

# BIOETHICS NOTES

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**"It isn't the mountains ahead to climb that wear you out; it's the pebble in your shoe."**

-Muhammad Ali

## **Killing or Letting Die?**

by Robert Shabanowitz

Treatment decisions that involve the possible death of a patient can be controversial, and at times ambiguous. These decisions become problematic because we live in a free society in which value judgments are often avoided or held neutral. Every individual has the autonomy to establish his/her own interpretation of the good and individuals are free to pursue their own aims, so long as no harm is done to others nor infringement upon their fundamental freedoms; we are tolerant to opposing views so long as they do not interfere with our own goals. In considering medically futile treatments such as withholding or withdrawing treatments, physician assisted suicide, or euthanasia, differences in values can effect conflict. Our individual values are paramount to personal decision making, and any opposition to these value judgments are interpreted as intrusions upon our autonomy. In terms of rights claims, the balance suddenly shifts from a predominance of negative liberties, where we expect not to be interfered with, to an emphasis on positive liberties, where we expect or demand duties from others.

Most of these conflicts arise from differences between the patient or patient's family and the health care team. However, as with euthanasia, there are also strongly held value differences among all the decision-makers. At the center of each of these conflicts is patient autonomy. How far can patient autonomy dictate medical treatments and is there a limit to the demands placed on others in the fulfillment of these treatments? How do we resolve the rancor of these intractable conflicting value systems?

Less conflict exists when considering a patient's right to refuse medical treatments. There is strong support for this right as well as substantial protection by a long history of legal doctrine. Patient autonomy is protected, and rightly so, since we deserve the right not to have others interfere with our bodies. Conflict arises, however, when patients or family desire continued treatments when there is minimal or insignificant medical benefit. This is a conflict of values. In fact, whereas one patient may request withdrawal without compunction, another may demand continued treatment with calls to "do everything". Many times, however, such demands may eventually be assuaged by open and candid conversations. Hopefully, compassionate concern for the patient's well being, coupled with discussions of realistic outcomes will effect resolution. In this manner, we disengage from the problems associated with attempts to define such vague and ambiguous terms as futile, and do not allow competing value systems to clash. If the conflict can not be resolved, it is incumbent upon health-care providers to continue treatment because their rights to refuse treatment are subordinate to a patient's desire to continue treatment. In such cases, transfer of the patient or the involvement of an ethics committee may help resolve the conflict.

Whereas most people respect a person's right to refuse treatments, thereby letting someone die, there is no consensus on how to approach an individual's right to die when that patient is not on life-sustaining equipment. Legal doctrine prohibits voluntary active euthanasia and in most states, physician assisted suicide (which is now legal in Oregon, Washington and Montana). The conflict here is not always simply one of competing values but

also involves legal doctrine that can subject individuals to serious punitive consequences; a patient's autonomy does not compel a physician to commit an unlawful act. At most, a physician may legally provide terminal sedation, with the incidental consequence of death acceptable if it is based on informed consent and adheres to the doctrine of double effect.

Advising a dying patient who is in severe agony, with no hope for recovery would be a difficult task, especially if the patient had no desire to continue living. Assuming the patient is competent, or has previously specifically expressed his/her desires in an advanced directive or directly with the family and/or health care team, the physician must first abide by any legal restraints of his action. More problematic than the legal issue are the murky moral issues that surround euthanasia, and the conflicting values ascribed to different "approaches" to euthanasia.

The legal issues involved with refusal for treatments have been well established in our legal system, and support a patient's desire to refuse. However, there may be greater support for removal of ventilation, DNAR orders or refusal of dialysis versus removal of artificial nutrition and hydration. The hesitation for removal of artificial nutrition and hydration obviously reflects the moral view of many health care providers who feel obligated to provide health care and not take any perceived active role in hastening the death of their patients. This view is also supported by many professional organizations and can be interpreted as a strong belief in a doctor's role as healer, and a repudiation of "killing as healing." Advocates of this position believe any form of euthanasia is a slippery slope and anathema to the practice of medicine. These individuals can not reconcile their participation in such activities as being consistent with their professional or personal oath to nonmaleficence. In fact, their concerns may be justified in looking at the evolution of the Danish system, where it appears some of the supposed slippery slope concerns may have, in fact, become realized.

It is obvious that this issue is value laden and imbued with social, historical and legal concepts. Some interpretations cling

dogmatically to the fundamental beliefs that killing or suicide is inherently wrong. Many, however, argue that the manner in which we perceive killing or suicide must be evaluated in a less dogmatic approach. Killing in self defense and killing in times of war to protect basic freedoms are accepted forms of killing as well as death by "altruistic suicide". Therefore, why is it considered unethical to prevent insurmountable pain and suffering? Is it not compassionate and ethical to assist individuals in their approach to death when their lives are in agony? In fact, many believe there should be no moral distinction between an act and an omission or killing and letting die so long as the patient has acted autonomously and consented. Others would argue that no one needs to suffer from insurmountable pain if provided appropriate palliative care, which precludes the necessity for assisted suicide or euthanasia. However, those arguing against any form of euthanasia argue that suicide is an act incompatible with the notion of autonomy and death irreversibly alienates autonomy. They also argue that the difference between killing and letting die is valid because the intent of the physician is distinctly different, and demands a positive liberty not supported by any constitutional doctrine.

In conclusion, there are three major conflicts when dealing with issues of euthanasia, each with its own conflicting issues of value. First, our interpretation with the act itself, how we view killing. Second, our interpretation of the role of the physician and the practice of medicine. Lastly, our interpretation of autonomy and its demands on others. Each of these individual conflicts comes with its own set of values and each is open to varied interpretation. What makes the topic of euthanasia particularly difficult is attempting to resolve all three problems as if they were one.

Respectfully submitted,  
*Robert B. Shabanowitz*