IS THERE A MORAL DIFFERENCE BETWEEN ACTIVE AND PASSIVE EUTHANASIA?

TOM TOMLINSON, PH.D.
Medical Humanities Program
Michigan State University
East Lansing, Michigan

The purpose of this paper is to answer the question whether there is a moral difference between active and passive euthanasia. So long as a competent, informed, adult patient has requested it, does it matter whether what he has requested is active euthanasia instead of passive euthanasia?

Certainly institutionalized, traditional medical ethics holds that there is a difference between active and passive euthanasia. For example, the American Medical Association’s House of Delegates has issued the ruling that “The intentional termination of the life of one human being by another—mercy killing—is contrary to that for which the medical profession stands and is contrary to the policy of the AMA (House of Delegates, 1973). The opposition to active euthanasia in medical ethics goes back much further than the AMA. When the physician pledges the Hippocratic oath he promises that “I will neither give a deadly drug to anybody if asked for it nor will I make a suggestion to this effect.”

It is interesting to note that these uncompromising stands against active euthanasia may be lagging somewhat behind important shifts in public opinion. A series of Gallup organization surveys between 1950 and 1973 asked the question “When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient’s life by some painless means if the patient and his family request it?” In 1950 60% of respondents thought that the doctor should not be allowed to fulfill the patient’s request whereas 40% thought that he should. Twenty-three years later the distribution of opinion had flip-flopped, so that in 1973 only 43% believed that physicians should not have that discretion, while 57% thought that the physician should be allowed to end the patient’s life by painless means (Public Opinion, 1983). Within society as a whole there is clearly a sharp division of opinion about the relative acceptability of voluntary active euthanasia.

So is there “a moral difference” between active and passive euthanasia? First of all we have to be clear about what question we are asking. One way of getting clearer about that is to be clear about what kind of answer we may be looking for. There are two kinds of “NO” answers that might be given. The first kind of “NO” answer would say that active euthanasia and passive euthanasia are “morally equivalent.” That is, in any situation in which passive euthanasia would be justified active euthanasia would be justified also, and vice-versa.

The other kind of “NO” answer that might be given to the question is to say that there is no moral difference between active euthanasia and passive euthanasia that can justify permitting the use of passive euthanasia, but absolutely prohibit the use of active euthanasia. In this second sense of the question we are asking a question about policy: whether the current policy absolutely prohibiting active euthanasia can be morally justified.

When I ask the question whether there is a moral difference between active euthanasia and passive euthanasia I will be asking it in the second of these two senses. I will be focusing on this second sense for two reasons. First of all the claim of moral equivalence of active and passive euthanasia is
probably false, since we can readily think of circumstances under which passive euthanasia would be justified, but active euthanasia would not be. For example, we might imagine a patient who while competent made a clear request for some form of passive euthanasia. She subsequently lapses into unconsciousness from which she will not recover. Perhaps the patient asked that she not be put on a respirator under certain circumstances. Such a request might well justify a decision to withhold the respirator under the circumstances specified by the patient. But the administration of active euthanasia would not thereby also be justified. The patient might, for example, have strong religious objections against "mercy killing," in which case the administration of active euthanasia would be an affront to her values. The other problem with the first sense of the question is that it does not directly address the social policy that aims to allow some forms of passive euthanasia but absolutely prohibits active euthanasia. Certainly if it were true that active and passive euthanasia were morally equivalent, it would follow that we could not justify a policy that allows one but prohibits the other. But if active and passive euthanasia should turn out not to be morally equivalent in the sense that I have described, it does not follow that the policy of prohibiting one but allowing the other is morally or socially justifiable. For example, it might be argued that active and passive euthanasia are not "morally equivalent" because active euthanasia offers opportunities for abuse—only active euthanasia can be abused by killing healthy people who don't want to die (More on this argument later). But even if this is true, it doesn't follow that it is impossible to develop an acceptable policy permitting active euthanasia. All that follows is that it will have to address some additional concerns than those dealt with by the current policy permitting passive euthanasia.

In what follows I will want to argue that there is no systematic moral difference between active and passive euthanasia that will justify allowing some acts of passive euthanasia, but at the same time prohibit all acts of active euthanasia. To show that I intend to use the following strategy.

The first step in the strategy is to establish that if there is a moral difference between active and passive euthanasia, then acts of active euthanasia must meet two conditions: Condition 1. Acts of active euthanasia must have some characteristic not shared by acts of passive euthanasia. Clearly, if active and passive euthanasia were exactly alike in all respects there could be no justification for taking a different moral or social attitude toward active euthanasia. If we continued to have a different attitude, it would be a difference for which no reasons could be given. Our rejection of active euthanasia would then have the character of a superstition or taboo. Condition 2. Such a unique characteristic of active euthanasia must imply a significant moral difference between the two. The reason for this second condition is to rule out the use of morally irrelevant or insignificant differences. A hyperbolic example of this would be if someone were to claim that the difference rested on the fact that active euthanasia was abbreviated AE and passive euthanasia was abbreviated PE. This is a difference that satisfies the first condition, but it is not a morally significant difference that would justify a different social policy on one than on the other.

If these two conditions are accepted (I won't argue for them any further), then the second step in the strategy is to show that none of the reasons which have been given to justify the prohibition of active euthanasia meet both conditions. If this can be accomplished, then we will have all the steps of an argument which shows that there is no moral difference:

1. If there is a moral difference between active and passive euthanasia, then conditions 1 and 2 must be met.
2. Conditions 1 and 2 cannot be met
(none of the reasons put forward satisfy both conditions).

3. Therefore, there is no moral difference between active and passive euthanasia.

It should be noted that this is an “open-ended” form of argument, since not every possible difference can be canvassed. In the remainder of the paper, I intend to describe some of the arguments that have been offered for making the distinction between active and passive euthanasia and show why they fail the conditions that I have set forth.

Probably the argument that’s offered most frequently points out that passive euthanasia is “letting die” whereas active euthanasia is active “killing.” Since it is always wrong to kill an innocent human being, active euthanasia but not passive euthanasia must always be wrong.

I think that this argument meets condition 1 but not condition 2. This can be demonstrated using an example provided by James Rachels (Rachels, 1975). Rachels describes two evil uncles named Smith and Jones. Each of these uncles has a young cousin and each of the uncles stands to gain a considerable inheritance if the young boy suffers an unfortunate accident. Each of the evil uncles therefore forms the intention of drowning the child when he is taking his bath. And each of the evil uncles enters the boy’s bathroom fully intending to hold his head under water until he drowns. The one evil uncle Smith goes into the bathroom and forces the child’s head under water until the child dies from drowning. The second evil uncle Jones enters his cousin’s bathroom with the same intention, but just as he walks in the door the young boy slips on a bar of soap and hits his head on the side of the tub so that he is knocked unconscious. Since this fits in very neatly with Jones’ plans he just stands by, does nothing, and lets the boy drown.

As Rachels points out there is a difference between what Smith and Jones did. What Smith does is an active killing but what Jones does is a passive letting die. But Rachels asserts—and I agree—that that makes no difference to our moral evaluation of Smith and Jones. We think that what each of them did is equally reprehensible. The bare fact that one is a “killing” does not make it morally worse than the other and the bare fact that the other can be described as a “letting die” does not make it less morally objectionable.

The example is not an attempt to draw a direct analogy between what Smith or Jones did and what doctors do when they allow passive euthanasia. Doctor’s intentions are almost always more benevolent. All that the example is intended to show is that the distinction between killing and letting die is by itself not a reliable guide to what’s morally justifiable or defensible. If indeed the example shows that this distinction is not a morally reliable one, then we should not use it uncritically to try to mark a moral difference between active and passive euthanasia. There must be some other difference beyond the bare fact that one is a killing and one is a letting die if indeed we are to justify our different moral attitudes toward active euthanasia.

This leads me to a second argument which is sometimes brought forward to articulate a bit more what the difference is between killing and letting die in the medical context. When we let a patient die, it is said, it is the disease or the condition that is the cause of the patient’s death and so the physician is not responsible for the death in the same way that he or she would be if death were caused by a lethal injection (as in active euthanasia).

This argument meets condition 1, but not condition 2: if this identifies a difference, it is not a morally relevant difference. Even if we admit that there is a difference in the “causes” of the patient’s death this cannot show that passive euthanasia is permissible whereas active euthanasia is not. This conclusion would follow only if we equivocate with the word “responsible.” The following
argument is an example of how this equivocation works.

(a) When a patient is allowed to die it is the disease that is responsible, for his death.
(b) When the disease is responsible, for the death, then the physician is not responsible, for the death.
(c) Therefore when the patient is allowed to die (passive euthanasia), the physician is not responsible, for the death.

In the first premise of this argument the word “responsible” is being used as a synonym for “causes.” This use of the word “responsible” is morally neutral, just as it’s morally neutral in the sentence “spontaneous combustion was ‘responsible’ for last night’s fire.” However, when we get down to the conclusion of the argument, the word “responsible” is not being used in a morally neutral way and is not being used as merely a synonym for “causes.” “Responsible” in the conclusion is a synonym for “blameworthy.” The only way we can link these two distinct senses of “responsible” is by the use of a claim like premise (b). But such a claim is clearly false. Cases of gross negligence by physicians would be an example in which the disease or underlying lethal condition was the cause of the patient’s death and yet in those cases the physician would remain blameworthy for that patient’s death. The fact then that in passive euthanasia the disease rather than the physician is the immediate cause of the patient’s death does not by itself provide us any grounds for relieving the physician of moral responsibility and certainly cannot provide any grounds for justifying a physician’s decision to withhold a potentially life saving medical treatment. The physician’s merely indirect causal role in passive euthanasia does not relieve him of moral responsibility. A physician who lets a patient die can be morally blameworthy for that action just as much as a physician who deliberately kills a patient.

A third argument that is often heard points out that in medicine one can never be sure of the diagnosis or prognosis for any particular patient. Medicine is not an exact science and physicians are the first to admit that they make mistakes. Every physician as well as every subscriber to Reader’s Digest can report anecdotes describing cases of patients who miraculously recovered. The argument is then made that the moral difference between active and passive euthanasia is that in active euthanasia such a lucky break (the miraculous recovery) is denied the patient who has been killed by his doctor. The philosopher Tom Beauchamp presents a version of this argument when he points out that if we prohibit active euthanasia we will save those people who are wrongly diagnosed as hopeless, but who would have survived with a good outcome even if treatment had been stopped. (Beauchamp)

I think this alleged moral difference fails both conditions 1 and 2. It fails condition 1 if the significant difference is supposed to be the fact that there will be a greater number of unnecessary or tragic deaths if we permit active euthanasia than if we permit only passive euthanasia. If this is a real difference between active and passive euthanasia, it’s also a real difference between passive euthanasia and aggressive treatment. That is, we can make exactly the same kind of comparison between permitting passive euthanasia and prohibiting passive euthanasia. Beauchamp admits that a policy that permits passive euthanasia runs the risk of allowing tragic deaths. If avoiding unnecessary or tragic deaths justifies a policy prohibiting active euthanasia, it would seem on exactly the same score to justify a policy of prohibiting passive euthanasia as well. This alleged difference marks no real difference between active and passive euthanasia.

It also fails condition 2, because even if we assume that the “tragic deaths” are connected only with active euthanasia, this would not be a morally significant difference that would justify prohibiting active eutha-
nasia on request. The patient who is requesting active euthanasia can knowingly accept the risk of false diagnosis and prognosis, which is just what well-informed patients do when they are asked to make any kind of medical treatment or non-treatment decisions.

A third argument that is offered against permitting active euthanasia claims that active euthanasia offers a much greater likelihood of abuse than passive euthanasia, where abuse means killing patients who don’t want to die. We can find this argument, for example, in a letter to the New England Journal of Medicine from Dr. Fernando Vescia, in response to James Rachel’s article: “Central to the condemnation of active euthanasia is the lack of protection from when this choice would be motivated by other than charitable purposes.” (Vescia, 1975)

This argument may meet condition number 2, because certainly the likelihood of abuse is a morally relevant consideration in deciding whether or not to permit a certain practice. If indeed active euthanasia offers a much greater likelihood of abuse than passive euthanasia, we would have reason not to allow active euthanasia even on request. At least this would be so if in addition there were no practical mechanisms for reducing the additional threat of abuse that active euthanasia might pose. But even if this argument meets condition 2, it does not meet condition 1, because the potential for abuse does not mark a real difference between active and passive euthanasia.

The worst abuse would be to cause the death of patients whose death was avoidable or forestalling, and who didn’t want to die. But one can do this with passive euthanasia as well as with active euthanasia simply by withholding potentially life-prolonging treatments from people who want to continue to live. Indeed, you might argue that abuse of this kind would be easier with passive euthanasia since it would often be plausible in the circumstances to attribute the death to the patient’s grave condition, rather than to a physician’s decision not to act. I think there is indeed evidence of this kind of abuse of passive euthanasia.

There may, for example, be reason to believe that there is some abuse of passive euthanasia in the institutionalized elderly. In a study appearing in the New England Journal of Medicine by Brown and Thompson (1979) it was found that of a hundred and ninety patients in nine nursing homes who had suspected bacterial infections (probably pneumonia, in most cases) antibiotics which probably would have resolved the bacterial infection were withheld from 81 patients. Predictably, of those 81 who were not treated a much larger proportion subsequently died of that infection. In how many of these 81 cases had permission to withhold treatment been granted by the patient and/or the patient’s family? Unfortunately Brown and Thompson don’t ask the question directly but some of the other information they gather can provide some grounds for making an inference. Usually when permission to withhold a treatment has been explicitly sought by the physician and granted by the patient and/or the patient’s family, that permission is noted in the patient’s medical records as a very important form of legal protection. Brown & Thompson did determine the cases in which a notation had been made in the patient’s medical records of the physician’s intention to withhold the antibiotic treatment, which is still not quite the same as a documentation of consent. As it turned out in only 23 of the 81 cases was there such a notation. The proportion 23/81 probably represents a liberal estimate of the proportion of cases in which consent had explicitly been granted. That leaves a very large proportion of cases in which abuse of passive euthanasia should at least be strongly suspected.

Despite abuse such as this, the response has not been (and should not be) to call for the prohibition of voluntary passive euthanasia. The more defensible approach is to
develop ways to prevent or lessen the abuse. Active euthanasia is just like passive euthanasia in that it, too, poses a threat of abuse. But if the real and present threat of abuse can’t justify prohibiting passive euthanasia, then neither can it justify prohibiting active euthanasia.

The final argument that I wish to consider is one that I myself made a couple of years ago but have come to reject (Tomlinson, 1981). The argument points out that permitting voluntary passive euthanasia of competent adults is justified by the existence of a right to refuse treatment which physicians must recognize whether they agree with the decision of the patient or not. There is by contrast no analogous “right to be killed” that would justify active euthanasia because such a “right” would require that physicians actively participate in an action that they may deem immoral. The patient, however, can’t have a “right” that the doctor violate his or her conscience. The upshot of the argument is that the moral difference between active and passive euthanasia is that patients have a right to passive euthanasia, which they can demand of physicians, but they don’t have any such right to active euthanasia which entitles them to physician cooperation.

Although I once thought that this was a very significant difference between active and passive euthanasia, I no longer believe so. I think that the argument violates both conditions 1 and 2.

First of all I think it fails condition 1 because it does not mark a real difference between active and passive euthanasia. Notice that the argument proposes that the morally relevant distinction between active euthanasia and passive euthanasia is based on the degree of moral responsibility placed upon the physician. When the responsibility is solely the patient’s (as in passive euthanasia) it is more defensible to permit it as a matter of policy than when responsibility is “shared” with the physician or thrust upon him (as in active euthanasia). But if this is a genuine distinction that justifies us in accepting one form of euthanasia but in rejecting another it seems to condemn most passive euthanasia as well. The only form of euthanasia that would involve no supporting activity or cooperation from the physician or the hospital is when the patient is permitted to haul himself out of bed and stagger to the elevator under his own power. As a matter of fact, however, we think that patients have a right to something more than this when we advocate a policy permitting passive euthanasia, even though anything more than this is going to require some supporting activity or cooperation from the physician. If the logic of this argument was acceptable, for example, the policy of the University of Southern California Burn Center would have to be rejected. There, burn victims who have burns so severe that their survival is unprecedented are fully counseled on the alternative of no treatment, and if they elect that option they are provided with a private room, unlimited visitation, and full pain relief. (Imbus and Zawacki, 1977)

I also think this argument fails condition 2. Even if there is a real distinction here between active and passive euthanasia so that all and only forms of passive euthanasia are protected by a right that obligates physicians to respect the patient’s request, how can that show that only passive euthanasia should be permitted? It shows only that a patient can’t justifiably demand that a physician kill him as he can demand to be left alone. But this doesn’t show at all what would be objectionable about a mutually agreed upon active euthanasia. That is, the argument doesn’t show why we shouldn’t or couldn’t have policies regarding active euthanasia which would be similar to those we now have governing abortions and sterilizations. With abortion and sterilization we can also point out that no patient has a right to demand of a particular physician that he or she perform an abortion or sterilization when that would violate that physician’s conscience. But all this point justifies is policies permitting peo-
ple to refuse to perform abortions or sterilizations. Conscientious refusals cannot justify the prohibition of abortions or sterilizations, any more than they could justify the prohibition against active euthanasia.

These are all the arguments I have space to review. I believe I have successfully shown that each of them fails one or both of the conditions I’ve set out. If the same is true of any other plausible arguments that might be offered, then I think we will have a well-grounded basis for changing our moral attitude regarding active euthanasia.

NOTES


