
Palliative Care and Killing: Understanding Ethical Distinctions

by Patrick F. Norris

Recently, spokespersons for aid-in-dying have morally equated assisted suicide and euthanasia with such practices as foregoing life support, providing morphine, and terminal sedation for dying patients because all of these actions may physically hasten death. This blurring of ethical distinctions between physical causality and moral culpability, which results from a rejection of the fundamental principle of double effect, threatens the practice of sound palliative care for the terminally ill.

In a recent debate about physician-assisted suicide, Dr. Timothy Quill stated that during the course of the evening, he hoped to raise some doubts in the minds of the audience, regardless of people's current opinions about the controversial topic.¹ Quill, debating with Dr. Linda Emanuel, proceeded not only to raise doubts, but to create unfortunate confusion that threatened to jeopardize the cause he purported to champion, that of appropriate palliation and care for the dying.

Hastening Death and Causality

Specifically, Quill mentioned six ways in which death frequently is hastened for the terminally ill:

- the withdrawing or withholding of life-sustaining treatment
- the use of opiates for pain, which may decrease respiratory drive
- terminal sedation
- voluntary cessation of eating and drinking
- assisted suicide
- active euthanasia

He indicated that all of those actions may physically cause or contribute to the death of the patient. However, he then implied that because they all physically hasten death, they also share a similar moral causality and responsibility.

In the debate about assisted suicide and euthanasia, Quill is not the first person to conflate the realities of physical and moral causality, or, in the words of Daniel Callahan, causality and culpability (Callahan 1992). Consider two typical examples.

First, Dan Brock argues that allowing a patient to die and euthanizing the patient differ only on a physical level in that one is an act of *commission* and the other an act of *omission* (Brock 1992). According to Brock, both involve foreknowledge and causation of the death of the patient. Secondly, although the reasoning has been rejected by the recent U.S. Supreme Court ruling, the Ninth and Second Circuit Courts of Appeal, in overturning assisted-suicide bans, also assumed a moral intentionality to kill in the withdrawal of treatment because the physician plays an active role in hastening the death of the patient. In particular, the Second Circuit Court in New York argued that if patients already had the right to hasten death by discontinuing treatment, the equal protection clause of the Fourteenth Amendment would guarantee the right to hasten death through the prescription of lethal drugs.

The Threat to Palliative Care

This line of reasoning offered by the courts and the proponents of assisted suicide and euthanasia must be challenged beyond its conceptual inadequacy. If the removal of life support, the provision of opioids, and terminal sedation are

understood to be types of killing, families and health care professionals who are opposed to direct killing will become reluctant to remove life support or use appropriate analgesics out of fear of morally causing the death of the patient. Physicians, already reluctant to remove life support and to use narcotics because of legal concerns, will become even more reticent to choose such treatment plans. Consequently, an argument originally constructed to lessen patient suffering may unwittingly and ironically result in additional technological assaults and poorer pain management for patients.

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Evaluating the Essence of the Argument

What flaws exist in this line of reasoning? One evaluates a moral action based on what one does and why one does it in a given set of circumstances. Thus, a moral action involves two intentions. The first more proximate intention defines what one is, in fact, doing on a moral level. The second more remote intention indicates why one has done the action. The proximate intention provides the initial moral meaning for the physical action. For instance, a surgeon and a violent assailant may physically cut a person. However, because different proximate intentions attend their respective actions, different moral evaluations are made. The physician performs a curative action of surgery, the assailant an act of assault. The second more remote intention provides the motive or the overall end for doing the action, which also plays a part in moral evaluation. Hence, the surgeon might have done the right thing for the wrong reason, having cut the patient to cure disease, but in order to pay for illegal drugs. An action is not evaluated based on the physical action or causality in and of itself but on

the physical action as it is informed by proximate intentionality and its ultimate motive. Rather than the physical action itself, intentionality (both proximate and remote) gives rise to moral causality or culpability. How would this understanding of moral action be applied to Quill's six ways of hastening death?

Applying the Moral Norms

Withdrawing and/or Withholding Treatment

When treatment is either withdrawn or withheld, the intention informing those physical actions (or inaction in the case of withholding treatment) is to forego a treatment that is either gravely burdensome or ineffective. The fact that these actions may also hasten death do not ordinarily enter into the patient's or family's intention but is an unintended and accidental byproduct of performing a good action. That is, if the patient were to start breathing spontaneously after the removal of the respirator, people, in theory, would not be disappointed. Although the immediate physical cause of death may be the removal of life support, the moral cause of death would be the underlying fatal pathology one no longer had a duty to circumvent.

However, there may be times when the removal or refusal of life support does constitute an intentional hastening of death. Treatment may be refused in order to cause death rather than to avoid a gravely burdensome or ineffective treatment. In such cases, the more remote second intention or motive of the patient or family may be good or bad (to relieve pain or to garner an inheritance). The proximate intention though, which predominantly gives moral meaning to the physical action, is that of killing.

In one sense, Quill, Brock, and the courts recognize the fact that not all foregoings of life support are ethical. Brock cites the case of a greedy son who extubates his rich mother from a respirator (withdrawing life support) in order to cause her death (Brock 1992). That proximate intention creates the species of moral action. Thus, Brock rightly concludes that both acts of omission and commission can constitute acts of killing.

However, Brock erred by moving inappropriately from these specific cases of intentional killing to a general conclusion. That is, although some removals of treatment hasten death in an unethical manner because of the intention of the agent, this does not prove that all cases do so. This faulty logic leads to an overly physicalist moral methodology, which evaluates an action based on its physical causality independent of the intention that shapes the physical action and gives it moral meaning.

Providing Opioids

Sometimes, although not usually, opioids used to control pain may also lead to hastening death through a suppression of respiratory drive in the terminally ill patient (Foley 1991). Usually the proximate intention that informs the physical action is the relief of pain. In this case, the remote intention is generally the same as the proximate, to provide proper pain management. Again, the potential hastening of death is an unintended, albeit foreseen, physical side effect. Certainly, if there were an equally effective and economical analgesic that did not cause respiratory depression, one would utilize it.

However, as was the case with foregoing life support, an intention to kill may inform the physical action. In their survey of health care professionals, William Wilson, et al., report a certain ambiguity and ambivalence of intentionality. They indicate that nearly forty percent of the studied ICU physicians and nurses administer narcotics primarily to decrease pain, anxiety, and air hunger but also secondarily to cause respiratory depression in order to hasten death (Wilson, et al. 1992).

Terminal Sedation

Terminal sedation occurs when, in the end stages of life, pain becomes so severe in comparison with the benefits of being conscious, that physicians must sedate the patient to the point of unconsciousness in order to provide relief from pain. Often this occurs only in the last day or two of life and so does not hasten death. However, there may be cases in which death is not so imminent.

Because patients in terminal sedation cannot eat or drink, artificial nutrition and hydration must be provided if life is to be preserved. If a decision is made to forego such medical treatment, then death may be physically hastened. Is this a de facto type of killing because one sedates the patient knowing one will not provide artificial nutrition and hydration? Conceptually, it does not have to be because two ethically and temporally distinct decisions are made. The first involves the decision to relieve pain. Avoidance of an ineffective treatment constitutes the second. As in previous cases though, there may be instances when the intention is to hasten death precisely because one will forego nutrition and hydration.

Voluntary Cessation of Eating and Drinking

In this case, one must distinguish a suicidal ideation from the tendency among the dying and frail elderly to lose interest in eating and drinking. In the former case, the intention that gives moral definition to the action of refusing food is that of trying to commit suicide as opposed to disinterest in the latter case. For example, consider the case in which a quadriplegic wishes to die but has no underlying disease for which he or she is receiving life-sustaining interventions. Therefore, the person stops eating and drinking specifically in order to die.

Assisted Suicide and Euthanasia

In suicide and euthanasia, although the remote intention may be to relieve suffering, the means utilized to achieve that end involve intentional killing. Death is not a side effect of a physical action designed to achieve another goal. In both of these cases, the intended death itself provides the relief from suffering. Thus, the physical action of hastening death coincides with the proximate intention of direct killing.

All six cases envisioned by Quill that hasten death could constitute acts of suicide or euthanasia depending upon the intention of the agent. However, the intentionality to kill is *necessarily* present only in the cases of assisted suicide and euthanasia. In the other cases, such an intention usually does not exist. By properly distin-

guishing between intended effects and foreseen but unintended effects, one can avoid the moral ambiguity and confusion generated by Quill's remarks.

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A Proper Understanding of Double Effect

Fortunately, most health care professionals recognize the distinction between physical causality and moral culpability (Buchan and Tolle 1995). For example, when giving chemotherapy to a cancer patient, one necessarily and physically causes a vast array of deleterious effects. Yet such effects are termed "side effects" precisely because they are foreseen but not intended in the provision of chemotherapy. The intention of arresting the cancer defines the moral action associated with the physical action of providing chemotherapy. By using the term "side effects," health care professionals explicitly indicate that they do not view their actions as intending to cause evil or harm (the side effects), which are justified by a greater good (treatment of the cancer). They do not adopt a methodology of doing evil to achieve a good. Rather they merely intend the good while predicting the unintended side effects.

This common sense understanding has been articulated formally in the classical ethical principle of double effect. At times, people realize that they cannot achieve a desired good effect without physically causing some harmful effects. Ideally, one must try to achieve the intended good without causing the harmful effects. But sometimes, that is either impossible or excessively inconvenient. The principle of double effect states that a moral action that causes harmful effects through its physical performance may be acceptable if four conditions are satisfied. First, the

action must be morally good or neutral in and of itself. Secondly, one may not intend the bad effects. Thirdly, one may not use the evil or bad effects as the means to the good effects. Fourthly, there must be a proportionality between the good effects and the bad effects.

Classical medical ethics has frequently relied on this principle in such cases as the provision of chemotherapy and the performance of a hysterectomy on a pregnant woman with uterine cancer. However, recent supporters of aid-in-dying such as Quill have jettisoned this time-honored principle when it comes to comparing the ethical character of a host of actions that physically hasten death. Why is this so?

The Critique of Double Effect

In the past thirty years, philosophers and moral theologians have critiqued the principle of double effect (Garcia 1995) using two main lines of criticism. One line focuses on the first condition — that the action must be morally good or neutral. Critics claim that one cannot judge any action abstractly but only in the context of motive and circumstances. Thus, although an action such as euthanasia would contain what is termed ontic, physical, or pre-moral evil, its ethical acceptability is determined by the proportionate relationship between the good and evil effects.

Until recently, the debate over euthanasia has focused primarily on this line of argument. That is, proponents simply state that aid-in-dying represents a legitimate form of intentional killing. They posit that such killing need not be inherently evil and may, in fact, be ethically good. Opponents of assisted suicide and euthanasia, including many medical societies, have argued that aid in dying is *inherently* incompatible with the healing role of the physician and would result in dangerous consequences for society as a whole. This debate continues unabated. However, the conflation regarding the hastening of death by Timothy Quill and others does not rest on this critique of double effect.

Rather, their argument relies on a second line of critique of the principle, which has to do with

the relationship between physical causality of the bad effects and moral responsibility. Critics argue that the principle of double effect relies on a semantic distinction rather than a real one. They insist that the deleterious "side effects" are so central to the performance of the moral action that they cannot be considered accidental circumstances but are part of the very means of achieving the good effects and are, therefore, intended, if in fact we intend the means when we intend the end.

Certainly, there are cases in which the application of double effect is disputed when the action and its bad effect are so inextricably and simultaneously connected that they are seemingly related conceptually rather than contingently. For example, could one perform a death-dealing craniotomy on a fetus during delivery to save the mother's life when the pelvic cavity is too small? Ordinarily, cases of double effect admit of a more clear-cut analysis.

In particular, the palliative care practices of removing life support, using morphine, and terminal sedation exhibit a contingent relationship rather than a conceptual one between the intended good effects and the predictable side effects precisely because the bad effects are not the means to the good effects. This is most easily seen with regard to the foregoing of treatment because it does not even always hasten death. Moreover, one does not introduce a new cause of death but merely allows the primary cause of death to be actualized because there no longer is a duty to circumvent it. Furthermore, there is a clear temporal sequence between the good effect and the bad effect, with the good preceding the bad. In the case of the use of opioids, one potentially contributes to the death. However, as mentioned previously, the use of narcotics need not hasten death. The bad effect clearly follows sequentially after the good effect and is not the means to relieving pain. Finally, in the case of terminal sedation, one physically introduces a fatal pathology (unconscious state) whose effects, if left untreated, would result in death. Nevertheless, the good and bad effects are not conceptually related in that one

could, in theory, provide nutrition and hydration artificially. The good effect temporally and causatively precedes the bad effect. These cases differ essentially from the cases of voluntary *intentional* starvation, assisted suicide, and euthanasia in which the bad effect is the intended means utilized to achieve the good effect. One cannot envision the good effect without the bad effect first preceding it.

Perhaps some of the confusion regarding physical causality and moral culpability emerges from the fourth element of double effect, namely that there be a proportionality between the intended good and unintended bad effects. Thus, one would not perform a hysterectomy on a pregnant woman who had noncancerous tumors in her uterus because the death of the fetus would not be proportionate to the good of removing benign tumors. As a result, the principle implies that one does take certain moral responsibility for unintended consequences. However, this legitimate moral responsibility for physical causality does not alter the essential moral meaning of an act as Quill and others would argue. Aid in dying still remains a type of intended killing, whereas the removal of treatment and the use of opioids and sedatives for terminally ill people in general is not. Consequently, although the application of the principle of double effect can be murky in regards to the distinction between physical and moral causality, this is *not* the case in regards to palliative care practices.

Conclusion

The issue of assisted suicide and euthanasia is a contentious one. The debate as to whether aid in dying is a good means to relieve suffering will continue and is beyond the scope of this article. Proponents of assisted suicide and euthanasia may believe that equating aid in dying with socially acceptable practices like removing life support may facilitate its acceptance by society. However, the ethical conflation of appropriate palliative care practices with aid in dying is both logically untenable and potentially counterproductive to sound palliative care for the dying.

In the past twenty years, health care professionals have advanced in their ethical understanding so that actions such as the appropriate removal of life support and the use of narcotics and sedatives at the end of life are rarely questioned. If accepted, the arguments of Quill and others threaten to destroy that progress.

Endnotes

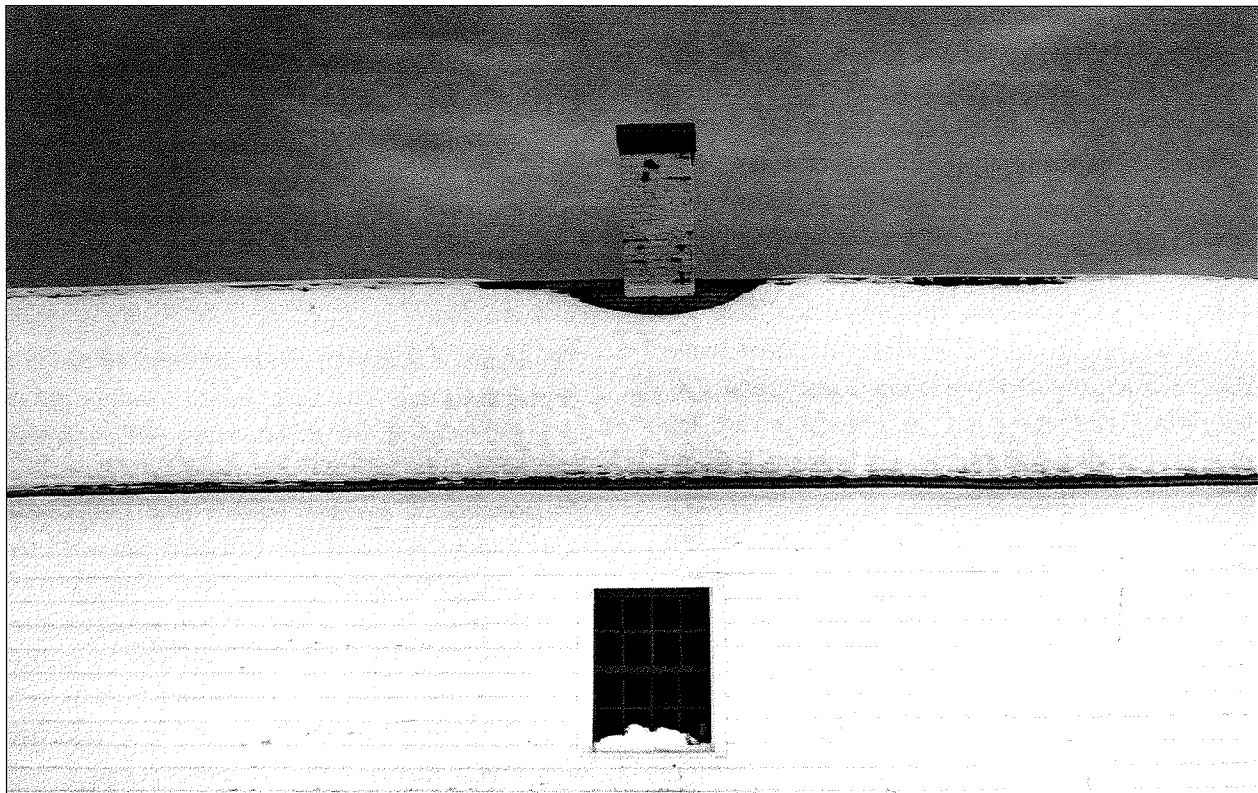
1. The debate was held at Barnes Hospital in St. Louis, Missouri, February 25, 1997.

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