Is There a Difference Between Passive and Active Euthanasia?

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Active euthanasia, which is defined as the intentional act of causing the death of a patient experiencing great suffering, is illegal in France, whereas allowing patients to die (by withholding or withdrawing treatment) is authorized by law under certain conditions. However, the distinction between the different end-of-life decisions that healthcare professionals can make is perhaps less clearly defined than we might think; administering a lethal injection is far from being the only method by which a doctor can 'kill'.

Oh, you who prolonged my life,
Take back a gift that I detest!
Diana I beg you,
Stop the course of my days!
(Iphigénie in C.W. Gluck's *Iphigénie en Tauride*)

According to a study carried out across six European countries by EURELD (European end-of-life decisions) between 2001-2002, between 36% and 51% of all deaths were the direct result of medical end-of-life decisions (apart from Italy, where the figure was 22%)[1]. In almost half of these cases, healthcare professionals decided to stop, limit or withhold treatment, whether or not the patient had explicitly requested it. In the other half of cases, they decided to alleviate pain and symptoms by intensifying medication to a level which may hasten death. Even in countries where euthanasia is legal, only a small percentage of all deaths (0.1% in Italy, and from 0.2% in Sweden up to 3.4% in Holland) occurred as a result of the administration of lethal drugs, whether voluntary or involuntary[2]. What these figures show is not only how often such end-of-life decisions are made by physicians, but also that they are carried out in very different ways, which often fall outside the scope of our current definition of euthanasia.

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1 A. I. van der Heide *et alii*, « End-of-life decision-making in six European countries: descriptive study », *The Lancet*, n° 362, 2003, p. 345-350.

2 See Pennec S, Monier A, Pontone S, Aubry R. End-of-life medical decisions in France: a death certificate follow-up survey 5 years after 2005 act of parliament on patients' rights and end of life. *BMC Palliative Care* 2012; 11(25):22-28. See also Ferrand E, Vincent-Genod C, Jabre P, Duvaldesin, P. Les conditions de décès à l'hôpital. Enquête nationale Mort à l'hôpital (MAHO). *Annales Françaises d'Anesthésie et Réanimation* 2005; 24(9):1043-4. A previous study (LATAREA) carried out across 113 intensive care units found that 53 % of deaths in intensive care units were due to withdrawal and/or withholding of treatment (E. Ferrand *et alii*, « Witholding and withdrawal of life support in intensive care units in France: a prospective survey », *The Lancet*, vol. 357, 6 janvier 2001, p. 9-14).

Choosing to die

Despite the fact that the Leonetti report evaluating the 2005 French "end of life" law (2008) [3], the Sicard report (2012)[4] and the recent recommendation by the CCNE (n. 121, 2013)[5], have all concluded that euthanasia should remain illegal, debate on ethical legitimacy of euthanasia and assisted suicide, will probably intensify. Indeed, the subject continues to be controversial: public intellectuals continue to debate about it[6], and a citizens' consensus conference held in the fall of 2013 has reached the conclusion that lethal injection should be an option, albeit in exceptional cases[7]. And this is no bad thing, for the current law fails to address the ethical issues that arise, most notably for medical professionals, in particular end-of-life decisions. The law only establishes a specific legal framework in which medical decisions might be taken, implicitly prohibiting what is not explicitly allowed. In no way does it clearly show what the best course of action would be in any given situation. This is precisely why more reflection is needed on the ethical implications of end-of-life decisions, and why frequent and thoughtful examination of the decisions medical professionals have to make is so important in terms of any potential changes that might be made to the law[8].

In the context of end-of-life decisions the difference between the moral legitimacy of euthanasia and its legalization is even more important than in other controversial areas of medicine. The implications of explicitly allowing medical professionals to kill, regardless of whether this is done with the commendable intention of alleviating pain and suffering, is considered, particularly by doctors themselves, as being far more problematic in nature than the actual act itself when it is performed within the private confines of the doctor/patient relationship. The fear that legalizing the practice, however rarely it might occur, could change our understanding of euthanasia and lead to a dangerous conceptual and practical slippery slope is stronger than the belief that euthanasia may be, in some cases at least, necessary and justified.

Public support for the legalization of euthanasia remains strong, despite the law, and it has no doubt been amplified by the media coverage of certain particularly upsetting cases in which no available treatment could alleviate the patient's suffering. However, this support is also due in large measure to the public perception that such extreme remedy as active euthanasia is a direct consequence of modern medicine itself and its practices. Such a perception exists for two reasons.

The desire to "die standing", which is so often used as an argument by advocates of the 'right to die in dignity', can be achieved in large part thanks to medical techniques which can extend the end-of-life period, making it not only more comfortable for the patient but also

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3 Available at http://www.jalmalv.fr/k/fichiers/530.pdf

4 http://www.ladocumentationfrancaise.fr/var/storage/rapports-publics/124000675/0000.pdf

5 http://www.ccne-ethique.fr/sites/default/files/publications/avis_121_0.pdf

6 Two authors have recently expressed opposing opinions: Doctor Axel Kahn, *L'Ultime Liberté* (Ultimate Freedom)(Plon, 2008), and the philosopher Ruwen Ogien, *La Vie, la mort, l'État : le débat bioéthique* (Life, Death, and the State: a bioethical debate) (to be published by Grasset). For some interesting articles on the topic, see A. Bondolfi, F. Haldemann and N. Maillard, *La Mort assistée en arguments*, (Assisted suicide: the arguments) Georg éditions, 2007.

7 http://www.ccne-ethique.fr/sites/default/files/publications/avis_citoyen.pdf

8 On the French debate about euthanasia, see Marta Spranzi, « The French euthanasia debate : exception and solidarity », *The Cambridge Quarterly of Healthcare Ethics*, 22, 2013, 1-9.

easier to foresee and control. Death need no longer be hushed up or associated with feelings of absolute powerlessness. This notion of the freedom to choose also gained legitimacy through the progressive integration of the concept of patients' rights into medical practice. The right to control one's own body can be considered one of the most fundamental of all human rights and therefore falls within the scope of the right to self-determination[9]. The moment a patient's death depends on a medical end-of-life decision, it becomes one of the most fundamental human choices. Whether one is for or against medically assisted death, one has to admit that it is an inevitable consequence of contemporary medical practice.

Killing and letting die

We now turn our attention to medicine itself. Aside from the fact that killing is prohibited, how does the medical profession intend to address the issues raised so tragically by its own practice? This is the meaning of the epigraph, in which Iphigénie implores Diana, who has 'prolonged' her life, to take back her gift: the life Diana has saved and for which she is responsible has now become unbearable to Iphigénie,.

The answer to this question, which is currently upheld both in the law and in the recommendations of many medical organizations, is based upon a very clear distinction between the action of deliberately and directly *causing* the patient's death and the action of withdrawing or withholding life-saving treatment in order to *allow* the patient to die. The latter can include the use of double-effect pain medication, i.e. treatment which can both relieve pain and accelerate death. Such treatment can be legally administered if this is done with the intention only to relieve pain and not with the aim of ending the patient's life.

Palliative care specialists use all these different approaches (withholding, withdrawing and double effect treatments), which they consider to be not only justified, but also, in certain circumstances, necessary. Not only are these methods fully disassociated from those which directly aim to cause death, but they are also fully justified; indeed, medicine is stepping back and fulfilling its most simple, sacred role, that of alleviating suffering. Such a stance, which can be found in the Leonetti law, is also expressed by the French-Language Society of Intensive Care in their recommendations:

> In hopeless situations, the decision to limit or to end therapy can be the only ethical alternative to "therapeutic obstinacy", which is contrary to the medical code of ethics. This is in no way equivalent to euthanasia, but it aims at restoring the natural character of death[10].

The law also considers end-of-life decisions to withdraw, limit or to withhold treatment as the legitimate rejection of what it describes as 'unreasonable obstinacy,'[11] thereby reaffirming the basis for the ethical legitimacy of the practice.

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9 This question is crucial to the debate on the 'right to choose to die'. A well-known text written by American philosophers in support of this law (« Philosopher's brief », http://www.nybooks.com/articles/1237) can be read alongside a decision by the European Court of Human Rights (the Pretty judgment, 29 April 2002). For a detailed analysis, see Jean-Claude Dupont, « Euthanasie : la loi belge et la position des juges européens » (Euthanasia: Belgian law and the decisions of European judges) (http://www.philodroit.be/IMG/pdf/euthanasie.pdf).

10 E. Ferrand, *Réanimation*, n° 11, 2002, p. 442-449.

11 « Ces actes ne doivent pas être poursuivis par une obstination déraisonnable. Lorsqu'ils apparaissent inutiles, disproportionnés ou n'ayant d'autre effet que le seul maintien artificiel de la vie, ils peuvent être

The distinction between 'killing' and 'letting die' is thus crucial. Medicine, and more particularly opponents to the legalization of euthanasia, have to prove that this approach provides the appropriate answer to the questions raised by an increasingly medicalized end-of-life, and that it is in no way necessary to resort to what is currently referred to as euthanasia.

In order to examine the practical and ethical differences between various 'end-of-life acts', we must first settle a terminological issue: what is euthanasia and how are we to define the medical practices of withdrawing and withholding treatment, as well as the use of double-effect drugs? This will then allow us to better understand the fundamental question of the moral legitimacy of the various end-of-life acts. As we shall see, the issue of intention, which provides the basis for the distinction between passive and active practices can be turned on its head and support the argument that both forms of euthanasia are ethically equivalent. According to the second argument, passive acts of withdrawing and withholding are morally superior to active end-of-life acts insofar as they put an end to medicine's excessive power and to "therapeutic obstinacy" and rather allow the restoration of the natural order of things. Despite its intuitive appeal, the argument will require a more nuanced examination.

Terminology

Regardless of the voluntary or involuntary nature of the end-of-life act[12], euthanasia can be defined in two different ways. Some use the term euthanasia in its strictest sense to describe the act of intentionally causing another person's death, most commonly through lethal injection. Others use it more broadly to describe any act or intervention, an action or an omission (also described as positive or negative acts), which contributes to a particular result, in this case the death of a patient. In both cases, the aim of medical intervention is to relieve pain and suffering or to 'fulfill any other ethical purpose'[13], in particular that of respecting the patient's autonomy and preventing unnecessary suffering.

These different definitions of euthanasia reflect a profound normative difference. Those who use the strict definition maintain that the decision to withdraw or to withhold treatment is in no way a form of euthanasia, since there is a clear difference between the administration of a lethal injection and the withdrawal of treatment. The former can be easily condemned as murder and the latter justified as the legitimate refusal of "therapeutic obstinacy", the opposite evil. This is the discontinuity thesis put forward by those who oppose the legalization of active euthanasia. Those who argue in defence of the broader definition however, maintain that there is little difference between different actions which all implement end-of-life decisions; they are all forms of euthanasia. Thus they refer to lethal injection as 'active' euthanasia while the decision to withhold, limit or withdraw treatment is referred to as 'passive' euthanasia. This "continuity" approach makes it easier to justify active euthanasia

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suspendus ou ne pas être entrepris » (These acts should not be pursued with unreasonable obstinacy. If they appear to be useless, disproportionate or with no effect other than to maintain life artificially, they can be suspended or not initiated.) (Law n°2005-370 from 22 April 2005 on the rights of patients and the end of life).

12 Evaluating the ethics of an act is obviously crucial, but it remains independent of the distinction between active and passive euthanasia.

13 According to the Robert Dictionary (1990).

through an analogy with the passive form: indeed, if withdrawing and withholding treatment is widely accepted as legitimate, and if what we refer to as 'passive' euthanasia is sufficiently similar to 'active' euthanasia, then the latter is also arguably morally justifiable. It is therefore not surprising that the term passive euthanasia is used most often by those who advocate *for* the legalization of active euthanasia.

I would personally advocate for the broader definition of euthanasia. Firstly, because it allows one to better grasp the differences between the two forms, while still highlighting their common characteristics. Putting active and passive euthanasia into two separate categories from the outset ignores the more subtle intuitions underlying the issue; indeed, these intuitions are complex and difficult to articulate precisely because they include certain differences between the two forms of euthanasia despite a certain continuity. Unlike certain advocates of the legalization of active euthanasia, I do not think that the two forms of euthanasia can be simply characterized as active and passive. Secondly, defining passive euthanasia as a legitimate refusal of "therapeutic obstinacy"— as do those who see a strict boundary between the active and passive end-of-life acts—implies that we can clearly define therapeutic obstinacy, the French equivalent for futile care. However, defining care as "futile" presupposes an evaluation of what is best for the patient. This evaluation has a strong subjective component, and it requires in turn a comprehensive ethical assessment.

My final point is that if someone wishes to argue effectively against the legalization of active euthanasia, or to claim that active euthanasia is morally less legitimate than passive euthanasia, he/she must refute the continuity thesis. Otherwise, he/she would be forced to admit that the law already allows actions which amount to killing the patient, albeit indirectly.

The grey areas of intention and responsibility

The broad definition of euthanasia quite rightly suggests that passive and active euthanasia share substantial moral ground. Firstly, there is very little difference between the degree of responsibility of healthcare professionals in each case; for both active and passive euthanasia, the doctor must make an end-of-life decision which can include a whole host of different acts, including withdrawing or withholding treatment, as well as the administration of pain-killers and anesthetics. Even if the intention behind each of these acts ("intention in action") is different and specific to the action in question (for example, switching off the life-support machine from a terminally ill patient is different from withholding antibiotics from the same terminally ill patient who has pneumonia, both of which are 'passive' acts and both of which are in turn also different from administering pain medication that may hasten death), the 'prior intention'[14] underlying each of these acts remains to hasten the death of the patient for ethical reasons, namely the fact that his/her future existence will be unbearable. Similarly, even if the 'intention in action' behind the administration of a lethal injection is to cause death, its 'prior intention' may still be to relieve suffering where all other forms of treatment have failed.

The principle of double-effect, which uses intention as a marker to distinguish between morally acceptable and morally unacceptable practices of administering potentially

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14 J. Searle, *Intentionality*, Cambridge University Press, 1983.

lethal drugs (by distinguishing between whether the intention is to relieve pain or to cause death) is particularly problematic in the current context. Indeed, since active euthanasia is illegal, doctors may instead simply administer pain-relief medication at fatal doses to alleviate the suffering caused by the withholding of food and drink, which is entirely legal in France since food and drink are considered forms of treatment. Another practice which may be used by doctors is what is referred to as terminal (or palliative) sedation, in which the underlying prior intention may well be to hasten death, even if the intention in action is to relieve physical or psychological suffering through sedation[15]. Intention in action may therefore be a poor indicator of the ethical nature of a given act, since it is contingent upon a decision based on prior intention, and it is the latter which is the main motivation behind all the actions which might follow. Intention in action is thus ethically neutral. Moreover, even if we accept for the sake of argument that a subtle distinction does exist between those who administer drugs in potentially lethal doses with the aim of relieving suffering and those who do so in order to hasten death, one question remains: how are we to maintain a minimum of transparency and control over medical practices if the only distinction between a morally justified and legal act and one which is morally unjustified and illegal is based upon the private intentions of the person carrying out the act? Are we forced to conclude then that society and medicine must finally reject the misleading idea that to kill and to let die are somehow morally different[16] ? Not before considering another possible difference between active and passive euthanasia.

Nature and the different end-of-life acts

One significant distinction between passive and active euthanasia is that passive euthanasia attempts to support and to gently guide the patient through what is otherwise the natural process of dying instead of actively initiating the dying process, whereas active euthanasia initiates the biological processes by which the patient will die. As Daniel Callahan points out, even if the withdrawal of treatment involves certain positive and negative actions which engage doctors' responsibility, a lethal injection would kill anyone, whereas withdrawing treatment would only kill a sick person[17].

So it seems that what truly sets passive euthanasia apart from its active form is the way in which it relates to the natural process of death and which makes the former morally superior to the latter. This in turn raises a crucial question: is the traditional doctrine, still very popular in the medical world, that it is better to let nature run its course than interfering with it, justified? If so, under what circumstances?

The word 'natural' is most commonly understood as 'what occurs independently of any voluntary and intentional human action'[18]. It is the opposite of all that is artificial. Thus, since the act of removing that which was artificially introduced into a patient's body amounts to reverting back to a more natural state in which death is merely the result of the underlying disease, doctors are absolved of all moral responsibility. "We would like it to be AS IF medicine had not intervened at all"; "we don't want to push the needle"; indeed, patients'

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15 Terminal sedation must be evaluated as a complex set of action which may each have very different ethical connotations. See Johannes J. M. van Delden, « Terminal Sedation: Source of a Restless Ethical Debate », *Journal of Medical Ethics*, Editorial, n° 33, 2007, p. 187-188.

16 H. Kuhse and P. Singer, « Killing and letting die », *in* J. Harris (ed.), *Bioethics*, 2001, p. 60.

17 « When self-determination runs amok », *Hastings Center Report*, vol. 22, 1992.

18 J. S. Mill, « On nature », *Collected works*, vol. X, Routledge and Kegan Paul, 1969, p. 375.

families and patients themselves express themselves in this way and aspire to this counterfactual state of affairs more often that we might think.

However, the apparent simplicity of the distinction between the natural and the artificial, and the ease with which all acts which consist of removing that which was artificially introduced would be exonerated from all moral evaluation is misleading at best, illusory at worst. Firstly, all human actions, even one which attempts to preserve the natural state of things, represents a conscious form of interference, however minimal, with the natural course of nature. What is natural is only so by degrees and it always includes a measure of the artificial. A truly natural death would have to take place entirely outside of the medical world. Also, it is unconvincing to consider that withdrawing antibiotics or even deciding not to administer them in the first place is practically and morally equivalent to a situation in which such treatments would not have been considered—or available—at all.

Secondly, one might argue that distinguishing between natural and artificial practices amounts to 'moral timidity', or even hypocrisy. As Patrick Hopkins writes, 'when we believe beyond all doubt that it is better for the patient to die but we are not willing to accept moral responsibility for being the one to kill, nature offers us an easy way-out.' We may even go as far as labelling certain medical practices as artificial, in order to justify their discontinuation[19]. Lastly, following nature would not only be impossible and hypocritical but also immoral. Indeed, even if medicine could imitate nature and ceased to interfere with it artificially, it would be immoral do to so since nature is capable of killing in such horrible and cruel ways. As Mill has so eloquently put it, 'If the maker of the world can all that he will, he wills misery, and there is no escape from the conclusion'[20]. It is undeniable that passive euthanasia, by way of limiting treatment or even administering double-effect medications, can sometimes lead to a longer dying process and therefore to more physical and mental suffering for the patient and/or his family than if a lethal injection had been administered.

Moral intuition, death and the law

A careful examination of the different moral intuitions involved in end-of-life decisions shows a real continuity between the different end-of-life acts. A lethal injection is not the only way to 'kill', even if these acts are carried out for entirely justifiable moral reasons[21]. However, contrary to what many advocates of the legalization of active euthanasia argue, the continuity between different end-of-life acts—from the most passive to the most active—does not automatically imply that the different end-of-life acts are morally equivalent. On the contrary, acts which are defined as the most 'active' are also often considered the most morally problematic, even if the active/passive distinction does not exactly correspond to the difference between legal and illegal acts in France[22]. For example, withholding treatment (not

19 « Why does removing machines count as passive euthanasia? », *Hastings Center Report*, May-June 1997, p. 37.

20 J. S. Mill, « On nature », art. cit., p. 388.

21 In a recently published book, a mother describes her experience of watching the withdrawal of artificial nutrition and hydration from her daughter after seventeen years of treatment which she acknowledges was as intensive as it was filled with love. In the end, it required a lot more than simply withholding treatment to put an end to her suffering. (Méral Tuzun, *Une dernière preuve d'amour*, Paris, Max Milo, 2009).

22 The legal scholar Denis Berthiau explains how the Leonetti law collapses a fundamental question (under what circumstances may we hasten a patient's death?) and an operational one (which are the acts that are

starting it in the first place) is considered less problematic than withdrawing the same treatment which has already been started, and it is ethically more difficult to withdraw artificial nutrition and hydration than to withdrawother forms of medical treatment. It is also important to consider that the specific circumstances of these different "passive actions" are of paramount importance for evaluating their ethical relevance; withdrawing artificial nutrition and hydration in the case of an elderly person who does not feel hunger and no longer wishes to eat and drink is less problematic than withdrawing artificial nutrition from a patient in the final stages of a fatal neurological disorder who wishes to die, but who still desires to eat and drink.

Conversely, and contrary to those who argue that withdrawal of treatment has nothing in common with euthanasia since it amounts to refusing futile care, actions of withdrawing, limiting and withholding treatment are not as morally neutral as we might be led to believe. This is well expressed by two nurses who describe their experiences withdrawing and withholding treatment: "to let die is not simply allowing someone to die". They explain that letting die is not simply a question of allowing someone to die; you have to know *how* to let a patient die both technically and morally[23].

By way of conclusion, we may affirm that euthanasia raises two questions it is crucial to distinguish. The first is to ask whether lethal injection, the most active of all the possible end-of-life acts and the only one which remains illegal along with assisted suicide, is morally justifiable, and if so, under what circumstances. The second is to ask whether it could, or should, be legalized. We have already seen that there is a real continuity between the various end-of-life acts, and that the more active acts are considered to be morally more problematic than the more passive ones. However, this does not preclude in itself the possibility of legalizing lethal injection under certain strict circumstances in the future. The law merely aims at providing healthcare workers with the means necessary to carry out end-of-life decisions in the best possible way given the constraints of each particular case. It is up to those caring for the patients, the 'midwives of the dying process'[24], to balance the morally problematic nature of active end-of-life acts with two other major moral constraints: respecting the patient's wishes and limiting the patient's suffering. This having been said, the depenalization of active euthanasia should very carefully consider the potential for abuse and take appropriate measures in order to avoid this risk. A detailed examination of the situation in the Netherlands, which was the first European country to legalize active euthanasia, will help identify a few essential questions: should euthanasia be allowed for patients who are not at the end of their life? Would the right to die be a negative or a positive right? (could we simple request it or could we demand it?); how can we avoid creating a situation in which lethal injection becomes the default response rather than the last resort?[25] Whatever we decide as a society, it is useful to remember that modern medicine has forever lost the ethical

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passive and which can therefore be permitted?) (« De Chantal Sebire à l'évaluation de la loi Leonetti : la pédagogie d'un point de traverse », *Médecine et droit*, 2008, p. 100-105).

23 D. Hildgen and C. Leau, « Les soignants face à l'abstention ou à l'arrêt des soins. Expérience dans un service de réanimation » (The experiences of medical professionals in intensive care units dealing with the withdrawal and withholding of treatment), *Les annales médicales de Nancy et de l'Est*, 31 (1992) 333-336.

24 Timothy Quill, *A Midwife Through the Dying Process*, Johns Hopkins University Press, 1996.

25 For an in-depth and relevant evaluation of the Dutch system, see an article by Henk ten Have, « End-of-life decision making in the Netherlands », edited by Robert H. Blank and Janna C. Merrick, *End-of-Life Decision Making : A Cross-National Study*, MIT Press, 2005, p.147-168 (Note that it does not discuss the situation in France).

innocence which previously characterized the end-of-life decisions it must inevitably make. It is to no avail to strive to recover the "lost paradise of letting die."

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