

Passive Euthanasia

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The controversy of passive euthanasia (e.g. the withholding or withdrawing of life-sustaining treatments in patients that are either disabled or terminally ill) has been long-debated because, it has been argued, passive euthanasia violates the physician's Hippocratic Oath to do no harm to the patient. This withholding or withdrawal can include one or more of the following: ventilators, feeding tubes, and life support. In this paper we will explore the major debate points of passive euthanasia in light of four ethical theories: utilitarianism, virtue ethics, Kantian, and evolutionary ethics.

There are three well-known definitions of death to consider: whole-brain, higher brain, and brain stem death. All definitions hold that the conditions described are irreversible.

Whole brain death is defined as “the cessation of all brain clinical functions including those of the cerebral hemispheres, diencephalon (thalamus and hypothalamus), and brain stem.”¹ This means that a patient is not consciously aware, able to breathe, or able to control circulation. This definition is accepted as the official definition of death in the United States and most other parts of the world.

Higher brain death is defined as “the irreversible loss of consciousness and cognition.”² With this definition of death, the patient may in fact be able to breathe and have his or her heart beat on its own because the brain stem is still functioning. The patient, while unaware, may also still be capable of sleep-wake cycles and pupil reflexes. The most common illustration of this is the permanent vegetative state, or PVS. This definition of death is recognized by no jurisdictions.

Brain stem death is similar to whole-brain death. Brain stem death is defined as “the loss of consciousness and the capacity for breathing.”³ While there can still be electrical signals in the higher brain, there is no communication with the rest of the body; the brain stem is irreversibly nonfunctional. Because of this, the outward effects of brain stem death are virtually the same as whole-brain death: loss of consciousness, inability to breathe, and inability to maintain heartbeat without artificial means. This definition of death is accepted in the United Kingdom.

Utilitarian Ethics

There are several ethical theories from which to examine passive euthanasia with these definitions of death. One of these is utilitarianism. There are several variations of utilitarianism yet all of them share one common goal: to maximize happiness and reduce suffering. How this goal is accomplished and which variation takes precedence is where the variations differ; we will discuss four of them: preference, rule, act, and classical (or hedonistic) utilitarianism.

¹ Bernat, 2006, p. 322-327

² *ibid.*

³ *ibid.*

Preference utilitarianism maintains that an action is right if it fulfills preference of the individual, or individuals, involved.⁴ In other words, what is good is solely dependent on individual preferences, making preference utilitarianism extremely subjective.

Rule utilitarianism states that right actions conform to a rule that leads to the greatest good.⁵ This seems more objective than preference utilitarianism. With rule utilitarianism all may agree to always wear a seatbelt while inside a moving vehicle. Because the use of seatbelts saves more lives than if not worn, this rule will always lead to a greater good and safety for the general public. Because of this, no exceptions to the rule may be made; rule utilitarians agree that rules are made and are in effect for the greater good. Even if in a specific instance it seems better to not wear a seatbelt, overall, the obedience to the rule of wearing a seatbelt would provide for the greatest good.

Act utilitarianism maintains that a right action produces at least as much happiness as any other action that could have been performed at that time.⁶ This is utilitarianism on a case-by-case basis. It is possible that the same action at different times could produce different amounts of happiness, thus making it a right action in one case, and a wrong action in another. Each act is treated independently.

Classical utilitarianism, also known as hedonism, is the most well-known and broadest form of utilitarianism. This version of utilitarianism is the textbook definition of utilitarianism: the maximization of pleasure and the minimization of suffering. It can be

a bit more selfish than other views of utilitarianism that prioritize happiness; this is especially the case if the pleasures sought are mere eroticism. Classical utilitarianism places pleasure and suffering as the only things of intrinsic value.

In general, utilitarian thinkers would accept withholding or withdrawing life-sustaining treatment. One of the main reasons for this is organ donations. James Bernat points out that a goal of a utilitarian thinker regarding a brain dead individual would be “cessation of medical treatment and organ procurement.”⁷ Statistically, one individual who donates his or her organs has the potential to save up to eight lives. The tension here is one person surviving via life support (potentially only for a few more weeks) and many people potentially dying from organ failure versus many lives being saved by organ transplants from one dead person.

Numerically, by withholding or withdrawing life-sustaining treatments, more people survive (thus there is greater happiness) by one person’s death (a lower number of suffering). Utilitarians would also agree that withholding or withdrawing life-sustaining treatment is acceptable because it saves not only the hospital money, but the family who was left behind with the hospital bills as well.

Virtue Ethics

Virtue ethics emphasizes one’s virtue, rather than rules or consequences.⁸ That being said, virtue ethics is very much an individual and case-by-case ethical theory. Different characteristics can influence virtue ethics, such as religious beliefs, ethics, morals, and values.

⁴ Singer, 2003, p. 526-528

⁵ *ibid.*

⁶ *ibid.*

⁷ *op.cit.* ref. 1.

⁸ Hursthouse, 2003

Because virtue ethics seems dependent on one's character, and because virtues vary from individual to individual, the view of life-sustaining treatment through this lens will differ greatly. Should two individuals be designated surrogates for a patient that is brain dead, each has to make a decision regarding life support. On one hand, one of them may view taking the patient off life support as murder; consequently, the patient is maintained on life support. On the other hand, the second person may see taking the patient off of life support as relieving her of suffering, so the second person decides to withdraw treatment.

Both of these actions may result in the same feeling of benevolence and goodness in the virtue ethicist. As a result, opposite decisions are attained dependent on the decision maker and his or her personal morality.

Kantian or Deontological Ethics

A Kantian approach to ethics is based on the idea of the categorical imperative (CI). The CI is the idea that if someone were looking at a specific situation, their decision under those circumstances would become a law for all similar situations.⁹ As Kant himself said, "Act only according to that maxim whereby you can, at the same time, will that it should become a universal law."¹⁰ Using this "one-size-fits-all" approach to passive euthanasia is complicated by the facts of various degrees of brain death, coma, and types of life support used. Using the CI would require that it apply only to similar situations. Under these regulations, a person in a certain category would always be maintained while another in a slightly different circumstance would always be taken off life support. Thus, by definition, the CI would no longer be universal.

⁹ Johnson, 2004

¹⁰ Rachels, 1999

Evolutionary Ethics

An evolutionary approach to ethics explains morality and ethical implications based on evolutionary history. One of the most relevant characteristics that evolution has provided is the "tendency to make certain particular kinds of moral judgment or inference, or to have certain characteristic moral intuitions (i.e., a 'moral sense')." ¹¹

Even if the moral sense has been derived from natural selection, the content of a specific person's morality would be derived autonomously. One needs to be judicious with this perspective when it encompasses making decisions on behalf of others who are unable to make decisions for themselves. Therefore evolutionary ethics can be used to approach the issue of passive euthanasia through two lenses. The autonomy lens requires the patient, or the patient's family, to decide on a case-by-case basis; it is dependent on the belief set of the patient or her family. Seen through the natural selection lens, however, passive euthanasia allows a disease or illness to take its course and leads to death, just as it would have but without medical interference.

Practical Applications

Considerations of Autonomy

Disagreement arises for determining when passive euthanasia is acceptable. Passive euthanasia is considered acceptable for patients who are either terminally ill or dealing with an incurable debilitating illness. The Council on Ethical and Judicial Affairs of the American Medical Association says, "The principle of patient autonomy requires that physicians respect a competent patient's decision to forgo any medical treatment. This principle is not altered when the likely result of withholding or withdrawing a

¹¹ FitzPatrick, 2008

treatment is the patient's death."¹² The Council also said that the value of additional life must be contrasted with the burden of additional treatment.¹³ When a patient is making the decision whether or not to withdraw life support, he or she must be fully autonomous – meaning the patient should have no internal or external pressures on his or her decision – and he or she must be fully informed. If those criteria are not filled, there is room for this system to be manipulated. For example, if a person is dealing with severe depression, she could be considered incompetent to make a refusal decision, as depression is an internal pressure on the patient's autonomy.¹⁴

Complications of DNRs and ADs

A Do-Not-Resuscitate (DNR) order is one written by a patient stating their desire to not be resuscitated if they die. For example, if a person with a DNR has a heart attack, she may have requested that cardiopulmonary resuscitation (CPR) not be performed.

Tomlinson and Brody give three rationales for a DNR.¹⁵ The first is if there would be no medical benefit for the patient. An example is CPR that would be ineffective in bringing the patient back to life. The second rationale occurs when the patient would have a poor quality of life after CPR. In these two situations, the patient's likely future is taken into account. The final rationale is prolonging an already poor quality of life by the intrusion. Patients with a poor quality of life – whether they are incapacitated or incompetent – would likely not want to be brought back into an unfavorable situation.

Many problems with DNRs occur due to the lack of specifics in the order. Tomlinson and Brody provide an illustration of an elderly woman who had a DNR order for the possible case of a cardiac arrest. A little while later she was successfully defibrillated to correct a cardiac arrhythmia, but both she and her family argued that the action of defibrillation violated her DNR.¹⁶

Similar to a DNR is an Advance Directive (AD). There are two types: instructional and proxy. An instructional AD tells the doctors what to do if the patient ends up in a certain condition, while a proxy AD places a single person in charge of all medical decisions if the patient becomes incompetent.¹⁷ ADs also suffer from the same lack of specificity problems as DNRs in that they cannot cover every possible situation. One recent example concerned a brain dead pregnant woman. She had previously told her husband that in a situation where she was dependent on life support with no hope of recovery that she would prefer passive euthanasia with no intervention; she never specified if she would like him to do something differently if she were pregnant and could serve to carry the fetus to term despite her comatose state.¹⁸

Another other common problem with ADs resulting from lack of specificity include past wishes versus present ones. Mappes gives an example where a person is not aware of her circumstances due to a mental disorder of some kind, but she is content. She had previously requested non-intervention if she became incompetent; the doctors had to decide whether to base treatment on the patient's previous wishes or

¹² Council on Ethical and Judicial Affairs of the American Medical Association, 1992, p. 341-343

¹³ *ibid.*

¹⁴ Powell & Lowenstein, 1996, p. 344

¹⁵ Tomlinson and Brody, 1988, p. 354-357

¹⁶ *ibid.*

¹⁷ Mappes, 1998, p. 366-370

¹⁸ CNN, 2014

to accommodate the patient at present.¹⁹ Mappes also raises the question of whether or not this is still the same person as the woman who wrote the AD. Similarly there is the issue of incompetent revocation. This occurs when a person requests to be taken off life support at a certain point but later, once the decision is made to remove life support, she refuses. Unless the AD states she wants the doctors to remove life support even if she disagrees later, the doctors must acknowledge the patient's current wishes.²⁰

Conclusion

Although still being debated, passive euthanasia is still prevalent in the United States. There are doctors and experts on both sides of the issue; it is unclear if this issue will be resolved in the near future. No matter what ethical theory is used to judge passive euthanasia, it is important to understand the facts of passive euthanasia in order to be able to make a wise decision should this issue ever become personal. It is also in a patient's best interest to think ahead and plan for a potential situation involving death and end of life decisions

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¹⁹ Op. cit. ref.17

²⁰ *ibid*.