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Yale Kamisar

In the past two decades, we have witnessed a "sea change in public, medical, and legislative judgments" about "letting die" and the "right to die." But it is no less true today than it was 35 years ago, when I first wrote about this subject, that in Anglo-American jurisprudence active euthanasia (what used to be called "mercy killing") is murder.2

So far as the law on the books is concerned, it matters not that one who intentionally kills another human being "does so at the victim's request" or that "his motive is the worthy one of terminating the victim's sufferings from an incurable and painful disease."3 As one commentator recently explained it, "So great a value is put on life that a person may not waive his right to life; killing does not become nonculpable because the victim consented."4

But all this may change in the near future. As one of the nation's most forceful and eloquent opponents of active euthanasia, the University of Chicago's Leon Kass, observed several years ago, "So-called active euthanasia practiced by physicians seems to be an idea whose time has come."5

Not a few would say that Kass exaggerated the potency of the assault on the long-standing prohibition against "direct" or "active" euthanasia. After all, although most forecasters predicted in 1991 that Washington state would become the first jurisdiction in the Western world to legalize active euthanasia, Initiative 119 (euphemistically called the "death with dignity" or "aid in dying" referendum) went down to defeat. And last November, although once again early polls indicated overwhelming support for a similar proposal in California (Proposition 161), it, too, failed.

At first blush, these political setbacks for the active euthanasia movement seem fairly decisive. But I think not; they can be explained away or at least minimized. I believe that Kass's concerns are as well founded today as when he first voiced them in 1989.

Jack Kevorkian, the Michigan pathologist who practices as well as preaches assisted suicide, may have significantly affected the outcome in Washington. Less than two weeks before voters went to the polls, Kevorkian used his "suicide" machine twice in one night. From that point on, according to a spokesperson for the Hemlock Society in Seattle, voter support for the "aid-in-dying" measure fell dramatically.6 At the very moment Kevorkian swung into action, a TV blitz against the measure hit the airwaves, and "Jack Kevorkian put a face on [people's] fear,"7

But proponents of assisted suicide and active euthanasia have distanced themselves from Kevorkian, noting that the women whose deaths he assisted were not his patients and not terminally ill. They point instead to the "aid-in-dying" performed by Timothy Quill, a Rochester, New York, doctor who is also a member of the University of Rochester Medical School faculty. Quill was neither indicted nor disciplined by medical authorities for prescribing enough barbiturates to enable a long-standing patient to commit suicide following her refusal of treatment for a severe type of leukemia.8

The response to Quill's action and to the article he wrote in a medical journal spelling out what he had done and why has been "very positive" and has "moved public discussion away from the suicide machine."9 Many who were jolted, or at least greatly troubled, by Kevorkian's actions supported Quill.10

Although last November California voters defeated Proposition 161 by a 54 percent to 46 percent margin, support for the measure was impressive—considering that a coalition of 100 organizations (including the Roman Catholic Church, the California Medical Association, and the California Nurses Association) fought the proposal, nearly every major newspaper in the state editorialized against it, and opponents of the proposition outspent proponents by a margin of at least 3 to 1.11

Moreover, opponents of Proposition 161 did not frontal attack the basic notion embodied in the measure as much as they raised fears that it lacked adequate protections.12 They pointed out that although the initial directive had to be witnessed by two people not linked financially with the patient, no

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witnesses were mandated at the time of the actual request for and implementa-
tion of euthanasia;
- although an “enduring request” by a qualified patient was required, it
was simply defined as one “expressed on
more than one occasion” (perhaps only
a day or several hours apart);
- there was no required “waiting pe-
riod” after a patient decided to seek
help in dying; and
- the proposal did not require a psy-
chiatric evaluation to rule out treatable
depression as a basis for the request. 13

Public Acceptance
Most opponents of Proposition 161
hammered away at its inadequate safe-
guards rather than its basic idea prob-
ably because they were well aware that
“the marked increase in public accep-
tance of killing terminally ill patients . . . has been striking.” 14 According to
public opinion polls, not only does a
large majority of U.S. citizens now sup-
port laws allowing terminally ill patients
to refuse or stop life-sustaining treat-
ment, 15 but many Americans now favor
active euthanasia for incurable and coma-

tose patients. 16

According to a close observer of the
Proposition 161 contest, “The ranks of
those voting no swelled as the opposi-
tion coalition focused its advertising
during the final weeks on what worked
a year earlier to bring down a similar
measure in Washington state by a nearly
identical margin (54-46): voters’ fears
that mistakes would be made.” 17 But
only six months before Proposition 161
went down to defeat, surveys showed
that 75 percent of California voters sup-
ported the basic idea of physician aid-
in-dying, 54 percent strongly so. 18

Thus, Alexander Morgan Capron, the
former executive director of the Presi-
dent’s Commission for the Study of
Ethical Problems in Medicine and Be-
havioral Research, now professor of law
and medicine at the University of South-
ern California, had good reason to issue
the following warning:

Proposition 161’s defeat should not
obscure the remarkable fact that mil-

ions of people are so fearful of how

they think they’ll be treated by the
health care system when they’re very
ill that they’d rather be dead. . . .

Average people are . . . so dismayed
at how death occurs in this country
and so distrustful of physicians’ ability
or willingness to give them a “good
death” that they will consider over-
turning thousands of years of medical
ethics and societal prohibitions to le-
galize direct killing by physicians. 19

I noted earlier that Leon Kass observed
recently that active euthanasia appears
to be “an idea whose time has come.” 20

But he was quick to add, “In my view,
it is a bad idea whose time must not
come—not now, not ever.” 21

I agree. I was pleased when Washing-
ton’s Initiative 119 went down to defeat
in 1991 and when California’s Proposi-
tion 161 met a similar fate last year.

But proponents of these measures are
not easily discouraged. They can be ex-
pected to try again (perhaps in Oregon
or Florida or in Washington a second
time) with more finely honed versions
of the measures that failed. And I share
Professor Capron’s concern that unless
health care providers who oppose active euthanasia "change those aspects of the system that make a quick death such an attractive alternative, support for legalizing euthanasia is sure to build and eventually to prevail."22

In resisting the active euthanasia movement in the years ahead, I shall be aligned with, and rooting for, Capron, Kass, and such other well-known commentators and spokespersons as Daniel Callahan, Arthur Caplan, Albert Jonsen, John Pickering, and Susan Wolf.23 But the law and politics of euthanasia make strange bedfellows. My anti-active-euthanasia conferees are favorably disposed toward, or at least willing to accept, what used to be called, and I still call, passive euthanasia—a practice that has gained wide acceptance. But I have always been greatly troubled by it.

I have reexamined the earlier writings of my "allies" and read their most recent contributions to the literature.24 Insofar as they maintain that individual acts of "direct" or "positive" or "active" euthanasia are fundamentally different from the "passive" or "negative" variety—that the former is unacceptable or intrinsically immoral while the latter is permissible—I find many of their arguments unpersuasive and none of them convincing.

As Dean Guido Calabresi of Yale Law School has pointed out, when we have to make "tragic choices"—choices that confront us when fundamental beliefs clash—"we look for solutions which seek to cover the difficulty and thereby permit us to assert that we are cleaving to both beliefs in conflict."25 A good example is how we have dealt with death, dying, and euthanasia.

Beliefs in Conflict

Two sets of beliefs are in conflict. On the one hand, we want to respect patients' wishes, relieve suffering, and put an end to excessively burdensome and seemingly futile medical treatment. On the other hand, we shrink from the concept of a life not worth living. We want to maintain the salutary principle that the law protects all human life, no matter how miserable a person appears or how worthless she happens to feel.

In short, we want it both ways. The two sets of beliefs are in conflict, or at least in great tension, but somehow we cling to both.26

We say all human life is inviolate, but we do not always mean it. We make "quality of life" judgments, but we deny it. We practice a kind of euthanasia in a soft light, subdued by history, but we would rather not examine this practice in the bright spotlight of utmost analytic clarity.

As I see it, the purpose of the distinction between "direct killing" and "letting die" is not (as some claim) to separate deaths caused by human action from those caused by the processes of nature. Nor (as others claim) is it to separate intrinsically immoral practices from permissible ones. Rather, the purpose of the distinction—or at least its effect—is to have it both ways.

For a long time we have had it both ways. In the 1940s, 1950s, and 1960s— as the many failures to indict, acquit, and suspend sentences attest—when "mercy killing" occurred, the law in action was "as malleable as the law on the books [was] uncompromising."27

In the 1970s the distinction between "extraordinary" (or "heroic") and "ordinary" medical treatment proved serviceable.28 Although the terms are so spongy and were used so loosely that the distinction is now widely rejected, in its time this distinction, too, mediated or obscured the conflict between our two sets of beliefs.

Calling a life-sustaining medical procedure extraordinary was more an expression of the conclusion that the procedure could ethically be discontinued than it was a justification for doing so. But the terminology reassured the public that "only certain kinds of lifesaving measures could be, and would be, terminated; that disconnecting an unconscious patient's respirator in some vague way only constitutes a 'slight deviation' from our official morality."29

The extraordinary/ordinary distinction has not fared well in the law of death and dying. Another distinction, one also rooted in Roman Catholic tradition, has proved to have much greater staying power—the distinction between killing and letting die. Interestingly, an increasing number of those who defend the distinction are so determined to keep a chasm between the two practices that they insist that the withholding or withdrawal of lifesustaining measures is not passive euthanasia or any other kind of euthanasia and that to use the "E" word in this context only causes confusion.30 (I would say rather that it causes, and ought to cause, concern.) But I think one of the leading proponents of euthanasia (both active and passive), the renowned British legal scholar Glanville Williams, had it right when, 20 years ago, he said,

A toehold for euthanasia is provided by the practice of letting die, or what is now called passive euthanasia... If this distinction between an act and an omission is thought to be artificial, its artificiality is imposed on us by our refusal to accord the same moral freedom for action as we do for inaction. Pending a change of thought, the concept of an omission is a useful way of freeing us from some of the consequences of overrigid moral attitudes.31

I have no doubt that Alex Capron, Daniel Callahan, Leon Kass, and other opponents of active euthanasia draw the line at letting die as a matter of principle. They support the "right to die," but strongly resist direct killing.

Many others, however, have never been happy with this distinction. They were willing to draw the line between letting die and active euthanasia not as a matter of principle but only as a matter of tactics. I count among them the two leading euthanasia proponents of our time—Glanville Williams and the late Joseph Fletcher, the prominent medical ethicist.

For them, the distinction was a serviceable one because it afforded the physician and the patient's family much more room to maneuver than would be possible if one had to proceed by lethal injection—and it gave the rest of us, or most of the rest of us, less cause for alarm. But these people were always committed to the realization of active euthanasia. For them, acceptance of the "right to die" was only a partial victory—a stopgap measure.32

They are no longer content to have it both ways. They are not, and never were, satisfied with euthanasia in a soft light, subdued by history; they also want it in a bright spotlight.

At a euthanasia conference held nearly two decades ago, Fletcher maintained...
that there is no real difference between letting die and active euthanasia: "A deliberate act of omission, when death is the goal or purpose or end sought, is morally the same as a deliberate act of commission." He argued that doctors ought to engage in both forms of euthanasia.

Fletcher's views disturbed some who attended the conference. Another speaker warned that since some do not clearly distinguish between active and passive euthanasia and "since active euthanasia is morally repugnant to so many..." this confusion has led many physicians to avoid the use of the very desirable, accepted passive form. According to this speaker, the distinction between the two forms of euthanasia had to be maintained "so that physicians will continue and in fact increase their use of this age-old passive form" and "to insure that passive euthanasia not be tainted in any way by the active euthanasia movement."

Fletcher gave this response: "Though the alleged difference between [passive and active euthanasia] is not a real one ethnically or philosophically or theologially regarded, it is arguably possible to separate them for pragmatic reasons of prudence and workability."

Since that conference was held, doctors have greatly increased their use of the "age-old passive form" of euthanasia. Negative or passive euthanasia—"even removal of the feeding tube—is now a fait accompli in modern medicine. That battle is over. And there is now more support for active euthanasia than there ever has been—and I fear that that support will grow even stronger.

Fletcher is no longer with us, but his allies and his followers are, and they are making their presence felt. They no longer feel the need to separate active euthanasia from the passive variety for pragmatic reasons. Passive euthanasia is now so well established that people of Fletcher's persuasion are no longer concerned that it will be "tainted" by the active euthanasia movement.

Proponents of active euthanasia are in a strong position, and they know it. As they see it, the time has come to upset the compromise between letting die and direct killing. The time has come to move on to the next stage of euthanasia.

Compromise Position

"It is one thing to justify an act; it is another to justify a general practice." Thus, those who can imagine individual circumstances where active euthanasia would be hard to condemn (and I certainly can) may still oppose legislation authorizing the practice. We may do so, as Rutgers Law School's Norman Cantor has argued, on the ground that "such a radical alteration" in the legal framework surrounding gravely ill patients "ought not to be instituted unless it is absolutely essential"—and no such showing has been made.

The reasons laypeople most often give for supporting active euthanasia are that it is inhumane to make patients suffer from intractable pain or that it is inhumane to keep them biologically alive when they seem to have "no life to live." But many physicians fail to use means that are now available to relieve virtually all pain. And though advances in medical technology have made it possible, as one commentator has put

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The new law establishes a commission to study the issue of assisted suicide. The commission is to report to the legislature within 15 months after the statute becomes effective, and the ban is to remain in effect until six months after the commission makes its recommendations. During this time the legislature will decide whether to continue the ban or to deal with the problem in some other way.

Assisted suicide is not quite active euthanasia. The final act, the act that brings on death, is performed by the patient herself, not another person (a physician or relative or friend).

And there is always the possibility that the patient may change her mind and not carry out the final act. On the other hand, assisted suicide is certainly something more than passive euthanasia. At the least, it strikes me, it is a bridge between active and passive euthanasia.


See Altman, supra note 8.


Kadish, supra note 1, at 861.


See Melinda Beck, The Doctor’s Suicide Van, NEWSWEEK, June 18, 1990, at 47; Andrew Malcolm, Giving Death a Hand, N.Y. TIMES, June 9, 1990, at 6; Should Death Be a Patient’s Choice?, PARADE, Feb. 9, 1992, at 26 (of those surveyed who had a position on the issue, a plurality (49 to 35 percent) favored doctors assisting conscious, rational, dying patients with their suicides).


Id.

Id.

Kadish, supra note 5, at 26.

Id.

Capron, supra note 17, at 33.

Calahan is the director and co-founder of the Hastings Center, noted for its work in the field of medical ethics. Calahan is the director of the Center for Biomedical Ethics at the University of Minnesota. Jonsen is professor and chair of the Department of Medical History and Ethics at the University of Washington School of Medicine; he was a leading opponent of Washington state’s Initiative 119. Pickering is chairman of the ABA Commission on Legal Problems of the Elderly; he led the opposition to a proposal—defeated overwhelmingly—that
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A. Historically the favorite asset for funding structured settlements has been an annuity (sometimes called a "settlement annuity") issued by a life insurer. This type of annuity is unlike other annuities in some respects; for example, a plaintiff cannot own one.

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Settlement annuities still have the dominant market share. Tort lawyers are more familiar with this product, and the payment options available allow great flexibility in planning. For example, annuities can be life-contingent (a large share of the market belongs to annuities which will pay as long as the plaintiff lives); usually there is also a guarantee ranging from 10 to 40 years.

The Executive Life debacle encouraged a "flight to quality" which drove some less stalwart annuity companies from the market. The remaining players (with an exception or two), retained high ratings, even though the major rating services toughened standards.

Both types of assets are used in a single deal. In certain climates the yield on a bond structure will about match the yield on a settlement annuity, but more often the settlement annuity will have a better yield. A structure funded by either asset will offer tax-free financial performance which, as to the conservative part of his or her portfolio, only the unusually fortunate plaintiff could match by investing an all-cash settlement.

Next Month: Structured Settlement Tax Tips

From an article by WILLIAM L. WINSLOW, attorney, Santa Monica, CA.

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