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**Why active euthanasia and physician assisted suicide should be legalised**

If death is in a patient's best interest then death constitutes a moral good

[Len Doyal](http://www.ncbi.nlm.nih.gov/pubmed/?term=Doyal%20L%5Bauth%5D), professor of medical ethics

St Bartholomew′s and Royal London School of Medicine and Dentistry, Queen Mary, University of London, London E1 2AD

[Lesley Doyal](http://www.ncbi.nlm.nih.gov/pubmed/?term=Doyal%20L%5Bauth%5D), professor of health and social care

University of Bristol, School for Policy Studies, Bristol BS8 1T2

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Last month Diane Pretty was refused the legal right to choose the circumstances of her own death.1 She suffers from motor neurone disease and is experiencing the disintegration of her body. She faces a death that she believes will entail indignity and suffering and physically cannot kill herself. The court has denied her request that her husband be allowed to help her. This decision may be consistent with legal precedent but is morally wrong. That is why the law should be changed.

Suppose that Mrs Pretty became permanently and severely incompetent as a result of brain damage and that her life was being sustained by medical technology. If her doctors believed that medical treatment could provide no benefit because of her inability ever to engage in any self directed activity, then legally they could withdraw life sustaining treatments, including hydration and nutrition.2 In such circumstances they would foresee that she would die as a result of their failure to perform what would ordinarily be their duty to protect life and health. In most other circumstances clinicians are not allowed this discretion to accelerate foreseeable deaths through inaction.

Against the background of the duty to care, the moral and legal status of not saving a life through failing to treat can be the same as actively taking that life.3,4 For example, a doctor who knowingly allows a patient who could be saved to bleed to death in emergency care might be accused of murder. What is deemed to be morally and legally important here is not the emotionally appealing distinction between omission and commission but the justifiability or otherwise of the clinical outcome. Indeed, the distinction between omission and commission may be of little value in some healthcare settings. When doctors turn off ventilators, foreseeing that death will result, it makes little sense to say that they do so passively.

So it is sometimes acceptable for doctors to stop life sustaining treatments when there are grounds for assuming that this is in the best interests of severely incompetent patients. Equally, action and inaction may be deemed morally and legally equivalent in the context of a deliberate failure to carry out the duty of care to save life when clinicians agree that it should be saved. Thus parliament and the courts should take the next step of recognising that this same equivalence should hold when there is clinical agreement that it is in the best interests of some severely incompetent patients to end their life.5

The most articulate opponents of involuntary passive and active euthanasia accept that there is no moral difference between commission and omission in the medical withdrawal of life sustaining treatment. Nor do they reject the non-provision of life sustaining treatment in principle. However, they do argue that to be acceptable, such non-provision must fulfil two conditions that rule out involuntary euthanasia in practice.6,7

Firstly, for severely incompetent patients the continuation of treatment must be deemed to be of no medical “benefit” or too “burdensome.” However, for opponents of euthanasia such judgments of benefit and burden must not be linked to any claim that the patient's life is no longer worth living. Once it is accepted that doctors should be allowed to make clinical decisions to end life passively on the basis of such claims, active euthanasia in the best interests of such patients would be the next logical step. Secondly, opponents argue that withdrawing treatment for severely incompetent patients must never be done with the intent of causing death—even if death is a foreseeable consequence. It can only be done to relieve suffering. To do otherwise, they claim, would be tantamount to active euthanasia, and this they see as morally wrong. These arguments are unacceptable for two reasons.8,9

On the one hand, we need to ask what makes life sustaining treatment of no benefit or too burdensome if it can achieve its designated aim of saving life. Severely incompetent patients can only be said to be unable to benefit from further life sustaining treatment or to find it too burdensome if—bottom line—they are judged incapable of benefiting from further life itself. Therefore, when the continuation of life sustaining treatment is described as being of no benefit or of too much burden, the clinician must already have decided that the life of the incompetent patient in question is not worth living and therefore not worth prolonging. This is why withdrawal of treatment is deemed to be in the best interest of the patient and consistent with the duty of care to protect this interest.

On the other hand, if death is in the best interests of some patients—if the withdrawal of life sustaining treatment can be said to be of benefit in this case—then death constitutes a moral good for these patients. And if this is so, why is it wrong to intend to bring about this moral good? For example, suppose a doctor refuses to withdraw life support from an incompetent patient when the clinical team agrees it to be appropriate. He does so for no other reason than his realisation that part of his intention is that she dies a quick and painless death. Far from being morally commendable, his refusal should be viewed as incompatible with what is of real moral importance—the best interests of his patient.

Provided the circumstances are clinically warranted, doctors should be able to withdraw life sustaining treatment when they intend to accelerate death as well as to relieve suffering. Morally, the distinction is irrelevant in this particular context. If passively ending the life of severely incompetent patients is legally and professionally acceptable then involuntary active euthanasia should have the same status.

Returning to Mrs Pretty, why should we not also legalise voluntary active euthanasia in light of these arguments? Were she permanently and severely incompetent, we have seen the circumstances in which her doctors would be allowed to end her life passively and should be allowed to do so actively. Therefore, should she not be able to invite them actively to end her life and to advise them about how this should be done? No one has questioned her competence or courage. Yet her own perception of her best interests, and the perception of those who know and love her, have been judicially overruled.

This decision becomes all the more morally questionable when we realise that Mrs Pretty can refuse life sustaining treatment at any time, and her doctors are legally obliged to respect her choice.10 Some doctors would probably be only too glad to help Mrs Pretty to end her life. This support should be regarded as a moral good instigated in her interests and at her request. It should be legally condoned—either by the interpretation of existing law by a more courageous judiciary or by new legislation.

Finally, if it can be morally right to kill some competent patients at their request, then it must be morally justified to give them the medical wherewithal to kill themselves. It is open to debate whether what Mrs Pretty requires can best be described as voluntary euthanasia or assisted suicide. To provide either of these to appropriate patients who make a competent request represents respect for their autonomy and their desire to die with what they perceive to be dignity.

Of course, any coherent advocate of active euthanasia and physician assisted suicide must take seriously the problem of slippery slopes—of deciding when a request for helping dying is appropriate. Though this may be difficult, it cannot be impossible. The most important question remains: in the face of so much moral right, where is the wrong?

**Thesis:** In some cases, euthanasia and physician assisted suicide should be legally acceptable.

1. Diane Pretty believes she is facing a death that will entail indignity and suffering and can’t physically kill herself.
2. If death is in the best interests of some patients, then death constitutes a moral good for these patients.
3. If death constitutes a moral good for these patients, then it is sometimes acceptable for physicians to passively withdraw life-sustaining treatments.
4. If Pretty was severely and permanently incompetent, then her doctors would be legally allowed to end her life passively.
5. If Pretty can refuse life-sustaining treatment at any time, then her doctors are legally obliged to respect her choice.
6. If doctors respect her choice in her interests and at her request, then it would be regarded as a moral good.
7. If respecting patient’s choices regarding their death is morally good, then sometimes active euthanasia should be a legal action too.
8. Diane Pretty believes she is facing a death that will entail indignity and suffering and can’t physically kill herself.
9. If respecting a patients choice in regards to their death is morally good, then it is sometimes acceptable for physicians to passively withdraw life-sustaining treatments.
10. If it is sometimes acceptable for physicians to passively withdraw life-sustaining treatments, then active euthanasia should be legalized too.
11. Therefore, active euthanasia should be acceptable in some cases.

Active euthanasia is a medical life-ending procedure in which a lethal dose of medicine is administered in order to alleviate suffering and avoid prolonging a patient’s death. The focus presents the specific case of a woman, Diane Pretty, who suffers from motor neuron disease and is experiencing the tragic symptoms of the end stage of the illness. She believes, and fought for legal permission to carryout her death-plan to be actively euthanized by her physician, but was denied her preferences due to the deemed legally immoral procedure. On the contrary this article explains, and I support, that active euthanasia is morally acceptable in some cases and therefore should be legalized.

It is known that Diane Pretty feels as if she is facing a drawn-out death that will entail indignity and suffering and she can’t physically kill herself. To begin, it must be agreed that a physician’s duty is to protect and promote the well being of his or her patients, even if that well-being may constitute a quicker death and reduced suffering. A competent patient would be concrete in their choices regarding their well being throughout their life. In order for a physician to comply with his job to protect a patient’s well being, a physician must uphold the highest respect to their patients’ choices throughout their life, which inevitably includes their death as well. All in all, a physician who respected a patient’s choice in regards to his or her death would be acting morally good. If this should be the case, then no physician would deny their patient’s advanced wishes to be passively withdrawn from life-sustaining treatments in the instance that they should be permanently unconscious. The law supports this claim, giving legal ethicality to the idea that allows such measures to be taken by physicians under certain circumstances. In the United States today it is legally permissible to remove a patient from life support if the physician and family members feel as if it is in the patients best interest. Clearly if respecting a patient’s choice in regards to their death is morally good, then it is sometimes morally acceptable for physicians to make the decision to withdraw life-sustaining treatments for the well being of an incompetent patient.