**Passive and active euthanasia – What is the difference?**

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**Abstract.** In order to discuss the normative aspects of euthanasia one has to clarify what is meant by active and passive euthanasia. Many philosophers deny the possibility of distinguishing the two by purely descriptive means, e.g. on the basis of theories of action or the differences between acting and omitting to act. Against this, such a purely descriptive distinction will be defended in this paper by discussing and refining the theory developed by Dieter Birnbacher in his „Tun und Unterlassen." On this basis I will suggest a new definition of active and passive euthanasia.

**Key words:** Active and passive Euthanasia – Theory of action – Ethics – Action and Omission

## *I. Active/passive: Only a verbal difference?*

The following case is often encountered in hospitals: A dying and suffering patient is on a respirator. The patient has declared that he wants to die in such a situation. Now the question for the doctor is, how to commit euthanasia. Shall he stop the respirator or not? Here, some doctors find themselves in a grey zone. To stop the respirator is an action and the doctor is then an "active factor" in the death of the patient. Therefore he fears committing active euthanasia, which he believes to be morally wrong. In order to avoid this problem the doctor waits until the patient is not getting enough oxygen through the respirator. After a while the respirator needs to be adjusted to a higher dose. The doctor omits to do this, and the patient dies after prolonged suffering. The doctor believes that

he has circumvented the grey zone and that he has merely carried out “harmless” passive euthanasia.

The following thoughts serve to reduce the grey zone between active and passive euthanasia and to classify this and other problematic cases more clearly. The grey zone is not a moral one, because our doctor is sure that active euthanasia is wrong. The grey zone is about how to differentiate between active and passive euthanasia descriptively. But is it not just a false use of language that lies at the bottom of this problem? In fact, the terms active and passive euthanasia are often charged normatively. Maybe one should therefore simply avoid using them and replace them with other terms, like “killing on demand” “and letting die”.[1] Does the problem mentioned above disintegrate in consequence? I don't think so. Why does the physician feel guilty in the example mentioned above? The answer is, because he is doing something which he himself interprets as killing and because he thinks killing people is morally wrong.[2] Additionally, this view is supported by wide parts of our Common-Sense, the Ten Commandments and other authorities. The physician will tend to interpret the term “letting die” more as an euphemism and refrain from actions, unless he is completely assured that those actions won't kill anybody. This conviction shall be justified in the following essay. To do this, I will use traditional terminology instead of “killing on demand” and “letting die”, because I doubt that a revision will prevail. But the arguments that will be made will define the limits as well for passive euthanasia as for letting die; the problem will be the same, irrespective of the terms used.

A descriptive differentiation between active and passive euthanasia is not very popular. Many philosophers deny not only the moral relevance of the distinction between active and passive euthanasia, they go on to deny that there is a descriptive difference at all. Is there really such a difference concerning the actions themselves, or does the difference depend on the moral standpoint or language of the observer?

Traditionally, killing and letting die were seen as different types of action. For example, James Rachels defines the difference by considering *action* versus *omission*. He illustrates this distinction by two examples. Smith wants to collect money on a life insurance policy from his six-year old cousin. To do so, he goes into the bathroom while the child is bathing and drowns him. Jones has the same intention concerning his own cousin and also goes into the bathroom while the child is bathing. But he sees the child slip, hurt his head, become unconscious and sink under the water. Smith omits to do anything until the child drowns. According to Rachels, Smith acted and Jones omitted to act. This difference between acting and omitting is for Rachels the basis of the difference between active and passive euthanasia, and it is descriptive.[3]

Rachels' distinction is given a causal aspect by Tom Beauchamp who comments on Rachels' example: „The (...) point is, that in both of Rachels' cases the respective moral agents – Smith and Jones – are morally responsible for the death of the child (...) – even though Jones is not causally responsible. In the first case death is caused by the agent, while in the second it is not."[4] Beauchamp's point is that action and omission play different causal roles. Doing things actively means causing them, while omitting to do them does not. This analysis is often rejected by the current literature:

Bruce Reichenbach formulates for example a critique of the thesis that the differences between 1) killing and letting die through acting and omitting, respectively, and 2) acting and omitting themselves, can be defined descriptively.

Regarding 1), Reichenbach remarks that it is possible to kill both through doing (action) and omitting (omission). The doctor can kill his patient by intentionally omitting to stop a life-threatening haemorrhage during an operation if the patient would otherwise have survived.[5]

Regarding 2), Reichenbach claims that there is no sharp distinction between action and omission. He argues that it is often a matter of terminology whether we describe

something as a case of one or the other. The same event can sometimes be described as an action and sometimes as an omission. Reichenbach provides the following example: A doctor does not want a patient to be connected to a respirator because the patient's case seems hopeless. Is this a case of not acting? The doctor does not start the machine. In fact he may say nothing, and avoid the patient and his family. He does not verbally refuse to use the machine but instead avoids the situation entirely. Is this "non-action" not a kind of action? The difference seems to be merely verbal.[6] This criticism has convinced some philosophers that there is no good definition of killing and letting die on the basis of the concepts of action and omission. They argue instead that the a crucial part in distinguishing between the two cases is played by the intentions of the actors.

Others argue that only the distinction between causal roles can establish the distinction between killing and letting die. But they deny that action is always a kind of causation and that omission is not. In the dominant theories of causation, the singular circumstances are among the causal factors in an experiment. These circumstances can be called „negative" factors, e.g. the absence of disturbing factors. *Causal factors* are components that cannot be eliminated from the quantity Q of factors sufficient for event A, without Q losing the property of being sufficient for A (77-78).[7] In this sense negative singular circumstances – in our case omissions – belong to the quantity of causal factors for A. In a second step it can be demonstrated that omissions are not only causal factors but that they can be causes of events in a stronger sense. *Causes* are causal factors of great psychological relevance to an observer. *„The cause"* of event A is often the most informative or unexpected causal factor. To be "the cause" depends on descriptions, to be a causal factor does not. In reality, all causal factors are on the same level. As a whole they are sufficient to cause event A (83).

As a consequence, it seems that we cannot make a descriptive distinction between action and omission if the causal roles of both are the same.[8] But is this the last word?

In the next section the theory of „letting it happen through acting“ (LHA-theory) will be explained. Some problems with this theory, problems that will lead to a refinement of the theory, will then be discussed. The conclusion will be that a refined LHA-theory does indeed ground an adequate descriptive distinction between active and passive euthanasia.

## *II. Letting it happen through acting*

The debate about active and passive euthanasia often overlooks an important theory. In his book „Tun und Unterlassen“ Dieter Birnbacher suggests a solution of the problems discussed above by introducing the concept of „Letting it happen through acting” (LHA). This theory provides sharp criteria for acting and omitting, for killing and letting die, and thus for active and passive euthanasia. We are interested primarily in the last distinction. Birnbacher wants to find a difference *in re* between the different categories because if one only considers differences in language – like J. McMahan[9] – one again encounters Reichenbach’s problems.

Birnbacher first defines exterior and inward acting and omitting. *Exterior acting* is the case when a bodily motion, which constitutes an action, is executed. *Exterior omission* occurs when such a motion fails to be executed. A bodily motion is *constitutive of action*, if it contributes to the success of the action, which is defined at a higher level of description. To clarify: To exhibit an exterior omission is not the same as being a completely passive actor. Karen can do a lot of things while omitting saving Jane. She omits the things that would constitute the act of saving her, e.g. the application of a ligature to the bleeding arm that is responsible for Jane´s death. It is irrelevant if Karen tries at the same time to save one of Jane’s hands which is stuck under a wheel. The act of saving Jane is an action so defined that it ensures that Jane survives. In any other case

one cannot describe the action as a kind of rescue. The arm and not the hand is important for the rescue. What is constitutive of an action depends on the conditions of successful action that are defined from case to case. It is independent of the fact that Karen is active or passive.[10] *Omitting through inward acting* consists in doing or not doing constitutive inward acts that can be influenced voluntarily, e.g. by decisions or deliberations (34-35). I can omit for example thinking about the consequences of an action because I fear those consequences.

The LHA –theory aims to provide a necessary and sufficient criterion for the omission of an action H. Such an omission is present if, "1) It is not the case that A does H although 2) A could have done H" (32). We can illustrate what means 2) with our previous example: a) A is *physically* able to perform an act of rescue H; b) A is in a *mental* position that allows him to do H; c) it is *knowable* for A that B must be saved and that there is a way to do this; d) A must have *really known* that H could be carried out, e.g., that B is in danger and that there is a way of saving him (H)). That does not mean that omissions are always *intentional*: A can know that H could be done without consciously knowing that he himself is omitting H at that moment. It is not always the case that you reflect on possibilities for action if you have objective knowledge of a situation. (36-45). Exterior omissions will in most cases be intentional, inward omissions will not.

Are many omissions then just behavioural, because there need not be intentionality in order to omit something and intentionality is the criterion divorcing action from behaviour? I do not think this is the case. There need not be the intention to omit something in order for something to count as an omission under the heading of action (in a broad sense this includes actions and omissions and separates them from behaviour) and not under the heading of behaviour for which one is not responsible.

Donald Davidson says: An omission that is not behaviour must be intentional under at least one description and it has to be within the consciousness of the omitting person under at least one description, but, Davidson does not mean that A must describe his omission as an omission.[11] Look at the difficult case of inward omissions. Jill omits taking care of Harry while having lunch. Davidson would call this an omission and not just behaviour, if Jill intends the mental event during the lunch under any description at all. Jill claims that she thought about eating at lunchtime. So Jill has not just shown inward behaviour at lunchtime. According to her own description she thought about eating, but she also omitted taking care of Harry (assuming that she was mentally sound at that time). The mental event at lunchtime was not just behaviour, because it was controlled by an intention. Perhaps Jill also omitted infinitely many other thoughts at lunchtime. These omissions, however, are of no importance to us. The ones we are concerned with are the morally problematic ones.

A further aspect of the LHA theory is the definition of letting it happen. Ordinary language is able to categorize the same processes as letting it happen (e.g. letting die) or acting (killing). We therefore cannot follow ordinary language. Instead, we will apply the criterion of constitutive body motion. Letting it happen is always dominated by an omission. Actor A's omission takes place in the presence of a process independent of A that leads to event E. A could avert E but he doesn't (103). That means that A lets E happen. This letting happen must always occur *knowingly*: A expects that E will happen. And E is *intended* if there is a purpose in letting it happen that will be fulfilled by E. The process in which A does not intervene must not have its source in A's own actions. The process of dying in which the doctor does not intervene by using a respirator must have *started independently* of the doctor's actions (105f.).

The central point of the theory is the concept of "letting it happen through acting": „In the case (of LHA, B.G.) B is in a process that started independently of A's acting

and A tries to stop this process through an action. While A finishes his intervention actively he abandons B to the process in which B was already before his intervention" (110-111). An example from the area of euthanasia: Remember the doctor who stopped the respirator. Here the doctor is an actor who presses the off button. The debate is divided as to whether or not the case belongs to actions or omissions. Guckes argues that we should analyze the intentions of the doctor.[12] But these are difficult to know. Often the actor himself is not aware of all of his intentions.

What does the LHA theory say in this case? The process in which the patient finds himself is independent of the doctor's actions.[13] The patient, for example, has a fatal disease and will soon die from it. By using a respirator the doctor tries to slow down this process. In ending this attempt actively and turning off the respirator, he abandons the patient to the preceding and (causally) autonomous process. One could say that this is a case of letting a preceding process happen and that this letting it happen is connected with an action of a doctor. To let something happen is a kind of omission and therefore is a case of passive euthanasia. This classification is supported by objective facts (body motions) and not just by intuitions about language that may be relative to a group of speakers.

Recall Reichenbach's example of the doctor who leaves and in doing so effectively refuses to treat the patient. The doctor acts actively in many ways. He leaves, and perhaps says „no" and performs a bodily motion in the act of refutation. But the patient's dying is an autonomous process. By refusing to treat the patient, the doctor is merely letting this process happen.

### *III. Problems of the LHA-theory*

Letting it happen through acting can be described by using the concept of constitutive bodily motion. I discuss this concept now, and in so doing reveal some problems with the theory that we will deal with later. If you turn off the respirator at t2 you execute a bodily motion constitutive of killing B at t2. But this action is not constitutive of the preceding condition that B is in, a condition that would have caused B's death at t1, without the respirator being applied. Letting it happen can never *by itself* be the only cause of the death of the patient. So the LHA-theory provides a clear criterion by taking into account the presence of bodily motions and by looking at whether these are constitutive or not. So we can presume that turning off the respirator constitutes passive euthanasia and we can at the same time maintain that the difference between active and passive depends on the actions and omissions of the doctor. Without the LHA-theory it is not possible to maintain both at the same time.

Nevertheless this reconstruction reveals problems. The difference between active and passive euthanasia is a causal one[14]: The involved action is not *sufficient* to cause death if you have a case of LHA. To cause death there must be a preceding condition or process on the patient's side that is a further cause of death. Active euthanasia is sufficient to cause death under standard conditions.[15] The range of passive euthanasia becomes too large if you use this causal difference alone as the criterion for active and passive. An example: A doctor gives poison to a very ill patient. A normally healthy person would never die from this dose. The patient however is weakened and dies. So he dies not only because of the poison. In keeping with our definitions, this would be a case of passive euthanasia because the poison is not sufficient for death. But this result is unintuitive. Of course the LHA-theory need not answer to intuitions, but to dismiss them entirely is not to its advantage.

Birnbacher instead tries to limit passive euthanasia. „While the doctor lets something happen with the patient in the case of passive euthanasia, he must have physical contact with the patient if he commits active euthanasia“ (344). So the *location* of causal intervention becomes relevant. Is the doctor in direct physical contact with the patient or does he merely try to stop certain life-support machines? This is not enough to solve the problem of the excessive inclusiveness of the concept of passive euthanasia. What does “direct physical contact” mean? Is an injection a case of direct contact even if only the needle touches the patient? Why is this contact more direct than the contact between a respirator and a patient? Is the doctor not in direct contact with the patient if he takes the hose of the respirator out of the patient’s mouth and in so doing touches his face? But nobody would call this active euthanasia. And is it not a clear case of killing if a doctor injects poison into the liquid of an intravenous drip?

How can we save these intuitions with a descriptive differentiation that regards the causal differences but narrows the concept of passive euthanasia? I offer the following suggestion:

*Passive euthanasia occurs if the general conditions for euthanasia are fulfilled and if letting it happen leads to death. If it is a case of LHA only those actions may be involved that withdraw a medical measure that a doctor started previously. Every other form of euthanasia is active.*

According to this definition, to give a little dose of poison to a weakened patient is active euthanasia if it is euthanasia at all. To take the hose of the respirator out of the patient’s mouth is passive euthanasia. The location of the intervention is irrelevant. *The treatment history of the patient* would be relevant as well as the causal differences. It would be relevant if a doctor stopped a measure that was employed to interrupt the

preceding process of illness. So it is not always passive euthanasia if an action (that falls under the definition of euthanasia at all) is not sufficient for the death of a patient.

In this way, the LHA-theory comes close to other definitions: for example those of Baruch Brody[16], Frances Kamm[17] and Bruce Reichenbach.[18] These authors however do not argue with the distinction between action and omission. In this way they differ from the LHA-theory. An example:

Artificial nutrition of a patient is stopped in order to alleviate suffering. According to Brody this can be both active and passive euthanasia. Brody thinks that you only commit passive euthanasia if you fail to do something that keeps the patient's disease from causing his death. Active euthanasia occurs when the patient's death after the feeding tube has been removed has no causal connection to the disease that created the necessity for the artificial nutrition. This might be the case if a patient suffers from paralysis necessitating artificial nutrition. But the paralysis is in no way causally responsible for the death, which comes about in the same way as it does for an individual who is healthy in every other respect.[19]

Brody says that it is not sufficient for passive euthanasia that there be present a prior autonomous process on the patient's side that the doctor lets happen. In addition, there always has to be a preceding *process of dying*. Only death caused by a patient's fatal disease is characteristic of passive euthanasia. Different from this, the LHA-theory only requires that the total condition of the patient leads to a process that a doctor lets happen.

This move has two advantages:

1. *The individuation of a process of dying:* Brody's account forces us to individuate the process of the patient's dying. One always has to know whether the patient's death was caused by the allegedly fatal disease or whether it was the result either of other physical deficits or of external intervention. Take the example of the weakened patient and the

small dose of poison. Is the patient's death caused by his disease, or by external intervention? This seems to be an arbitrary decision.

2. *Accordance with widespread intuitions*: It is normally counted as passive euthanasia if a doctor lets a consenting patient die because his general physical condition is bad. Nobody differentiates which part of the physical condition is responsible for death. Brody has to reclassify a lot of cases. The LHA-theory precludes this.

Let me conclude by returning to our initial example. Is it active euthanasia to turn off the respirator? The LHA-theory denies this, maintaining that the doctor does not need to be uncertain and that the patient does not need to suffer senselessly any longer. It defends the descriptive difference between active and passive euthanasia against many critics. What is the use of this theory for normative purposes? The normative debate about standard cases of active euthanasia is not influenced by it.[20] But the theory redefines the borderline between the types of euthanasia, and as a result, the grey zone disappears. Many cases previously relegated to this zone can now be classified as passive euthanasia, thereby diminishing the highly problematic cases of active euthanasia. This may not be important for those philosophers who have no problem with active euthanasia. But it might be important to many people who have such problems, especially doctors, and, in many countries, lawyers and legislators.

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[1] Nationaler Ethikrat, 2006, S. 49-56.
[2] McMahan, 1994, 400.
[3] Rachels 1985, 139-141.
[4] Beauchamp 1985, 443-444.
[5] Reichenbach 1987.
[6] Reichenbach 1987.
[7] All pages in brackets within the text refer to: Birnbacher 1995.
[8] An alternative that cannot be discussed here is to defend a theory of agent-causality what Vihvelin and Tomkow did recently: „An agent causes an outcome *if* the outcome is caused by a basic action of the agent.“ Vihvelin, Tomkow 2005, 188.
[9] McMahan, 1994, 391.
[10] Bennetts „weakest fact“ explanation and his criticism of A. Donagan have prepared the way for the concept of constitutive body motion. Bennett 1994, 233, 246. Norcross 2003, 459.
[11] Davidson 1980.
[12] Guckes 1997, 147-149.
[13] McMahan asks the difficult question: What are the criteria for deciding that a preceding process still continues when you act? Cf. his „The Pipe Sealer“ example McMahan 1994, 389f. See Norcross 2003, 458.
[14] This should not be confused with the radical causal difference defended by Beauchamp.
[15] I.e., normal human physical conditions. Before you give someone a deadly poison the patient should not have consumed an antidote etc. So you can question the use of the term „sufficient condition“ in the context of active euthanasia because there are some further standard conditions. But the difference in the sum of the causes in the case of active and passive euthanasia remains even if you label it without using the idealised term “sufficient condition.”
[16] Brody 1988.
[17] Kamm 1998, 30.
[18] Reichenbach 1987.
[19] Brody 1988, 121.
[20] For a recent debate about pros and cons of active euthanasia, cf. Callahan 2005 and Tooley 2005.