TERMINOLOGY:

- **Euthanasia**: only applies in cases where a patient is terminally ill and their suffering cannot be mitigated

- **Active Euthanasia**: ‘Killing’
  - Painless lethal injection
  - Was illegal in all states
  - Oregon legalized it in 2007

- **Passive Euthanasia**: ‘Letting die’
  - Stops providing life-sustaining support
  - Legal in every state

POLICIES / LAWS:

- **American Medical Association (AMA)**:
  - (163)*
  - Passive E is OK / Active E is *not OK*
  - Most states / people agree with this position
**Suffering Argument:**
(164)

P1: Passive E is moral / legal

P2: Passive E & Active E are both based on the principle of relieving (not prolonging) suffering

P3: Active E ends suffering sooner than Passive E

P4: Passive E prolongs suffering longer than Active E

C: Thus, IF Active E is moral / legal, THEN passive E should also be moral / legal.

Rachels: “Once the initial decision not to prolong his agony has been made, active euthanasia is actually preferable to passive euthanasia” (164)
Killing vs. Letting Die
Smith & Jones

It is possible to agree Active E better relieves suffering but maintain it is wrong because it is killing and killing is wrong.

Smith & Jones example: is meant to show that killing, per se, isn’t wrong – it depends on the circumstances

Argument: when we examine two situations in which every relevant factor, except whether it is an act of killing or letting die, stays the same, we find no moral difference.

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>SMITH</th>
<th>JONES</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intention</td>
<td>Kill cousin</td>
<td>Kill cousin</td>
<td>None</td>
</tr>
<tr>
<td>Act</td>
<td>Kill</td>
<td>Let die</td>
<td>Different</td>
</tr>
<tr>
<td>Consequence</td>
<td>Cousin dies</td>
<td>Cousin dies</td>
<td>None</td>
</tr>
<tr>
<td>Motive</td>
<td>Inheritance</td>
<td>Inheritance</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>Active E</th>
<th>Passive E</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intention</td>
<td>Kill patient</td>
<td>Kill patient</td>
<td>None</td>
</tr>
<tr>
<td>Act</td>
<td>Kill</td>
<td>Let die</td>
<td>Different</td>
</tr>
<tr>
<td>Consequence</td>
<td>Patient dies</td>
<td>Patient dies</td>
<td>None</td>
</tr>
<tr>
<td>Motive</td>
<td>To not prolong Suffering</td>
<td>To not prolong Suffering</td>
<td>None</td>
</tr>
</tbody>
</table>
**Conflation Argument:**
Why do people think killing is worse than letting die?

**Rachels:** They conflate two different questions / issues: (166)

1. whether killing is worse than letting die
2. whether most actual cases of killing are worse than most actual cases of letting die

- **Killing:** Most cases are murder (bad)
- **Letting die:** Most cases are doctors motivated by humanitarian reasons (good)

Thus,
- We think of killing in a worse light
- But nothing about killing, *in itself*, is worse than letting die - if there’s a difference, it must lie in another factor:
  - Intention / motive / consequence
Foot - Killing & Letting Die:

Conclusion:
- There is a moral difference between killing & letting die

Implications:
- Difference between Active & Passive E
- Even if Active E relieves suffering sooner, it’s still immoral.

Her arguments:
- **Agency of Harm Argument:** (175-176)
  - Wrong to kill, but not to allow to die

- **Interference vs. Withholding Argument:** (177)
  - Takes more to justify interference than to justify withholding

**Agency of Harm Argument**
• Critical distinction: (175)

  o Agent of Harm: One person may or may not be the agent (cause) of the harm that befalls another

    ▪ (176) - agency

    ▪ Proof: Rescue I & II

**Rescue I & II:**
Conclusion: There’s a difference between killing & letting die

<table>
<thead>
<tr>
<th>Factor</th>
<th>Rescue I</th>
<th>Rescue II</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intention</td>
<td>Rescue 5 people</td>
<td>Rescue 5 people</td>
<td>None</td>
</tr>
<tr>
<td>Act / means</td>
<td>Let 1 die</td>
<td>Kill 1</td>
<td>Different</td>
</tr>
<tr>
<td>Consequence</td>
<td>5 live, 1 dies</td>
<td>5 live 1 dies</td>
<td>None</td>
</tr>
<tr>
<td>Motive</td>
<td>Save 5</td>
<td>Save 5</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factor</th>
<th>Active E</th>
<th>Passive E</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intention</td>
<td>Kill patient</td>
<td>Kill patient</td>
<td>None</td>
</tr>
<tr>
<td>Act / means</td>
<td>Kill</td>
<td>Let die</td>
<td>Different</td>
</tr>
<tr>
<td>Consequence</td>
<td>Patient dies</td>
<td>Patient dies</td>
<td>None</td>
</tr>
<tr>
<td>Motive</td>
<td>To not prolong Suffering</td>
<td>To not prolong Suffering</td>
<td>None</td>
</tr>
</tbody>
</table>

**Interference vs. Withholding Argument:**
Two kinds of Rights:

a) To Non-Interference: negative duty

b) To Goods: positive duty (to provide)

**Interference:** breaking into a sequence  
**Withholding:** not breaking into a sequence

- It takes more to justify interference than to justify withholding goods (177)
- Implication: it takes more to justify Active E than Passive E

**Some Issues to Consider**
1) **Involuntary Euthanasia is a separate issue:**
   a. Terry Shaivo case…

2) **One argument against Active E has been settled by empirical evidence:**
   a. Oregon & Active Euthanasia

3) **Is it true that in Passive E we do nothing (allow a sequence to run its course)?**
   a. Rachel’s argues not (166)

4) **Is Active E actually interference?**
   a. Compare to Foot’s property example (175)

   b. What is it that Active E is interfering with?
      i. Not the patient’s wishes
      ii. Some other good?

5) **Does Foot conflate killing with interference / harm?**
   a. See 4

   b. Is all killing interference or only some killing?
      i. Foot’s example – depriving someone of their property (177)

      ii. **Question:** Is this analogous to euthanasia?

**AMA Policies – Euthanasia:**
E-2.21 Euthanasia

Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient’s intolerable and incurable suffering. It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come to decide that death is preferable to life. However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks. The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient’s life. Euthanasia could also readily be extended to incompetent patients and other vulnerable populations. Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (I, IV) Issued June 1994 based on the report "Decisions Near the End of Life," adopted June 1991 (JAMA. 1992; 267: 2229-2233); Updated June 1996

E-2.211 Physician-Assisted Suicide

Physician-assisted suicide occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act (eg, the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide). It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks. Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (I, IV) Issued June 1994 based on the reports "Decisions Near the End of Life," adopted June 1991, and "Physician-Assisted Suicide," adopted December 1993 (JAMA. 1992; 267: 2229-33); Updated June 1996.