continuing to live is the “default” position. If someone wants to seek treatment for their condition, or does not want to be removed from life support, no one questions this choice. Death is not a legally sanctioned option. But, if death is an option, patients may feel some pressure to have to “justify” their continued existence. This pressure may lead to many patients feeling guilty or incapable of explaining their continued will to live, and therefore be indirectly coerced into euthanasia.
- (3) The Slippery Slope: Even if we restrict euthanasia to “clear-cut” cases, such as the patient with the terminal disease who is suffering from agonizing, unrelievable pain, there is a slippery slope. What begins as voluntary active euthanasia in extreme cases may slide easily into voluntary active euthanasia in less extreme cases, and then into non-voluntary (patient in a coma and cannot consent) active euthanasia, and ultimately into INvoluntarily (patient is conscious but has not consented) active euthanasia.

Involuntary euthanasia may BEGIN with the APPEARANCE of consent—grandparents in a nursing home, or a currently healthy patient diagnosed with cancer subtly pressured into euthanasia because their continued care or treatment is too expensive, etc. (We can imagine, “Grandma, at this rate, in a couple of months you'll have no inheritance to leave for your children. Then we'll be footing the bill. I guess they said euthanasia was an option, but don't worry. We'll figure out how to pay for all of this. Euthanasia is not an option as far as we're concerned.” But, grandma may feel pressured into concluding that it IS an option—maybe THE only option.) But, even worse, we may even someday euthanize the elderly or the sick completely against their will (think of the sci-fi movie [Logan's Run](#). Check it out if you haven't.)

Brock's Replies:

- (1) Patients need not fear their doctors. To prevent this fear, we must insist that euthanasia is always VOLUNTARY, and thus assure patients that they will never be euthanized against their will.
- (2) We already allow people to refuse life-sustaining treatment. Has the legalization of this option caused society to put pressure on patients to "justify" their continued existence? It doesn't seem so.
- (3) To prevent the slippery slope of abuse, we would simply need to place strict regulations on euthanasia. Before it could be used:
 - (a) The patient would need to be INFORMED; that is, made completely aware of the nature of their medical condition, what their current prognosis is, their likelihood of recovery, of suffering, and so on.
 - (b) Euthanasia is a last resort. ALL other reasonably effective options would need to be explored first.
 - (c) The patient's choice would need to be VOLUNTARY, and persist over time. (For instance, after their initial voluntary decision, there might be a short waiting period where they are asked to re-confirm their voluntary decision).
 - (d) A psychiatric evaluation would need to be made in order to assess whether or not the patient was competent, and acting voluntarily, and not simply being coerced—either by others or by untreated pain or depression.

Objection: Is Informed Consent Possible?: Take a look at these suggestions for regulation. Do they seem familiar? They should look a lot like those in place to regulate and guarantee INFORMED CONSENT. We defined informed consent as follows:

Informed Consent: Consent which has the following features:

- (a) The patient is **competent** enough to make a decision.
 - (b) The patient receives adequate **disclosure** of relevant information.
 - (c) The patient **understands** the information.
 - (d) The patient makes a decision **voluntarily**.
- (a) Competence: Clear examples of incompetent patients (those who are incapable of making informed decisions) are those who are severely psychotic, or mentally disabled or very young. But, what about these less clear cases: Those who are not thinking clearly because they are crippled by fear or pain?

Question: Can a terminally ill patient in extreme agony ever be deemed "competent"?

(b) Disclosure: The relevant information to be disclosed is generally thought to at least include (i) the nature of the proposed procedure, (ii) alternatives to the proposed procedure, (iii) their potential risks, and (iv) their potential benefits.

(c) Understanding: Obviously, one can only consent to something if they understand what they are agreeing to. But, some have argued that many patients will NEVER truly understand what they are agreeing to, unless they themselves have been to medical school, since most treatments and medical issues are incredibly complex. So, is understanding really possible?

Question: Can a patient ever fully and vividly understand the irreversible repercussions of DEATH?

(d) Voluntary: Obviously consent is only valid if it is voluntary. This is, for instance, why we consider contracts to be rendered invalid if signed at gunpoint. But, there are much subtler forms of coercion than being held at gunpoint. For instance, is subtle manipulation a violation of freedom? Or, failing to disclose ALL of the relevant alternatives, and their potential harms and benefits?

Question: If Grandma is the victim of subtle suggestion, and has become confident that she has no other choice but euthanasia, if she wants to leave any inheritance for her grandchildren, can she truly be said to have CONSENTED?

Well-Being vs. Autonomy: Note the fact that, if we make voluntary active euthanasia illegal, this is a special case of paternalism. But, paternalism, remember, is the act of restricting autonomy for the GOOD of the patient. Forcing suffering, dying patients to continue living, however, seems to be for the BAD of the patient. As such, paternalistically banning active euthanasia is not justified.

Reply: But, viewing euthanasia as “for the patient’s own good” can be dangerous. Note that the worry is that what BEGINS as voluntary euthanasia may slide into INvoluntary euthanasia. For, what if a patient does not WANT to be euthanized? In this case, the physician and family may be tempted to “put down” their suffering patient “for their own good”. But, this would be a violation of the patient’s autonomy.

Furthermore, Howard Brody suggests that many physicians do not really try very hard to fulfill the spirit of the laws requiring informed consent. Rather, they typically see it as a bureaucratic burden—red tape to be cut through as quickly and haphazardly as possible. He writes,

It is not enough to see informed consent as a nonmedical, legalistic exercise designed to promote patient autonomy, one that interrupts the process of medical care. However ... this is precisely how physicians currently view informed consent practices. Informed consent is still seen as bureaucratic legalism rather than as part of patient care. ... Physicians may also view informed consent as an empty charade, since they are confident in their abilities to manipulate consent by how they discuss or divulge information. (205-206)

In short, TRUE informed consent of patients is still far away. In light of this, does it seem likely that the regulation of euthanasia will be treated with the respect that it deserves, and not just be perceived as "red tape" to be cut through?

Paternalism: Another Look: It seems that it is worth one more look at the conflict between well-being and autonomy that sometimes arises. Euthanasia is a special case because, in order to maximize well-being, the physician must KILL the patient (to alleviate their suffering).

Question: Why should we insist that all euthanasia be voluntary? That is, why should we assume that the patient "knows better" when the physician knows that death is sometimes the best way to alleviate suffering?

In short, why should we think that autonomy can trump well-being?

Note: When we are asking whether beneficence ever trumps (i.e., takes greater moral importance than) the patient's autonomy, we mean beneficence TOWARD THAT PATIENT. Doctors might want to violate a patient's autonomy in order to be beneficent to THEMSELVES (e.g., by telling a patient to pay for all sorts of treatments that they don't need in order to make more money), but this is clearly wrong. Similarly, a doctor might want to violate a patient's rights in order to be beneficent to OTHER PATIENTS (e.g., by harvesting their organs and saving 4 other people's lives), but this is clearly impermissible too.

The worry about the paternalistic deception that may occur if active euthanasia is legalized is as follows:

1. Allowing a patient to continue living may sometimes negatively affect their well-being (e.g., a suffering, terminally ill patient).
2. Well-being has priority over all of the patient's other interests.
3. Therefore, it is permissible to kill, or manipulate a patient into agreeing to be killed, in cases where doing so is in THAT PATIENT'S best interests.

Is this argument correct? Goldman challenges premise 2. He asks, are health or well-being is REALLY of the greatest value, or priority? It seems that we often do things that trade in health or well-being in the interest of doing things we prefer NOW, and when we do so, it is not generally viewed as irrational. For instance, we:

- Eat delicious food that we know is bad for us.
- Fail to exercise even though it would make us healthier.
- Smoke cigarettes or drink alcohol.
- A person with a heart condition may still work hard to pursue unfinished business or projects, even though they know this will worsen their condition.

These things do not seem to be irrational. These things are “bad for us” but we freely choose to do them anyway. It is natural to make these sorts of trade-offs. Similarly, a dying patient may choose to ENDURE pain and suffering for the purposes of, e.g., taking care of their affairs, saying goodbye to their loved ones, etc.

Health and Life Not Intrinsically Valuable: When something of value is said to “trump” all other things, it is generally thought that it must be INTRINSICALLY valuable in order to do so. But, Goldman suggests that health and life are not intrinsically valuable. Rather, they are only of INSTRUMENTAL value. They are valuable only because we need to have these things in order to accomplish the things that are truly valuable to us (e.g., life projects, building relationships).

Is life intrinsically valuable? If life were intrinsically valuable, then it would be valuable to just keep people alive in persistent comas. But, that doesn’t seem right. [what do you think?]

Is pleasure/happiness intrinsically valuable? Even pleasure may not be intrinsically valuable (Goldman references the experience machine to support this). He writes,

“Many people are willing to endure frustration, suffering, and even depression in pursuit of accomplishment, or in order to complete projects once begun.” (97)

People are not pleasure-seekers. For, they often forego pleasure for things that they think are more important, just as they also sometimes forego life or health for this same reason. Imagine the following thought experiment:

Life Algorithm: Imagine if there were an algorithm for determining the best fit for marriage, or career, or school. Would you follow its advice? Or would you still prefer to make your own choices—even if we could pretty much guarantee that our own choices would not make us as happy as the algorithm’s choices?

Goldman thinks we would clearly not follow the advice of the algorithm.

[Objection: Is this correct? I think we would agree with Goldman only if we were not properly imagining the proposed scenario. Imagine that the algorithm was 100% accurate, such that it was GUARANTEED that you would be immensely happy for the rest of your life? Would we really reject such a resource? Think of Netflix's movie algorithm, or various dating sites' algorithms.]

Autonomy Intrinsically Valuable: The underlying thing of value behind all of our decisions to forego life, health, or happiness to pursue life projects and relationships is AUTONOMY—the freedom to direct our own actions. This is why the experience machine is so unattractive, or why slavery seems so awful. They remove our freedom of self-determination.

Autonomy Fundamental: Autonomy seems, even, to be the most basic of all values. Self-determination is what makes us US. **It is what makes us who we are.** It is what makes us human beings, or "persons".

Conclusion: Manipulating a patient because you believe you know better than they do "what is best for them" fails to respect the fact that autonomy is valuable—perhaps of the UTMOST value.

A Final Worry: "Inalienable Rights": All of this pro-euthanasia stuff seems to assume that we can "give up" or "forfeit" our right to life, so that others may permissibly kill us. Still, we might think that there are certain rights that simply CANNOT be waived. Any attempt to do so is invalid. For instance, recall the idea of selling one's self into slavery, or consenting to be killed. Typically, we are thought to have a RIGHT not to be enslaved or killed. Can these rights be WAIVED, or are they, rather, "inalienable"? Most people think that it would be wrong for a HEALTHY person to request someone else to kill them. But, what if they are a suffering, dying person? Can their right to life be WAIVED? [What do you think?]