Moral Permissibility of Active Euthanasia

Reid Johnson

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Professor Franco Trivigno
University of Oslo
Department of Philosophy, Classics, History of Arts and Ideas
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Preface

This dissertation is designed to examine the moral arguments behind euthanasia practices in the United States. I would like to thank Professor Franco Trivigno for his guidance and supervision during its writing over the spring and fall semesters of 2016, as well as all of my family and friends for their support and helpfulness with this project.

Reid Johnson

Oslo, December 15\textsuperscript{th}, 2016
Abstract

The objective of this dissertation is to examine the moral arguments commonly presented in the current debate on active and passive euthanasia in the United States. I claim the belief that there is a moral permissibility difference between active and passive euthanasia, which is that active euthanasia is impermissible and passive euthanasia is permissible, is unable to be supported by the arguments given in its defense. I first clarify what types of medical conditions commonly associated with euthanasia debates I will be considering as well as different types of euthanasia, and why there is no clear guidance in the medical field. I then present the three strongest arguments in defense of the moral permissibility difference. They are an application of the Doctrine of Double Effect, an appeal to the distinction between killing and letting die, and an appeal to patient rights. I present counterarguments to each, concluding that the original arguments fail in defending the moral permissibility distinction.
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Section I – Introduction

Euthanasia is a tricky subject to discuss, and is one that is both incredibly important and inflammatory in the public, medical, and philosophical forums. It is now, more than ever, important to discuss euthanasia due to the technological and procedural advancements in the medical field that allow for people to live longer and longer in increasingly varied and troubled circumstances. There has been a gradual shift in the mindset of physicians along with these advancements such that they will do and try anything to keep their patients alive. While I do not fault these attempts or advancements in technology, I believe that the states in which patients are surviving due to them are not representative of a good life, and the goals of care that we should strive for need to be refocused from how long a patient lives to how well a patient lives. One major part of this refocusing effort is to allow for euthanasia to be allowed as a viable care option. In recent years passive euthanasia (in which treatment is withheld from patients upon request) has been used widely across the United States. “The American Hospital Association says that about 70 percent of the deaths in hospitals happen after a decision has been made to withhold treatment” (Kolata, 1997). Many of these patients are those with incurable and terminal illnesses and conditions such as cancer or bowel obstructions which cause tremendous amounts of pain for the patient. But the process of passive euthanasia can take time, sometimes weeks in order for the patient to die, all the while suffering in their condition. Active euthanasia is another type of euthanasia in which the patient is given an overdose of medications to end their life quickly. The factual distinctions between the two has led some philosophers to believe that they are morally distinct and in particular that passive euthanasia is permissible while active euthanasia is not. This restricts patients and physicians from utilizing all available care options. I will challenge this distinction in this paper and promote active euthanasia as a viable care option.

In an attempt to delve into the moral permissibility of euthanasia, I will first go over some of the medical terms and conditions in which euthanasia is usually considered, as well as the numerous types and classifications of euthanasia. Then I will look into the medical field to see if there are any guiding doctrines that will help us to analyze euthanasia in the context of the medical field. After this background has been given I will be providing what I believe are the three strongest arguments supporting the moral permissibility distinction
between active and passive euthanasia, then provide counterarguments against each of these. I aim to demonstrate that active euthanasia is morally equivalent to passive euthanasia and should be incorporated in treatment as a care option.

**Section II – Medical Terms**

In this section, I will provide an overview of the medical distinctions amongst persistent vegetative state, locked-in syndrome, coma, and brain death. These distinctions are very important because they are often cases where euthanasia is considered in addition to cases such as late stage cancer, bowel obstructions, and various other diseases and conditions. These states vary not only in the state of consciousness of the patients but also whether patients in these states can even be considered ‘alive’. These definitions also provide us help in determining which of these states allow for voluntary euthanasia and those that do not.

Persistent vegetative state (PVS) refers to a patient who has received severe cerebral damage and has been in a chronic state of unconsciousness for a minimum of four weeks (Martin, 2010, s.v. persistent vegetative state). This damage can be the result of stroke, cerebral hemorrhaging, disease, infection, or numerous other causes. In this state, the patient may exhibit limited wakefulness, spontaneous eye or bodily movements, or groaning. Limited wakefulness refers to patterns in sleep, and appearing to be awake, including tracking movement or responding to non-voluntary reflex physical stimuli although the movements are random and only responses to particular physical stimuli. The patient is never fully conscious even during these times of activity, meaning that their brain is not capable of conscious thought nor responses to stimuli such as voice commands or emotional or visual stimuli. The patient is able to breathe on their own but unable to eat or drink on their own, requiring the use of an artificial nutrition and hydration system. A patient is highly unlikely to recover from this state, especially when the time in this state has lasted longer than three months.

A locked-in patient is one who has received damage to the brain stem (particularly the pons region) and as a result has become fully paralyzed (Martin, 2010, s.v. locked-in). This means these patients are unable to move any muscles in the face or limbs, they cannot
speak, and sometimes they can have difficulty breathing. These patients, unlike the persistent vegetative state patients, have full consciousness and have control over vertical eye movement and some can control blinking, and they all can also feel pain. The reason a patient in this state has full consciousness is because the cerebral portion of the brain (responsible for conscious thought) has been undamaged. These patients require an artificial nutrition and hydration system, and some need artificial respirators as well, depending on the exact type and severity of the damage. Patients in this state are also highly unlikely to recover.

Coma patients also have received severe trauma to the cerebrum, resulting from stroke, bleeding, disease, or infection like the persistent vegetative state patients, and as a result are in a chronic state of unconsciousness (Martin, 2010, s.v. coma). The difference between a coma patient and a persistent vegetative state patient is that a coma patient is completely unconscious, with no spontaneous movements or waking cycles. These patients also have no conscious thought, but do have some brain activity. They do not respond to stimuli, cannot eat or drink, but can breathe on their own. These patients usually recover within a month but chances of recovery drop considerably after that time.

These three definitions are sometimes debatable because the severity of these conditions come in degrees, resulting in possible classifications in multiple categories or transferring between categories such as a PVS and comatose state. The definition of brain death, however, is much more definitive. To be classified as brain dead, patients must meet three criteria. One, they must be in a comatose state, meaning they are unconscious and unable to respond to all ranges of stimuli such as voice commands or pain. Two, they must have an absence of brain stem responses. These responses are involuntary responses such as a pupil dilating to changing light conditions. And three, they must have no breathing movements or response if removed from an artificial ventilator (Martin, 2010, s.v. brain dead). If these conditions are met the patient is brain dead, and thereby legally and clinically dead, even if he or she remain on the ventilator and their heart continues to pump blood through the body. The heart is not directly controlled by the brain, so circulation is not a factor in brain death.

Here is a small chart summarizing the main features of these conditions:
<table>
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<tr>
<th></th>
<th>LOCKED IN</th>
<th>PVS</th>
<th>COMA</th>
<th>BRAIN DEAD</th>
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<tbody>
<tr>
<td>CONSCIOUS THOUGHT</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>RESPONSE TO STIMULI</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>WAKEFULNESS</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>UNASSISTED BREATHING</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>UNVOLUNTARY RESPONSES</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>SOME BRAIN FUNCTION</td>
<td>YES (Full Function)</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>OTHER BODILY FUNCTIONS</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>POSSIBLE TO FEEL PAIN</td>
<td>YES</td>
<td>*</td>
<td>*</td>
<td>NO</td>
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*It is still debated in the medical community whether these patients feel pain or not. There have been studies showing blood flow to parts of the brain associated with pain in these patients matches that of healthy patients, though it is still not known what the actual subjective experience of these patients is.

Cognitive function of the patient is necessary for patients to give consent, the way in which voluntary and non-voluntary euthanasia are distinguished. In the states described above, patients who are in locked-in states are the only ones who have full cognitive function and are therefore able to provide consent for euthanasia procedures at that time as the other patients who may be considered such as the cancer or bowel obstruction patients. However, patients can also provide consent beforehand by making living wills. Living wills state the wishes of the patient and give consent for particular courses of treatment in a case where they are unable to give consent themselves at that time. With living wills, comatose and persistent vegetative state patients are also able to give consent to euthanasia procedures by doing so before entering a states where they are unable to provide consent. This means that all the states above except for brain dead will be considered because they can provide consent through living wills, though only locked in patients can give consent at the time of the procedure.

Section III – Types of Euthanasia

In addition to the numerous classifications of patient states, there are also several classifications of euthanizing procedures that need to be made. Euthanasia refers broadly to intentionally ending the life of a living thing in order to relieve pain or suffering (Martin,
2010), but can become more complex when used with human patients. Distinctions need to be made between active and passive euthanasia, as well as voluntary and non-voluntary euthanasia. Additionally, there is also the term assisted suicide which will need to be clarified.

First, the distinction between active and passive euthanasia. Active euthanasia is to take specific and deliberate steps in order to cause a patient’s death. This usually means that the doctor will inject the patient with a lethal dose of medications. Typically this involves injecting a sedative to put the patient to sleep if they are in a conscious state, and then injecting a muscle relaxant which lowers the heart rate until death occurs. This is a procedure done where the doctor knowingly and willingly gives a lethal dose of medications, but this definition does not define the willingness of the patient, meaning that this can be done with or without the consent of the patient. The distinction between definitions involving patient consent will be made shortly.

Passive euthanasia, on the other hand, is to knowingly and willingly withhold or remove common treatments or care that would have resulted in the continued life of that patient, and is commonly referred to as “pulling the plug” outside of the medical field. This essentially means that instead of actively causing the death of the patient, the doctor instead just does not save them, or removes the treatments that were maintaining the patient’s life, resulting in the death of the patient due to the disease or state they are in. The most common examples of this relevant to our cases can include ceasing the use of a respirator or the use of an artificial nutrition and hydration system, which would then result in the death of the patient by either suffocation or dehydration and starvation. The active or passive distinction simply refers to whether an action is taken which directly causes the death of a patient or whether an action (or inaction) is taken that results in the death of the patient from a different causal chain. This is a more specific subset of a broader debate going on which attempts to distinguish killing and letting die. There are those, such as Warren Quinn, who believe that killing is worse than letting die. He argues that “an agent’s most direct contribution to a harmful upshot of his agency is the contribution that most directly explains the harm” (Quinn, 1989, p. 301) meaning that it is the direct action of killing which makes it worse than letting someone die in which your action does not influence the course of events. However others such as James Rachels and Jonathan
Bennett who argue that action is simply behaving in one of a few ways which brings you to a particular outcome and inaction is behaving in one of many ways which brings you to a particular outcome (Rachels, 2001, p. 5). The morality is not in the action or inaction but rather in external factors. This debate in its entirety is too broad for this paper, yet we will refer back to it periodically in this specific medical context for reference. Active euthanasia in this wider context of killing vs letting die would be considered killing since it is an active choice and action. Passive euthanasia would be labeled as letting die in the larger debate because the medical condition of the patient is what kills them, not the direct action of the doctor. The doctor removes the treatments that were sustaining the patient’s life, and by removing them, the doctor allows for the current state of the patient to kill them; it is not the doctor that is the cause in the chain of the events that lead to the patient’s death.

The voluntary vs. non-voluntary distinction tracks the patient’s willingness to be euthanized. Voluntary euthanasia is when a patient who is in a competent and unaltered state of mind makes a decision and asks that treatment be stopped or action be taken to end the patient’s life, with full knowledge that this will result in his or her death. This can be done in a formal verbal or written manner at the time the patient wishes the treatment to be stopped, but also may include wishes that have been placed in a living will. So if a patient is unconscious in a comatose state and has a living will that dictates he wishes for euthanasia after a given amount of time in a comatose state in which his recovery is deemed extremely unlikely, the euthanasia would be voluntary because of his living will.

Non-voluntary euthanasia is when a patient’s consent on the euthanasia is unable to be obtained because they are in a physical or mental state in which they are unable to give consent. This can mean that the patient is too young, lacks decision-making capacity, or is physically unable to respond. This can only apply to patients without living wills because a living will is considered a form of giving consent. Consent must still be gained from someone for the procedure to occur, and can be obtained from the legal surrogate. This is very different, however, than involuntary euthanasia. Involuntary euthanasia is when a person is able to give consent, but does not because they either do not want to be euthanized or because they were never consulted. The only type we will be considering in this paper is voluntary euthanasia, because involuntary euthanasia is morally wrong in any realistic
medical circumstance and non-voluntary raises different issues around how to attain
consent from a patient who is unable to provide it which will not be addressed in this paper.

The last definition is physician-assisted suicide. This is when a patient voluntarily
wishes and consents to ending their own life, but rather than administering the lethal
treatment, the doctor simply provides it to the patient, who administers it to themselves.
While the doctor provides the necessary means for the patient to end his or her life, it is the
patient that actively takes their own life, and not the doctor; hence the term suicide and not
euthanasia. This can either be done through ingested or injected medications, but it
requires the patient to be in a state where they are physically able to take or inject the
medications themselves.

Finally, we must add the current legality of these procedures. At this time, active
euthanasia is illegal across the entire United States, but passive euthanasia is legal due to
rights of the patient to have treatment discontinued at any time. Physician-assisted suicide
is legal in 5 states, Oregon, Montana, Washington, Vermont, and California, and also in one
county in New Mexico. Across the world the laws vary greatly and are also at times
confusing and unclear. Active euthanasia is legal in Belgium, the Netherlands, Luxembourg,
and Columbia, while physician-assisted suicide is legal in Belgium, the Netherlands,
Luxembourg, Canada, Finland, Germany, and Switzerland. Passive euthanasia is the most
confusing, mainly because many countries do not have laws that specifically state whether
or not it is legal and others have laws that allow it, but in practice rarely perform it. In India,
for example, passive euthanasia is legal, but there was a case in which a woman was in a
coma and deemed highly unlikely to recover. She had no living will, no family, but had
several close friends. The law stated that if there was no living will or family, the decision fell
to her closest friends whether to allow passive euthanasia because they would know the
patient’s wishes best. Her friends decided that she would have wanted to be taken off the
life support and allowed to die. However the medical staff disagreed and wanted to keep
her on life support. The matter was taken to court and the judge ruled that the medical staff
was closer to the patient than her friends, and she remained on life support for 42 years
until she died of pneumonia. These kinds of cases show that even if a law is in place which
allows this kind of procedure it is not always done in practice.
Now that I have explained the differences between many of these types of conditions, we will narrow the scope to include only those in which voluntary active euthanasia is conceptually possible. Fully conscious patients and those with locked-in syndrome are included because they are able to give voluntary consent to the procedure because of their normal cognitive function. Comatose patients and patients in persistent vegetative states cannot give consent in their state, but can provide consent in living wills. Patients in comatose or persistent vegetative states without living wills will not be considered in this paper because they represent the non-voluntary situations. Additionally, brain dead patients are both medically and legally considered dead, and therefore cannot be euthanized. I will now be comparing the moral permissibility of passive and active euthanasia in these specific voluntary medical cases.

Section IV – Absence of Definitive Moral Guides in Medicine

For the purpose of this paper I will be restricting my discussion to only medical cases because they are special cases set within hospitals and have regulated procedures performed by doctors rather than ordinary citizens in random and varied circumstances. Doctors are special cases since they have a large amount of training, it is their occupation, and they have a moral, legal, and professional duty to maintain certain ethical standards. While the legal guidelines are clear from the laws passed, laws should reflect morals, and we should then be able to find within the field of medicine some sort of morally guiding document or principle which will reflect these legal guides.

A commonly suggested source has been the Hippocratic Oath. The Hippocratic Oath is an oath originally written by Hippocrates in ancient Greece but is now recited by medical students upon finishing school and training. This oath is a promise to uphold a certain ethical standard of care and practice, and although it is not legally binding, it is a tool used to guide professional behavior and duties. Since its original creation in antiquity, it has been re-written several times throughout the years with major changes, the most recent being in 1964. Here is the modern oath in full:
I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given to me to me save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

- Louis Lasagna, Academic Dean of the School of Medicine at Tufts University, 1964

There is a problem however. Even since this version was published, changes continue to occur. Each medical school has its own version which promises to uphold different practices and some schools do not even have an oath anymore. A 1993 survey of 150 medical school Hippocratic Oath variations from the U.S. and Canada found that 14% prohibit euthanasia,
8% foreswear abortion, and 11% hold covenant with a deity (Orr, 1997). This wide range of differences with contradictory principles and covenants means that if doctors cite the “Hippocratic Oath” in order to guide their decision making, they may be guided towards contradictory answers. Because of the range of versions, The Hippocratic Oath cannot be referred to as a unified professional ethical doctrine which can give guidance.

Despite this ambiguity, there are other sources in which physicians can base their moral convictions. Biomedical ethics is an area in applied ethics concerned with biomedical research, medicine, and health care. Its recommendation for patient care is composed around four main principles: respect for autonomy, nonmaleficence, beneficence, and justice (Beauchamp, 2014).

Patient autonomy is an important principle to consider, for it should never be assumed that a patient wishes for (or denies) a certain treatment to be performed. Informing the patient and receiving consent after discussing the patient’s wishes is necessary for appropriate care. The requests must also be compatible with the policies of the institution involved. It is important to remember the patient has the decision-making power; the doctor is an expert sources to provide options, benefits and detriments to each option, and can provide their professional recommendation (which most of us will follow), but they are not the ones choosing the care. It is well within your right to go into the hospital for foot pain, receive the diagnosis of a broken foot from the doctor, and deny the advised treatment of a cast from the doctor.

Nonmaleficence is the principle of abstaining from causing harm to others. Under this category, obeying general rules such as ‘do not kill’, ‘do not cause pain or suffering’, and ‘do not incapacitate’ provide the basic ways in which to abide by this principle. However, these are not always absolute rules, as it may be necessary to cause a proportional amount of pain in order to reach a desired outcome. Surgery, for example, can cause great harm and pain to people, but it is temporary pain and is done to provide the means to a cure, to improve quality of life, or alternately to relieve pain. Chemotherapy or radiation therapy also harms the body but is intended to improve the outcome of cancer treatment. Finally, to not incapacitate is impossible to abide by all the time because any procedure requiring general anesthesia to minimize intraprocedural pain and distress directly opposes this.
Physicians even go so far as to put patients in medically induced comas if they have received a traumatic brain injury in order to limit the damage and help recovery.

Beneficence means contributing positively to the patient’s welfare. The treatments which a physician undertakes must be based on more than simply not harming the patient, there must be a personal or public benefit that will be achieved by any treatment in order for it to be considered ethically responsible. Personal benefit is directly gained by the patient, whether that be pain reduction or symptom management, while public benefit is gained by the wider community, such as research data accrued from the patient’s procedure in order to better treat other patients in the future.

Justice promotes equality and fairness, but what type of justice to use, especially in medicine, is relatively unresolved. This is because types of justice or even different theories on one kind of justice support different courses of action. In medicine, the two most common kinds of justice are distributive and procedural justice. Distributive justice judges the fairness of the distribution of resources, whereas procedural justice deals with the fairness of the process in which a decision is made. Cases of distribution of resources in situations of crisis or where limited resources must be divided among patients with different likelihoods of survival epitomizes this ethical struggle. The most common example of this would be organ transplants. For example, let us say there is a 70 year old man and a 30 year old man waiting for a transplant. The 70 year old has been waiting on the list for six months, has a prognosis of approximately 5 years after the transplant, and has no remaining family. The 50 year old man has been waiting a month for a transplant, a prognosis of 20 years after the transplant and has a wife and two children. Procedural justice might stipulate that the organ go to the 70 year old man because he was on the list first and for longer, but distributive justice might stipulate that the 50 year old man has a greater need and benefit from the transplant and therefore he should get it.

These bioethical principles may at first seem better for action guiding, but they also fall short. As I have already explained, nonmaleficence is overruled in many circumstances in order to treat patients; so harming a patient by either actively or passively euthanizing them to bring a better outcome cannot be ruled out on principle. Beneficence might be in favor of euthanasia if the patient believes it is a benefit to them, and it might be a benefit to others in terms of justice and reallocation of resources. Patient autonomy may be satisfied as well.
in euthanasia if that is the request of the patient, however, patient autonomy does not mean that the doctor must do whatever the patient asks. A doctor is not always required to satisfy all requests for treatment so autonomy may be overridden as well. As we can see, these principles cannot provide us with a course of action either, as some of the principles might indicate one course of action, whereas the others give contradictory advice. Since neither the Hippocratic Oath nor Bioethical Principles are able to provide unified guiding results, we must look outside the field of medicine to philosophy to judge the permissibility of euthanasia.

Section V – Arguments for the Moral Permissibility Distinction

The purpose behind the analysis of the permissibility of euthanasia is quite simply to allow for more options in health care that can then allow for care to be better tailored to the individual patient. But currently in the United States active euthanasia is deemed illegal, not even being considered for those certain patients who may benefit from it. I feel this is a mistake and believe that more options will result in better patient care. Notice this is not an argument to implement euthanasia in all possible circumstances, nor to say it should be used over other kinds of treatment, but to be made available for those patients who are in a state which euthanasia may be acceptable and when they request it.

In this section, I will be looking at the arguments put forward by those claiming that active euthanasia is morally worse than passive euthanasia. Factually, active and passive euthanasia are clearly different, the former being death caused by the intentional administering of a combination of drugs and the latter being death from whatever condition or disease the patient suffers from, but I disagree in that these facts are sufficient to constitute a moral permissibility difference. Because the intention of passive and active euthanasia (relieving pain through death) is the same in both, and the result of patient death is the same, the burden of proof to show that there is a moral, not just factual, difference in permissibility between active and passive euthanasia falls on its supporters. I will be looking at what I take to be the three strongest arguments made by its supporters, and in the next section show that these arguments fail to provide an adequate basis for the permissibility of one and the forbiddance of the other. The first argument applies the
Doctrine of Double Effect, the second appeals to the distinction between killing and letting die, and the third appeals to patient rights.

First let us take a look at the Doctrine of Double Effect, referred to hereafter as DDE. DDE is “the moral significance of the distinction between intending harm (as a means or as an end) and bringing about harm as a foreseen but unintended side effect of one’s action” meaning that “it is sometimes permissible to bring about as a foreseen but unintended side-effect of one’s action some harm it would have been impermissible to aim at as a means or as an end, all else being equal” (FitzPatrick, 2012, p. 183). There are certain constraints inherent to DDE. There is a permissibility constraint in which “the fact that a harm was brought about as a merely foreseen side effect of pursuing a good end does not, all by itself, show that it was brought about permissibly” (McIntyre, 2001, p. 221) and “if some other equally feasible course of action would realize the good result with less harmful side effects, then that should be pursued instead” (McIntyre, 2001, p. 224). The limited scope constraint means the application of DDE “is limited to a contrast between harms intended as means to a good end and harms foreseen as side effects of promoting a good end” (McIntyre, 2001, p. 226). DDE must also be neutral in that “the distinction underlying DDE must be drawn in a way that does not directly or indirectly reflect judgements of permissibility” (McIntyre, 2001, p. 233). And there must be reasonability in the application of DDE in that if “the agent has some reason to set [a foreseen consequence] aside when deliberating in a particular context, then... the consequence was merely foreseen and the agent did not aim to bring it about” (McIntyre, 2001, p. 237). The purpose of detailing the constraints is to immediately rule out objections to DDE that do not truly grasp its concept, such as the objection claiming that DDE explains the action of someone acting rightly for wrong reasons or acting grossly disproportionatate to a situation.

In the case of passive euthanasia, the argument would go as follows; the doctor intends to remove the patient’s life support because of the patient’s right to stop treatment even though the doctor foresees the unintended consequence of the patient’s death. The doctor removes the life support intending to respect the rights of the patient and the patient dies. Because the intention was only to remove the life support and not to kill, DDE claims this action is permissible. If the doctor’s intention was to kill the patient by removing life support, the doctor would be acting impermissibly because he intended the harm rather
than just foreseeing the consequence. DDE cannot accommodate active euthanasia for the same reason of intending to kill the patient, even if the intention is to relieve pain by causing death. There is, however, a small subset of active euthanasia which IS supported by DDE. This subset is called indirect euthanasia and occurs in hospice care. Sometimes a patient is in such great pain at the end of their life that they require large amounts of narcotics to relieve their pain. These pain medications can sometimes cause patient death which is by definition active euthanasia since it is death directly at the hands of the physician, but because of the physician’s intention to only relieve pain it is able to be explained by DDE. The physician gave the drugs intending to reduce the pain of the patient and foresaw but did not intend to kill him, therefore acting permissibly. This is different than standard active euthanasia because in the standard case, the physician uses the drugs to relieve pain by means of death. Death was a direct intention to result in pain relief while the indirect euthanasia is aimed at pain relief with death as a side effect. The intentions of the physician in the active euthanasia case is to end the life of the patient with a purposeful overdose of medications with no foreseen but unintended consequences. The physician in the passive euthanasia case has the intention of removing intrusive medical treatments with the foreseen but unintended consequence of the patient dying. The physician is respecting the rights of the patient or the patient’s family to refuse treatment and so by removing treatment, the intention is purely to respect these rights, not to kill the patient. If the patient were in a non-life threatening situation and they requested all the treatments and machines stopped and removed the intention and action would be the same, but the results would be different. Supporters of the moral permissibility distinction between active and passive euthanasia feel that this illustration of DDE and the intention behind the physician shows moral differences between active and passive euthanasia, and that by intending death of the patient, active euthanasia is morally worse than passive euthanasia.

According to the second line of argument, supporters also use the claim that performing an action which results in the death of a person is morally worse that simply allowing a causal chain to unfold and to result in the patient’s death. McLachlan explains that “the absence of a ventilator kills no one. The presence of a ventilator might, in some instances, serve to counteract a cause of death. The switching off of a ventilator might, in a sense, be an indirect cause of death but it will not kill directly as, say, a heavy dose of some
drugs will” (McLachlan, 2008, p.636). This is an appeal to the widespread intuition that killing is morally worse than letting die due to the causation of the circumstances that cause a patient’s death. If a patient has a disease or is in a state which requires a ventilator, and the ventilator is not present in the first place then nothing can be done and the patient dies. The same goes for if the ventilator is turned off. It is not the absence of the ventilator but the condition of the patient that kills them. However, if a high dose of drugs is given by a doctor, then the cause of death would be the drugs, and therefore the doctor kills the patient. By using the ventilator, the sequence of events and causes that result in the death of the patient are merely interrupted, and not started by the physician, whereas if the overdose of drugs were used then the sequence of events that led to death would be started by the physician. We must be careful to not let the sequence of events that directly cause death go back too far. For example, we cannot say that the manufacturer of the drugs kills the patient because by them creating the drugs it allowed the physician to kill the patient. The manufacturer may be an indirect cause of death but not a direct one, and only the direct causes are subject to this argument.

Supporters of this argument have three choices; they are either committed to saying that killing is always morally impermissible and letting someone die may be permissible in some circumstances, or that in some circumstances both killing and letting die may be permissible but that in the cases of euthanasia it is always impermissible to kill but not always impermissible to let die, or that killing is simply worse than letting die and do not take a stance on permissibility. It cannot be said this last option is used because then it would not be an argument that claimed active euthanasia was impermissible. And for the other two, either way, when restricted to euthanasia cases, the claim is that killing is always impermissible because if it allowed for active euthanasia to be permissible in some cases, it would have to be allowed in medicine. So a physician who actively euthanizes a patient is acting impermissibly because he is the direct cause of death. In passive euthanasia, the physician is a blocking agent between the patient’s condition and death until he removes himself and allows the chain of events to occur whether or not he was there, thereby acting permissibly.

The final reason for why active euthanasia is morally impermissible but passive euthanasia is not is because everyone has certain rights, and we have moral obligations to
not violate those rights. Everyone has the right to not be killed, and therefore “we are obliged to refrain from killing each and everyone. We do not have a similar obligation to try (far less to continue to try) to prevent each and everyone from dying” (McLachlan, 2008, p.636) because there is no right to be prevented from dying. This asymmetry in the rights you have correlates to the duties of people around you. A physician may try their best and fail to save you, but that does not mean that your rights have been violated by him. Because there is no obligation to prevent someone from dying, it becomes morally permissible to let someone die as you would in passive euthanasia. You are permitted to remove the ventilator because you have no moral obligation to prevent the patient from dying. It may be the case that you have a professional obligation as a physician to prevent them from dying, but you also have the professional obligation to respect the wishes of the patient in terms of treatment options. If the patient wishes to stop treatment which will result in their death, the physician must oblige, but need not oblige to pursue treatment which results in killing the patient because that would violate the moral obligation to not kill. So if a physician were to actively euthanize a patient, he would be violating the patient’s right to not be killed, thereby making active euthanasia impermissible. If a physician removes life support systems from a patient, the physician is not violating any right the patient has to be saved, and is therefore acting permissibly.

The combination of these three reasons, DDE, the distinction between killing and letting die, and patient rights, provide the basis for describing the moral distinction between active and passive euthanasia, and the conclusion that active euthanasia is impermissible. DDE argues along the line that in some circumstances it is the case that harm can be caused as a foreseen side effect of an action intending good. So passive euthanasia is permissible because death is a foreseen side effect of respecting the patient’s right to have their life support removed. Active euthanasia has death as the main intention, so cannot be permitted. The killing and letting die distinction appeals to the belief that killing is worse than letting die, and therefore active euthanasia is not permitted when passive euthanasia is. Lastly, the rights of the patient clearly state that they have the right to not be killed, making active euthanasia impermissible, but do not have a right to be saved, making passive euthanasia permissible.
Section VI – Arguments Against the Moral Permissibility Distinction

While the Doctrine of Double Effect, differences in killing and letting die, and the appeal to moral rights seem to provide a seemingly stout defense of the difference in moral permissibility between active and passive euthanasia, I believe each is faulty, resulting in the need to reject the conclusion that active euthanasia is impermissible and passive euthanasia is permissible, and replace it with the claim that both options are permissible. I will begin with two objections to DDE, the first is to claim the death of a patient when performing passive euthanasia is unintended is incorrect, and the second is the idea that death may not even be a harm, and therefore no need for DDE to be used. Then I will argue that the intentions of the physician negate the factual differences in killing and letting die rendering them equal, and lastly, address the waiving of rights to allow for active euthanasia.

In the argument for the use of DDE to explain why passive euthanasia is permissible and active euthanasia is not, supporters claim that in active euthanasia the intention of the physician is to kill the patient which is impermissible, while in passive euthanasia the intention is to respect the rights of the patient by removing unwanted and intrusive forms of care. I believe however that the intention of the physician in passive euthanasia is also to kill the patient due to a “problem of closeness” principle Alison Hills describes originating from Philippa Foot. An example is given about explorers trapped in a cave: “A fat man who is stuck in the mouth of the cave has trapped some explorers inside the cave. The only way for the explorers to escape is to blow up the fat man with dynamite. The explorers intend to escape from the cave by blowing up the fat man” (Hills, 2007, p. 263). Hills explains that “assuming that they foresee that he will die, the explorers kill him intentionally. But they claim that they do not intend to kill him” (Hills, 2007, p. 263) and that DDE will support their actions. Foot argues that this is absurd to accept. Killing the man by blowing him up is necessarily part of escaping the cave in this example, so it cannot be the case that they intend one and not the other. This is because “it is impossible in principle for any agent to have the plans that the explorers... are described as having without intending to kill, for example, we might claim that anyone who intends to blow someone up into little pieces must also intend to kill him” (Hills, 2007, p. 264). The two are too closely related to be separated from one another, and for that reason they must be both taken as intentional. This can be easily transferred to the passive euthanasia case as well. The only supposed
intention of the physician is to remove life support from the patient, and the foreseen but unintended consequence of that is the patient’s death. But these are necessarily related, for the doctor is performing a passive euthanasia on a patient. If the patient is removed from life support (ventilators or artificial nutrition and hydration machines) then the patient will die, and the objective has not been reached until the patient dies. The physician does not remove the life support and then say ‘the euthanasia was successfully carried out!’ That does not happen until the patient’s life has also ended.

Alison Hills attempts to reject this closeness argument by stating:

“Intentions are intentional: however “close” X is to Y, even if X is identical with Y, it is possible for an agent to intend that X and not to intend that Y... Even where an agent correctly believes that X is identical with Y, she may intend that X and not intend that Y; she may simply have not drawn the requisite inference” (Hills, 2007, p. 265-266).

I believe this argument does not work because it is based on the ignorance of the person. The first part is correct in that you can intend X and not intend Y even if they are the same but you do not know that they are the same. For example, I could intend to eat the lunch in the refrigerator, but not intend to eat your lunch. If the lunch in the refrigerator is yours, but I did not know that, it is entirely correct that my intention was to eat the lunch but not eat your lunch even though the lunch I ate was yours. This is totally reliant on my ignorance to the fact that your lunch and the lunch in the refrigerator are the same. However, Hills extends her claim to include even cases where you know the two are the same. This means that I could have full knowledge of the fact that the lunch in the refrigerator is yours, but still only intend to eat the lunch in the refrigerator and not eat your lunch. This does not work. Once you are aware of the connection between the two it becomes impossible to intend one without intending the other. Changing the label used to describe the thing does not change the intention unless the person is ignorant of the fact that they represent the same thing. When we limit this to the euthanasia cases this becomes even clearer because physicians must know or have a very reasonable assumption at least that when they remove life support from a patient they will die. By intending to remove life support, the physician also necessarily intends the death of the patient because he cannot be ignorant of it without being totally incompetent. Thus, passive euthanasia is mischaracterized as being different in
intention from active euthanasia. They both have the intention to kill the patient, one path is just more direct than the other.

So if active and passive are both the same, it could be concluded that both are therefore impermissible. I disagree because it assumes that death of the patient is a harm, which is why DDE is attempted to be used in the first place. But in circumstances where passive or active euthanasia is considered, it is often the case that death may be a benefit for the patient. A study by Peter Singer et al states that many “participants were afraid of ‘lingering’ and ‘being kept alive’ after they no longer could enjoy their lives... They wanted to be ‘allowed to die naturally’ or ‘in peace’” (Singer P, 1999, p.165). This is supported by a 2014 study which found that “many Americans say they would tell their own doctors to stop treatment so they could die: if they had an incurable disease and they were suffering a great deal of pain (57%), if they had an incurable disease and were totally dependent on another for care (52%), or if they had an incurable disease and it were difficult to function in day to day life (46%)” (“Dying”, 2014, p.348). This implies that some people believe that there are states of existence that are worse than death. By allowing euthanasia we bring a benefit to these people and not a harm. Some may ask about the people who believe that any existence is better than death, or no existence. Allowing euthanasia does not mean it must be used. Those who believe all existence is good are free to not ask for euthanasia, and continue existing in any state they are in. DDE assumes that death is a harm, and I am willing to grant that in most cases that is true. However, euthanasia is not most cases in that the patient is in such a state where death could be a benefit to them. Because DDE assumes death is a harm it cannot be used in cases of euthanasia.

The second argument against active euthanasia is that killing is morally worse than merely letting someone die, and more specifically, that in the medical field, killing is impermissible but letting someone die is, in some circumstances, permissible. However, many who argue against this fact claim that this difference is due to situational differences, and not in the act itself. James Rachels makes this very clear by providing an example that removes all differences from a situation except for that one fact of whether someone kills or lets someone die. He presents a pair of cases about Smith and Jones:

“In the first, Smith stands to gain a large inheritance if anything should happen to his six-year-old cousin. One evening while the child is taking his
bath, Smith sneaks into the bathroom and drowns the child, and then arranges things so that it will look like an accident. In the second, Jones also stands to gain if anything should happen to his six-year-old cousin. Like Smith, Jones sneaks in planning to drown the child in his bath. However, just as he enters the bathroom Jones sees the child slip and hit his head, and fall 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. With only a little thrashing about, the child drowns all by himself, ‘accidentally’, as Jones watches and does nothing” (Rachels, 1975, p.79).

It is clear that both Smith and Jones are equally morally wrong in their actions. What these cases provide is a situation where the only difference is the fact of whether the child was killed by Smith or merely let die by Jones. The intention to kill, motivation of greed, plan to kill, and the result were all the same. When the only difference is the actual act of killing, we can see that the two are morally equivalent. “If the difference between killing and letting die were in itself a morally important matter, one should say that Jones’s behavior was less reprehensible than Smith’s” (Rachels, 1975, p.79). But since we think that they are the same, this cannot be the reason for thinking that killing is morally worse than letting die.

Winston Nesbitt agrees with Rachels on his critique on the killing and letting die distinction in that there is no distinction in the fact itself. However, instead of rejecting the distinction altogether, he proposes that what really is at work in the distinction is the preparedness of both Smith and Jones to kill. He states “that someone who is fully prepared to perform a reprehensible action, in the expectation of certain circumstances, but does not do so because the expected circumstances do not eventuate, is just as reprehensible as someone who actually performs that action in those circumstances” (Nesbitt, 1995, p. 103). So the reason the two are equally morally reprehensible is not because killing and letting die are morally equivalent, nor from the circumstances of the situation, but that there is an additional factor of readiness to kill tied to the moral agent that determines the morality. I believe that Nesbitt’s argument could absolutely be true in general, I will not argue for or against its validity here, but only say that it is not applicable to euthanasia cases because of a point brought up by Sarah Beth Shaw. She correctly points out that “Nesbitt takes for granted that our intuition or immediate reasoning will tell us that willingness to kill in a person is always worse than willingness to let die. But is it? The problem with all of the aforementioned cases lies in the framing of them as a way to harm people” (Shaw, 2014,
p.14). If we look at cases of euthanasia, they are motivated by compassion, care, and respect, whereas all of Nesbitt’s examples of killing are motivated by malice, greed, and hate. I would agree that any euthanasia performed with intentions to harm are morally reprehensible, but also that they are not truly euthanasia.

Remember the term euthanasia comes from wanting to relieve pain and suffering. If we imagine a euthanasia case; a person already in intense pain and suffering but with a long prognosis due to the life support machines they are on, it can be seen as moral to remove them from the machines. But in cases where death still may come weeks afterwards, it may be considered better to end the suffering sooner by actively euthanizing. Imagine you are walking through the woods and find a rabbit caught in a trap. You wish to save the rabbit, but its leg is broken and it is unable to run or survive on its own if you set it free. You are also several days hike from your car so are therefore unable to get it help. It is clearly in a tremendous amount of pain and suffering a great deal, though the construction of the trap shields it from any predators that may come by. There is also food and water in the trap which was the bait used to draw the rabbit into it. You are left with three choices: leave the rabbit in its cage to die suffering from its wounds, let it out where it will continue to suffer until found and killed by a predator, or kill the rabbit yourself quickly to end its suffering. I believe, and I feel most others would agree, that the best moral action would be to kill the animal to save it from suffering. This is an action motivated by mercy, compassion, and care, the same qualities as in euthanasia of people. Active euthanasia is a case in where it actually may be that killing is morally better than letting die. Killing the patient will reduce the time the person is in pain and suffering, as opposed to letting the patient die where there is potentially more suffering depending on their state. In order to perform passive euthanasia on a patient who is not on a ventilator but is on nutrition and hydration machines will take several days to die of thirst and starvation, adding to the pain they already have in their condition. A patient on a ventilator will die within minutes after removal but will die of suffocation. By actively euthanizing, pain associated with letting the patient die is avoided along with the time spent in pain caused by the condition making it a better moral option.

The final argument against active euthanasia is an appeal to moral obligations of the physician to not kill the patient due to the patient’s right to not be killed which makes active euthanasia wrong, and the moral obligation of the physician to respect the rights of the
patient to refuse treatment which enables passive euthanasia. What I believe McLachlan forgets is that rights can be waived with permissions. For example, you have a right that your property not be taken from you. So if I were to take your car that would be stealing. But if you were to give me permission to take your car, it is no longer stealing. The act is the same, yet your giving me permission changes the moral permissibility of the action. Every right can be thought of as having a clause on the end of it stating that a permission can waive the right. So ‘I have a right that my property not be taken’ becomes ‘I have a right that my property not be taken unless I give you permission to do so’. If I give you permission to take my car, then it is morally permissible for you to take it. However, this is only if the person giving the permission actually has the authority to grant that kind of action. For example, I do not have the authority to give you permission to take someone else’s car. The authority of the permission is derived from whose rights are being waived by the permission. So the reason I have authority to give you permission to take my car is that I have the right that my property not be taken. If my car is taken without my permission it violates my right. If your car is taken it does not violate my rights, which means I have no authority to give permissions to negate your right.

This can be extrapolated to other rights as well such as the right to not be killed. I have a right to not be killed unless I give permission for doing so explains why it is permissible to euthanize someone if they give a voluntary permission. Since it is the patient who has the authority to make the decision regarding his own life, he is able to give permission to waive his own right to not be killed. Furthermore, since we have obligations to respect these rights, we also have an obligation to respect the permissions waiving these rights. But respecting these rights does not necessarily mean that we have an obligation to act. It would be incorrect to say that you are obligated to take my car if I gave you permission to take it, just as it would be incorrect to say that you are obligated to kill me if I give you permission. However, euthanasia are special cases where physicians not only have moral duties but professional ones as well. I believe morally, doctors are not required to euthanize, but professionally they might be. Whether physicians are actually required to perform euthanasia is a discussion that is unable to be dealt with here because this paper is focusing on morality, not on the professional duties of physicians. So the argument that active euthanasia violates the patient’s right to not be killed but passive euthanasia acts in
accordance with a patient’s right to refuse treatment is incorrect. A patient voluntarily waiving his right to not be killed releases the physician from his moral obligation to not kill him, and allows him to perform active euthanasia.

We have now looked at the three best arguments attempting to explain the moral permissibility distinction between active and passive euthanasia, claiming that active euthanasia is impermissible due to its violation of DDE, that killing is morally worse than letting someone die based only on the act itself, and that the patient’s rights are violated. After an analysis of each argument we have determined them to be false and fail in making a moral permissibility distinction between the two. DDE cannot be applied because the intention of both active and passive euthanasia are to kill the patient, and it assumes euthanasia to be a harm when it may not be. The factual difference between killing and letting die is irrelevant when the intention is to relieve pain and suffering, and the rights of a patient to not be killed can be waived by the patient, allowing for active euthanasia. With no good cases left, I have concluded that active euthanasia is at least morally equivalent if not morally better than passive euthanasia in some cases. Because of this, the health practices must be changed in order to reflect the change in permissibility of active euthanasia.

Section VII – Implications for the Medical Field

If we assume that this paper is correct in that active and passive euthanasia are morally equivalent, this will have a major impact on the practices in the medical field. First and foremost, it would lead to the legalization of active euthanasia for voluntary patients. This means that, for patients that choose this course, they would be able to pass away in a quicker and less painful manner than if they choose passive euthanasia. This could lead to less anguish for them and their families, resulting in a better end of life experience. By allowing active euthanasia, you give another care option for not only those who are reliant on life support systems, but also those who are in immense pain who are not reliant on life support and have previously not had a viable way of relieving pain. A study published in 2015 looked at the rates of patients who die with pain, depression, or confusion in the United States between 1998 and 2010. It found that there were increases in all three during that period of time. While all of the data is interesting and should be looked at to benefit
patients in end of life care, the statistic most important was that 60.8% of all patients die in pain (Singer AE, 2015, p.180). The fact that so many patients die in pain, and that that number is increasing leads me to believe that one of the core tenants of medicine needs to be examined. Maintaining patient life is no longer enough, and now medicine must focus on maintaining a patient’s good life. Expanding the treatment options provides patients and their families with more options for them to choose one that suits their particular situation the best, and allows for them to choose how best to proceed when they feel they are no longer living a good life.

As much of reasoning behind a patient choosing active euthanasia is based on pain, it raises the question of whether locked-in, comatose, and persistent vegetative state patients can feel pain. Locked-in patients are able to feel pain, and can express that to the physicians, but it is unknown what the subjective experience of the persistent vegetative state and comatose patients is to pain. A study performed by Boly et al. has shown that for some patients in these states, blood flows to the part of the brain associated with pain perception when stimulated with pain just as in healthy participants (Boly, 2008). What is still unclear is what the subjective experience of the patient actually is, though it suggests they can feel pain. If it is the case that they feel pain, then the reasons for choosing active euthanasia also apply to them. However, if it is not the case that they can feel pain, an appeal to the dignity of the patient could be argued. It can be explained in the living will that existence in that state represents a loss of dignity and identity and the wish to not exist in that state.

Despite my stance on the benefits of allowing active euthanasia, it does not come without some practical and logistical concerns. There are worries that active euthanasia might become an option that is abused, such as by those with depression, or that it might be applied to other groups such as those with disabilities. In order to combat these fears there will obviously need to be strict and clear guidelines on who is able to pursue this type of treatment option, and I feel it is best restricted to those who are in medically terminal conditions with no reasonable chance of recovery, and who are able to give voluntary consent to do so. This means that patients with conditions in which they are unable to give consent are unable to have this form of care option because these would be considered non-voluntary active cases, and this paper only supports voluntary active ones, however, it
is my personal belief that non-voluntary active euthanasia should be allowed as well though I give no solid argument in support of it at this time. I will say though that an argument in support of this will need to address consent. If the patient is in a state where they cannot offer consent and they have no will, it is possible it could be left to the family to decide. If the family is acting within the best interests of the patient and in accordance with what they believe to be his wishes it seems in theory permissible to argue.

An additional concern include patients feeling pressured into this option if they feel themselves to be a burden. Since this is such an important and difficult decision, I believe each request for euthanasia should be reviewed by an ethics committee that involves the patient, family, and physician in addition to the ethicists to promote an open, clear, and honest dialogue on the options. The last concern addressed here will be physicians who do not feel comfortable with this care option. If they do not have a moral obligation to perform euthanasia, then how will the process work if they refuse? If it is the case that their professional obligations demand that they do, then that will suffice, but if they do not have that obligation it may be the case that other physicians will have to be called in to perform the procedure. There may be other practical concerns with implementing euthanasia, but that should not sway us away from acknowledging the morality of the argument for it.

Section VIII – Conclusion

While passive euthanasia is a valuable care option, the introduction of active euthanasia in the United States would have a strong positive impact on the treatment and care of patients in the medical field. I have taken the three strongest arguments against the use of active euthanasia; the use of the Doctrine of Double Effect to rationalize the harm of ending a patient’s life, the claim that killing in active euthanasia is morally worse than letting die in passive euthanasia, and that there is a moral obligation to respect the patient’s right to not be killed, and brought up counterarguments to all three. I maintain my claims that the Doctrine of Double Effect cannot argue that the death of the patient is unintentional nor that death is a harm in euthanasia cases, that all else being equal the factual difference between killing and letting die does not constitute a moral difference, and that the patient can waive their right to not be killed by voluntarily requesting euthanasia. These
counterarguments show that in the specific cases of voluntary euthanasia, active and passive euthanasia are both morally permissible and should both be allowed as care options.
Cited Literature


Quinn, Warren S. "Actions, Intentions, and Consequences: The Doctrine of Doing and


