Killing and Letting Die: What is the Difference?

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Three Views of the Difference between Killing and Letting Die

Most people say 'boo' to killing and 'hooray', or at least no 'boo', to letting die. But what's the difference, apart from how we feel when we hear the words? I will begin by outlining three views of the difference, which I take to be representative ones, the first which says it makes all the difference in world, the other two which say it makes no difference at all.

The common sense view

According to the common sense 'all the difference in the world' view, deliberately killing people is obviously evil, whatever the circumstances, ulterior motives or consequences. In a medical environment it conjures up images of healthcare workers secretly and possibly involuntarily killing their patients, of handicapped infants and elderly people in institutions being quietly snuffed out, of wicked experimental or eugenics programmes. But even more benevolent killing has, at least until recently, been forbidden according to the common view. 'Letting people die', on the other hand, suggests the much more acceptable practice of 'letting nature take its course', facing up to the limitations of medicine and the fact of impending death, and avoiding heroic measures such as aggressive surgery, drug therapies or intrusive devices. In the end it is not our responsibility to keep everyone alive, nor could we if we tried. And it is a good thing to be allowed to die in peace.

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This kind of view is common place in conventional morality, in law, and in medical practice. Whether this is coherent and an accurate interpretation of the classical tradition will be considered later. What is of interest here is that the weight of the distinction is placed on the difference between acts-causing-death, which are said to be immoral and illegal and omissions-causing-death, which are said at least in some situations to be moral and legal.

The consequentialist view

The consequentialist 'no difference at all' view says that all that matters are consequences. If a person dies because we kill them or just because we sit by and let them die, the result is the same. Any attempt to distinguish the two morally is transparent hypocrisy, designed to appease our queasy consciences and evade out responsibilities. Furthermore, this distinction might well have terrible effects, as when a person who would obviously be better off dead is forced to endure a long period of suffering or undignified existence or expense to self and others, just because no-one is willing to assist her in ending it all.

This view, promoted by some philosophers, is gaining currency among the medical profession and healthcare bureaucrats, in the popular press, and even among the judiciary in some countries.

The vitalist view

The vitalist 'no difference at all' view is that we have an absolute duty to save as many lives as possible for as long as possible. Letting a person die when some intervention might save her is just as wicked, or almost as wicked, as killing her yourself. Any attempt to distinguish the two is (again) a transparent sophistry, designed to cover up a murderous or suicidal activity.

This is the view popularly attributed to the pro-life movement and to its sympathisers such as the mainstream churches, often by those who would like a convenient caricature to criticize, but sometimes by members of those groups themselves.

My View

I think all these views are wrong. I want to propose instead a qualified form of the (first) common sense view. Properly understood, there is an important difference between killing and letting die; and while intentionally killing the innocent is unethical, letting someone die, can be permissible, even required. This requires careful explanation.

Two kinds of euthanasia

In medical situations there are lots of opportunities to save life; there are likewise many ways and means to kill people. When killing is done in the course of medical care for the patient's supposed good (i.e. to alleviate suffering, indignity etc.) we call it *euthanasia;* where a healthcare worker does something to hasten a patient's death in these circumstances it is called *active euthanasia;* when a healthcare worker aims to hasten a patient's death by omitting to do something she should otherwise have done for a patient she did not wish dead, it is *called passive euthanasia.*

Celebrated cases of active euthanasia include the many engineered by the infamous Dr Kevorkian ('Doctor Death') who, at least until now, has evaded prosecution. In Britain Dr Nigel Cox was in recent years convicted of attempted murder after giving a lethal dose of potassium chloride to a 70-year-old cancer patient. The Netherlands has effectively legalized the practice and several thousand people die in Holand each year as a result. Last year the US state of Oregon became the first in the world to legalize active euthanasia, following a referendum although that law has now been challenged and may well be struck down as unconstitutional. There is considerable lobbying for the legalization of this practice, in many countries at the moment, and it has been renamed "physician aid-in-dying" for that purpose.

Passive euthanasia-by means of dehydration, starvation, failure to perform necessary operations or to give necessary drugs-is far more common that killing in the more active way. Thus I am advised that in many places infants with certain handicaps are less likely to survive hospitalisation today than they were a decade ago, despite the advances in medicine. There have also been a string of cases in which

older patients, often persistently unconscious ones, have been denied all food and water with a view to speeding up their deaths. This second *kind of medical killing —by neglect or abandonment— is the most* likely way for more widespread euthanasia to be introduced. In many places there is considerable lobbying for the legalization of this practice, called euphemistically 'benign neglect by physician'.

Moral equivalence

I believe active and passive euthanasia are morally equivalent. Usually, of course, the distinction between action and omission, intervening and 'letting nature take its course', is morally important, even decisive, and much of law and social practice follows this. There are only so many things we reasonably can choose and do, and we are not guilty of failing to choose or do all the other possibilities. We are not morally responsible for the deaths of every person we might conceivably have helped, if we are devoting our time and energies to other morally reasonable purposes, fulfilling our responsibilities.

But it is also the case that we can intend to kill someone but organise or exploit the situation so that this requires no positive act on our own part: only our failure to do something. Obvious examples of this would be where a parent sees her baby drowning in the bath and fails to intervene; or where children fail to feed a starving elderly parent; or where ancient Greeks or modern healthcare workers abandon handicapped infants. Of course in these situations the agents can say "I didn't do anything": but that is precisely the problem: they should have, and someone died as a result. These situations are morally equivalent to acts of killing. Whatever the legal situation, from the moral point of view it makes no difference whether one uses active or passive means to kill: once one has decided to hasten someone's death, active or passive is simply a question of strategy.

This may seem a strange assertion, since I said only a few minutes ago that I thought the difference between killing and letting die is important, vitally important. Where, then, would I draw the line between immoral killing (euthanasia) and morally permissible letting die, and how would I justify the difference? I would suggest that we might consider four basic principles.

The Sanctity of Human Life

The first basic principle has traditionally been called 'the sanctity of human life'. The principle was said to be deeply embedded in our law and ethics throughout the world, included in international human rights documents and some national constitutions, and strongly felt by people of all religions and none. It is basic to our common morality. Human beings are held to be entitled to great and equal respect; their lives are of such intrinsic importance that no choice intentionally to bring about all (innocent) person's death can be right. Thus the principle has traditionally been worded "You shall not kill" or "everyone has (all equal and inalienable) right to life".

Applied medically the sanctity of life principle excludes medical killing: amongst the ways in which healthcare workers may not deal with their patients, killing them is one. Thus traditional medical ethics has held that physicians might not be called upon to act as public executioners. Likewise it has excluded both active and passive euthanasia.

Most people regard killing someone simply for advantage or convenience of others as inconsistent with recognition of that person's dignity, and immoral. The more difficult cases are when the person keeps asking to be killed, or is in excruciating pain, or is very dependent, or is a great strain on the financial and personal resources of others, or is living in a state of persistent unconsciousness. Then we will certainly sympathise with the person who feels permitted, even driven, to killing. The question is: should we condone the killing?

I think we must face up to the fact that we cannot do so and at the same time give full force to the sanctity of life principle. Thus proponents of active and passive euthanasia must deny the principle in some way. Some for instance argue that there is nothing about human beings which is especially or equally valuable or deserving of respect. Some would hold that only human beings with certain qualifications-such as consciousness or a certain level of intelligence or social interaction are entitled to such respect. Again, some would argue that some human beings are simply 'better off dead': their value is overridden by their suffering or degradation.

There are also those who would respect every person's right to life in principle, but hold that in some situations it might legitimately be

compromised to serve other important values. When we talk, for instance, of "putting granny out of her misery", what we often mean is "putting granny out of our misery." In these situations we may dress up the interests of the family, the medical staff, and the paying community in the language of the patient's 'best interests' of 'the interests of all concerned'. The individual's life, then, is compromised to serve other interests or values.

The underlying premise of all these approaches -that our mere existence as human beings has no value as such, or that it can be discounted by some countervailing disvalue- is clearly inconsistent with the traditional doctrine of the dignity and inalienability of every human being, whatever his or her condition. It ultimately assesses some people as being of negative value. This in turn highlights the fact that essential to the killing / letting die distinction is a high view of human dignity and equality, and of our moral responsibilities in acting and forbearing to act with respect to it.

Care for the Sick

A second basic principle in this area is the duty to care for others. Negatively this means we may not harm people or treat them negligently or with disrespect. Positively it refers to 'Good Samaritan' duties to show kindness to others, especially the most needy, and to our special responsibilities towards dependent persons in our particular care. These duties are again supported by beliefs and documents ranging from the Bible and Koran to the International Covenant on Economic, Social and Cultural Rights. Thus certain basic measures such as food, water, shelter, clothing, sanitary and nursing care must be maintained out of respect for the human dignity of every person; anything less is unjust discrimination.

In addition to these common humanitarian duties we have towards each other, there are the special duties of care peculiar to healthcare workers. Because of the special vulnerability of patients, it is important that healthcare workers have a clear sense of what is owing to their patients by way of action and restraint. The western medical tradition has developed an ethic of *medicine-as-therapy* ('medical beneficence and non-maleficence'), i.e. that a healthcare worker will do no harm to, nor take any undue risks with, her patients, but will, rather, seek to promote the patient's good health. The principle of

medicine as therapy excludes the use of medicine for other purposes such as social engineering, exploitative experimentation, profit maximisation etc. And it has traditionally excluded euthanasia: killing cures no one, is not nursing care, not therapy.

Respect for Patient Autonomy

That the dignity of human beings requires respect for their free will, autonomy of right of self determination is a third basic bioethical and medico-legal principle. 'Autonomy' is an acknowledgment that all human beings are free and equal, and have an inalienable right and duty to make responsible, rather than forced, arbitrary or whimsical decisions. Thus in law and ethics healthcare workers only have as much authority as they are given by their patients. They must respect the directions of their patients, or give those patients who cannot consent therapy which is in their best interests. So both under-treatment and over-treatment are assaults. Patients, for their part, must exercise this freedom responsibly, in pursuit of their own good health and respect for the good of persons in community.

As understood in the classical tradition, autonomy is not licence or whimsy, but carries with it responsibilities. We are not free to do 'whatever we choose'. We have to respect the autonomy of others. We have to consider the implications of our choices for their lives. And we have to take into account the intrinsic morality of our choices and their self-constitutive effects, what they do to us, what they make us and say about us. However, when used in the pro-euthanasia polemics or in public debate, autonomy is often a catchall category for the range of supposed fights guaranteeing to the individuals that they can pursue their own life and death plans whatever they are. Detached from its richer ethical context in this way, the principle of autonomy seems to many people to allow, or even require, euthanasia, at least with consent, and by a dubious but common extension, involuntary euthanasia as well.

The Sanctity of Human Death

A fourth principle is what I call the sanctity of human death. The classical moral tradition recognizes that one needs not strive relentlessly to preserve the last vestiges of physical life. It is not a survival at any costs ethic, however often it has been portrayed as such. Indeed

a survival at any costs approach can well be due to therapeutic obstinacy, a refusal to face up to the limitations of healthcare and human mortality, a product more of despair that respect for life. Death is an evil, but not the greatest evil. For many people it is a merciful release, the natural end to a life-story well-written, and as believers claim, the door to eternal life.

At some point in most people's life death becomes, as it were, 'inevitable' and, if there is an opportunity to do so, it is important to compose oneself to die well, a need which can be frustrated by too strenuous an effort to prolong life. While one should always value the gift of life, one may not be obliged to prolong it with highly intrusive treatments. Care and respect for the dying often requires that kind of specialised help known as palliative and hospice care, and if this is to be applied it will be necessary for people to accept that death is near and that there is little more that human effort can properly do to postpone it.

Thus traditional medical ethics counsels against over-treatment and allows that some treatments will be withheld or withdrawn for good therapeutic reasons. There are three such situations. One is where the patient is actually dead. There is some continuing controversy over the diagnosis of death, but if whole brain death signals the irreversible disintegration of the organism it would seem to be a prudentially acceptable marker. Once a person is dead therapy is obviously no longer appropriate. A second situation is where the patient is still alive but where their continued treatment is futile. Again, here there is no therapeutic benefit to be gained by treating. The third situation is where the treatment, though therapeutically beneficial in some ways, can only be achieved by imposing such a burden (in terms of pain, indignity, disruption, confinement, risk, cost etc.) that those concerned judge the burden greater than the benefit. In this situation treatment would traditionally be termed 'extraordinary' and optional. Increasingly today the burdens of the treatments will include burdens to on-lookers and to the community. Even affluent societies cannot sustain patients indefinitely on complex and expensive medical regimes, and may choose to give preference to uses of public medicine which have a reasonable prospect of restoring or at least maintaining health (or some approximation to it) and of reducing pain and suffering.

Again, *prima facie*, this principle might be thought to allow euthanasia, at least by omission, in some cases.

Reconciling These Four Principles: When Letting Die Is Not the Same as Killing

How is one to reconcile these four principles? The simple answer is: *it is all a matter of intention.* When healthcare workers give a pain-relieving drug, or withhold or withdraw some treatment, and death results earlier than it might otherwise have done, hurrying up death may or may not be why they chose such a course of action. Encouraging death is often no part of the healthcare worker's reason for such chosen conduct. Death may or may not be foreseen, but it is not intended; it belongs neither to the healthcare worker's precise purpose, nor is it the means used to achieve that purpose.

On the other hand, a healthcare worker may give a pain-relieving drug or fail to treat because the healthcare worker believes the patient would be 'better off dead', or others would be better off were the patient dead, etc. In this case hurrying up the patient's death is certainly part or the whole of the reason for the healthcare worker's chosen conduct. It is all a question of intention.

From what I have said so far it should be clear that in healthcare contexts, as elsewhere in live, the negative norm "do not kill" is *not* the same as the positive norm "Preserve life in all circumstances and at all costs".

Obviously whether or not a medical treatment will prove disproportionately burdensome will depend upon the circumstances and condition of the patient and others: one cannot simply list ordinary and extraordinary treatments as such. But the judgment that a treatment is too burdensome is *not* the same as a judgment that a life is too burdensome. It does *not* involve any arbitrary quality-of-life judgment that a person lacks overall value and so for that reason may justifiably be ended. If a healthcare worker discontinues a treatment in order to avoid imposing disproportionate burdens on a patient, even if in consequence death is likely to result earlier than it otherwise would have done, killing is neither her purpose in making that decision nor her chosen means to avoid the burdens.

This, then, is where the difference between killing and letting die lies: *not* in the difference between acting and omitting to act; *not* in whether a person's life is burdensome to them or others; *nor* in whether the agent is well-meaning. The distinction lies crucially in the differ-

ence between intentionally bringing about a person's death —which is always a harm to the victim, the killer and the common good— and taking a course of action possibly foreseeing but not intending a person's death-which may harm no-one directly. *Whereas intentionally killing, whether by commission or omission, is immoral, it is permissible to withhold or withdraw treatment where such treatment is futile or overly burdensome, and in this sense (and this sense only) 'let the person die'.*

The importance of intentions lies in getting to the heart of who we are and what we are about, our real purposes. The difference between intending-and-causing and foreseeing-and-causing is not always simple, and people's intentions are often as confused as their motives are mixed. But for the most part what is intentional is not in doubt, and various questions and what-if tests can be used to clarify intentions.

Some Concluding Reflections

Victims

We should have great concern for all patients and seek by whatever means are morally and practically available to ease their suffering and respect their dignity. We should have tremendous sympathy for the family and healthcare workers surrounding such patients: when people take a long time to die, those who must accompany them often suffer the most. Perhaps we could do a lot more to support them. In hard cases like these sympathy and compassion also tempt us to compromise our basic norms and to fudge our laws. The temptation, one we all know in our moral lives, is to think that we can allow just one, or a few, exceptions; we can still hold the fine 'as a general rule'. But rational reflection —and human experience— suggest that the implications of such exceptions go far wider than the relief of hard cases.

Apart from the intrinsic evil of killing people, medical killing changes us individually and as a society. Even discounting the person killed, euthanasia is not victimless because the person who does it is also significantly harmed in the process and so almost inevitably is the community. The healthcare worker's character will be very significantly shaped by killing a patient, however noble the motivation. It

will change her attitudes, habits, dispositions, taboos. A healthcare worker disposed to think that some patients lack inherent worth or may be killed has, however well-meaningly, seriously undermined a disposition indispensable to the practice of medicine: a willingness to give what is due to patients just in virtue of their possession of basic human dignity. And the absence of that willingness is likely to be fateful for other patients. Ethically, psychologically and sociologically, euthanasia invites further extension of 'therapeutic killing', whether by the same healthcare worker or others. It also discourages alternative approaches to suffering, such as research into cures and the provision of good palliative care and pain management. Far from offering relief to those who are terminally ill, in great pain, or otherwise at a low ebb, the acceptance of euthanasia takes away a crucial barrier protecting their rights and is likely to cause a degradation both of the way they are viewed by others and the treatment they receive.

Other problems with euthanasia

There are other problems with the euthanasia answer which I have no time to explore here. So I might just flag a few. There are problems of interpreting the plea of patient or bystanders for euthanasia. There is the problem of the pressures, subtle and overt, conscious and unconscious, which would be experienced by patients, families and healthcare workers to seek or cooperate in euthanasia once it is permitted: pressure all the harder to resist when one is very vulnerable, one's freedom very limited, one's self-esteem very low. Licence for euthanasia would quickly become a duty to take part in it. There is the problem of the effects on the healthcare worker-patient relationship, and family relationships, poisoning the atmosphere with suspicion and guilt. Medical ethics and wider societal respect for human life would be further eroded. And there is the spectre of the economic argument, in a rapidly-aging society in which healthcare costs are escalating, to keep extending the occasions for medical killing.

But finally, we might question just how caring, compassionate and merciful euthanasia really is. Euthanasia is so often presented as the 'merciful' or 'compassionate' way to treat those in severe pain or incurable incompetence. But compassion is not the same as giving people whatever they want, or say they want, or we think they want. Nor is mercy the strategy of curing misery by killing the miserable. No one thinks the merciful answer to the starving millions is to poison

them. Compassion is wanting the best for the other, and having empathy with them in their suffering. Mercy entails staying by their side, offering good therapeutic and palliative care, and through friendship helping them to recover hope, meaning, and a sense of being loved.

Why do we care for persistently unconscious people, or those with profound intellectual handicap, Alzheimer's Disease, and so on. For some of them we may hope that they might regain consciousness and some greater measure of health and independence. But many will not. By supporting them we affirm that bodily life is not merely an instrumental good hi some way distinct from the human person, but basic to humanity so that death is always a harm. We conform with our basic duty of respect for every human life however wounded or handicapped. And we express our respect for that patient and each person's humanity, express our love for them, maintain our human solidarity or communion with them. This is a kind of respecting and loving which no one should pretend is easy.

But for all the polemics about 'dignified death' used by the euthanasia movement and now by the courts, we can forget that dignity is not recognised by telling the old, infirm or comatose how undignified their condition is, or how they would be better off dead -as when judges call some people 'grotesquely alive', 'an object of pity', 'the living dead' or 'cabbages' as they recently have. It is not recognised by abandonment. It is certainly not recognized by standing by and watching someone die of thirst and hunger. The 'mercy' killer adds the final rejection to the many already heaped upon the sick, invalid and dying by our community. Dignity in old age, handicap, unconsciousness, and suffering are above all a matter of knowing you are respected and loved. Surely we can find more creative ways of demonstrating love and respect than by killing.

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