

Is There a Morally Significant Difference Between Active and Passive Euthanasia?

The moral distinction between active and passive euthanasia has long played a central role in debates within medical ethics and moral philosophy. Active euthanasia refers to the deliberate act of ending a patient's life, typically through the administration of a lethal substance, while passive euthanasia involves allowing a patient to die by withholding or withdrawing life-sustaining treatment. Many legal systems and medical traditions have historically treated passive euthanasia as morally permissible in certain circumstances while condemning active euthanasia as morally wrong¹. The question, however, is whether this distinction reflects a genuine moral difference or whether it is merely a conceptual distinction without ethical significance. This essay will argue that although there are intuitive reasons for maintaining a moral distinction between killing and letting die, the arguments presented by philosophers such as James Rachels demonstrate that the difference between active and passive euthanasia is often morally insignificant, particularly when intention and outcome are the same.² Nevertheless, the distinction retains some practical importance in medical ethics because of concerns about responsibility, trust in the medical profession, and the potential for abuse.

Another important contribution to the debate about euthanasia focuses on the principle of respect for human life and the broader ethical responsibilities of medical professionals. Many critics of euthanasia argue that the moral prohibition against killing is one of the most fundamental principles within both moral philosophy and legal systems. According to this perspective, intentionally ending a human life—even in circumstances of extreme suffering—risks undermining an important moral boundary that protects individuals within society. Scholars such as John Keown have argued that maintaining a clear distinction between killing and letting die helps to preserve this boundary. Keown contends that once intentional killing is accepted within medical practice, it may become increasingly difficult to limit the circumstances in which it is permitted. For this reason, the traditional distinction between active and passive euthanasia is sometimes defended as a necessary safeguard against the gradual erosion of respect for human life. From this viewpoint, allowing doctors to withdraw futile or excessively burdensome treatment may be morally acceptable because the intention is not to kill the patient but to cease medical intervention that no longer benefits them. In contrast, actively administering a lethal substance involves a deliberate decision to end life and therefore crosses an important moral line. Supporters of this position argue that preserving this distinction reinforces the ethical integrity of medicine and helps ensure that physicians remain committed to the goal of healing and caring for patients. Although critics question whether this distinction can always be maintained in practice, defenders maintain that it continues to play a valuable role in guiding ethical decision-making in difficult end-of-life situations.

¹ John Keown, *Euthanasia, Ethics and Public Policy* (Cambridge: Cambridge University Press, 2002), pp. 8–12.

² James Rachels, 'Active and Passive Euthanasia', *The New England Journal of Medicine*, 292 (1975), 78–80.

To begin, it is necessary to clarify the concepts of active and passive euthanasia. Active euthanasia occurs when a medical professional deliberately performs an action intended to cause the death of a patient, typically to relieve suffering. For example, a doctor might administer a lethal injection to a terminally ill patient who is experiencing extreme pain. Passive euthanasia, by contrast, involves allowing death to occur by withdrawing or withholding medical treatment. Examples include removing a patient from a ventilator, withholding life-saving medication, or deciding not to perform a risky surgery that could prolong life. In passive euthanasia the underlying disease is often described as the cause of death, whereas in active euthanasia the physician's intervention directly causes death.³

The traditional view in medical ethics maintains that there is a morally significant difference between these two practices. This view is often grounded in the distinction between killing and letting die. According to this perspective, actively causing a person's death constitutes killing and is morally wrong, while allowing someone to die—particularly when treatment would only prolong suffering—can be morally permissible. The distinction is also reflected in the history of medical practice. The Hippocratic tradition emphasised the duty of physicians to preserve life and avoid intentionally causing death.⁴ As a result, many medical professionals have regarded the withdrawal of burdensome treatment as morally acceptable while continuing to view active euthanasia as incompatible with the role of a healer.

One reason offered for maintaining this distinction concerns moral responsibility. When a doctor administers a lethal injection, they appear to be the direct cause of the patient's death. In passive euthanasia, however, the patient dies from the underlying illness rather than from the doctor's intervention. The physician merely allows the natural course of the disease to take place. Some philosophers therefore argue that actively causing harm carries greater moral responsibility than passively allowing harm to occur. This idea is sometimes described as the moral difference between “doing” and “allowing” harm.⁵

Another justification for the traditional view relates to concerns about professional integrity and public trust. Doctors are generally expected to protect and preserve life. If physicians were permitted to actively end patients' lives, critics worry that this could undermine the trust that patients place in medical professionals. Patients might fear that doctors could prematurely end their lives rather than prioritising their care and well-being. Maintaining a clear prohibition against active euthanasia is therefore sometimes seen as a safeguard that protects vulnerable individuals and preserves confidence in the medical profession.⁶

Despite the intuitive appeal of these arguments, they have been challenged by several philosophers. One of the most influential criticisms comes from James Rachels, who argued that the distinction between active and passive euthanasia is morally indefensible.⁷ Rachels

³ Peter Singer, *Practical Ethics*, 3rd edn (Cambridge: Cambridge University Press, 2011), pp. 159–165.

⁴ Hippocrates, *Hippocratic Oath*, trans. by Ludwig Edelstein (Baltimore: Johns Hopkins Press, 1943).

⁵ Philippa Foot, 'The Problem of Abortion and the Doctrine of Double Effect', *Oxford Review*, 5 (1967), 5–15.

⁶ John Keown, *Euthanasia, Ethics and Public Policy*, pp. 14–18.

⁷ James Rachels, 'Active and Passive Euthanasia', p. 78.

contends that what ultimately matters morally are the intentions behind an action and the consequences that follow from it, rather than the mere distinction between acting and allowing. If a doctor withdraws treatment with the intention that the patient will die in order to relieve suffering, the doctor's moral responsibility may be similar to that involved in actively ending the patient's life.

Rachels famously illustrates his argument with a thought experiment involving two characters, Smith and Jones. Both stand to gain a large inheritance if their young cousin dies. Smith deliberately drowns the child in the bathtub. Jones plans to drown the child but arrives at the bathroom just as the child slips, hits their head, and begins to drown accidentally. Jones simply stands by and allows the child to die, ready to intervene only if necessary to ensure the child does not survive. Rachels argues that Smith and Jones are morally equivalent. Although Smith actively kills the child and Jones merely allows the child to die, both individuals share the same intention and are equally morally blameworthy.⁸ The distinction between killing and letting die therefore fails to capture what is morally important in this case.

Rachels applies this reasoning to the debate about euthanasia. If a doctor withdraws life-sustaining treatment from a patient with the intention of ending their suffering through death, the doctor is still intentionally bringing about the patient's death. The fact that death occurs through the underlying illness rather than through a direct injection does not fundamentally change the moral situation. According to Rachels, focusing on the difference between action and omission obscures the more important moral factors of intention and outcome.

Furthermore, Rachels argues that passive euthanasia may in some cases be morally worse than active euthanasia because it can prolong suffering unnecessarily. Consider a patient who is dying from an incurable and extremely painful illness. If life-support is withdrawn, the patient may suffer for several days before death occurs. In contrast, active euthanasia could end the patient's life quickly and painlessly. If the goal is to minimise suffering, it may seem more compassionate to permit active euthanasia rather than insisting on a slower and potentially more distressing death.⁹ From this perspective, prohibiting active euthanasia while allowing passive euthanasia appears inconsistent and potentially cruel.

The force of Rachels' argument has persuaded many philosophers that the traditional distinction between killing and letting die cannot bear the moral weight that has historically been placed upon it. If the intention in both cases is to bring about death in order to relieve suffering, and if the outcome is the same, then the moral difference between the two practices may indeed be negligible.

Nevertheless, critics of Rachels maintain that the distinction still has moral significance. One response emphasises the importance of moral rules that restrict certain kinds of actions. Even if the outcomes are similar, actively killing a patient may violate a stronger moral prohibition than

⁸ Rachels, 'Active and Passive Euthanasia', p. 79.

⁹ Dan W. Brock, 'Voluntary Active Euthanasia', *Hastings Center Report*, 22.2 (1992), 10–22.

allowing death to occur naturally. Moral rules against killing are deeply embedded in legal systems and social norms, and weakening these rules could have dangerous consequences.¹⁰

Another objection concerns the potential for abuse if active euthanasia were widely permitted. Critics worry that legalising active euthanasia could create subtle or overt pressures on vulnerable individuals—such as the elderly, disabled, or chronically ill—to end their lives in order to avoid being perceived as a burden on family members, caregivers, or society more broadly. These pressures may not always be explicit; they can take the form of societal expectations, financial concerns, or feelings of guilt and inadequacy that influence decision-making. For example, an elderly patient might consent to euthanasia because they feel responsible for the emotional or economic strain their care imposes on their family, rather than because they genuinely wish to die. Such circumstances raise serious ethical concerns about whether a person's consent can ever be considered fully autonomous when social or psychological pressures are present.

Passive euthanasia, by contrast, may involve fewer risks of this kind because it typically occurs within the context of decisions about medical treatment rather than deliberate life-ending actions. Withholding or withdrawing treatment is often framed as allowing the natural course of illness to proceed rather than actively causing death, which can help preserve the moral and psychological boundaries between physician and patient. Critics argue that this distinction may reduce the likelihood of coercion or manipulation because the decision is perceived as a choice about treatment options rather than a direct request for death. Nonetheless, some philosophers, such as, challenge the idea that this distinction sufficiently protects patients, suggesting that in practice, the moral and emotional pressures experienced by vulnerable individuals may be similar in both active and passive cases. Even so, concerns about abuse remain a central argument in favour of maintaining stricter controls on active euthanasia within legal and medical frameworks.

Additionally, some philosophers argue that the distinction between action and omission reflects an important aspect of moral psychology. People often perceive actively causing harm as more troubling than passively allowing harm to occur. This intuition may play a role in maintaining moral boundaries that protect human life. Even if philosophical arguments suggest that the distinction is difficult to defend in theory, it may still serve a valuable practical function by discouraging harmful behaviour.

A further consideration concerns the role of intention in medical decision-making. In cases of passive euthanasia, the physician's intention may sometimes be interpreted as allowing the patient to die naturally rather than directly intending death itself. For example, a doctor might withdraw treatment because it is medically futile or because it imposes excessive burdens on the patient. In such cases the intention is not necessarily to cause death but to respect the patient's wishes or to avoid prolonging suffering through ineffective treatment. Critics argue that this difference in intention may preserve a moral distinction between passive and active euthanasia.

¹⁰ Keown, *Euthanasia, Ethics and Public Policy*, pp. 20–25.

However, this response is not entirely convincing in all cases. When treatment is withdrawn with the clear expectation that death will follow shortly, it becomes difficult to claim that death is merely a foreseen side effect rather than part of the intended outcome. The line between intending death and foreseeing death can be difficult to draw in practice, which weakens attempts to rely on intention as a decisive moral distinction.

Ultimately, the debate over active and passive euthanasia highlights broader questions about the nature of moral responsibility and the role of medical professionals in end-of-life care. While the traditional distinction between killing and letting die has strong intuitive appeal, the arguments advanced by philosophers such as Rachels reveal that this distinction may not capture the most morally relevant aspects of euthanasia. In many cases the intention behind the act and the suffering experienced by the patient appear to be more important than whether death is brought about through action or omission.

Another influential way of analysing the distinction between active and passive euthanasia involves the doctrine of double effect, a principle discussed by philosophers such as Philippa Foot. The doctrine of double effect suggests that an action that has both a good and a bad consequence may be morally permissible if the harmful effect is not intended but merely foreseen. Within medical ethics, this principle is often applied to cases where doctors administer high doses of pain-relieving medication, such as morphine, to terminally ill patients. Although such medication may relieve suffering, it may also hasten death by depressing the patient's respiratory system. Supporters of the doctrine argue that the doctor's intention in this situation is not to cause death but to relieve pain, and therefore the action can be morally justified even if death is a foreseeable outcome. From this perspective, passive euthanasia and certain end-of-life medical practices can be distinguished from active euthanasia because the physician does not directly intend the patient's death.

However, critics argue that the doctrine of double effect does not fully resolve the ethical issues surrounding euthanasia. In many situations, it may be difficult to distinguish clearly between intending death and merely foreseeing it as a side effect. For example, when a doctor withdraws life-sustaining treatment from a patient who cannot survive without it, the physician is often aware that death will occur very shortly afterward. Although the official justification may be that the treatment is medically futile or excessively burdensome, the outcome is effectively the same as intentionally causing death. Critics therefore claim that the doctrine of double effect may sometimes function as a moral justification for actions that closely resemble active euthanasia in practice. If the intention is genuinely to relieve suffering and respect the wishes of the patient, the moral difference between actively causing death and allowing death to occur may once again appear less significant than the traditional distinction suggests.

In addition to philosophical debates about intention and moral responsibility, it is also important to consider the practical implications of euthanasia policies within modern healthcare systems. Decisions about end-of-life care often take place in complex medical contexts involving multiple healthcare professionals, family members, and legal considerations. Doctors must balance their duties to relieve suffering, respect patient autonomy, and preserve life. These competing responsibilities can create difficult ethical dilemmas, particularly when patients experience

severe and irreversible suffering. Some ethicists therefore argue that the rigid distinction between active and passive euthanasia may oversimplify the reality of medical decision-making. In practice, many end-of-life decisions involve a combination of actions and omissions that gradually allow death to occur. Recognising this complexity may encourage a more nuanced ethical framework that focuses on compassion, patient welfare, and careful professional judgement rather than relying exclusively on a strict conceptual distinction between killing and letting die.

In conclusion, the claim that there is a morally significant difference between active and passive euthanasia remains controversial. The traditional view emphasises the moral importance of the distinction between killing and letting die, as well as concerns about professional responsibility and the protection of vulnerable individuals. However, the critique developed by James Rachels demonstrates that when intention and outcome are the same, the moral difference between active and passive euthanasia becomes difficult to justify. Although practical considerations may still support maintaining a distinction in law and medical policy, the philosophical arguments suggest that the difference between the two forms of euthanasia is often less morally significant than it initially appears.

Bibliography

Brock, Dan W., 'Voluntary Active Euthanasia', *Hastings Center Report*, 22.2 (1992), 10–22.

Foot, Philippa, 'The Problem of Abortion and the Doctrine of Double Effect', *Oxford Review*, 5 (1967), 5–15.

Keown, John, *Euthanasia, Ethics and Public Policy* (Cambridge: Cambridge University Press, 2002).

Rachels, James, 'Active and Passive Euthanasia', *The New England Journal of Medicine*, 292 (1975), 78–80.

Singer, Peter, *Practical Ethics*, 3rd edn (Cambridge: Cambridge University Press, 2011).