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Should Active Euthanasia Be Morally and Legally Permissible?

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Within the last few decades in America, patient advocacy and a call for transparency in medicine have increased dramatically, resulting in increased patient autonomy and decreased paternalistic doctor-patient relationships. Generally, people agree that patient autonomy is important; however, many still question patient autonomy concerning controversial bioethical issues such as euthanasia. The two different types of euthanasia are active and passive euthanasia. In the United States, except for Oregon, Washington, Montana, Vermont, and California, "active euthanasia (whether voluntary or nonvoluntary) is unlawful, while passive euthanasia (both voluntary and nonvoluntary) is legal."[1] Recently, "the U.S. Supreme Court has ruled that states may legalize or prohibit [physician-assisted suicide] as they see fit."[2] Therefore, states decide whether active euthanasia should be morally and legally permissible. The majority of states still refuse active euthanasia. The patient's choice to end his/her life is controversial because Americans and western culture views death more negatively than other countries and cultures. Because of this, hospitals and new technologies continuously develop to prolong life no matter the cost. The moral permissibility of active euthanasia is questioned, in part, due to some bioethical views, religious views, and the "yuck factor." I argue that active and passive euthanasia are both morally permissible because there is no moral distinction between the two. My argument will be further supported by rule-utilitarian ethics. Due to a lack of moral distinction between active and passive euthanasia, both should be legalized.

Utilitarianism supports the idea that good actions are those that result in the greatest good for everyone involved and that "we should maximize the nonmoral good (the *utility*) of everyone

[1] Vaughn, Lewis "Euthanasia and Physician-Assisted Suicide" in Lewis Vaughn, *Bioethics Principles, Issues, and Cases.* (New York and Oxford: Oxford University Press), 627.
[2] Ibid., 628.

affected, regardless of the contrary urgings of moral rules or unbending moral principles."[3] Within this ethical framework, there are two different approaches to how to achieve the greatest good. The first is act-utilitarianism, which is "the idea that the rightness of actions depends solely on the relative good produced by *individual actions*."[4] The effect of the act must be weighed and the greatest good involves choosing the action that produces more good than bad. The second approach is rule-utilitarianism, which "avoids judging rightness by specific acts and focuses instead on *rules governing categories of acts*."[5] This approach focuses on consistently following a set rule that leads to the most beneficial and moral outcome for all of those involved. My argument to legalize euthanasia is most supported by rule-utilitarianism. Legalizing euthanasia will allow for the greatest good of everyone involved in the decision by reducing suffering and burdens.

To better understand the morality of both active and passive euthanasia, James Rachels offers an example of active and passive killing. In the example, there are two men, Smith and Jones, who have the same motive to kill their six-year-old cousin for a large inheritance. However, when Jones tries to kill the child, he sees that the child accidentally drowns himself and does not help him. Smith, on the other hand, physically drowns the child. In both cases, the two men had the same motive to kill the child, but achieved the result using different methods. The author argues intention determines the morality of an action. Thus, actively killing in itself is not worse than watching someone die. Rachels further explains that there is a common misconception that doctors don't do anything in passive euthanasia. He argues that in passive euthanasia, letting a patient die is action in itself. The action to withhold treatment is an action

[3] Vaughn, Lewis "Bioethics and Moral Theories" in Lewis Vaughn, *Bioethics Principles, Issues, and Cases.* (New York and Oxford: Oxford University Press), 36.
[4] Ibid.
[5] Ibid.

that can be made both morally and immorally. Rachels explains that the doctor's decision to withhold treatment "is subject to moral appraisal in the same way that a decision to kill him would be subject to moral appraisal: it may be assessed as wise or unwise, compassionate or sadistic, right or wrong."[6] Thus, the action itself is not what determines morality.

In passive euthanasia, usually the doctor agrees to withhold treatment, which is accepted legally. The justification for withholding treatment is usually that the patient is going to die anyways and is in pain; therefore, it would be wrong to prolong suffering.[7] However, "if one simply withholds treatment, it may take the patient longer to die, and so he may suffer more than he would if more direct action were taken and a lethal injection given."[8] Therefore, Rachels argues that active euthanasia is preferable in this scenario because a lethal injection will immediately end suffering, whereas passive euthanasia will take longer and prolong pain and suffering. If patients are able to choose active euthanasia, they will be able to end suffering and pain very quickly.

James Rachels believes that "the benefits of directly killing terminally ill patients in many cases outweigh the burdens of letting them die."[9] He argues that by legalizing active euthanasia and letting doctors and patients make their own choice, suffering will be reduced, which is the greatest good for all of those involved. Rachels states that the legal difference between active and passive euthanasia "leads to decisions concerning life and death made on irrelevant grounds."[10] The author supports this claim by stating that Down's syndrome children with intestinal blockages can be left to die, even if a minor surgery with keep the child alive.

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[6] Rachels, James, "Active and Passive Euthannasia" in Lewis Vaughn, *Bioethics Principles, Issues, and Cases.* (New York and Oxford: Oxford University Press), 681.
[7] Ibid., 678.
[8] Ibid.
[9] Lindemann, Hilde. 2006. *An Invitation to Feminist Ethics.* McGraw-Hill.
[10] Rachels, James, "Active and Passive Euthannasia" in Lewis Vaughn, *Bioethics Principles, Issues, and Cases.* (New York and Oxford: Oxford University Press), 679.

However, Down's syndrome children without complications will live because they cannot be killed. Therefore, withholding treatment can be immoral and is an action in itself; Thus, not leading to the greatest good.

Daniel Callahan counters Rachels, opposing active euthanasia because he believes that physicians will gain too much power. Callahan also believes that the main role of a physician is to help maintain the health of patients and nothing more. He states, "when physicians could do nothing to stop death, they were not held responsible for it."[11] Therefore, he believes that doctors don't do anything immoral when they withhold treatment. He believes that there is a clear moral difference between active and passive euthanasia. However, Rachels describes that withholding treatment can be immoral if the intentions are immoral. For example, Rachels explains that if a physician withholds treatment that could cure someone, then that action would be considered immoral. Callahan fails to address that actions cannot be inherently moral or immoral without an intention. Additionally, he doesn't address the fact that active euthanasia gives patients autonomy and leads to less suffering. According to the ethics of principlism, doctors have the duty to respect autonomy, beneficence, non-maleficence, and justice. When a patient is suffering, the role of the doctor is to alleviate their suffering and respect autonomy. Active euthanasia allows for doctors to do so, especially for patients who are not terminally ill.

The perspective of patients suffering without the option for active euthanasia is further explained by John Hardwig. The suffering, that Rachels also discusses, includes

> dehumanization, loss of independence, loss of control, a sense of meaninglessness or purposelessness, loss of mental capabilities, loss of mobility, disorientation and

[11] Callahan, Daniel "When Self-Determination Runs Amok" in Lewis Vaughn, *Bioethics Principles, Issues, and Cases.* (New York and Oxford: Oxford University Press), 660.

> confusion, sorrow over the impact of one's illness and death on one's family, loss of ability even to recognize loved ones, and more.[12]

In many cases, those who are suffering do not have terminal illnesses to eventually relieve their pain. In cases with "no end in sight" people have the "duty to die" and "patient-assisted suicide cannot, then, be restricted to those with unrelieved pain and terminal illness."[13] Hardwig describes the "duty to die" as a duty that an individual has to accept death when the burden of caring for that individual compromises the lives of those who love them. The right to refuse treatment will not benefit these patients, and will continue to prolong suffering for a very long time.

Hardwig's argument about "the duty to die" aligns with rule-utilitarianism. He argues that legalizing active euthanasia will relieve patients and loved ones of burdens and suffering. He claims that prolonging life can devastate the lives of loved ones, and, because of that, there are moral justifications for active euthanasia. In order to provide the greatest good for all, some have the duty to die. Often times, bioethics cases are centered on one patient, without considering all of those involved. He states that "the burdens of providing care or even just supervision 24 hours a day, 7 days a week, are often overwhelming," as well as emotionally and financially taxing.[14] In other words, the burdens of staying alive are sometimes too great. Sick patients still have duties and obligations to loved ones "to try to protect [them] from serious threats or greatly impoverished quality, or an obligation to avoid making choices that will jeopardize or seriously compromise their futures."[15] Hardwig claims that sometimes the best good is knowing and acting upon when it is your duty to die. Some people are kept alive longer than they are able to "care

[12] Hardwig, John, "Dying at the Right Time: Reflections on (Un)Assissted Suicide" in Lewis Vaughn, *Bioethics Principles, Issues, and Cases.* (New York and Oxford: Oxford University Press), 683.
[13] Ibid., 684.
[14] Ibid., 685.
[15] Ibid., 686.

for [themselves], longer than [they] know what to do with [themselves], longer than [they] even *are* [themselves]."[16] Thus, modern medicine increases "deaths that come too late."[17] In most cases, especially involving non terminally ill patients, prolonging death in not what will bring the greatest good for everyone, because it prolongs suffering and adds prolonged burdens to family and loved ones. Therefore, the author argues that active euthanasia should be legalized.

John D. Arras counters and rejects active euthanasia, even though he sympathizes with the concept. Arras claims that "patients who fall outside the ambit of our justifiable criteria will soon be candidates for death."[18] He is concerned that doctors will abuse their power when given the ability to actively assist suicide. However, research has found that "only a minority of patients request euthanasia in the end of life and of [those] requests a majority [are] not granted" because careful planning is required.[19] There are regulations set by hospitals and the law that minimize corruption regarding euthanasia. The process is highly regulated, as is active euthanasia in the states that allow it. In Oregon, rates of assisted dying

> showed no evidence of heightened risk for the elderly, women, the uninsured (inapplicable in the Netherlands, where all are insured), people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations.[20]

Therefore, doctors will not unproportionally harm or exploit minority and vulnerable groups with active euthanasia.

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[16] Ibid., 691.
[17] Ibid.
[18] Arras, John, "Physican-Assisted Suicide: A Tragic View" in Lewis Vaughn, *Bioethics Principles, Issues, and Cases.* (New York and Oxford: Oxford University Press), 667.
[19] Battin, Margaret P., Agnes van der Heide, Linda Ganzini, Gerrit van der Wal, and Bregje D. Onwuteaka-Philipsen. 2007. "Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in 'Vulnerable' Groups." *Journal of Medical Ethics* 33(10): 591-97. https://doi.org/10.1136/jme.2007.022335.
[20] Ibid.

With better technology and biomechanical equipment, patients are increasingly able to prolong their lives, giving rise to problems surrounding the "duty to die." Americans have a difficult time confronting death, but need to be able to face it and understand when it is their "duty to die." There is no moral difference between active and passive euthanasia in itself. What makes the action moral or immoral is dependent on the intention behind the action. America already has set into place regulations for passive euthanasia that reduce corruption regarding euthanasia. By legalizing active euthanasia with parameters and strict regulations, doctors will have the ability to make ethical decisions and perform the greatest good for everyone involved. There is little tolerance for corruption in America, especially in health care. With the right laws and regulations in place, legalizing active euthanasia will end suffering for many people and alleviate burdens on family and loved ones.

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