Active and passive euthanasia: the cases of Drs. Claudio Alberto de la Rocha and Nancy Morrison

Education

Éducation

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In brief

Psychiatrist-in-training Daniel Gorman won the first prize of $1500 in *CMAJ*'s 1998 Logie Medical Ethics Essay Contest with this lively discussion about the 2 types of euthanasia. The entry deadline for the 1999 contest is June 1. Check entry instructions in *CMAJ* (160:315 [English] or 160:388 [French]) or at **www.cma.ca/inside/awards/logie.htm**.

Passive euthanasia is defined as allowing a patient to die by withholding treatment, while active euthanasia is defined as taking measures that directly cause a patient's death. The CMA supports the commonly held view that passive euthanasia is morally permissible in certain circumstances while active euthanasia is always wrong. In its policy summary on physician-assisted death, the CMA stated that both euthanasia and assisted suicide fall under this heading and said CMA members "should specifically exclude participation in" either practice. But the definition of physician-assisted death is qualified: "Physician-assisted death, as understood here, does not include the withholding or withdrawal of inappropriate, futile or unwanted medical treatment or the provision of compassionate palliative care, even when these practices shorten life."[1]

Two recent cases involving physician-assisted death not only illustrate the difference between passive and active euthanasia but also raise the question of whether active euthanasia should sometimes be allowed.

Case 1: Dr. Claudio de la Rocha

In October 1991, Ms. A, who had lung cancer and had been placed on a respirator at the former St. Mary's Hospital in Timmins, Ont., informed family members that she wanted a breathing tube removed so that her suffering would end. They supported her decision and conveyed it to de la Rocha. In accordance with standard practice, he removed the tube and administered 40 mg of morphine in 3 doses to ensure that she did not experience a suffocating feeling. He broke with standard practice, however, by then administering potassium chloride, causing her heart to stop.

In April 1993 he was convicted in criminal court of administering a noxious substance. His sentence was suspended, however, and he was given 3 years' probation. In an April 1995 hearing before the Discipline Committee of the College of Physicians and Surgeons of Ontario he was charged with professional misconduct because of the conviction in court, as well as failure to maintain the standard of practice. He pleaded guilty to the first charge and the college did not proceed with the second. His penalty was a 90-day licence suspension that would be lifted if he wrote a guideline on withdrawing life support from terminally ill patients.[2]

Case 2: Dr. Nancy Morrison

Mr. B had undergone 6 operations for esophageal cancer, and in November 1996 was being treated for severe infections at the Queen Elizabeth II Health Sciences Centre (QE II) in Halifax. When his family requested that life supports

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be withdrawn, he was extubated and given large doses of morphine and hydromorphone. About 2 hours later he remained in extreme distress, and Morrison is alleged to have administered nitroglycerin even though his blood pressure was already very low. After about 10 more minutes she is alleged to have administered potassium chloride, causing him to die within seconds.

In February 1997 Morrison received a 3-month suspension from the QE II. During an interview with Halifax police, a colleague of hers said that the patient's death was "basically active euthanasia," and he accused the hospital of covering up the incident. Morrison was arrested in May 1997 and appeared in court on a charge of first-degree murder. She pleaded innocent and was freed on $10 000 bail; in November, the Crown announced that it would seek a finding of manslaughter. A preliminary hearing was held in February 1998, and Judge Hughes Randall ruled that he would not commit her for trial because there was insufficient evidence for a jury to convict her of any offence. At the time of writing, the College of Physicians and Surgeons of Nova Scotia had not yet reviewed the case.[3]

In these cases the main ethical issue does not involve a simple decision about whether euthanasia is right or wrong, but whether the distinction between passive and active euthanasia is morally relevant. Virtually everyone agrees that in the circumstances described it was morally permissible for the doctors to allow their patients to die by extubating them and administering narcotics. Many believe, however, that in the same circumstances it was wrong for them to cause the death of their patients by administering potassium chloride.

In "Active and passive euthanasia," a paper published more than 20 years ago, James Rachels challenges the doctrine that passive euthanasia can be morally permissible but active euthanasia cannot.[4] He argues that killing someone is not, in itself, worse than letting someone die, and so active euthanasia is not worse than passive euthanasia. In his view, we should decide whether euthanasia is permissible in a particular case, irrespective of the means by which death would be brought about. Then, if we think that euthanasia is indeed permissible, we should favour the means that is most humane. Consequently, in cases where a dying patient's suffering cannot be adequately relieved by palliative care, active euthanasia should actually be favoured over passive euthanasia because it ends the suffering more quickly.

Rachels' key premise is that killing is not, in itself, worse than letting die. He defends this view by proposing 2 hypothetical cases.

- Mr. Smith stands to gain a large inheritance if his young cousin were to die. Motivated by greed, Smith sneaks into the bathroom while the cousin is taking a bath and drowns her.
- Mr. Jones also stands to gain a large inheritance if his young cousin were to die, and he too sneaks into the bathroom, planning to drown her. Just as Jones enters the bathroom, the girl slips, hits her head, and falls face down, unconscious, in the water. Jones is poised to force her head back down should it be necessary, but it is not. The girl drowns while Jones does nothing.

Rachels reasons that if killing is, in itself, worse than letting die, then it must always be worse than letting die. He then asks whether Smith's actions were more reprehensible than Jones'. Surely they were not, he argues, for it is ludicrous to suggest that Jones behaved better because he did not actually kill his cousin but "merely" let her die. Thus, Rachels concludes, there is no inherent moral distinction between killing and letting die.

If this conclusion is correct, why do many people think that killing is worse than letting die? The reason, Rachels argues, is that they "conflate the question of whether killing is, in itself, worse than letting die, with the very different question of whether most actual cases of killing are

more reprehensible than most actual cases of letting die." Most cases of killing involve murderers with evil motives, whereas most cases of letting die involve physicians acting out of compassion. Consequently, we come to think of killing as worse than letting die even though our moral reactions to these cases are really based on the different motives for ending life. Rachels maintains that when the motives and other circumstances are the same, as in the Smith and Jones cases, it becomes clear that whether a person is killed or allowed to die is morally irrelevant. Therefore, he believes that the means of bringing about death should play no part in decisions about euthanasia.

Consider rights and duties

In "Killing and letting die," Philippa Foot claims that Rachels' view is "extremely implausible" and offers examples in which the distinction between killing and letting die clearly seems to be morally relevant.[5]

Here are 2 of them, slightly embellished. First consider the dilemma of Dr. Brown, who has a limited supply of a drug and 6 patients who will die without it. The dilemma arises because 1 patient needs the entire supply of the drug to survive, while the other 5 need only one-fifth of the amount. Should he let 1 die to save 5? Then consider the dilemma of Dr. Green. She has 5 patients who will die unless they undergo organ transplantation, but the organs they require are unavailable. It occurs to her, however, that there is a healthy clinical clerk on the ward with all the organs necessary to supply the 5 patients. Should she kill 1 to save 5?

Both dilemmas involve choosing between life for 1 person and life for 5. The only difference is that Brown would have to let 1 die to save 5, whereas Green would have to kill 1 to save 5. But this difference is morally critical, for it is obvious that Brown should choose life for 5, whereas Green should choose life for 1.

We must now ask why the distinction between killing and letting die seems morally relevant in the Brown and Green cases, but not in the Smith and Jones cases. Foot argues that the answer lies in the kinds of rights and duties associated with killing and letting die.

Rights can be divided into 2 types, negative and positive. Negative rights are our rights not to be interfered with — not to be harmed, for instance, or not to have our property taken away. Positive rights are our rights to goods and services, such as our right to food and medical care. Corresponding to a person's negative and positive rights are other people's negative and positive duties: we have a negative duty not to harm others and a positive duty to feed the hungry.

Foot argues that the difference between the Smith and Jones cases is that Smith fails in his negative duty not to kill, whereas Jones fails in his positive duty to lend assistance. The moral significance of this difference is only academic, however, because in the circumstances described it is equally wrong to fail in either duty. The cases of Brown and Green are more complicated. If Brown lets 1 person die to save 5, he fails in his positive duty to provide the 1 person with medical care. If Green kills 1 person to save 5, she fails in her negative duty not to kill the 1 person. Here, though, the difference is morally important. In the Brown case, the positive right of 1 person to medical care obviously does not outweigh the positive right of 5 others to medical care. In the Green case, however, the negative right of the clinical clerk not to be killed does outweigh the positive right of the 5 to receive medical care. This is because "it takes more to justify an interference than to justify the withholding of goods or services."

Consequently, it is morally permissible — indeed, required — for Brown to fail to provide 1 person with medical care, but it is wrong for Green to kill the clinical clerk.

Foot's response to Rachels reveals that the distinction between killing and letting die can be morally relevant in some cases but not others. Therefore, Rachels' argument is invalid: although he is right that the distinction is morally irrelevant in the context of the cases involving Smith and Jones, it does not follow that the distinction is never morally relevant.

Real-life cases

Let us now return to the cases of Drs. de la Rocha and Morrison. Both involved terminally ill patients in extreme distress. Given Foot's conclusion that killing may be worse than letting die in some cases but not others, we must ask whether killing is worse in these 2 cases. I believe the answer is No, provided that appropriate consent was obtained.

In both cases the patient or patient's family waived the positive right to medical care in order to relieve suffering. When removing life supports did not bring about death as quickly as hoped, however, they might also have been willing to waive the negative right not to be killed. If they were to waive this negative right by consenting to a lethal injection, why would it be considered immoral to administer it?

Of course, administering a lethal injection is currently illegal, and so the doctors could not have asked for consent to do this. Instead, they had to make a difficult choice: either allow their patient's suffering to continue, or relieve it by performing an illegal act for which they had not obtained consent.

Although Foot, in an earlier article, acknowledges that

active euthanasia can be morally acceptable, she opposes legalization of the practice because she believes that it would have adverse social consequences.[6] Her main concerns are the potential for abuse and the possibility that severely ill patients would feel pressured to request a lethal injection. Notice, however, that in the 2 cases under consideration Foot's concerns apply as much to passive euthanasia as to active euthanasia. Both practices would be equally liable to abuse, for withdrawing life support is as easy as providing a lethal injection. And just as patients could feel pressured to request a lethal injection, they could also feel pressured to request that life supports be withdrawn. Therefore, if we allow passive euthanasia in these cases, as virtually everyone agrees we should, we should also allow active euthanasia.

Finally, there is another common position against legalizing active euthanasia — the "slippery-slope" argument. This is advanced in the CMA Policy Summary "Physician-Assisted Death": "Consideration should be given to whether any proposed legislation can restrict [active] euthanasia and assisted suicide to the indications intended. If [active] euthanasia or assisted suicide or both are permitted for competent, suffering, terminally ill patients, there may be legal challenges, based on the Canadian Charter of Rights and Freedoms, to extend these practices to others who are not competent, suffering or terminally ill. Such extension is the 'slippery slope' that many fear."[1]

I will not speculate on whether such legal challenges are likely to be successful, for this is obviously a question for legal experts. However, if the answer is Yes, then perhaps active euthanasia should remain illegal in all circumstances. Let us not forget, though, that regardless of how hard we strive to deliver the best possible palliative care, there will always be times when our efforts fail. Consequently, the cost of prohibiting active euthanasia is that some terminally ill patients who want to die are allowed to suffer longer than necessary.

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