A Case For Active Voluntary and Active Non–Voluntary Euthanasia

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**I pledge that I have neither given nor received any unauthorized aid on this assignment

. Euthanasia, from *eu* (well) and *thanatos* (death), describes bringing about a person's death, whether indirectly or directly, for that person's sake. Throughout this essay, four types of euthanasia will be discussed. These practices are formed by combining three levels of informed consent by the patient with two mechanisms of termination of life. The level characterised by the most informed consent is voluntary euthanasia, characterised by acting in accordance with the patient's will. Non–voluntary euthanasia concerns patients who are unable to verbalize their informed consent and the process is carried out without their will. Involuntary euthanasia involves cases where the patient's life is ended against their will, and will not be covered in this essay.

These levels of respect for autonomy can be combined with two actions by the medical practitioner. In active euthanasia, death of a patient is brought about by direct action. This may be through the prescription of lethal drugs or an overdose of medication. Some forms of passive euthanasia, characterized by some form of withdrawal or withholding, have become so normalized that we often don't think of carrying out these actions as euthanizing patients. If passive voluntary euthanasia[1] and non–voluntary passive euthanasia[2] are morally permissible, then their active counterparts should also be morally permissible, as there is no difference in the actions or morality between letting someone die and completing a so–called "mercy killing".

Euthanasia is morally permissible under both consequentialist and non–consequentialist theories. Utilitarianism, focused on producing the most favorable balance between good over bad outcomes for all involved, would say that when a patient's pain outweighs their perceived value of their life, forcing them to live that life is forcing a bad outcome. The only way to strike a favorable balance for that patient is to allow them a swift and good death if they wish for it. If terminating a patient's life will yield the most net happiness (in this case, likely the least net unhappiness), it is morally permissible to end the life of the suffering patient in line with their wishes. When looking

[1] Ex: compliance with a patient's Do Not Resuscitate order
[2] Ex: removal of life support from a patient in an irreversible coma

through a non–consequentialist lens, Lewis Vaughn describes Kantian ethics in chapter 2 of his *Bioethics: Principles, Issues, and Cases* by saying that “Kant believed the inherent worth of persons derives from their nature as free, rational beings capable of directing their own lives, determining their own ends, and decreeing their own rules by which to live” (Vaughn 39). It is in the last two points that Kant allows an argument for passive euthanasia to be made; the patient will determine the means by which they die and decree that they no longer wish to carry the burden that they feel their continued life has become.

According to the principle of beneficence, it is a medical practitioner’s moral duty to attempt to reduce the amount of suffering incurred by their patients. This holds only as long as this obligation does not infringe upon the rights of their patients. If a patient will certainly die shortly after cessation of treatment, as is common in passive euthanasia, it is the moral obligation of medical practitioners to minimize the amount of pain that the patient will incur. If the patient and physician come to the agreement that a swift and relatively painless death (i.e: death by self–administered lethal medication or an overdose of opioids) is preferable to allowing the condition to progress to a level of severity that will kill the patient, then the means for the patient to terminate their life should be made available. Along with the duty to minimize pain, there also exists an obligation to avoid inflicting undue hardship on a patient. By prolonging the life of a patient with a terminal condition or in an irreversible coma, doctors are placing a heavy toll on the body of a patient without providing a cure for the underlying issue (Spina 1998).

If the patient has the capability to make their own rational decisions after being presented with all the options available to them, then their desire for aid in dying should be respected. It is worth admitting that depending upon an opponent’s view, this may apply exclusively to people who are able to give their informed consent, removing non–voluntary euthanasia from the sphere of moral permissibility. However, if the patient or the person with power of medical attorney wishes to

terminate treatment after they have been fully informed of the options available to them, then their autonomy should be respected.

Opponents may argue that if a patient truly wanted to end their life, they would find a way to do so regardless of whether or not they could get a doctor to assist in their death. This poses a problem for all views of euthanasia, primarily that comatose patients and many persons in end–stages of terminal illnesses may be physically incapable of performing the actions that can end their life. There are also cases wherein the prolonging of life is not only unfair to the patient, but also to their caretakers. In chronic cases, it may become financially impossible for the family of the person to continue treatment. It also may become emotionally strenuous to the point of distress for attending medical practitioners, who see alleviation of suffering as a moral responsibility that they cannot perform.

Opponents of euthanasia argue that taking the life of a person under any circumstances is morally impermissible due to its disregard for every person's right to life. However, it is arguably more immoral to resign a patient to a life of unendurable pain, especially if doing so directly contradicts their wishes. With many terminal conditions, it is one of the least moral options to remove all treatments that have been keeping their pain under control just to let the patient die. Not all active euthanasia entails the medical practitioner pulling the metaphorical trigger. Physician–assisted suicide allows the doctor to prescribe medication that the patient must self–administer, thereby absolving the doctor of the moral weight that would come with their "killing" of the patient. If the patient, for any reason, is unable to self–medicate to terminate their life, it then falls to the person responsible for the patient's healthcare to decide what the best course of action is.

People who oppose active euthanasia may say that passive euthanasia is the only permissible form. In active euthanasia, someone must take direct action to end another's life. If

doctors utilize passive euthanasia, the patient will instead die from the natural progression of their disease, and no one is actually “killing” them. However, once the decision to end the life of the patient has been reached, it is morally preferable to reduce the amount of suffering the patient must endure than to eschew the possibility of ending a life in a swift and relatively painless manner. Simple cessation of treatment for some chronic conditions, such as late stage AIDS, forces the patient to continue to live with horrible pain as they eventually die from an opportunistic infection.

Another objection to euthanasia is stating that accepting voluntary euthanasia as a practice means accepting that some lives (those of the terminally ill) are less valuable than the lives of others. I feel that this is an inaccurate assessment of the situation, as it reduces a patient from an autonomous person to a passive agent who has little to no say in the decision to terminate their life. The patient, if they are unable to make their own decisions, is left in the hands of the people that the law thinks has the best interests of that person in mind.

Lastly, opponents of non–voluntary euthanasia argue that giving doctors the right to terminate the lives of patients who cannot give their explicit consent, including infants with terminal disabilities, will lead to a slippery slope where euthanizing disabled people becomes the norm, giving rise to Nazi Germany eugenics as doctors kill patients as they see fit. However, euthanasia advocates propose that the moral permissibility depends on the freedom of the agent or the voice for the agent to decide what is best for them. In order for the non–voluntary euthanasia to turn into involuntary euthanasia, all agents that have medical power of attorney that serve as patient advocates must disappear. Involuntary euthanasia, as described by these opponents, is immoral due to its disregard of the wishes of the patient.

Therefore, I put forward that there is no moral reason to oppose active euthanasia, provided the action is not conducted with malice or against the will of the patient. In addressing this, I propose that there are cases where it would be immoral to withhold the access to active

euthanasia. This conclusion hinges on the presumption that either 1) the patient has either autonomy and can make their own informed decisions or 2) has an advocate for their well-being that truly believes that they have the best interests of the patient in mind. I feel that medical practitioners and families should strive to attempt to curtail the most suffering possible as a patient moves into the end of their life, and sometimes the only way to do so is by aiding them in dying. I still take issue with calling involuntary euthanasia by that name, especially active involuntary euthanasia. The name of the practice implies that the killing is done for the sake of the person, and the violation of the patient's autonomy that comes with going directly against their will leans closer to homicide than aid in dying.

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